Delegate, undertake or negotiate:
Understanding nursing scope of practice
in the acute environment

by
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Statement of Originality

This work has not been submitted for a degree or diploma at any other university. To the best of my knowledge and belief, this thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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Jessica Erin Schluter
“The core of man’s spirit comes from new experiences.”

~ Christopher McCandless (1992)
Abstract

The past decade has seen increased patient acuity and shortened lengths of stays in acute care hospitals (Australian Institute of Health and Welfare (AIHW), 2005), resulting in an intensification of the work undertaken by nursing staff in hospitals. Changes in nursing work have also been compounded by the proliferation of health care roles, a blurring of skill boundaries (AIHW, 2001; Buchan & Dal Poz, 2002; Hayman, Cioffi & Wilkes, 2006; Jones and Cheek, 2003) and an aging nursing workforce that is predominantly working part-time (Creegan, Duffield & Forrester, 2003). Moreover, with increasing demand for acute care beds (ABS, 2005), there is simply not enough licensed nursing staff to fill current vacancies (AIHW, 2005; Duffield & O’Brien-Pallas, 2002).

Since 2003, the main response from the Australian government to the declining numbers of nursing workers has been to recruit more people to the nursing profession. However, it is becoming clear that recruitment alone is not enough, with shortages growing even as nursing school enrolments are increasing; therefore, it was timely to undertake a study to understand nurses’ perceptions of scope of practice to improve future efficiency in the nursing workforce by using the information derived to provide baseline data to guide workforce planning.

The specific aim of this study was to understand how medical and surgical nurses, from two Queensland hospitals, conceive their scope of practice in response to the available grade mix and skill mix of nurses—licensed and unlicensed—and other health care professionals in the acute care setting. By exploring these meanings, this study aimed to build an understanding of how nursing work patterns were shifting in the face of changing patient acuity, patient profiles and nursing skill mix. To address this aim, a constructivist methodology was used that allowed for exploration of nursing role and scope of practice. While the notion of constructivism best describes the main approach to this study, it was also naturalistic to the extent that participants were reflecting on day-to-day experiences.

The method used in this study is situated around the Critical Incident Technique (CIT) (Flanagan, 1954). CIT generates data representing experiences or perceptions of aspects of best and worst practice (Byrne, 2001). The researcher asked 20 registered
nurse (RN) and enrolled nurse (EN) participants to discuss up to two particular significant events during which they were undertaking a patient care activity they perceived they should be undertaking, and up to two events during which they believed those activities should have either been delegated or undertaken by a higher level of care provider. Using the CIT in this way, allowed the researcher to gain an understanding of the nursing scope of practice and the interactions between nurses and other clinicians (Byrne, 2001) while also minimising pre-interpretation of the events by participants and focusing on a rich description of the chosen event (Flanagan, 1954). Purposive sampling was used to assist with the discovery of opposing points of view (Guba & Lincoln, 1989) with all RN and EN participants being employed on selected medical and surgical wards within two large hospitals based in South East Queensland.

Inductive analysis, a process for searching for themes within the data, rather than imposing theories on the data (Guba & Lincoln, 1989), was used. Analysis revealed that the nursing work environment was changing. This was causing nursing staff to question what it meant to provide patient care given the increased numbers of health care workers (HCWs) in the acute care setting, rising patient acuity, and increased patient turnover. RNs were struggling with the notions that ‘hands-on’ care was sometimes not the best use of their time, and delegation did not equate with laziness. Five themes arose from the data: (1) **good nurses work in proximity to patients providing total patient care;** (2) **safeguarding patients;** (3) **privileging patients without mental illness or cognitive impairment;** (4) **developing teamwork strategies;** and (5) **picking up the slack to ensure patient safety.**

Findings have shown that negotiation has become a fundamental aspect of nursing practice given the variety of nursing care providers currently employed in acute care settings. Previously, there wasn’t a need for nurses to negotiate care between licensed and unlicensed staff because HCWs were not employed in these settings. Negotiation has allowed nurses to redefine appropriate nurse–patient proximity, promote patient safety and find innovative ways of working in nursing teams. Practice negotiation will become a prominent topic over the coming years as hospital administrators struggle to employ licensed nurses.
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AHWAC</td>
<td>Australian Health Workforce Advisory Committee</td>
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<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
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<tr>
<td>ANMNC</td>
<td>Australian Nursing and Midwifery Council</td>
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<td>ARC</td>
<td>Australian Research Council</td>
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<tr>
<td>ARChI</td>
<td>Australian Resource Centre for Hospital Innovations</td>
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<tr>
<td>ATNA</td>
<td>Australasian Trained Nurses’ Association</td>
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<td>AVCC</td>
<td>Australian Vice Chancellors Committee</td>
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<tr>
<td>AIN</td>
<td>Assistant in Nursing</td>
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<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CN</td>
<td>Clinical Nurse</td>
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<tr>
<td>EEN</td>
<td>Endorsed Enrolled Nurse</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
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<td>GW</td>
<td>Generic Worker</td>
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<tr>
<td>HCA</td>
<td>Health Care Assistant</td>
</tr>
<tr>
<td>HCW</td>
<td>Health care worker</td>
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<tr>
<td>I·R</td>
<td>Interactive-Relational</td>
</tr>
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<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>LPN</td>
<td>Licensed Practical Nurse</td>
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<tr>
<td>MODL</td>
<td>Migration Occupations in Demand List</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NHPPD</td>
<td>Nursing Hours Per Patient Per Day</td>
</tr>
<tr>
<td>NPDU</td>
<td>Nursing Practice Development Unit</td>
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<td>PAIS</td>
<td>Patient Assessment and Information System</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal Care Attendant</td>
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<tr>
<td>QNC</td>
<td>Queensland Nursing Council</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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</tr>
<tr>
<td>QNU</td>
<td>Queensland Nursing Union</td>
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<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>UAP</td>
<td>Unlicensed Assistive Personnel</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery and Health Visiting</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgments

To even consider undertaking a research degree was daunting. Actually starting it was even scarier. If it had been only up to me I would probably never have even contemplated it; however, with the support and guidance I have received over the past few years I have actually managed to do something I would never have thought possible. I will never be able to express enough gratitude to those who have helped me along the way but I will attempt to.

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Publications and presentations derived from this research


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Chaboyer, W., & **Schluter, J.** *Developing evidence based workforce models for nursing services in acute care hospitals.* Gold Coast Health and Medical Conference, December 2007, Gold Coast.
CHAPTER ONE
The Nursing Workforce

Introduction

Nursing, as a profession, has roots in the Nightingale model of education, which has been credited with improving nursing education and practice in many countries. In Australia, formal nursing began with the inception of the first nursing organisation in 1899, the Australasian Trained Nurses’ Association (ATNA), where a minimum standard of education for nurses and a professional register was established (Russell, 1990). Today, nurses comprise the largest component of the health workforce (Australian Bureau of Statistics [ABS], 2005).

Nurses provide a service that operates 24 hours a day, 365 days a year. Such a service makes nursing an essential element of the health workforce. However, increasing demands for acute care (ABS, 2005) cannot be met solely by registered nurses, simply because there are not enough staff to fill current vacancies (Australian Institute of Health and Welfare [AIHW], 2005; Duffield & O’Brien-Pallas, 2002); therefore, there is a critical need to ensure that the skills of nursing staff are being used in the most effective and efficient manner. Additionally, the introduction and improved use of unlicensed workers needs to be investigated while still ensuring quality patient outcomes.

In the face of changing health care systems, technological advances and increased consumer participation in health care, the demands on nurses are changing. At the same time, changes are being seen in the profile and skill mix of nurses in acute care wards. This work aims to understand how medical and surgical nurses conceive their scope of practice in the acute hospital setting. Information about the Australian population and nursing profession are found in this chapter.

Definitions

Throughout the literature, definitions of the various levels of nursing differ greatly depending on the source of the publication. For the purpose of this thesis, the following definitions will be used. Scope of practice will be used to refer to an individual’s scope of practice that is influenced by their education and experience, and is responsive to health care needs (International Council of Nurses [ICN], 2004a).
Registered Nurse (RN) will be used to describe personnel who are registered by a nurses’ registration board and are able provide all levels of nursing care including the administration of medication (Queensland Nursing Council [QNC], 2005a). Clinical Nurse (CN) describes a senior RN. Enrolled Nurse (EN) will be used to describe personnel who are enrolled by a nurses’ registration board and may practice within the scope of their educational training under the supervision of a RN (QNC, 2005a). Endorsed Enrolled Nurse (EEN) will be used to describe those ENs who have completed a competency that allows them to administer certain classifications of medications. In other countries, Licensed Practical Nurses (LPNs) are similar to ENs (Lundgren & Segesten, 2001). In Victoria, the term RN Division Two is used to denote an EN (McKenna, Sadler, Long & Burke, 2001). Licensed nurses will be used to collectively describe RNs and ENs. Health Care Worker (HCW) will be used to describe any unlicensed assistive personnel who work solely under the direction of a RN or EN. HCWs may be delegated certain aspects of nursing care; however, the supervising RN or EN remains responsible for the delegated activities. Examples of other titles associated with HCWs include: Unlicensed Assistive Personnel (UAP) (McLaughlin, Barter, Thomas, Rix, Coulter & Chadderton, 2000); Health Care Assistant (HCA) (Fowler, 2003); Assistant in Nursing (AIN) (QNC, 2005); Personal Care Attendant (PCA) (McKenna et al., 2001); and Generic Worker (GW) (McKenna, 1995).

Background
Within the nursing workforce there are staff shortages both nationally (AIHW, 2003; Cowin & Jacobsson, 2003; Creegan, Duffield & Forrester, 2003; Duffield & O’Brien-Pallas, 2003; Hegney, Plank & Parker, 2003; Morphet, McKenna & Considine, 2008) and internationally (Buerhaus, Donelan, Ulrich, Norman, Williams & Dittus, 2005; Cho, Ketefian, Barkauskas & Smith, 2003; Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002). These shortages, accompanied by an increasing incidence of chronic illness and the ageing of the Australian population (ABS, 2002), are challenging the Australian health care system. Not only do these societal trends have implications for the nursing workforce, but a nursing workforce that is both aging and changing in composition provides specific contexts for the shifts that are currently occurring in nursing work (Productivity Commission, 2005). With RNs making up the largest component of the health care workforce (ABS, 2005), the slightest drop in
numbers considerably affects not only patients, but also other health care professionals.

In order to understand and make positive changes to the nursing workforce, a number of contextual influences on the health care workforce must be acknowledged and examined. The following section will cover some of these influences, including the aging Australian population, workforce composition and workforce planning.

**Ageing population**

As health outcomes of Australians continue to improve and mortality rates decline, life expectancy continues to increase. The World Health Organization (WHO) ranks Australian life expectancy among the highest in the world (WHO, 2003). In 2005, women were expected to live until the age of 83.3 years and men until 78.5 years (ABS, 2008). By 2050, life expectancy is predicted to be 95.0 years for women and 92.2 years for men, an increase of more than 10 years over the next four decades (ABS, 2008). With this longer life comes a greater requirement for medical services for the elderly population. An expanding elderly population will result in an increased need for the services of nurses.

Advances in medicine and improved nutrition and lifestyle have added years to the average life span. Such increases in life expectancy can be attributed to a number of factors. Early in the twentieth century, the decline in deaths was related to the reduced number of infectious diseases and improvements in living conditions – mainly clean water, sewerage containment systems and better housing (Mathers & Douglas, 1997). Improved diet and access to health care and immunisation programs have also been markers for a rise in life expectancy (Mathers & Douglas, 1997). Additionally, advances in medical technology have been important, particularly in the past 50 years; however, increases in life expectancy slowed with a rise in chronic conditions, such as cardiovascular disease and cancer (Mathers & Douglas, 1997). The prevalence of these conditions increases with age, to the extent that at least one long-term condition is reported for almost all (99%) persons aged 75 years and over (ABS, 2006). Increasing incidence of chronic conditions results in increased use of health care systems, in particular the services of the nursing profession.
Nursing workforce numbers and composition

A total of 423,400 people were employed in Australian health occupations for the period 2006–2007 (ABS, 2008). The largest component of the health workforce was RNs, totalling 169,800 (40%). ENs comprised 6% (27,700) of the health workforce. These figures represent a 9.8% increase in employed RNs and ENs between 2001 and 2005 nationally, and a 5.3% increase in Queensland (AIHW, 2008). While there had been an increase in absolute numbers of licensed nurses, it seemed that it was not keeping up with the expanding Australian population. Statistics show that the Australian population growth was greater than the growth of employed nurses, with the nursing worker to population ratio declining (ABS, 2005).

The AIHW conducts a national survey of licensed nurses and midwives each year to investigate employment trends of nurses and midwives in Australia. This national overview provides information on the number and characteristics of nurses, their regional distribution and the overall supply of nurses in Australia. Between 2003 and 2005 there was a national increase in the number of nurse registrations and enrolments, and a subsequent rise in the number of employed nurses by 6.3% (AIHW, 2005). Figures also show that nursing remains a predominantly female occupation in which females comprise 92% of the registered nursing workforce (ABS, 2008; Productivity Commission, 2005). The average age of employed nurses increased from 42.2 years to 45.1 years between 2001 and 2005 (ABS, 2008). Thus, despite the increase in absolute numbers of nurses, this workforce is aging.

Using unpublished ABS Census data, Schofield and Beard (2005) demonstrated that general practitioners, medical specialists and nurses have aged since 1986 with the ‘baby boomers’ (those born between 1946 and 1964) making up more than half of the workforce in 2001. While the increasing numbers of senior health professionals in today’s workforce are of great benefit to the Australian population (Schofield & Beard, 2005), it will mean that workforce needs over the next 20 years will increase dramatically as retirement figures increase. Additionally, nurses approaching retirement may choose to decrease their hours or even change to part-time employment, causing further staffing problems (Creegan, Duffield & Forrester, 2003). Thus, there was a critical need to examine the health care workforce.
Understanding the numbers of nurses without considering the hours of work is not enough to calculate the capacity of the current nursing workforce. Despite survey results showing an increase in the number of hours worked per week, close to half of all RNs (48.2%) were choosing to work part-time (AIHW, 2008). With such a large percentage of nurses choosing to work part-time, greater numbers of nurses are required to provide the same level of care. In 1997, the average weekly hours for RNs was 31.0 (AIHW, 2005) and increased to 33.3 in 2005 (AIHW, 2008); however, it seemed the overall capacity of the nursing workforce still was not keeping up with the growing population.

Queensland statistics differed slightly from the national AIHW survey results. The average age of 46.5 years was higher than the national average of 45.1 years (AIHW, 2008). This could mean that in the next 10–15 years these nurses may retire, leaving a gap in supply in the nursing workforce. This age difference, in conjunction with close to half of all licensed nurses working part-time (49.8% in 2005), has resulted in critical shortages for Queensland nursing employers (Morphet et al., 2008). Interestingly, increases in the average working week (32.9 hours in 2003 to 33.5 hours in 2005) have not resulted in a rise in nursing supply. It would have been expected that an increase in nursing working hours per week would have provided some relief to the nursing supply shortage; however, this did not appear to be the case, and may be related to three factors: (1) the sharp increase in overall population; (2) overseas migration of nurses; and (3) increased patient movement in and out of hospital.

Queensland’s population was growing faster than the numbers of employed nurses. The average Queensland population growth (9.2%) was greater than the growth in employed nurses (5.3%) (AIHW, 2008). The ABS (2008) confirms that the cities of Brisbane and Gold Coast were the fastest growing of all Local Government Areas (LGAs) in Australia in 2005, with a yearly rise of 2.2% and 3.6% respectively. Brisbane’s growth rate was the second highest of all Australian capital cities. If the growth of the nursing workforce does not keep with up the soaring population, the shortage of nursing staff will continue to worsen.

Another trend that has the potential to impact on the nursing workforce is overseas migration. From 1997 to 2002, there was a 13.9% increase in the number of nurses choosing to work overseas and a 37.3% increase in the number of nurses choosing to
be employed outside of the nursing labour force (AIHW, 2005; Duffield & O’Brien-Pallas, 2002). Conversely, nurses seeking to migrate to Australia and obtain a visa on the basis of their work skills are finding it increasingly easy because of the inclusion of six nursing specialty categories in the Migration Occupations in Demand List (MODL) (Commonwealth of Australia, 2002). Statistics are showing more international arrivals than departures on a permanent or long-term basis (ABS, 2005), which is a positive trend for the nursing workforce.

The adequacy of the nursing workforce is affected by the population they serve. Patient movement in and out of hospital has also been rising. The number of patient separations from public hospitals during 2005–2006 (which includes discharges, deaths and transfers) was 4.5 million (ABS, 2008), compared with 3.9 million in 1998–1999 (ABS, 2005). Length of stay for patients is also falling. The average length of stay for public health patients during 2005-2006 was 3.8 days (ABS, 2008), a drop from 4.2 days in 1998–1999 (ABS, 2005). Shorter lengths of stay and increased numbers of patients mean an increased workload for nursing staff that have to manage this higher turnover of patients.

From the numerous reports published annually around Australia, it was becoming increasingly evident that major generational shifts in the working patterns of the nursing profession are likely to occur over the coming years. An aging nursing workforce and general population coupled with increasing patient turnover and reduced numbers of full time nursing staff is seriously challenging the Australian health care system. To ensure acute care hospitals are able to meet the health care needs of the Australian population, innovative strategies are needed. Queensland Health flagged the importance of organisations being able “to make informed and evidence-based decisions about clinical care, service models, service planning, policy and research” (Queensland Government, 2003, ¶ 18) as one of its top priorities. This study will provide a starting point in the development of evidence-based guidelines for the delivery of nursing services in acute care hospitals.

Workforce planning

The Australian Productivity Commission examined issues impacting on the health workforce including the supply of, and demand for, health workforce professionals (Productivity Commission, 2005). The commission proposed a set of national
workforce structures designed to: (1) support local innovations; (2) promote more responsive health education and training arrangements; (3) provide for national registration standards for health professions; and (4) improve funding-related incentives for workforce change (Productivity Commission, 2005). It was hoped that these measures would improve the overall distribution of health care professionals and increase the efficiency and effectiveness of the available health workforce.

Since 2003, the main response by the Australian government to the declining numbers of the nursing workforce has centred on increasing university places within nursing and allied health undergraduate programs (Nelson & Bishop, 2005). As a result, a total of 1,700 new undergraduate nursing places were introduced over four years from 2004. Medical school intakes have also been climbing over recent years. These increases have been some of the largest in Australia’s history. While increasing the number of university places was a positive step for the nursing workforce, without considering the working conditions, these may have little effect in the long term.

Evidence from the Australian Vice Chancellors Committee (AVCC) indicates that while these increases in university places have been made, it is not enough. Figures show that 4,545 eligible nursing student applicants missed out on a university placement in 2004 (AVCC, 2005). Interestingly, approximately 8,000 commenced an undergraduate nursing degree in 2001; however, only 5,702 (65%) completed it in 2004 (Australian Health Workforce Advisory Committee [AHWAC], 2004). This completion rate indicates that, in general, just over two thirds of all nursing students who gain placement into university are completing their degree in three years. While it remains to be seen whether new graduates will be able to fill workforce demands, it is generally agreed there will be a shortfall.

The nursing workforce is facing multiple challenges. An aging workforce—together with advances in life expectancy, increasing patient turnover and acuity—are worsening the shortage of nursing staff in acute care environments. Thus, there is an essential need to ensure the skills of the nursing workforce are being used in the most efficient and effective manner.
Nature of the nursing workforce

The nursing shortage is a worldwide phenomenon that is jeopardising health care and creating stressful working conditions for nurses. Associated with the shortage, the nursing profession has noticed a proliferation of health care roles, which has created role ambiguity and conflict. This study will address three interrelated problems: (1) proliferation of HCWs; (2) blurring of role boundaries; and (3) inefficient use of the nursing workforce. Each of these problems has the potential to negatively affect the quality and continuity of care, which may ultimately result in declining health care provision.

Proliferation of health care roles

In an effort to provide efficient and cost effective care to consumers, health care organisations are making major changes to the mix of staff that provide patient care. As a consequence, there has been a rapid proliferation in the number of health care roles (AIHW, 2001), a trend that is likely to continue in the future. Statistics from the AIHW show dramatic increases in the numbers of allied health occupations and in the mix of nursing and nursing assistant occupations within the health care workforce (AIHW, 2001). Between 1996 and 2001, there was a 20.3% rise (8,488) in the number of health care aides and a 20.4% rise (8,544) in the number of allied and complementary health professionals (AIHW, 2001). The number of people employed in an allied health occupation was relatively small compared to other health professionals in 2001, but recorded relatively large increases between 1996 and 2001. Interestingly, there was a decrease in the numbers of ENs between 1996 and 2001 as a result of their apparent replacement with a large number of lower paid HCWs (AIHW, 2001; Buchan & Dal Poz, 2002).

Increased use of HCWs has been noticed in acute care settings and has been seen as a solution to the shortage of licensed nurses (Hayman et al., 2006). Previously, this category of health care worker has been reserved for residential care facilities where they provide basic patient care under the supervision of RNs or ENs. More HCWs, coupled with extra allied health professionals and the expanding scope of nursing practice, could potentially lead to role conflict and overlap between various health professionals. Lack of role clarification, related to these workers assuming new roles, could further exacerbate the problem. If HCWs are used interchangeably with
licensed nurses, for financial reasons, clinical decision-making may be delegated to unqualified staff resulting in poorer quality of patient care and the nursing profession becoming increasingly task-orientated.

**Blurring of boundaries**

Traditional nursing boundaries have become increasingly blurred. Blurring occurs when the boundaries that previously existed between different professional roles and areas of responsibility overlap and become indistinct, and can often result from the creation of additional health care roles (Workman, 1996). Other reasons for the blurring of boundaries in nursing practice include the continuing growth of nursing knowledge and skills, medical advances that are increasing the complexity of nursing practice, and greater need for the services of health care professionals. With the creation of additional health care roles comes not only a blurring of role boundaries, but also role ambiguity. Role ambiguity always presents problems when new roles are introduced into a workplace, but has become more of a concern since the rise of technology, the overlap of roles between doctors and nurses, and delegation from licensed nurses to HCWs (Workman, 1996). Workman (1996) notes that “continual delegation of tasks to a subordinate will eventually lead to that being a perception of their role which, if no longer delegated will be felt to be a role threat” (p. 615). The process of delegation is suspected to be the origin of role ambiguity (Workman, 1996).

Role ambiguity has also been linked with role stress (Lambert & Lambert, 2001). Lambert and Lambert (2001) discovered that role stress stems from a disparity between an individual’s perception of the characteristics of a particular role and what is actually being achieved by performance of the role. Stress has been linked to higher absenteeism rates, poor work performance and increased staff turnover (Khowaja, Merchant & Hirani, 2005). With the current pressures on the health workforce, any factors negatively influencing staff retention require careful consideration.

In the past, nurses cared for the non-medical needs of patients. Now there is much overlap in the roles performed by nurses and doctors with nursing staff being expected to undertake increasingly more medical activities, resulting in a lack of clarity between the respective roles (Snelgrove & Hughes, 2000). For example, technological advances and pressure on the availability of doctors have resulted in
doctors relinquishing certain roles in order to become more specialised and ‘handing over’ some of the clinical decision-making and service provision to appropriately qualified and trained nurses (Royal College of Nursing, 2003). A systematic review by The Cochrane Collaboration on the substitution of doctors by nurses in primary care showed that appropriately trained nurses produce high quality patient care and achieve as good health outcomes for patients as doctors (Laurant, Reeves, Hermens, Braspenninck, Grol, & Sibbald, 2005). The main reasons for the shift of primary care from doctors to nurses appear to be to reduce the demand for doctors and to reduce the direct costs of services because nurses have lower wages than doctors (Laurant et al., 2005; Colyer, 2004); however, these two studies identified that while role development has benefitted both professions, further assessment of the impact of health care reconfiguration on consumers is needed. Thus, with technological innovations increasing exponentially and with continuing pressure from governments to cut the cost of health care, the push for nurses to take on more medical roles is likely to continue, hastening the need to determine how nurses conceive their scope of practice given the available mix of nurses and other health professionals in the acute care setting.

As nursing roles continue to develop, the scope of nursing practice becomes more variable. Nurse practitioners have advanced the roles of nurses (Hinch, Murphy & Lauer, 2005; Gardner, Carryer, Dunn & Gardner, 2004), while HCWs have allowed RNs and ENs to focus on patient care and be freed from some of the non-nursing activities previously required of licensed staff. Professional nursing bodies do not regulate HCWs and a lack of clear role definition is one of the problems surrounding their introduction (Tye & Ross, 2000). At times, personal care is devolved to HCWs and licensed nurses can become clinical managers, which has the potential to create confusion; however, any reallocation of task, and substitution of qualified by unqualified staff, should be based on sound evidence and not merely on staff availability, service demand, or apparent cost reductions.

With the introduction of HCWs, some licensed nurses believe that the interpersonal aspect of nurses’ roles should be transferred to HCWs to enable RNs to concentrate on the technical aspect of nursing (Olesen, 2004; Scott, 2004). The emphasis on licensed nurses being involved in patients’ activities of daily living may have shifted as other aspects of the nursing role, such as technical and managerial components,
have developed. The rapid expansion of specialties within nursing (Castledine, 2000a; Styles, 1989) and the developing role of the allied health professions (e.g. physiotherapy, occupational therapy and dietetics) have resulted in several separate professional groups being responsible for aspects of care, such as nutrition, that were previously nursing domains. There are also growing numbers of nursing specialties (Styles, 1989), such as continence and stomal therapy nurses, whose areas of expertise overlap with traditional nursing practice. Increasing specialisation may have had the unintended detrimental effect of de-skilling general nurses and creating role ambiguity.

With the proliferation of health care roles, and the blurring of skill boundaries associated with rise in the number of professionals providing patient care, comes the potential for inefficient use of the nursing workforce. The shortage of licensed nursing staff and staff working across professional boundaries has the potential for role confusion (Revill, 2005). Role confusion is associated with reduced productivity (Workman, 1996). If the management of all grades of health care providers is not optimal and role definitions are not established, then the efficiency of health services may diminish (Jamieson & Williams, 2002). While new roles have been introduced into the health care system, the challenge for the nursing profession is to ensure that these workers contribute to, and do not compromise, the quality of patient care (Henderson, 2004).

**Study aim**

The specific aim of this study was to understand how medical and surgical nurses in two Queensland hospitals conceive their scope of practice in response to the available grade mix and skill mix of nurses and other health care professionals in the acute hospital setting. Understanding nurses’ perception of scope of practice may help to improve future efficiency in the nursing workforce by using the information derived from this study to provide baseline data to guide workforce planning for the nursing profession.

Workforce planning aims to balance workforce supply with requirements (AHWAC, 2004). The process of workforce planning needs to begin with identifying what constitutes optimal patient care and how best that care can be provided, by determining the appropriate mix of licensed and unlicensed health care workers. The
National Health Workforce Strategic Framework has developed a set of seven principles to guide Australian health workforce planners (Australian Health Ministers’ Conference, 2004). The principles can be summarised as:

- **Principle 1:** Ensuring and sustaining supply.
- **Principle 2:** Workforce distribution that optimises access to health care and meets the health needs of all Australians.
- **Principle 3:** Health environments being places in which people want to work.
- **Principle 4:** Ensuring the workforce is always skilled and competent.
- **Principle 5:** Optimal use of skills and workforce adaptability.
- **Principle 6:** Recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system.
- **Principle 7:** Recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in this framework.

While these principles are comprehensive, the extent to which they are used is unknown.

This study involved describing the perceived scope of practice of the nursing workforce, including the provision of services to the population to ensure optimal use of workforce skills and ensure best health outcomes, thus it was directed at Principle 5. Principle 6 was also supported, as this study contributed to the body of research-based evidence on the Australian nursing profession. This study highlights the areas of practice in which nurses are currently involved and what they believe to be the best use of their skills. This study also assisted in defining the workforce and provides guidance on workforce redesign and how to meet service needs.

Redesigning care delivery models is interlinked with a number of concepts. Grade mix and skill mix, patient outcomes, staff satisfaction and effective service delivery are influenced both positively and negatively by changes to the provision of health care services. By obtaining evidence-based knowledge on the scope of nursing
practice during this study, each can be managed effectively and potential solutions to workforce shortages can be investigated.

**Significance**

This study is significant for three reasons. First, by understanding scope of practice from the nurses’ perspective, appropriate decisions can be made regarding the mix of staff required in the nursing workforce. Second, grade mix and skill mix affects patient outcomes and staff retention, both of which are important issues for workforce planners. Third, information on nursing grade mix and skill mix and its effect on patient outcomes will assist with making positive changes to the nursing workforce, which will contribute to the effective management of health care service delivery. Each of these issues will be expanded on in this next section.

**Staffing, grade mix and skill mix**

Skill mix is a broad term that refers to the mix of staff in the workforce. In the context of this research, it signifies the combination of skills available at any one time within one group of professionals, such as RNs or ENs (Buchan & Calman, 2004). Skill mix is not to be confused with grade mix, which refers to the proportion of RNs to other nursing and clinical staff within a hospital unit (Buchan & Dal Poz, 2002). Because grade mix and skill mix are influential within the hospital environment, finding the right balance is extremely important. However, hospital structure and budget constraints influence both grade mix and skill mix; therefore, determining the right combination of nursing staff is quite difficult when taking into consideration patient complexity, patient numbers, turnover, staffing budgets and staff availability. Consequently, the effect of changing nursing grade mix and skill mix is being increasingly investigated, and is one of the focal points in this study in the hope of finding cost effective, but also patient focused solutions, to alleviate nursing staff shortages.

Nursing skill mix and staffing decisions are closely linked to nursing workloads. In Australia, there are a variety of methods that have been used to measure nursing workload including: Patient Assessment and Information System (PAIS); Diagnostic Related Groups (DRG) nurse costing models; hours of care/patient day; nurse-patient ratios and mandated ratios; and commercial software packages (TrendCare, ExcelCare) (Duffield, Roche & Merrick, 2006). In the PAIS system, patient
dependency indicators classify patients into one of six groups. These groups are used to estimate nursing time with the amount of time for each indicator totalled to determine the amount of nursing time required for each patient (Duffield et al., 2006). The greater the number of indicators, the greater the need for nursing services (Hovenga, 1996). DRG is a system of categorising patients into specific groups based on diagnosis (Duffield et al., 2006). Nursing resources required for each DRG are defined as nursing service weights (Diers & Bozzo, 1997) and indicate the resources needed across specific DRGs. Commercial software packages go one step further through the development of a nursing care plan for a patient. This plan determines the patient’s requirement for units of care for each nursing activity. Within the unit of care, time it will take, the number of times it is needed and the level of staff it requires is evaluated (ExcelCare, 2004). While these systems have an ability to determine nursing skill mix based purely on ‘numerical endpoints’, they fail to take into consideration the individual skill sets and competencies of the attending nurse (Rischbieth, 2006, p. 397). Failure to consider these variables when considering skill mix in the acute care setting can lead to inappropriate staffing decisions and poor patient outcomes.

While there is no nationally accepted method or model in Australia, the method described here is commonly used in the major public hospitals in Queensland. This method involves calculating hospital staffing by determining the average bed occupancy divided by the number of beds. This number is then multiplied by a predetermined number of nursing hours per patient per day (NHPPD) (Duffield et al., 2006). Anecdotal evidence suggests that the Australian average NHPPD is approximately 3.5 to 4.0 hours (Duffield et al., 2006). Staffing needs based on this equation assume the number and acuity of patients is fixed and it merely becomes a measure that is collected, rather than a method for measuring nursing workload (Duffield et al., 2006). The main downfall of using NHPPD to allocate nursing resources is that it does not take into account patient needs or complexity (Duffield et al., 2006). Moreover, the belief that all nurses possess the same skills and competencies is also assumed. This is misleading because it fails to take into account newly registered nurses, agency staff and highly experienced nurses with varying skill sets. Despite this method of calculating nursing workload being inadequate—because it fails to indicate fluctuating patient acuity, high patient turnover or skill mix—it still continues to be used in a number of acute care hospitals.
Skill matching has been suggested as a new way to configure nursing skill mix and staffing in the acute care setting (Rischbieth, 2006). Skill matching systems involve the formal assessment of an individual nurse’s skills and the subsequent allocation of patients depending on those skills. This method for determining nurse staffing also considers the availability of support staff, the nurse’s familiarity with the clinical area, and peer understanding of the individual nurse’s knowledge (Rischbieth, 2006).

While this multifactorial approach marries the multitude of variables required for the determination of nurse staffing and appears to be a positive step for the nursing workforce, its applicability in acute medical and surgical settings is unknown.

The impact of nurse staffing and skill mix has been explored by a number of researchers (Anderson, 1997a; Dewar, 1992; Keeney, Hasson, McKenna & Gillen, 2005; McIntosh, Moriarty, Lugton & Carney, 2000; McLaughlin, Thomas & Barter, 1995; Tierney, 1993). Keeney et al. (2005), Dewar (1992) and Anderson (1997a) focused on describing the attitudes and perceptions of licensed nurses towards HCWs. These studies indicated that licensed nursing staff held HCWs in high regard because they created an improved and positive working environment, thus allowing nursing staff to complete their work more effectively (Anderson, 1997a; Dewar, 1992; Keeney et al., 2005); however, Dewar (1992) discovered that untrained staff perceived themselves as extremely important and were quoted as saying that they felt trained staff were not needed for the smooth running of the ward. While staff and patients hold positive views about HCWs and their roles, the two major areas of concern for licensed nurses were related to a lack of role structure and professional preparation. These studies highlight the importance of role description for both trained and untrained staff so that all staff are able to value the contribution they make to the profession.

All staff in the health care industry are likely to be influenced by any changes made to the nursing workforce, owing to the fact that nurses make up the largest component of the health care workforce; therefore, prior to making changes to nursing grade mix, it is important to understand what each position actually does. Tierney (1993) examined the work of each level of nurse in a general hospital in the United Kingdom (UK). This research enabled the role of the professionally qualified nurse to be clarified and highlighted that while a mixture of grades is important, further research needs to be
carried out in order to determine the mixture of skills required by individual team members for appropriate grade mix.

Because of the complexity of staff allocation and skill mix, any change in nursing roles or care delivery models requires extensive collaboration with all levels of nursing staff. McLaughlin et al. (1995) conducted a survey in the United States of America (USA) to examine the extent of changes in nursing care delivery models, skill mix, use of HCWs and RN role changes in healthcare delivery systems. Despite the low response rate (17%), findings showed that 90% of respondents incorporate HCWs into their nursing team; however, only 50% of these provide training to RNs on delegation and working with HCWs. In another study, Chang, Lam and Lam (1998) utilised activity sampling to determine the changes in the nursing role as a result of the introduction of HCWs. Results showed there were minimal differences in the amount of licensed nursing activity after the introduction of the HCWs. There was significant variability in the work performed by the HCWs, with the main work influences being, patient population and the delegation methods of the licensed nurses; however, these results should be viewed with caution, as there was only one HCW on duty at any time, which may have negatively influenced the ability to detect changes in work patterns (Chang et al., 1998). With the increased utilisation of HCWs in acute hospital environments, these studies highlight the importance of educating RNs on their scope of practice, delegation and the legal ramifications of working with HCWs. It is essential for safe nursing care that RNs are competent to supervise the increasing numbers of HCWs.

Brewer and Frazier (1998) conducted a study in the USA to determine the effect of structural hospital and unit characteristics, types of staffing and managed care responses on RNs. A total of 34 hospitals were surveyed (response rate 87%). Findings indicated that the type of patient that was being cared for drove staffing locally. Interestingly, unit secretaries (otherwise known as ward clerks) were improving the efficiency of the RNs by reducing paperwork. This finding is intriguing as it is unclear as to how the secretaries were reducing the amount of paperwork, as they were not actually completing it.

With the cost of patient care rising as a result of advances in technology and medicines, cost effective service delivery has been a priority for health planners for a number of years. While it would be expected that changing nursing grade mix—by
reducing the numbers of RNs and increasing the numbers of HCWs—would reduce staffing costs, a number of studies have found otherwise. Pratt, Burr, Leelarthaepin, Blizard and Walsh (1993) conducted a study in Australia that compared the cost and quality of nursing care of an ‘all RN’ with a ‘80% RN and 20% EN’ staffing. The quality of nursing care was assessed by patient outcomes and staffing costs were obtained from payroll records. Findings indicated that the cost savings related to increased use of ENs was offset because of the necessity to roster senior staff to counteract the experience and abilities of the ENs. Two thirds (65%) of RNs from the study thought ENs added to their workload owing to the tasks that ENs are unable to complete, such as intravenous medications; therefore, it is timely to undertake a study to investigate how changing grade and skill mix are influencing nursing scope of practice.

Once staff grade mix and skill mix have been considered, the allocation of staff to patients needs to be examined. Staff allocation is dynamic and changes from shift to shift and is influenced by patient needs, patient complexity, staff availability, and care delivery models. McIntosh et al. (2000) explored the way in which grade mix and skill mix are taken into account when nursing care is delegated. The findings reinforced what is already known – that staff experience and patient acuity influence nursing care delegation. Adequate supervision and training of HCWs mean that this level of worker can provide some aspects of direct patient care; however, as the numbers of HCWs increase within the nursing team, the consequences of these workers taking on roles outside of their scope of practice may go unnoticed as staff become accustomed to their usage (McIntosh et al., 2000). Thus, with grade mix and skill mix shown to influence team cohesion and staff satisfaction, it reinforces the need to understand how nurses are working in response to the available mix of nurses and other health care professionals. Access to this information on nursing grade mix and skill mix and its effect on nursing scope of practice will assist with workforce planning and making appropriate service delivery changes.

**Patient outcomes**

Rising consumer expectations and increased incidence of lawsuits resulting from health care malpractice is changing health care systems (Morris, 2002). Policy makers are focusing on patient outcomes to guide future directions in health care. The Senate Inquiry into Nursing (Commonwealth of Australia, 2002) highlighted the need for
more research to determine the relationship between nursing workforce skill mix and patient outcomes; however, there have been some studies that have already shown that nursing skill mix can affect patient outcomes and staff satisfaction (Anthony, Standing & Hertz, 2000; Blegen, Goode & Reed, 1998; Johnson-Pawson & Infield, 1996; Melberg, 1997; Needleman et al., 2002). These studies have shown a decreased incidence of adverse patient outcomes when a greater percentage of RNs were employed in the grade mix. Furthermore, attitudes towards different levels of nursing staff can have a profound impact on the cohesion of a team and ward environment (Anderson, 1997a/b; Dewar, 1992).

Skill mix influences patient outcomes (Anthony et al., 2000; Blegen et al., 1998; Johnson-Pawson & Infield, 1996; Melberg, 1997; Needleman et al., 2002); however, there are also a wide range of other factors that come into play. Staffing numbers and skill mix are incomplete measures of the quality of care nurses are providing because the quality of care is not always recognised (Duffield et al., 2006). A review by the Australian Resource Centre for Hospital Innovations (ARCHI) found that there are many other factors that influence the likelihood of adverse patient outcomes, including communication between doctors and nurses, working environment, and availability of allied health staff (ARCHI, 2003).

Evidence suggests that nursing grade and skill mix and patient outcomes are interconnected within the acute hospital environment. For example, Hunt and Hagen (1998) examined the relationship between nurse staffing and adverse patient outcomes. Blegen et al. (1998) and Needleman et al. (2002) both used hospital records to describe the relationship between adverse patient outcomes and the hours of care provided by nursing personnel. All three studies indicated that a higher proportion of RNs in the grade mix results in fewer adverse patient outcomes and a shorter length of stay. A limitation of these studies was the inclusion of all employed RNs, whether they provided direct patient care or not. Staffing numbers are an incomplete measure of the quality and amount of care nurses are providing. It is difficult to compare nurse staffing with readmission rates and adverse patient outcomes because there are many other factors that come into play, including discharge follow-up and support, hospital environment, and complexity of patient diagnosis. Similar results were found in a study conducted in a residential nursing care facility where the ratio of RNs to residents was directly related to a higher quality
of care score (Johnson-Pawlson & Infield, 1996). While there appears to be some association between nurse staffing and patient outcomes, understanding how nurses shape their practice in the current acute care environment is also important for the promotion of safe patient care.

Aiken, a recognised author on the relationship between nurse staffing and patient outcomes, has published a number of studies over the past decade. One study examined the relationship between the proportion of hospital RNs educated at the baccalaureate level or higher and risk-adjusted mortality and failure to rescue (deaths in surgical patients with serious complications) (Aiken, Clarke, Cheung, Sloane & Silber, 2003). Results showed that hospitals with greater proportions of nurses educated to a baccalaureate level or higher experienced lower mortality and failure-to-rescue rates. These results mirrored those in another of Aiken’s studies where hospital staffing was compared against patient mortality, nurse burnout and job dissatisfaction (Aiken, 2002). Both studies consistently found that lower patient-nurse ratios were linked to lower adverse patient outcomes (Clarke & Aiken, 2003); however, with shortages of licensed nurses being experienced worldwide, employment of an all RN workforce is unlikely in many acute hospitals. Thus, understanding how licensed nurses shape their practice and promote safe patient outcomes when working with multiple levels of care providers is a particularly pertinent issue that needs consideration.

A study conducted by Anthony et al. (2000) examined the factors influencing patient outcomes after delegation to and supervision of HCWs. Interestingly, these results showed that neither the licensed nurse’s nor HCW’s level of education was significantly related to the patient outcome. More negative events occurred when there was no direct observation of the HCW by a licensed nurse. Thus, this study indicated that positive patient outcomes require appropriate supervision. With HCWs increasingly being used in acute hospital settings, there is a great need to understand how their introduction is influencing the scope of practice of licensed nurses.

While patient outcomes are influenced by many factors within the hospital environment, it appears to have some connection to nurse grade mix and skill mix. As consumer expectations rise, the need to establish staffing standards or benchmarks is becoming increasingly important. While it is essential that managers adhere to their staffing budget, staffing levels and grade mix must not be payer dominated.
Determining grade mix and skill mix needs to be based on a specific patient population and health care setting, which restricts a universal ‘one size fits all’ approach from being used. This study will assist in describing the scope of practice of medical and surgical nurses from two Queensland acute care hospitals, which will provide tangible data for workforce planners. While there have been many studies worldwide that have described grade mix and skill mix, delegation, scope of practice, nursing tasks and their relationship to patient outcomes, data applicable to the Australian workforce is very limited. This study provides a basis for understanding the practicalities associated with nursing scope of practice in an Australian setting.

**Job satisfaction**

Heavy nursing workloads are associated with stress, absenteeism, reduced job satisfaction, and high turnover of staff, all of which are detrimental to an already struggling nursing workforce. Every year the number of unregulated and untrained care providers is increasing (AIHW, 2001), which is placing increasing pressure on RNs to be accountable for a rising number of patients. Two groups of researchers examined nurses’ perception of their work and the relationship between the organisation of nursing work and stress (Hegney et al., 2003; Makinen, Kivimaki, Elovainio, Virtanen & Bond, 2003). Hegney et al. (2003) randomly sampled 2,800 nurses who were members of the Queensland Nursing Union (QNU). The sample was taken from a total membership of 31,000 Queensland nurses. This study showed that the nurses were unhappy with their current nursing workload and with nursing as a career. Many stated there was too much reliance on short-term solutions, which failed to solve the underlying problems with the system. The large sample size and reasonable response rate (53%) indicates that Queensland nurses want their situation to be addressed and problems to be dealt with effectively. Hegney et al. (2003) notes that these results were mirrored in an unpublished survey circulated by the Australian Nursing Federation (ANF). It is claimed that over 80% of nurses who responded to the ANF survey indicated that poor pay rates, low morale, staffing shortages and high workloads were contributing to ongoing problems with the nursing workforce.

Results found in a Finnish study by Makinen et al. (2003), indicated that comparable problems were occurring in other countries. Increased workload and lack of time to complete nursing care were found to be the main contributors to increased pressure
and reduced job satisfaction. The increased responsibility for unlicensed nursing staff was also found to induce stress. As with the Australian study, the large sample size (n=568) and good response rate (84%) show that nurses were keen for their opinions to be acknowledged.

Job satisfaction is one of the key areas related to staff retention. The clinical environment in which nurses work is home to a number of factors that can have a negative effect on job satisfaction, including skill mix, clinical support, environmental conditions, heavy workload, and patient acuity. This study will explore how the roles of licensed nurses are shifting as a result of increased use of HCWs, which may help in improving job satisfaction, and ultimately staff recruitment and retention. It will also assist by describing scope of practice from a nurses’ perspective, which aims to help guide health service managers in workforce planning.

Structure of thesis

Chapter One

This chapter has described the national and international context of nursing shortages, workforce composition and planning. The nature of the nursing workforce, significance and aims of this study have been described. Terminology related to nursing staff used within this thesis has been defined.

Chapter Two

Chapter two critically reviews the theoretical and research literature related to nursing scope of practice. The theoretical literature will focus on Queensland policies to provide a context for the study. The review of the research literature examines concepts such as scope of practice, nursing role, nursing function and role expansion.

Chapter Three

Chapter three outlines the methodology used in this study. This chapter describes the constructivist approach that underpins this study, paying particular attention to the interpretive nature of this methodology. The sample, data collection, and analysis methods are described and the ethical considerations relevant to this research are addressed.
**Chapter Four**

Demographic information on the participants is provided in this chapter to assist in situating the study. The major themes arising from the critical incident interviews related to direct patient care are described. The findings described in this chapter include *good nurses work in proximity to patients providing total patient care, safeguarding patients, and privileging patients without mental illness or cognitive impairment*.

**Chapter Five**

The remaining themes related to indirect patient care are presented in chapter five. These themes are *developing teamwork strategies* and *picking up the slack to ensure patient safety*.

**Chapter Six**

Chapter six discusses the findings described in chapters four and five and the research aim so that conclusions may be drawn from the study. Recommendations for practice, nursing management, education, and research are also provided. The limitations of the study are also discussed to demonstrate the context from which the recommendations emerged.
CHAPTER TWO
Literature Review

Introduction
The purpose of this chapter is to review the theoretical literature on nursing scope of practice and to critically examine published research on nursing role, function, and scope within practice. Following a short description of the literature search methods, a brief overview of the national and international guidelines on nursing scope of practice is described. This section focuses on guidelines provided by the International Council of Nurses (ICN), Australian Nursing and Midwifery Council (ANMC), and the Queensland Nursing Council (QNC). The second section of this chapter critically examines the published research on nursing role and function and its link with the scope of nursing practice.

Search Methods
A comprehensive search for literature in the areas of nursing scope of practice, nursing role, and nursing function was conducted using CINAHL, Medline, Web of Science, ProQuest and the internet. To formulate a broad overview of the literature, the following key words were used: *scope of practice, nursing role, nursing function, nursing activities, nursing practice,* and *professional practice*. There were no limitations placed on the date or place of publication. All articles were in English. Regulatory information was also gathered from relevant websites relating to the ICN, ANMC, and QNC.

Scope of practice regulation
A description of nursing scope of practice from an international, national, and local level is provided in this section. These descriptions, which are updated and published regularly by nursing governing bodies, are important to place alongside the research literature to gain a better understanding of influences on nursing scope of practice.

*International Council of Nurses*
The ICN defines scope of practice as being dynamic and responsive to health care needs (ICN, 2004a). The ICN states that national nurses’ associations worldwide have
a responsibility to ensure their definitions relating to nursing roles are consistent with accepted international definitions. It is important to understand that most scope of practice documents are not limited to specific tasks; rather, descriptions generally focus on roles, competencies and accountability of nurses. An individual’s scope of practice is influenced by their education, experience, and area of practice (ICN, 2004a). Lifelong education and training aims to ensure that licensed nurses are practising competently.

Nursing scope of practice is influenced by the variety of other health care workers, both professional and non-professional, within the health care setting. Legislation relating to HCWs is important for licensed nurses who need to understand their and others’ associated accountability. This legislation is described in more depth in the section relating to the QNC guidelines. While the ICN supports the use of HCWs, it requires that the safety, quality and effectiveness of nursing care be considered when employing them. Consequently, the delegation of nursing care to HCWs requires either direct or indirect supervision by licensed nurses (ICN, 2004a). Additionally, the title ‘Nurse’ should only be used by those legally authorised to practise the full scope of nursing (ICN, 2000; ICN, 2004b). This allows members of the public to differentiate between licensed nurses and HCWs. The ICN advocates for the incorporation of educational programs to prepare licensed nurses on the responsibilities of delegation and on nursing team supervision to ensure that safe, competent nursing care is practised at all times.

Licensing bodies and nursing authorities that regulate the nursing profession focus on accountability, competence, affordability, evaluation, collaboration, and responsiveness (ICN, 2004a). Underpinning these principles is the importance of self-regulation by all members of the nursing profession. While governing bodies provide policies on scope of practice, it is essential that nurses constantly evaluate the care that they provide and that which is delegated to others. The principle of self-regulation will continue to be a crucial issue as the development of the nursing profession continues around the world.
While internationally the ICN provides guidance on nursing activities, there are regulatory bodies within Australia that facilitate a national approach to nursing and midwifery regulation. The ANMC (2003) highlight a number of factors that are contributing to changes in the management of unlicensed and licensed nursing staff. Among these are demographic changes, new technology, evidence-based practice, changing relationships among health workers, and rising consumer expectations. These demands require competent nursing staff who are aware of their responsibilities and accountabilities. The ANMC maintain standards of nursing practice by publishing national competency standards for RNs and ENs. The core purpose of having the competency standards is to protect health care consumers. Competence is defined by the ANMC as “the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a professional/ocational area” (ANMC, 2003, p. 3). Each year the competency standards are reviewed to ensure they are aligned with hospital environmental changes and professional development.

In conjunction with the national competency standards, the ANMC publish guidelines to assist nurses in making safe decisions relating to delegation and supervision of nursing practices. A joint position statement made by the ANF and the Royal College of Nursing, Australia (2004) stated, “registered nurses supervise, either directly or indirectly, aspects of nursing care delegated to assistants in nursing and other unlicensed workers.” (¶ 12). This can only be effective if RNs are competent in delegation and understand the scope of practice of HCWs and other unlicensed workers. The nursing regulatory authority within each state and territory is a member of the ANMC and has adopted the ANMC competency standards and delegation guidelines.

However, changes are being proposed to registration bodies around Australia for a number of health professions. National registration bodies such as the ANMC will continue their work until 2010 before being reconstituted under a national body in an attempt to improve “patient protection by ensuring only suitably trained and competent practitioners are registered; to cut red tape and allow for a more mobile workforce; to ensure high quality education and training; and for a more responsive
and sustainable Australian health workforce” (Carrigan, 2008, p. 24). Nurses and midwives, medical practitioners, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists, and dentists will be included in the scheme as proposed by the Council of Australian Governments (COAG, 2008). The scheme will promote national consistency among health care professionals (Cook & White, 2007), which is believed to improve professional standards and improve quality of care (ANMC, 2008).

The next section contains a detailed summary of the QNC delegation guidelines, which have been developed in accordance with the ANMC guidelines, and exemplify the ANMC guidelines.

**Queensland Nursing Council**

At a state level, the QNC is an independent statutory body responsible for the regulation of nursing and midwifery in Queensland. The QNC provides a Scope of Practice Framework for Nurses and Midwives (QNC, 2005a) that outlines the relationships between health care personnel, in particular RNs, midwives, ENs and HCWs. Similar to the ICN, the QNC clearly states that the scope of practice for nurses cannot be defined by a static list of procedures or tasks because of the constantly evolving health care environment. Scope of practice is influenced by practice settings, staff education level, and competence; however, nurses are still required to understand what constitutes safe practice.

RNs, ENs and HCWs need to work in collaboration with one another. To do this effectively, the actual scope of an individual’s practice must be clear, and congruent with the context in which they practice and the patients they are responsible for. Once the principles of scope of practice have been identified, the process of delegation can be introduced; however, there are certain activities that the QNC does not allow RNs to delegate to staff, other than RNs. These are care planning and delegation of activities from a nursing care plan, some aspects of drug administration, and legislated practice restrictions (QNC, 2005a). Legislated practice restrictions refer to the restriction that only RNs or ENs carry out the practice of nursing. There are a number of restrictions placed on ENs related to medication administration, which include the administration of intravenous medications (excluding intravenous fluids
without additives) and the need for RN supervision when administering PRN medications (QNC, 2005b).

As clearly outlined by the QNC, the primary motivation for the delegation of nursing activities must be to improve health outcomes and meet the needs of patients. Prior to delegation, all staff involved must understand the principles of delegation (QNC, 2005a); thus, a consultative and collaborative process is required between staff and the competence of the person completing the activity needs assessing (QNC, 2005a). Appropriate supervision and accountability are other aspects requiring consideration. Additionally, the service provider policies under which the individual is practising must be investigated as these vary between institutions and may influence practice. That is, what is legal may not be permitted in some organisations. Evaluation of the outcomes, and practice reflection by all staff related to the delegated activity, is beneficial (QNC, 2005a).

Delegation introduces two principles, namely accountability and responsibility. According to the QNC (2005a), accountability cannot be delegated; however, responsibility can. The QNC defines accountability as being able to answer to others for your own actions. Others may include clients, employers, or service providers. All RNs and ENs are accountable for their individual actions. RNs are also accountable for delegated activities and for activities carried out under their supervision. Despite this, if the supervision level is appropriate and the decision to delegate is made using the QNC’s principles for delegation, then the supervising RN would not be held accountable for the inappropriate actions of others. Responsibility is the obligation or duty that a person has, to perform a role or function to an expected standard (QNC, 2005a). The QNC states that responsibility can only be delegated if the nominated person is competent to perform the activity; therefore, if the activity was appropriate for delegation, then the RN and the person accepting the delegation share the accountability and responsibility (QNC, 2005a). Documentation of all actions, delegated or not, must also be completed.

As previously stated, scope of practice is dynamic and constantly changing. Nurses begin practising with limited experience and must be able to demonstrate beginning level knowledge and competencies. As nurses advance through their career, continuing education and ongoing competence development are essential elements in
their professional development. Consequently, nurses may advance their scope of practice but this should be done in accordance with the principles set out by the QNC. An example of practice advancement includes the introduction of the nurse practitioner role in Australia (Gardner et al., 2004). The role of the nurse practitioner may include the prescription of medications and ordering of diagnostic investigations, practices that have only come about through the advancement of the nursing role (Gardner et al., 2004).

In summary, at an international level the ICN identifies that while nursing governing bodies provide policies on scope of practice, it is essential that nurses continually reflect on their practice and ensure it is aligned with the associated legislation. Nationally, the ANMC asserts that the core purpose of competency standards is to protect health care consumers. Locally, the QNC maintains that the scope of nursing practice cannot be defined as a static list of procedures and tasks, but states that nurses are required to understand what constitutes safe practice. It is evident that scope of practice is a very important aspect in the provision of patient care; however, it is unknown how nurses integrate and operationalise these guiding principles in their daily practice. With the rising number of unskilled workers in today’s health workforce, it seems important to investigate the way in which scope of practice is conceived by licensed nurses given fluctuating grade mix and skill mix of nursing staff in acute care settings.

**Research on nursing scope of practice**

A clear understanding of the legislation that guides the scope of nursing practice provides a context within which to examine the current research in this area. The following section reviews the research literature, focusing on scope of practice, role expansion, role blurring, nursing activities and the effects of HCWs on nursing practice. A body of literature on the scope of practice and activities of advanced practice nurses or nurse practitioners was uncovered during this literature search (Bryant & Di Censo, 2004; Bryant-Lukosius, Di Censo, Browne & Pinelli, 2004; Jamieson et al., 2002; Lloyd Jones, 2005; Wilson-Barnett, Barriball, Reynolds, Jowett & Ryrie, 2000). While there is a large and growing body of literature related to advanced practice nurses and nurse practitioners, it is not directly applicable to the majority of licensed nurses working in acute care hospitals and is only touched upon
in this review; however, understanding how nursing activities are influenced by the context in which they are practised may provide some insight into the roles and function of hospital nurses.

**Nurses’ perceptions of regulation**

The nursing literature is replete with largely descriptive, non-research based accounts of nursing scope of practice that focuses on the consequences of stepping outside of the widely accepted boundaries of nursing practice (Anonymous, 2000; Austin, 2004; Blair, 2003; Castledine, 2004a/b; Castledine, 2000b; Doherty, 2005; Garratt, 1999; Laskowski-Jones, 1998). A number of studies have, however, been executed to examine scope of practice policy documents from a nurses’ perspective (Davies, Fox-Young, 2002; Jowett, Peters, Reynolds & Wilson-Barnett, 2001; Terry, Greer & Lydon, 1998). For example in Queensland, Davies and Fox-Young (2002) surveyed 1,000 licensed nurses to determine their perception of the ‘Scope of Nursing Practice Decision-Making Framework’ as developed by the QNC. A large majority of respondents (86%) agreed that they ‘completely’ or ‘mostly’ understood the ‘Guiding principles to expand the Scope of Practice for Registered Nurses’ and 69.1% agreed that it was readily applicable to their practice. Similarly, 70% and 92% respectively indicated that they could apply the principles of delegation and understood the ‘Delegation Principles for Unregulated Care Providers’. While this study suggests that nurses found the Framework practical and helpful, it fails to answer the question of how nurses are structuring their work to ensure that it remains within the principles given the increased numbers of HCWs and changing patient characteristics found in the acute care system. Additionally, with only a 30.1% response rate, the findings may not be representative of Queensland nurses views in general. Further, given nursing turnover, the extent to which these findings reflect nurses today is unknown.

Similarly, Jowett et al. (2001) undertook a survey to describe UK practitioners, managers and educators perceptions of the ‘Scope of Professional Practice’ as published by the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC). The 212 respondents identified that expanding nursing roles would result in improved patient care (70.7%), more appropriate use of skills (40.1%) and better access to health care services for patients (21.2%). However, the expansion of nursing
roles was also met with some negative feedback. Approximately a quarter of respondents believed nurses were already being pulled in many different directions (28.3%) and expansion would result in nurses becoming more focused on the managerial side of patient care (25.9%). This study emphasises the growing interest in developing innovative systems for nursing care delivery and further supports the need to understand how nursing scope of practice is operationalised so that new systems can be devised and implemented. However, this study also had a low response rate (36%). Comparable results were found in an earlier study by Terry et al. (1998) where the implications and awareness of the UKCC ‘Scope of Professional Practice’ document was investigated via questionnaire. The results from both studies were consistent, showing that nursing staff saw many benefits related to role expansion, including improving the timeliness and quality of patient care. Additionally, the increasing pressure on nursing staff to expand their practice and minimise fragmentation of care was also found.

Understanding the way in which nurses interpret scope of practice policy documents is important and is the first step in understanding how nursing practice is conceived within legislative boundaries; however, before safe decisions can be made to change grade mix, it is crucial to make sense of how scope of practice is actually operationalised in practice. Understanding the extent to which nurses comprehend the policy documents surrounding scope of practice provides insufficient insight into the practice implications of the changing nursing roles and grade mix that appear to be occurring worldwide.

**Enacting scope of practice**

Some studies have shown that scope of practice frameworks are understood by clinicians (Davies & Fox-Young, 2002; Jowett et al., 2001); however, it is also important to determine whether this understanding extends into practice. Exploration of how nursing scope of practice is operationalised has been recently studied in Australia and Canada. These qualitative studies provide insight into the components of nurses’ scope of practice (Jones & Cheek, 2003; Lillibridge, Axford & Rowley, 2000) and are important in being able to understand how scope of practice frameworks influence practice. Using purposive sampling, Jones and Cheek (2003) described what nurses did in everyday practice. A total of 38 nurses from a variety of
work settings, with equal representation from RNs and ENs, participated in semi-structured in-depth interviews. Interestingly, the results did not specify particular or discrete nursing tasks; rather they provided a thematic and descriptive analysis of nursing patterns. Many of the themes that emerged overlapped and interlinked. Overwhelmingly the study indicated that nurses believed that there was no such thing as a typical day. Additionally, participants viewed assessment, communication, leadership and management skills as particularly important skills for nursing staff to possess. Heavy workloads, shrinking resources, violence in the workplace and feelings of isolation were also highlighted as some of the main causes of a stressful working environment. This study adds to the body of knowledge on nursing patterns; however, it does not answer the question of which level of nurse or health care worker is best equipped to perform and manage the numerous patient care activities and ward responsibilities. Nevertheless the results emphasise the importance of reflective practice as a means to devise innovative ways of working with all types of health care workers.

In another Australian study using in-depth interviews, Lillibridge et al. (2000) explored the scope and boundaries of registered nursing practice in a variety of environments. Twelve interviews were conducted and an additional 24 nurses were involved in participant observation. Two prominent themes to arise in this study were that scope of practice was influenced by the specific work environment and adjusted on an individual basis. Findings highlighted that work occurring outside of an individual’s scope of practice most commonly occurred when the designated health care professional was absent. The use of methodological triangulation adds to the trustworthiness of this data. While these studies add to the knowledge on nursing scope of practice, it is necessary to understand how nurses construct their work as roles evolve, responsibilities grow, and HCWs are more commonly employed.

In Canada, White et al. (2008) undertook a study to draw out the perceptions of nurses of what “working to full scope of practice” meant (p. 55). Participants included acute care nurses from three health regions in western Canada. A key finding from this study indicated that nurses mostly referred to scope of practice by describing the activities they undertook with assessment and care coordination being the two main differences in the work of RNs and LPNs. White et al. (2008) cite insufficient role
differentiation among and between registered and unregistered nurses as being one reason why many felt undervalued. Making clear the contributions of each nursing care provider and ensuring that scope of practice frameworks are congruent with practice may assist in improving morale among the nursing profession. Nursing scope of practice is more than a discrete list of nursing tasks, it reflects the nursing practice that nurses are educationally prepared for and competent to undertake, a notion that appears to be misunderstood by some nurses and may be influencing the idea that nursing care providers are a homogenous group.

Despite the studies by Davies and Fox-Young (2002) and Jowett et al. (2001) indicating that scope of practice frameworks are understood by clinicians, three other studies (Jones & Cheek, 2003; Lillicbridge et al., 2000; White et al., 2008) suggest that understanding does not extend into practice. While it may be that nurses from these studies were unable to articulate what scope of practice means to them, there does appear to be a deficit in the literature on how scope of practice is actually conceived of in practice.

**Activities undertaken by nurses**

Qualitative research provides insight into how scope of practice frameworks are understood; however, quantitative studies explain how nurses divide their time, which is important when considering how nursing practice is conceived. Work sampling—the most common method for investigating the activities undertaken by nurses—has been extensively used by researchers over a number of years (Duffield & Wise, 2003; Duffield et al., 2005; Chaboyer et al., 2008; Lundgren & Segesten, 2001; Pelletier, Duffield & Donoghue, 2005) and was originally developed in the USA by Urden and Roode (1997). In this study, Urden and Roode (1997) investigated the amount of time that licensed and unlicensed nursing staff spent in direct and indirect patient care activities, described the differences in time spent in various activities, and examined shift variations in time. It was identified that RNs and LPNs spent 37% and 36% undertaking direct care and 22% and 24% undertaking indirect care.

In Australia, Chaboyer et al. (2008) undertook a study to describe the activities undertaken by RNs, ENs and HCWs in the provision of patient care in the acute care
setting. This descriptive study used work sampling to observe 114 nurses in two public hospitals. On average, approximately one third of all activities were recorded as involving direct patient care, with ENs and RNs spending similar amounts of time assisting with activities of daily living. Differences were shown between nurse classifications with ENs spending nearly equal amounts of time providing direct and indirect care. This is in contrast to RNs, who spent less time providing direct patient care. These findings differ from the study by Urden and Roode (1997) and may reflect the differences in the American and Australian health care environments and evolving nursing roles and practices that have occurred over the past 10 years. Understanding aspects of scope of practice for all levels of care providers is highlighted by the results of this study. Additionally, assessing task overlap and role boundaries so that all levels of health care providers are used efficiently is also apparent.

The finding that ENs and RNs were similar in terms of direct and indirect care completion (Chaboyer et al., 2008) is supported by a study by Gibson and Heartfield (2005). In this qualitative study, semi-structured telephone interviews were undertaken as a part of an Australia-wide multi-phased investigation of enrolled nursing practice and competency standards. ENs from a variety of settings across Australia were involved, with the study indicating a lack of role differentiation between ENs and RNs. This finding suggests that further qualitative research should be undertaken to explore how licensed nurses conceive their scope of practice when working with multiple levels of nursing care providers. Further, while similarities have been shown between ENs and RNs, the education level of these staff varies substantially. Expecting ENs to undertake activities that would normally be undertaken by RNs increases the risk of adverse events (Aiken et al., 2003) and could occur if staff are used interchangeably.

Duffield has collaborated on a number of studies to examine the activities of Australia hospital nurses (Duffield & Wise, 2003; Duffield et al., 2005; Pelletier, Duffield & Donoghue, 2005). In one study set in a private hospital, work sampling was again used to measure the activities of multiple nurses. RNs, ENs and HCWs were found to spend 40% of their time on indirect care and 29% on direct care (Duffield & Wise, 2003), a finding supported by Chaboyer et al.’s work (2008). In another of Duffield’s studies (Pelletier et al., 2005), 7% of nurses’ time was spent documenting patient care.
Determining the differences between RNs and clinical nurse specialists has also been examined by Duffield et al. (2005). An interesting result from this study was that clinical nurse specialists were spending significant amounts of time on activities not expected of the role. These activities included clerical and administrative work and meeting attendance, with Duffield et al. (2005) concluding that it is unclear whether completion of these activities value-add to patient care. Using nursing staff to undertake activities that do not require their skills wastes money and increases nursing turnover (Duffield et al., 2005). This draws attention to the need to explore nursing role and scope of practice so the most appropriate staff member is allocated to patient care and ward organisation activities.

Two groups of researchers used surveys (Gran-Moravec & Hughes, 2005) and non-participant observations (Lundgren & Segesten, 2001) to examine how nurses spend their time on selected tasks. Gran-Moravec and Hughes (2005) conducted their study on a telemetry unit and showed similar results to Lundgren and Segesten (2001) who focused on a medical/surgical ward staffed only by RNs. Both studies found that direct and indirect patient care—for example documentation, medication administration and patient education—were the most time consuming, accounting for 42–60% of allocated nursing time. Gran-Moravec and Hughes (2005) reported that 39% of nursing care could only be performed by RNs, 12% of their activities could be performed by HCWs, and 49% was spent on tasks that both RNs and HCWs could perform. These findings support the employment of HCWs in acute settings because it appears there are a large number of activities that can be undertaken by this type of worker. Moreover, with shortages of licensed nursing staff being experienced worldwide, increasing patient acuity and greater responsibilities being placed on licensed staff, understanding which activities other workers can undertake is important. However, all of these changes affect licensed nursing practice and it is essential to ensure these changes can safely occur within the current scope of practice framework.

Making sense of how nurses divide their time is essential for unraveling nursing practice; however, completion of patient care activities does not explain how scope of practice is constructed due to the fact that scope of practice is not a discrete list of tasks. Moreover, work sampling measures the primary nursing activity but does not
allow investigation of role expansion or blurring, two concepts that are expanded on in the following sections. Therefore, it is timely to undertake a qualitative study, which can be placed alongside the quantitative work in this area, to examine the construction of nursing scope of practice in acute care environments.

**Role expansion**

Increasing patient acuity, changing grade mix and increasing nursing knowledge is advancing the roles of nurses in a number of settings (Allen, 1998; Casey, 2002; Dimond, 1995; Elsom, Happell & Manias, 2008; Goldman, 1999; Harris & Chaboyer, 2002; Hind et al., 1999; Riley & Peters, 2000). If a nurse has the skills and competence to complete an activity, and non-action by the nurse may affect the patient outcomes then role expansion has been recommended by some (Carson, 1988; Sbaih, 1995). However, the perceived benefits of role expansion must be directly related to the patient (Sbaih, 1995) with careful planning, underpinned by professional scope of practice frameworks, encouraging proactive, dynamic and sensitive patient care rather than reactive care (Sbaih, 1995). Dimond (1995) listed a number of activities associated with the ‘extended role’ of nurses working in emergency departments, which included suturing, ordering of radiology tests, ordering of pathology tests, prescribing, and minor surgery. While these activities have been specified, not all staff within the emergency department were competent to undertake them. Rather, the natural development of extended roles beyond traditional boundaries should be facilitated safely according to individual practitioner competence, skills and expertise, and should be unconstrained by the beliefs of medical or allied health staff (Dimond, 1995).

In the UK, role expansion via the extension of knowledge, skills and competence must be established in conjunction with nurses and other members of the multidisciplinary team (United Kingdom Central Council (UKCC) 1992a; UKCC 1992b; Carlisle 1992). The rationale for this is that nursing role expansion will influence the practice of many other hospital staff (Sbaih, 1995). Professional frameworks have been shown to guide knowledgeable and proactive emergency department nurses in their quest for role expansion (Sbaih, 1995); however, it is unclear how this process would work in general settings.
Nurses’ perceptions of the impact of role expansion on the nursing profession have been studied (Carver, 1998; Olsson & Gullberg, 1991; Pelletier, Donoghue, Duffield, Adams & Brown, 1998; Riley & Peters, 2000; Wilson-Barnett et al., 2000). In the UK, Wilson-Barnett et al. (2000) asked a purposive sample of 19 RNs to reflect on components of advancing nursing practice. The findings highlighted that role expansion should be underpinned by a holistic rather than technical skills focus. In another study, Carver (1998) conducted four individual interviews and one focus group with RNs and identified that nurses appeared to accept tasks that doctors did not want to carry out, rather than considering how these newly acquired tasks benefited patient care. Carver (1998) emphasises that role expansion is not merely the acquisition of new skills, that it is “the analysis and acceptance of responsibilities that enhance professional practice” (p. 89). Support of advancing nursing roles was also found in Riley and Peter’s (2000) study of Australian perioperative nurses. A mailed questionnaire was sent to a random sample of 224 perioperative nurses and a 79% response rate was obtained. Close to two thirds of respondents wanted to extend their current role, with the cost of tertiary education being the main consideration when planning career development and role expansion.

The question of whether role expansion requires role abdication was investigated by Pearcey (2008) through semi-structured interviews. An increasing lack of patient contact, a shift towards the technical side of nursing, and a resignation of nursing roles to assistants were believed to be some of the products of nurse role expansion (Pearcey, 2008). For some participants, role expansion was welcomed; however, it was later regretted because nursing practices such as hygiene cares were devolved to HCWs. For others it was seen as undertaking roles that medical staff did not want to do. Thompson and Watson (2005) believe this dissonance of thought has emerged because nursing is losing its identity due to poorly conceived roles and functions. However, viewing role expansion negatively may well be accurate if the only driver is medical staff shortages, which accentuates the need to ensure that role expansion is carefully planned and underpinned by professional scope of practice frameworks to encourage proactive nursing practice. An alarming finding from this study was the suggestion by participants that HCWs and licensed nursing staff are interchangeable, with the main difference between the levels cited as the ability to administer medications (Pearcey, 2008).
Role expansion leads some nurses to consider postgraduate study. A questionnaire was used to determine the factors that influence nurses to undertake graduate studies in a study by Pelletier and colleagues (Pelletier et al., 1998). A total of 480 students responded (72%) and highlighted the most important reasons for undertaking postgraduate study as personal satisfaction (42%), increased professional status (22%), and improved job opportunities (17%). Family (24%) and job (24%) commitments were seen as the most likely to cause problems. In their interviews with 30 RNs, Olsson and Gullberg (1991) found that time constraints were proving to be a major issue in expanding professional practice and role expansion for nursing staff. Both studies yielded a good response rate (78% and 72% respectively) and emphasise the importance of professional development within the nursing profession. It would appear from these studies that positive views are held by nurses on the development of the nursing role and workforce redesign.

Rushforth and McDonald (2004) investigated the views and experiences of nurses working within acute care settings, in respect to expansion of their nursing practice into areas usually the domain of medical staff. A questionnaire comprising 14 closed-and open-ended questions was distributed to 624 nurses across the UK with a second phase of the study utilising individual, semi-structured taped interviews with a subgroup of the questionnaire respondents. A total of 217 responded (35%) and 49 were interviewed. Findings indicated that the central focus for most nurses was on the best interest of the patient, with this principle being a primary determinant of professional practice expansion. Ongoing education and supervision were also cited as important for role expansion; however, professional and patient vulnerability, and how to determine nurses’ competence to undertake new roles were highlighted as the main practice implications associated with nursing practice expansion (Rushforth & McDonald (2004).

Expanded roles in community nursing practice have also been studied. Recently, Elsom et al. (2008) explored the views of community mental health nurses in relation to their confidence to undertake expanded roles, their opinions regarding the necessary preparation for such roles, and the barriers they perceived to role expansion. A questionnaire containing seven items designed to ascertain the nurses’ level of confidence to undertake expanded practice roles was sent to 296 community
mental health nurses. The findings showed that practising community mental health nurses have the confidence to undertake expanded practice roles, they recognise the need for further education and experience, and are aware of the potential barriers to role development (Elsom et al., 2008). However, the extent to which these findings can be generalised to other nursing groups, such as medical and surgical nurses, is unknown.

Despite role expansion being viewed favourably by nurses (Casey, 2002; Elsom et al., 2008; Riley & Peters, 2000; Rushforth & McDonald, 2004) it has been met with some concern by others. Undue pressures, exploitation, abuse, liability, lack of employer support, and conflicts with doctors have been proposed as some of the possible outcomes associated with role expansion (Dimond, 1995). In a string of commentary articles, a UK-based nurse lawyer has debated whether expansion of nursing’s scope of practice should even be sought (Fullbrook, 2004a-h). Fullbrook questions whether it is appropriate for nurses to undertake medical roles because nursing education is not as extensive as medical education. She argues that extra training and nurse up-skilling, coupled with doctor shortages, are not good enough reasons to expand nursing roles; however, Barker, Reynolds and Ward (1995) suggest that nurses stop trying to define what nursing practice is and instead focus on how it is achieved. If health care evolution requires scope of practice to be widened to include ‘medical’ activities to ensure safe patient care, then an acceptance of this may be necessary.

However, Pearcey (2008) recommends that consideration should also be given to what is lost to ensure the meaning of nursing is not lost at the expense of role expansion.

While studies indicate there are possible benefits of role expansion in the areas of mental health (Allen, 1998; Elsom et al., 2008), emergency nursing (Dimond, 1995), perioperative (Riley & Peters, 2000), renal (Casey, 2002), and critical care (Goldman, 1999; Harris & Chaboyer, 2002; Hind et al., 1999), it is unclear how the concept would be accepted in general medical and surgical environments. Research on role expansion has tended to focus on specialty environments, which highlights the need to explore how scope of practice is constructed in general settings before role expansion is even considered in these environments.
Role blurring

Role expansion has the potential to create a certain level of role blurring. What is appropriate, and what is not, is usually determined by role descriptions; however, when the edges of practice become blurred, as a result of role expansion, determination of appropriate practice can be difficult. Clear boundaries create a sense of safety and predictability; however, this has been shown to impede growth and creativity (McCabe & Burman, 2006). Role blurring in practice can have both positive and negative effects. It can lead to the development of new practice models, which improves patient outcomes (McCabe & Burman, 2006); however, if left unexamined role blurring can result in a dilution of professional identity (McCabe & Burman, 2006). It has been stated that “the challenge of blurred boundaries is to not ignore them and to cross over at will, nor to unnecessarily tighten them, refusing to see across the line, but to use that indistinct and undefined area to rethink and reconceptualize…practice” (McCabe & Burman, 2006, p. 8).

A number of qualitative studies have been undertaken to explore what role blurring means to practising nurses (Bonner & Walker, 2004; McGillis Hall, 2004; Snelgrove & Hughes, 2000; Tye & Ross, 2000). Bonner and Walker (2004) examined the concept of ‘blurring the boundaries’ in nephrology nursing. A purposive sample of six non-expert and eleven expert nurses were involved with the study, which used participant observation, a review of nursing documentation, and semi-structured interviews. Nephrology experience, formal nephrology postgraduate education and the perceptions of nursing peers were the main criteria that were assessed when determining whether participants were ‘expert’. The study uncovered that only expert nurses ‘blurred the boundaries’ of professional practice (Bonner & Walker, 2004). This was achieved by operating purposefully, for the sake of patient care, in the medical territories of prescribing, dispensing, and pathology requisitions. Non-expert nurses were not seen to cross these professional boundaries (Bonner & Walker, 2004). This study is interesting in that it makes explicit the kinds of nurses that purposely blur role boundaries, which is useful in making sense of how individual nurses operationalise their scope of practice in day-to-day practice.

In another qualitative study, role blurring in relation to nurse practitioner roles in the emergency department was investigated (Tye & Ross, 2000). Nine face-to-face semi-
structured interviews were carried out with the key multidisciplinary stakeholders in the organisation including medical consultants, nurse practitioners and a hospital chief executive. The shifting of boundaries between professional groups, as a result of the implementation of nurse practitioners, was perceived as a threat by some medical staff because of their fears that junior doctors would become de-skilled in the area of minor trauma management (Tye & Ross, 2000). While this study has provided some insight into role blurring between nurse practitioners and medical staff, it is unknown whether role blurring is occurring between RNs and medical staff on general medical and surgical wards. While it is not proposed that this study will specifically investigate this concept, it will give some indication as to whether it is an issue for general nursing staff.

Role blurring between doctors and nurses has also been examined by Snelgrove and Hughes (2000). In their semi-structured interviews with 20 doctors and 39 nurses there was some recognition of blurring of occupational boundaries, particularly when managing increased workloads and working after hours. While Tye and Ross (2000) uncovered some opposition from medical staff on advancing nursing roles, medical staff from this study respected the flexibility of nursing staff in being able to undertake some traditional medical activities (Snelgrove & Hughes, 2000). However, role blurring between medical and nursing work was only considered appropriate when undertaken by experienced nurses (Snelgrove & Hughes, 2000). Conversely, formal education and advanced nursing qualifications were viewed by nursing staff as better reasons for role expansion than workload need. While this single study suggests incongruencies between doctors and nurses in the UK, it is not known if this is applicable in current Australian settings.

Role expansion has lead to role blurring between medical and nursing staff (Bonner & Walker, 2004; Snelgrove & Hughes, 2000; Tye & Ross, 2000) and it appears that similar ambiguities are occurring between the practices of HCWs and nursing staff. In Canada, McGillis Hall (2004) undertook a study to determine the relationship between staff mix models and patient outcomes. A comparative correlational study was conducted in 30 adult, acute care wards within eight hospitals. Thirty RNs were randomly chosen from each of these wards and surveyed to measure role conflict, role ambiguity, job satisfaction, perceived effectiveness of care, and perceived quality of
care. RNs in this study experienced a moderately high degree of role conflict, ambiguity, and blurring when working with HCWs. However, McGillis Hall (2004) states that the role conflict described by the participants may not be directly linked to working with HCWs, rather it may be “a reflection of broader issues in the work environment” (p. 222). For example, a number of the sites involved in the study were in the midst of a large restructuring initiative that included mergers between hospitals, bed closures, and changes in RN staff layouts. This was believed to have created a climate of uncertainty that may have contributed to RN perceptions of role conflict (McGillis Hall, 2004). While this study has shown there are challenges for Canadian nurses and HCWs working collaboratively, it is unknown whether Australian nurses are facing similar challenges, and with HCWs more commonly employed in acute hospital settings, it is important to find out how these workers are influencing scope of practice for licensed Australian nurses.

Boundary blurring has been shown to occur between nurses and medical staff and between nurses and HCWs. It appears inevitable that this will continue as licensed nurses care for increasingly acute patients, medical staff manage larger workloads and HCWs are employed with greater frequency in acute settings. The influences of HCWs on nursing roles is further expanded on in the following section. The challenge now is to ensure role blurring promotes safe patient outcomes and does not breach scope of practice legislation. To understand this, it is important to first examine how the current scope of practice legislation is conceived in nursing practice in response to fluctuating grade mix and skill mix of nurses and other hospital staff – a concept that is currently unknown.

**Effects of HCWs on nursing roles**

In an attempt to provide efficient and cost effective care to consumers, health care organisations are making changes to the mix of staff providing patient care. This has resulted in increased use of HCWs in acute care settings and has also been viewed as a solution to the shortage of licensed nurses (Hayman et al., 2006). Role blurring has been shown to occur when licensed and unlicensed staff work together (McGillis Hall, 2004), which indicates that there may be other effects of combining employment of these workers in acute care settings. A number of studies have been conducted to investigate nurses’ perceptions (Atwal, Tattersall, Caldwell & Craik, 2006; Keeney et
al., 2005; Spilsbury & Meyer, 2005) and student nurses perceptions (McKenna et al., 2006) of working with HCWs. It is interesting to note each of these studies originated in the UK, which highlights how HCWs have been used in acute care settings in the UK for a number of years.

Nursing and patient perceptions of the HCW role was investigated by Keeney et al. (2005). Twenty-five nurses and midwives were surveyed and six patients were interviewed. Overwhelmingly, the nurses from this study believed HCWs provided ‘valuable assistance’ to licensed nursing staff. HCWs were seen to enable closer nurse-patient contact; however, patients found the HCWs were more accessible, which suggests that the direct patient contact maintained by licensed nursing staff was not adequate for patients. Interestingly, in another study, Santo-Novak (1997) found that patients had difficulty in distinguishing the nursing role from other health care workers and couldn’t describe the unique contribution that nursing makes to the health care profession. The descriptions of nursing role by patients may not reflect actual nursing practice and, as the author states, could relate to anyone who assumed the position of a nurse (Santo-Novak, 1997). However, studies involving patients’ perspectives are useful in gaining an understanding of how any changes to the organisation of nursing work might affect recipients of care.

In another study by McKenna et al. (2006), student nurses’ perceptions of HCWs and how they affect clinical placement was explored. Focus groups (n=26), individual interviews (n=13) and discussion groups (n=6) were held with first, second and third year undergraduate nursing students. An additional questionnaire was distributed to 650 students rendering a 67% response rate. Thirty-eight percent (n=165) could not distinguish between the role of HCWs and student nurses, with the lack of clear role demarcation resulting in role confusion and conflict. Students perceived that HCWs were undertaking nursing activities and they, as students, were undertaking HCW activities. Moreover, students felt ill-prepared to work alongside HCWs (65%) and felt that they were at the bottom of the chain of command because HCWs were delegating tasks to them. These findings are supported by a study conducted by Wakefield (2000), who observed student nurses becoming frustrated when activities were delegated to HCWs at the expense of student learning. These findings provide insight into the overlap in the roles and functions of HCWs, students and licensed
nurses, and draws attention to the need to consider how HCWs contribute to student learning and how student nurses are prepared, at an undergraduate level, for working with multiple levels of care providers.

Another study described the multidisciplinary perceptions of the role of nurses and HCWs in adult rehabilitation (Atwal et al., 2006). This action research project employed interviews with 10 nurses, 5 HCWs, 3 physiotherapists, 2 occupational therapists, 2 therapy assistants and 2 doctors. There was a general agreement among participants that HCWs were best placed to “deliver therapy carry over” because they were the most actively involved in patients’ activities of daily living (Atwal et al., 2006, p. 1421). An example of therapy carry over was patient mobilisation after a physiotherapy review to monitor the progress in the absence of therapy staff. This view was shared by HCWs; however, they identified their exclusion from multidisciplinary meetings. If HCWs are viewed as essential information sources regarding the patient and their abilities then more research is needed to explore how they can be better incorporated into the health care team.

The relationship between HCWs and RNs was explored by Spilsbury and Meyer (2005). Individual interviews followed by participant observation and concluded with focus groups was the approach used (Spilsbury & Meyer, 2005). There was frustration among the RNs in this study because they believed their role was involuntarily changing to comply with wider health care agendas rather than as a result of proactive nursing leadership. Additionally, there were occasions noted during this study when RNs were seen to actively discourage the skills and knowledge of HCWs in an attempt to control their work; however, the authors state that “ambivalence towards the HC[W] role by RNs and nurse managers is no longer an option” (Spilsbury & Meyer, 2005, p. 80), which emphasises the importance of understanding how licensed nurses conceive their practice given the changing grade mix of care providers in the acute setting.

The use of unlicensed assistive personnel has also been shown to impact on the role and function of RNs. A study in Hong Kong by Chang et al. (1998) utilised activity sampling to determine the changes in the nursing role as a result of the introduction of HCWs. In contrast to other studies (McGillis Hall, 2004; Atwal et al., 2006), these results showed there were minimal differences in the amount of nursing activity after
the introduction of the HCWs. There was significant variability in the work performed by the HCWs with the main work influences being patient population and the delegation methods of the nurses; however, these results should be viewed with caution, as there was only one HCW on duty at any time, which may have negatively influenced the ability to detect changes in work patterns. While this study shows little change or improvement after the introduction of HCWs, replication of this study in an Australian setting may produce very different findings, which therefore limits the transferability of these results.

Nursing roles are changing. These changes are having a subsequent effect on the work of HCWs, in particular, their contribution to direct patient care. Considerable overlap has been shown between licensed nurses and HCWs with some nurses perceiving this to be threatening (Workman, 1996) and some HCWs seeing this as opportunities for professional development (Daykin & Clarke, 2000). Understanding how HCWs affect licensed nursing practice and scope in Australia is currently unknown and provides an aspect of the rationale for this study.

**Summary**

Policies on scope of practice are provided at an international, national and state level. These policies do not specify discrete lists of nursing activities; rather, they focus on the roles, competencies and responsibilities of varying levels of nursing care providers. Using scope of practice legislation to understand what constitutes safe practice is a challenge for all levels of nursing staff.

Research on the scope of nursing practice in Australia is limited. Some studies in Australia have shown that scope of practice frameworks are understood by clinicians (Davies & Fox-Young, 2002; Jowett et al., 2001); however, it is unclear whether this understanding extends into practice (Jones & Cheek, 2003; Lillibridge et al., 2000; White et al., 2008). Role expansion is believed to be a positive step for the nursing workforce (Carver, 1998; Pearcey, 2008; Riley & Peters, 2000) as long as it is facilitated safely according to practitioner competence, skills and expertise (Dimond, 1995; Sbaih, 1995) and is in the best interests of the patient (Rushforth & McDonald, 2004; Wilson-Barnett et al., 2000). However, role expansion has the potential to create a certain degree of role blurring that has been shown to dilute professional
identity (McCabe & Burman, 2006) and cause role conflict (McGillis Hall, 2004). A number of studies have been conducted to describe the activities undertaken by nurses (Chaboyer et al., 2008; Duffield & Wise, 2003; Duffield et al., 2005; Pelletier, Duffield & Donoghue, 2005; Urden & Roode, 1997); however, very little research has been conducted to understand the meaning that changing patient acuity, patient profiles and nursing skill mix have for nurses, and the impact they have on how nurses view themselves and structure their work. Given the broad advances in the development of new roles and the introduction of new health care positions in Australia, it is timely to undertake a study that explores the operationalisation of scope of practice from an Australian nurse’s perspective.
CHAPTER THREE
Research Methodology

Introduction
This study formed Phase Two of a three-phase Australian Research Council (ARC) funded Linkage Project. The primary objectives of the larger project were to determine the activities undertaken by various levels of nurses providing patient care and to use these findings to develop guidelines for the future delivery of nursing services in acute care hospitals. This study was planned to fit with the other phases of the larger project. Phase One employed work sampling, and provided a better understanding of current nursing activities undertaken to deliver patient care (Chaboyer et al., 2008). Participants from Phase One were invited to participate in Phase Two and a broad cross-section of all levels of staff were included. Findings from Phases One and Two provided foundational evidence for Phase Three, in which focus groups were used to gather wider organisational and health system perspectives on current work patterns and issues. The combined aim of the three phases was to develop practice recommendations and guidelines. For the remainder of this thesis ‘the study’ will refer to Phase Two of the larger project.

The aim of this study was to understand how medical and surgical nurses’ conceive their scope of practice in response to the available grade mix and skill mix of nurses and other health professionals in the acute hospital setting. By exploring these meanings this study aimed to build an understanding of whether, and how, nursing work patterns were shifting in the face of changing patient acuity, patient profiles, and nursing skill mix. The following section outlines the research methodology, sampling criteria and methods, data collection and data analysis methods that were used in this study to extend knowledge of nursing scope of practice and its relationship to the activities that nurses perform. The ways in which trustworthiness of the findings was maintained, and the ethical considerations of this study are also described.

Methodology
In the previous chapter, exploration of the literature indicated that nursing roles and scope of practice influence, and are influenced by, a number of factors; however, research on this topic is limited. This study therefore sought to understand individual
nurses’ perceptions, interpretations, and constructions of their scope of practice, and experiences within their role. To gain this understanding a methodology that allowed for in-depth exploration of the nursing role and scope of practice was required. Thus, this study was situated within a constructivist methodology (Guba & Lincoln, 1989). While the notion of constructivism best describes the main approach to this study, it was also naturalistic to the extent that participants were reflecting on day-to-day experiences. In a naturalistic study it is important to understand that the meanings participants give to the world are grounded in their own experiences. The qualitative nature of this research acknowledges the socially constructed nature of reality, and the relationship between the researcher and participants (Denzin & Lincoln, 1994) that was developed during the data collection period.

Guba and Lincoln (1989) define constructions as “created realities” (p. 143). Realities are generated through the interaction of the constructor with situations, contexts, and other constructors, and exist within the person who creates them (Guba & Lincoln, 1989). Constructions are created from previously constructed knowledge by means of an individual building upon information received (Steffe & Gale, 1995). By reflecting on life experiences, individuals construct their own understanding of the world in which they live, and generate rules or principles that are used to make sense of everyday experiences (Steffe & Gale, 1995). Constructivism recognises that knowledge is constructed and constantly reconstructed as a result of life experiences. Knowledge is not waiting to be to be discovered, rather it is created cognitively through life experiences (Crotty, 1998). Prior knowledge is essential to be able to actively construct new knowledge. Therefore, the primary role of the constructivist researcher is to tease out the constructions that individuals within a common setting hold, and interpret them to understand the concerns and issues of the stakeholders (Guba & Lincoln, 1989). The constructivist paradigm was seen as the most appropriate for this study because of the emphasis it places on the individual view (Appleton & King, 2002) or, as Crotty (1998) puts it, the “the meaning making activity of the individual mind” (p. 58).

Constructivism is the individualistic understanding of meaning (Crotty, 1998). The unique experiences of each individual were emphasised in this constructivist research because it was important to consider individual experiences, abilities, and knowledge
in the construction of scope of practice. Scope of practice legislation provides a framework for licensed nurses to help ensure safe and competent practice and specifically states the importance of considering an individual’s level of competence, experience, and context within which they work when considering scope of practice (QNC, 2005a). It was for this reason and also because of the wide range of experiences, abilities, and knowledge within the nursing workforce, that it was important to consider the views and meaning-making of individual nurses. It would be impossible to locate one distinct construction that helps to understand how the nursing profession conceives scope of practice; therefore, the aim of this research was to identify the variety of constructions existing within participants, and from them find common understandings (Guba, 1990).

There is, however, a second school of thought about constructions: constructionism. Due to the collaborative nature of nursing work, constructionism cannot be overlooked. Unlike constructivism, constructionism focuses on the collective generation and transmission of meaning (Crotty, 1998). Gergen (1995), an authoritative author in the field of social constructionism in learning, describes constructionism as meaning that is realised through social interaction, and influenced by cultural, social and historical conditions. Constructionism claims that meanings are constructed by human beings as they engage with the environment they are interpreting, rather than by individuals “sense-making” as espoused in constructivism (Guba & Lincoln, 1989, p. 142). Interpretation in constructionism occurs against a background of shared understandings, practices, and languages (Schwandt, 2000). Language plays a pivotal role in social constructionism, and is emphasised over the processes of the individual mind that underpin constructivism (Gergen, 1995). While dialogue between nursing staff is essential for practice, and highlights the constructionist nature of the nursing profession, constructionism underplays the presence of cognition in understanding and operationalising scope of practice legislation. Thus, the constructivist approach was chosen for this research due to the importance of individual constructs in this context. As the aim of the study was to understand how nurses conceive of their own individual scope of practice, constructivism provided the appropriate emphasis. Participants were asked their perceptions of nursing activities and roles, as they saw them. The constructions that participants derived from their personal perceptions and experiences in the workplace were the foundation of this study and provided the
focus, however, the notion of social constructionism could not be completely disregarded due to the highly cooperative nature of the nursing profession. Consequently, the shared constructions of participants realised through interactions with colleagues were acknowledged; however, it was the individual explanations and experiences that were sought and given precedence in this study.

Ontologically, constructivism accepts a relativist ontology in which beliefs and knowledge exist in relation to individuals, social groups and situations, and are not absolute (Guba & Lincoln, 1989). Realities are socially and experientially grounded and can often be shared by many individuals across similar and differing situations (Denzin & Lincoln, 1994). The constructions of individuals are created as they attempt to make sense of their experiences and reality (Guba & Lincoln, 1989). Guba (1990) states that, “realities are multiple, and they exist in people’s minds” (p. 26). It has been recognised that individuals inhabit contrasting worlds (Crotty, 1998) and with the extensive ranges of knowledge, experience, age, and beliefs situated within the nursing profession, a relativistic approach was essential. It has been argued that understanding is not a procedure; rather it is essence of being human (Schwandt, 2000) and the basic structure of our experience of life (Gadamer, 1970). Using a methodology that reflects this ontology was important for this study due to the diverse ways of knowing in the nursing profession.

Constructivist epistemology adopts an interpretive view whereby knowing originates from being (Crotty, 1998). Epistemologically, constructivism takes a subjective and transactional approach (Appleton & King, 1997). This approach acknowledges that the findings of the study exist because of the interaction between the researcher and participants, and these are impossible to consider one without the other (Guba & Lincoln, 1989). Interactions between the researcher and the participants shape the results of the inquiry (Guba, 1990; Walker & Dewar, 2000) with each individual being an active constructor of knowledge. In this study, an inductive approach was utilised to uncover deeper meanings of the constructs and reconstruct the ideas, thus enabling commonalities and new possibilities to emerge, and allowing transferability of the findings.

Methodologically, constructivism espouses a hermeneutic and dialectic approach (Guba & Lincoln, 1989). The name ‘hermeneutics’ is derived from Hermes, the Greek
messenger who transmitted knowledge between the gods and humans. Hermeneutics, the art of interpretation (Benner, 1994), allows for not just an understanding of the superficial meanings, but also provides scope for achieving understanding of the “essential meaning of constructions” (Appleton & Lang, 1997, p. 16). Interpretation, or understanding, requires an engagement with one’s own biases, prejudices and perspectives in order to understand ourselves and others (Schwandt, 2000). In this respect it is reflexive, where the researcher’s assumptions were examined as part of the analytic strategy. Hermeneutic inquiry stimulates thoughtful reflection and deeper exploration of the constructs through open communication and questioning so that meanings can be uncovered (Guba, 1990). In practice, this involves the analytic movement between the parts or aspects of the phenomenon and the whole, with the objective of gaining a growing understanding of the phenomenon (Paterson & Higgs, 2005). It involves repeatedly returning to the object of inquiry, each time with an increased understanding and a more complete interpretive account (Packer, 1985). For this study, the goal was to decipher the ways that scope of practice was constructed which required open discussion, reflexive questioning, and a trusting relationship between researcher and participant. The examples that participants discussed could be understood in a basic sense by examining the activity at face value. However, the methodology required the researcher to uncover the essence of participants’ constructions to ensure that a list of activities was not produced in an attempt to understand nursing scope of practice.

Understanding is also “participative, conversational, and dialogic” (Schwandt, 2000, p. 195). A dialectic approach allows for inquiry into the complexities of the data by investigating contradictory, as well as consistent and coherent, ideas and behaviours in order to reach more credible conclusions (Denzin & Lincoln, 1994). Dialectically, knowledge is constructed through dialogue or hermeneutic conversation between the text and the researcher (Koch, 1999). It allows for the complexity of constructs to be realised, consequently allowing for deeper understanding. This is particularly relevant in constructivist research where the development of an individual and distinct explanation for a particular phenomenon is impossible because of the numerous interpretations constructed by different individuals (Appleton & King, 1997). This means there is no absolute external reality that can be known independently of human interpretation (Shotter, 1995). The researcher sought to illuminate the way the
individual nurses understood their world, the concepts they used, and tried to understand their view of the world. The goal was to penetrate as deeply as possible into the ideas and constructs of the participants and gain the greatest insight into their thoughts and behaviours related to scope of practice.

Method

The aim of the study dictated the need to espouse a design and method that unravelled the key roles and scope of practice of acute care nurses, but were also able to elicit situations where these roles were not being used to their full potential. It was for this reason that the critical incident technique (CIT) (Flanagan, 1954) was chosen. Rich and detailed descriptions of the events, and context in which the events occurred were crucial in understanding the essential meaning of participants’ constructions. The need to avoid pre-analysed accounts of the nursing role was imperative to allow a complete and in-depth understanding of the events that the participants had chosen. The CIT design met these needs. Flanagan describes the CIT as a set of procedures to collect observations of human behaviour (Flanagan, 1954) thus providing findings that are “highly focused on solutions to practical problems” (Kemppainen, 2000, p. 1265). Previous research has shown that it allows nurses to understand the dimensions of their role and provides insight into nursing issues (Byrne, 2001), both of which were fundamental to this study’s aims.

Because of its practical applicability, CIT has been used successfully in a variety of nursing research studies, including the examination of quality of nursing care (Redfern & Norman, 1999), aged and extended care nursing (Cheek, O’Brien, Ballantyne & Pincombe, 1997), the practical knowledge held by expert nurses (Conway, 1998), reflective practice in mental health nursing (Minghella & Benson, 1995) and exploring consumer views of nursing care (Cox, Bergen & Norman, 1993). These studies demonstrated that the CIT was sufficiently versatile and flexible to capture nurses’ experiences in differing clinical contexts. Given the success of its use in these studies and the types of information obtained while using the technique, CIT was chosen for this study.

Central to CIT is the incident. Flanagan (1954) defines an incident as “any observable human activity that is sufficiently complete in itself to permit inferences and
predictions to be made about the person performing the act” (p. 327). In this study, the rich and encompassing descriptions of the incidents allowed the researcher to discover the underlying meanings of, and make inferences from, the examples provided by the participants. The term critical incident is used to refer to a “clearly demarcated scene, with a clear beginning and end” whereupon an observer is able to make a judgement on the positive or negative impact the incident has on the outcome of the situation (Norman, Redfern, Tomalin & Oliver, 1992, p. 595). While these definitions provide a guide to CIT, there were a number of considerations the researcher needed to take into account when using CIT in the healthcare and nursing context that helped shape the study methods. Norman et al. (1992) prefer to use the term ‘revelatory’ instead of ‘critical’ as it indicates to participants that the situation in question should be significant or meaningful, rather than a dangerous situation. Further, an incident is defined in everyday use as “any event which is not part of the standard operation of a service and which causes, or may cause, an interruption to, or a reduction in, the quality of that service” (Macquarie Dictionary, 2005, p. 956). That definition is synonymous with nursing perceptions of the term ‘incident’ where it is generally used to refer to situations where the possibility of injury—to staff or patient—is greater. For example, an incident with the hospital setting may include a medication error, a patient fall, or a needle stick injury; therefore, the notion of a significant event—rather than a critical incident—was used when interviewing participants (Schluter, Seaton & Chaboyer, 2008) because it provided a better description of the types of examples that were pertinent to the study.

Commonly, CIT generates data representing experiences or perceptions of aspects of best and worst practice (Byrne, 2001; Schluter et al., 2008). For the purpose of this study, the researcher asked participants to discuss up to two particular significant events where they were undertaking a patient care activity they perceived they should be undertaking and up to two events where they believed those activities should have been either delegated or undertaken by a higher level of care provider. Using the CIT in this way, allowed the researcher to gain an understanding of the nursing scope of practice and the interactions between nurses and other clinicians (Byrne, 2001) through focusing on a rich description of the chosen even and minimising pre-interpretation of the events by participants (Flanagan, 1954). This research aimed to interpret the meanings individuals ascribed to their everyday experience; therefore, it
was important to also gain an understanding of nurses’ perceptions regarding the ambiguities, difficulties, and inequities of their role.

When using CIT, the researcher’s role is to assist participants to be as specific as possible in their description of specific incidents. This was particularly important in this study as the incidents were elicited from the participants’ memories rather than through direct observation. While the retrospectivity of the study had the potential to distort the participants’ perceptions of the events (Guba & Lincoln, 1981), the individual interview format was seen as the most appropriate method of data collection because it allowed more opportunities for discussion than observation, which was important for developing rich interpretations. A strategy to reduce the provision of inaccurate information was to encourage participants to provide a full and descriptive account of the event and the surrounding circumstances. Therefore, in order to gain the best descriptions of the events, the semi-structured interview technique was chosen. Utilising an unstructured interview approach lacks direction, whilst a highly structured interview is too limiting (Cox et al., 1993). A semi-structured interview technique, guided by the events discussed by participants, best satisfied the hermeneutic and dialectic approach aligned with constructivism.

An additional way of reducing the presentation of erroneous information was by having an adequately trained interviewer. Flanagan (1954) states that the accuracy of the technique depends on the ability of the researcher to tease out precise behavioural descriptions. Chirban (1996) attributes the ability of the interviewer to affect a deeper understanding of the interviewee to the interactive-relational (I:R) approach. The I:R approach encompasses five components: (1) self-awareness; (2) authenticity; (3) attunement; (4) personal characteristics; and (5) new relationship. Self-awareness is essential for the interviewer because the degree to which the interviewer can differentiate their perspective from that of the interviewee is crucial in being able to obtain accurate and reliable data (Chirban, 1996). Application of this component is described in the next section titled, Researcher as instrument. Attunement ensures that a sense of richness and insight is gained from the interview by going beyond the answers, to explore the context, situation, and experience of the interviewee (Chirban, 1996). This process was extremely important for this study, as it ensured that the interviews did not lack depth, and that the process of genuine communication was
achieved through the responsiveness of the interviewer. The incorporation of personal characteristics into the interview was also significant because it allowed for a genuine exchange to occur (Chirban, 1996). This was achieved by sharing previous nursing experiences with participants, which had a settling and calming effect, encouraging open discussion between participant and interviewer. Additionally, Appleton and King (1997) note that when using constructivist methodologies in nursing inquiries, the researcher’s “personal and intuitive knowledge of the field can inform the inquiry process” (p. 18). Therefore, self-awareness was exercised by the researcher and was regularly discussed with supervisors. Once the conversational nature of the interview is attained and a new relationship is formed, a “new shared space for a fuller appreciation of the facts” exists (Chirban, 1996, p. 7). The researcher prepared for the interviews by conducting a number of pilot interviews incorporating the CIT and the I:R approach to gain confidence in these interview techniques.

**Researcher as instrument**

In constructivist inquiry, the researcher is the primary instrument for obtaining data from participants. The advantages of researchers as instruments include the opportunity to capitalise on the interactive process that exists as a result of the interview process (Lincoln & Guba, 1985), and that the researcher is able to be proactive, responsive, and flexible, which ensures the progression of a successful inquiry (Appleton & King, 1997). Another relevant point raised by Lincoln and Guba (1985) is that naturalistic, or constructivist inquiry, functions under conditions of indeterminacy. Constructivist inquirers have no choice but to use the human instrument “because only the human instrument has the characteristics necessary to cope with an indeterminate situation!” (Lincoln & Guba, 1985, p. 193). The researcher facilitates the flow of communication, identifies cues, and sets respondents at ease. A facilitative interaction where the researcher remains neutral and non-judgmental encourages participants to share rich data about their experiences (Polit & Beck, 2004), as was the case in this study. Moreover, it is the researcher who is pivotal in translating and interpreting the data generated from the participants. Pyett (2003) views the process of qualitative analysis as involving continuous reflexivity and self-scrutiny.
As the researcher, I had a background of eight years experience in medical and surgical nursing. I was employed as a clinical nurse at one hospital that research participants were recruited from, and had been for the previous six years. The benefits of being a clinician meant that I was better placed to interpret the findings because I was familiar with the workings of the Queensland public health system and I understood the context within which the participants worked. While employed there, I had been involved in an evidence based practice study that was conducted on the ward that I was working on at the time. Thus, I had some first-hand experience in working with employees from my place of work. I also participated in Phase One of the larger project of which this study was a part, assisting with data collection, analysis, and interpretation of findings. Having worked within the department of medicine for a number of years and having prior experience working with colleagues enabled me to develop a sense of trust with some participants. Having a shared medical/surgical background also helped with all participants. Walker and Dewar (2000) state that one of the main benefits of interviewer and participant familiarity is that it allows for a more relaxed inquiry, thus allowing greater opportunity for discussion. The pilot interviews, and initial interviews of the study, were conducted at my place of employment with the experience from these carried over to the next hospital where the nursing staff were unfamiliar to the researcher. Every effort was made to be attentive to participants’ needs while also being mindful of my expectations.

**Sample and Setting**

In the constructivist paradigm, it is imperative to discover the variety of constructions that exist within the study context (Appleton & King, 1997). Purposive sampling can assist with the discovery of opposing points of view (Lincoln & Guba, 1985), and enhanced the dialectic approach of this constructivist study. Purposive sampling was, therefore, chosen as the sampling method for this study. It was also one of the methods used in this study to enhance rigour and counteract the formation of premature interpretations.

The populations involved in this study were RNs and ENs who worked on selected medical and surgical wards within two large hospitals based in South East Queensland. Hospital A was a 712-bed metropolitan hospital employing
approximately 1700 nursing staff. Hospital B was a 580-bed hospital located in a high growth regional centre and employed approximately 1400 nursing staff.

Nurses involved in Phase One of the larger project were invited to participate in this study. The findings from Phase One were presented to ward staff and it was during these sessions that information and invitations for Phase Two were extended to nursing staff. Participants volunteering were purposively selected to ensure new and experienced ENs, EENs, RNs and CNs were included in the study. A purposive sample of RNs and ENs was important to ensure that a broad cross-section of nursing experience was included, from graduate nurses to nurses with more than five years of experience. The inclusion of all levels of nursing staff ensured coverage of the broadest representation of professional activities. An information letter was given to potential participants (see Appendices 1 and 2).

In CIT, the sample size should be based on the number and quality of critical incidents rather than the number of participants (Flanagan, 1954). Prior to the commencement, the exact number of participants was not known because of the general rule that sampling continues until redundancy occurs (Kemppainen, 2000). Twelker (2003) recommends the collection of no less than 50 incidents; however, this is variable depending on the complexity of the research question. Taking into consideration Twelker’s recommendations and the purposive sample of participants, a total of 20 nursing staff were interviewed. A sample of 20 nurses, reporting four incidents each, elicited a total of 80 incidents with redundancy occurring after about 17 to 18 interviews.

Data collection

Each participant was required to sign a consent form prior to any data being collected (see Appendices 3 and 4). Demographic data—such as designation, gender, years of nursing experience, and years of experience on the particular ward—were collected to provide context-specific information. This information was gathered prior to participants being selected to ensure a wide range of experience was represented. Semi-structured audiotaped face-to-face individual interviews were conducted. Prior to the interviews, participants were asked to prepare in writing (see Appendix 5) by recalling up to two specific examples during which the care provider perceived:
1. They were undertaking patient care activities that they should be undertaking.

2. They were undertaking patient care activities that should have either been delegated, or undertaken by a higher level of care provider.

Scope of practice per se was not included in the interview prompts. Rather, by asking participants to discuss the significant events and exploring the roles they enacted, allowed conclusions to be drawn in relation to role differentiation and how nurses understood the scope of their practice. Using this approach encouraged rich discussion about the context, situation and experiences of the participants.

Immediately after each interview, a contact summary sheet (Miles & Huberman, 1994) was completed. Production of this sheet is the beginning of the analytic process. Miles and Huberman (1994) encourage the use of summary sheets as they help guide planning for the next interview and aid in reorientation when returning to the interview transcripts. By reflecting on the interview, the main concepts and issues raised in the interview can be identified. Contact summary sheets pull together these salient points and summarise them onto a single sheet of paper. Any questions arising that required inclusion into the next interview were also documented on the summary sheet. A copy of each contact summary sheet was attached to the corresponding section of analysed data so that ongoing interpretation of the data was made easier. A copy of a completed contact summary sheet used in this study can be found in Appendix 6.

**Data analysis**

Analysis in a constructivist inquiry occurs both during and following periods of data collection (Appleton & King, 1997). Preliminary analysis allows for new meanings to be reconstructed, which in turn helps to guide subsequent data collection and analysis. During data analysis, constructions that emerge are reconstructed into meaningful wholes, by means of inductive analysis (Lincoln & Guba, 1985). Guba and Lincoln (1985) define inductive analysis as searching for themes within the data, rather than imposing themes on the data; therefore, themes were derived from the study’s data using a bottom-up approach. Diekelmann and Ironside (1998) describe the fluid approach to data interpretation and analysis as “reflective, reflexive, and circular in nature” (p. 1348). As the researcher constructs, or reconstructs, meaning, guided by
specific objectives relevant to the study, the starting point of interpretation can be reexamined. Reflexivity during the data analysis process, achieved by reflecting on my own perspective and experiences as a nurse, acknowledging the reciprocal influence of researcher and participants, and keeping an open mind to new ideas, assisted in improving the reliability of the data analysis process. This is in sharp contrast to the deductive approach underlying positivist research that begins with a priori hypotheses and theory that are confirmed or disconfirmed by the data collected (Denzin & Lincoln, 1994). Thus, inductive analysis ensured rich and detailed interpretations were drawn from the data.

The process of inductive analysis used in this study involved two levels of interpretation. The analysis of the individual transcripts was the first level of data analysis. It was important that the transcripts were read individually without comparison to ensure that independent themes were not overlooked. The first level of analysis involved the individual transcripts being read and re-read several times to identify sub-themes and then themes. This allowed the researcher to engage in a hermeneutic dialogue with the transcripts by moving between the parts and the whole in order to remain open to divergent interpretations (Whitehead, 2004). Continuous re-reading, or iteration, allowed for consistencies and inconsistencies to be discovered and emerging themes to develop. Rich discussions were held with supervisors to interrogate the data analysis and challenge the emerging findings. To fully understand one part of a concept or idea, one must understand the whole and, at the same time, to understand the whole without also understanding all of the parts is impossible (MacLeod, 1996); therefore, the event, context and circumstances were analysed concurrently to fully understand the meaning of the constructions.

The second phase of data analysis involved the transcripts being read ‘horizontally’, which involved assembling portions of text, between transcripts, by sub-theme (Whitehead, 2004). This is also known as comparative analysis (Polit & Beck, 2004). Paralleling the differences and similarities of the transcripts aided the development of overarching themes. The themes were continuously reinterpreted in light of emerging information. Repeated reading of the transcripts ensured that the researcher remained close to the text to “preserve the temporality and contextuality of the situations” (Benner, 1994, p. 77). The emerging sub-themes were given broad, descriptive names
in order to capture the significant lines of inquiry (Benner, Tanner & Chesla, 1996). Initial interpretations elicited multiple sub themes within sections of the transcripts; however, with repeated iterations these sub-themes were refined into themes. All themes were given a descriptive name. All drafts of the data interpretations were kept to easily allow for them to be revisited once new themes emerged. Retrieval of the themes for future and ongoing interpretation was made easier as a result of the naming of the themes (Benner et al., 1996). Once no new themes emerged, it was assumed that all themes had been identified.

Rigour

In evaluating a study’s quality, qualitative researchers stress the importance of enhancing the trustworthiness of the data (Lincoln & Guba, 1985). For constructivist inquiry, addressing the issue of rigour is one of the fundamental considerations (Guba & Lincoln, 1981) with there being many schema and varying terminology related to rigour. The four criteria of rigour as described by Guba and Lincoln (1981) include truth value, applicability, consistency, and neutrality. Similarly, Polit and Beck (2004) describe the four dimensions associated with trustworthiness as credibility, dependability, confirmability, and transferability. The criteria identified by Polit and Beck (2004) were used in this study.

Credibility refers to “confidence in the truth of the data and interpretations of them” (Polit & Beck, 2004, p. 430) and is the preeminent goal of qualitative research (Guba & Lincoln, 1985). Maintaining credibility is reliant on rigorous standards of data collection, analysis, and reporting (Patton, 2002). Data credibility and trustworthiness can be enhanced by a systematic search for information that is both contradictory and congruent with the emerging themes (Polit & Beck, 2004), presenting findings that are comprehensible to allow the reader to determine the applicability of the construction to other contexts (Patton, 2002). This was achieved through repeated review of the transcripts and emerging themes, each time with a deeper understanding of the events. Data triangulation has been suggested as a means to improve credibility (Polit & Beck, 2004); however, this was not employed in this study. Some investigator triangulation, where two or more researchers analyse the collected data (Polit & Beck, 2004), was exercised. This involved the researcher’s supervisors reviewing two transcripts and the subsequent emerging themes. An iterative process
between researcher and supervisors, where interpretations were scrutinised, and evidence was provided by the researcher that showed interpretations were warranted, was conducted over a period of 24 months, which also prolonged the hermeneutic engagement between researcher and transcript.

Polit and Beck (2004) describe the process of developing an audit trail as a means to improving the confirmability of qualitative data. This process involves the systematic collection of documents from initiation to study completion in order to develop a record of the research process and the decisions made by the researcher (Byrne, 2001). In doing this, it allows an independent researcher or reader to test the consistency of the study and, after evaluation, conclude that given the same perspective and data they would have reached a similar conclusion (Guba & Lincoln, 1981). This thesis provides an audit trail of the background and a decision made regarding this study and allows independent review of the data conclusions.

Another criteria for assessing trustworthiness—similar to confirmability—is dependability (Polit & Beck, 2004). Dependability denotes the stability of data over time (Polit & Beck, 2004). Polit and Beck (2004) encourage the use of independent reviewers who are able to scrutinise the data and related documentation. Incorporation of this technique assesses the degree to which the researcher has followed a consistent, systematic, and auditable process when conducting the study and established whether the conclusions are warranted and grounded in the data (Patton, 2002). Within this study, the researcher’s supervisors provided examination and investigation of data and related findings to satisfy the dependability criteria. Monthly meetings were held over a period of 24 months, between supervisor and researcher, where themes and sub-themes were continuously reviewed, revised, and reconstructed based on emerging understandings.

Transferability, as defined by Polit and Beck (2004), is where the findings of the inquiry are questioned to determine their fittingness to another, but still similar, setting. Despite the inclusion of the transferability criteria in addressing the issue of rigour, Guba and Lincoln (1981, 1989) question whether transferability is even possible at all, because circumstances change so rapidly. They give the example of a person who views a similar situation at different times who will, therefore, be forced into making different conclusions about the situation. This emphasises the notion that
situational interactions are complex and only have meaning at the time of the actual situation (Guba & Lincoln, 1981). Guba and Lincoln (1989) go on to comment that applicability is never attained anyway, and that claiming to have achieved it “merely wastes time and money” (p. 269). Having said that, the concept was not abandoned entirely in this study because of the many similarities that can be found between hospital wards and daily problems that occur for nursing staff around Australia.

**Ethical considerations**

The focus of this study was to understand how the current changes in grade mix and skill mix of nurses in acute care wards was influencing scope of practice. The first step in undertaking this study was to safeguard the participating nurses from any physical, psychological, or social harm as a result of the study. Thus, all participation was voluntary; participants were able to withdraw at any point, and were provided with the opportunity of debriefing sessions. No personal identifiers were present on the interview transcripts. A pseudonym replaced the participant’s name; however, the title of the participant (RN, EN or HCW) remained because it is important to understand the grade of the nurse when the findings are presented. The naming of participants has been chosen to help the reader connect with the participants’ stories (Seaton, 1998). Collection of demographic data allowed for a general description of the sample. The principal investigator’s contact telephone number was provided to allow participants to voice any concerns and make further inquiries about the study. Contact details for the Human Research Ethics Committee from all campuses (hospital and university) were also provided.

The principle of beneficence (National Health and Medical Research Council (NHMRC), 2007; Polit & Beck, 2004) was upheld by ensuring the risk of harm, discomfort, and distress was minimal. There was potential for distress from participation in this study if the event discussed was traumatic; however, the participants were free to decline participation in the study and free to withdraw from the study at any point. The phone number of the staff counsellor was provided to all participants to allow for debriefing after the data was collected, should the participant wish for it. Therefore, the researcher believed that while there was some risk associated with participation in the study, there were processes in place to support
participants, and, that the benefits of participation in the study included the potential help to the future of the nursing profession.

The principle of respect (NHMRC, 2007; Polit & Beck, 2004) was upheld by allowing nurses to participate in the study voluntarily, thus allowing them to the right of self-determination. Additionally, full disclosure of the study aims, data storage and management, and the possible risks and benefits resulting from the study, were clearly laid out for participants prior to their giving consent to participate. No covert data collection or concealment of collected data occurred as verbatim transcripts were provided to participants, at their request, to allow for removal of any information they may have provided that, in retrospect, they wished to have removed.

The principle of justice (NHMRC, 2007; Polit & Beck, 2004) was maintained by the researcher by providing neutral and unbiased treatment throughout the course of the data collection. The researcher remained non-judgmental at all times and respected the views of the participants. Consent to participate in the study was gained prior to any data collection and confidentiality was maintained by the removal of all personal identifiers from the transcripts. Participants were assured that all personal identifiers would be removed and this was carried out. Any references made to third parties within the transcripts were de-identified. Any sections of the transcript that were impossible to de-identify, because of the inclusion of third parties or easily identifiable circumstances or contexts, were not published in the reported findings. The only original identifying information from participants that was used when reporting quotes was their grade (RN, EN or HCW). The taped interviews were destroyed upon completion of the transcripts. The transcripts were kept in a locked cabinet, and in accordance with the university policy, and will be kept for a period of five years.

A transcription typist transcribed the audio taped interviews and electronic copies of the transcripts were stored and secured by a password protected electronic file. No identifiers were included in the transcripts. Hard copies of the transcripts are kept in a locked cupboard, in a secure location as required by the various ethics committees. Access to the data is limited to delegated personnel by the ethics committee. The audiotapes containing the interviews were destroyed.
This study was approved by the Ethics Committees at Griffith University, and the participating hospitals.

**Summary**

This chapter has presented the ontological and epistemological underpinnings of this study. A constructivist epistemology and its underlying ontology have been outlined. A description of the method employed in this study, the way in which rigour was ensured, the ethical considerations, and the actions taken to protect the participants were discussed.
CHAPTER FOUR
Direct patient care

Introduction
Constructivist research aims to tease out the constructions that individuals, in a common setting hold, and interpret them to explicate the meanings for those individuals. The specific aim of this study was to understand how medical and surgical nurses’ conceive their scope of practice in response to the available grade mix and skill mix of nurses and other health professionals in the acute hospital setting. By exploring these meanings, this research sought to build an understanding of how nursing work patterns were shifting in the face of changing grade mix, patient acuity, and fluctuating role boundaries. This chapter, and chapter five, present the findings from a thematic analysis of 20 semi-structured individual interviews undertaken using CIT.

Participants
A total of 20 licensed nurses were interviewed, with 17 being female and 3 being male. Thirteen participants worked full-time and the remaining seven worked part-time. The average age was 33 years, with the youngest being 23 years and the oldest being 57 years. The majority of participants were RNs, with four ENs participating. The average number of years of nursing experience was 5 years and 3 months, with the shortest being 7 months and the longest being 21 years. The average number of years of experience on the ward they were working on at the time of the interview was 3 years and 3 months, with the shortest being 5 months and the longest being 11 years. All participants worked on medical and surgical wards within two large hospitals based in South East Queensland. A total of 10 participants were interviewed from each hospital. Each participant discussed a total of four critical incidents.

To aid in assessing the transferability of the findings of this study, the following information describes the ranges of some general characteristics of the participants and wards on which they worked. The participants were consistent with nursing’s typical cohort, in that the majority of them were female, often over the age of 35 years, and working part time (ABS, 2008). The clinical settings from which the participants originated were general medical and surgical wards located within large
metropolitan hospitals. These wards had, on average, 24 beds with a variety of multidisciplinary and allied health staff also employed at the sites. Both sites employed primary nursing as their main nursing care model with RNs also having to provide certain aspects of care to the EN’s patients. HCWs had only recently been introduced to the nursing team at both sites. Therefore, the transferability of this study is limited to contexts and environments similar to those within which this study was conducted.

Overview of findings

Analysis of the data confirmed that the nursing work environment was changing. This was causing nursing staff to question what it meant to provide patient care given the increased numbers of HCWs in the acute care setting, rising patient acuity, and increased patient turnover. RNs were struggling with the notions that ‘hands on’ care was sometimes not the best use of their time, and delegation did not equate with laziness. Five themes arose from the data: (1) good nurses work in proximity to patients providing total patient care; (2) safeguarding patients; (3) privileging patients without mental illness or cognitive impairment; (4) developing teamwork strategies; and (5) picking up the slack to ensure patient safety. The themes were divided into two groups: (1) themes related to direct patient care; and (2) themes related to indirect patient care. Each of these themes had a number of sub-themes, which together comprised the main themes. Throughout the description of each theme, excerpts from the interviews with participants are provided to demonstrate and illuminate the interpretations. Table 4.1 outlines the themes and sub-themes that elucidate participants’ perspectives of how scope of practice is conceived on a day-to-day basis. This chapter presents the themes related to direct patient care and chapter five describes the themes related to indirect patient care.
Table 4.1  Themes and sub-themes

<table>
<thead>
<tr>
<th>Group</th>
<th>Theme</th>
<th>Sub-theme</th>
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| Direct patient care | Good nurses work in proximity to patients providing total patient care | • Striving for close patient proximity  
  • Proximity allows for control and builds trust and rapport with patients  
  • Recognising a new clinical reality  
  • Renegotiating patient proximity |
| Safeguarding patients |                                                | • Synthesising cues and observations in assessment  
  • Tempering assessment with gut instinct  
  • Ramping up critical thinking  
  • Piecing it all together |
| Privileging patients without mental illness or cognitive impairment |                                                | • Prioritising physical conditions  
  • Disrupting ward routines  
  • Decreasing quality of care |
| Indirect patient care | Developing teamwork strategies | • Delegating activities  
  • Trading tasks  
  • Valuing others |
| Picking up the slack to ensure patient safety |                                                | • Role blurring  
  • Nurses impeded by doctors omissions  
  • Working beyond job description  
  • Working below expertise level |

These insights into nursing work offer a basis for understanding scope of practice from the nurses’ perspective and how nurses practised within their legislative boundaries given the rapidly changing acute care environment.

**Direct patient care**

Direct patient care is the completion of activities where nurses had direct ‘hands on’ contact with their patients. Examples of direct patient care activities provided by participants included hygiene cares, administration of antibiotics, and treating chest pain. The themes discussed in this section include *good nurses work in proximity to patients providing total patient care*, *safeguarding patients*, and *privileging patients without mental illness or cognitive impairment*.

**Good nurses work in proximity to patients providing total patient care**

The most prominent theme from all of the interviews was *good nurses work in proximity to patients providing total patient care*. Patient proximity is understood in the context of this study as the physical distance between nurses and their patients. In the eyes of participants, close proximity to the patient was the goal; however, there
were many factors that restricted this proximity. These included increased use of HCWs, time constraints, and increased indirect care responsibilities. While participants noted that each of these factors had been gradually becoming more prominent in the acute health care system, participants’ discussion suggested that each of these constraints was reaching a level that was affecting nursing practice in a negative way. Managing each constraint individually was seen as ‘reasonable’ but the combined effect was creating stress and consternation among nursing staff.

When I was student, there was only really the RN and the EN…but now we are working more and more with [HCW]s on the wards. As much as they are good for us because they are able to help with things like cleaning the treatment room, they make it hard because I think we are now being expected to use them into our day-to-day work…I find that it takes me away from my patients. I am meant to be providing holistic care to these people but I can’t because I don’t really have time and I am expected to use the [HCW]s to help with ADLs and things like that but I find I don’t really get to know who I am looking after. (Sally, RN: Page 8)

Nurses struggled against increased use of HCWs and time limitations to work in close proximity to patients; however, this struggle resulted in frustration when they did not succeed. Participants viewed close patient proximity as beneficial to patient outcomes because it was believed to improve patient care. Close proximity to the patient allowed nurses to take an holistic approach to patient care. This involved managing the technical aspect of patient care (such as intravenous (IV) fluid hydration, IV antibiotics/infusions, and wound care); and attending to their physical needs (such as activities of daily living (ADLs)) and social needs (such as organising community services in preparation for discharge).

I like to be able to have the time to do everything for my patients. It just doesn’t work when you have someone doing this and then someone doing that. We used to team nurse on [the ward] but we found it was better to split the patients and have one nurse doing everything for their patients. You get it right when you know when their [antibiotics] are due, and their dressings and everything else just goes more smoothly when you are in control. It’s so much better. And I think a good nurse should be able to manage all this. (Elena, RN: Page 12)
The goal of close patient proximity was associated with the notion that acute care nurses define themselves in relation to their closeness or physical nearness to their patients. The frustration, connected with the struggle to maintain close patient proximity, stemmed from an idea among participants that ‘good’ nursing staff should provide total patient care to their allocated patient group. If they have to delegate activities to other workers, a limitation to nurse patient proximity, they saw it as failing to provide good nursing care and believed their colleagues would view them as lazy. As Megan stated, “I want to be able to look after my patients, see it through to the end, not just do bits and pieces”.

‘Good’ nurses placed more emphasis on physically demanding tasks carried out in close physical proximity to patients than on supervisory or managerial work. Equating hard work with physical labour, such as showering a patient, was a common idea for many participants. By judging difficulty by the degree of physicality, technical activities (such as drawing up IV medication or phoning to organise the discharge needs of their patients) appeared to some participants to be hardly work at all compared to sponging a patient in bed. This idea, that nurses were being lazy if they chose to delegate ADLs or other more physical activities, was interesting because they were still attending to pertinent patient care needs despite them being away from the bedside.

One participant’s story exemplifies the stories of many others about the struggle to remain in close proximity to the patient. John believed HCWs could attend to patient ADLs, but only after he seemed to wrestle with his own thoughts and accept the delegation of these activities did not equate to being a substandard nurse. The reasons provided for his change of mind centered on time pressures and increased patient acuity where more acute techniques were required.

[Hygiene cares are] just something that gets missed because it is easy to sometimes go ‘well here’s the cloths, have a wash, I have to attend to another patient’. But it’s mainly because the other things that happen are more acute. That would be the main reason why you miss your personal cares because you have to do some acute thing…and you try and go back, [but] you get caught up. The job, I really hate to say it, it’s a job that a [HCW] can do. If you have an extra [HCW] on the ward, they could do that, I hate saying it because there’s
nothing wrong with me. I could do it if I had the time to do it.  
(John, RN: Page 6)

John’s discussion exemplifies the changing workload priorities of nurses in response to increased patient acuity, new grade levels, and HCWs in acute care settings. John understood he needed to make changes in his practice to ensure he continued to provide safe nursing care; however, determining which care activities should take priority was still an issue he was struggling with.

*Good nurses work in proximity to patients providing total patient care* was a common theme originating from the data. There were four sub-themes associated with this theme: (1) *striving for patient proximity*; (2) *proximity allows for control and builds trust and rapport with patients*; (3) *recognising a new clinical reality*; and (4) *renegotiating patient proximity*.

**Striving for close patient proximity**

The first sub-theme, *striving for close patient proximity*, was significant for many participants. Participants emphasised the importance of close patient proximity because of the improvements they perceived it to have on the continuity of patient care, the ability to understand patients’ needs and the provision of holistic care. Participants also spoke of how referrals to allied health and community health were made easier because nursing staff were aware of their patients’ physical and social needs through communicating with them while attending to their ADLs.

> It’s really hard when [the community health coordinator] asks you questions about your patients and how suitable they are for discharge if you haven’t even seen them going to the toilet or having a shower. I mean how can you tell what they will be like if you haven’t even done that basic stuff?  
> (Megan, RN: Page 5)

Many believed things “slip through the system” and adverse events were more frequent when nursing care was divided among nursing care providers because problems could go unnoticed or be forgotten when staff were only responsible for one aspect of patient care. Finding time to holistically assess their patients’ needs if limited time was spent in close contact with patients was also discussed. This was a typical comment of many participants:
For me, doing a shower is a really good way of assessing a patient and it worries me that if we don’t do that and the only thing we do is eye ball a patient, do the medications and some obs, is that we are not really assessing them, their mobility, not assessing whether they are going a bit blue when moving around, if they have pressure areas on their back, how well they are managing with their ADLs. In a ward like this you want to be getting a pretty good idea so you can communicate with the [community health] nurse and I find when that’s delegated, in general, like if you haven’t seen the patient before, it’s very hard to know what they will need on discharge. (Derrick, RN: Page 3)

One participant described feeling like an “overpaid [HCW]” when she was prevented from providing total patient care. She described how when practice was diced up between staff members she struggled to piece together nursing care with patient diagnosis. “My whole nursing experience is incomplete and I reckon it is as well for the patients” were Sally’s exact words. This shows that while proximity is necessary for nurses to provide “good” nursing care, it is not sufficient by itself for holistic care. Dividing work between numerous nursing staff still allows some level of proximity but limits the ability to provide total care to individual patients. So, while proximity is important, proximity when it is related to care as a whole appears to be paramount.

Another participant's comments demonstrated the difference between nursing practice conceived as ‘tasks’ (such as showering) and practice as nursing ‘interventions’ (such as assessment or patient education). Laura stated that showering, when it was not linked to patient diagnosis or treatment, was a one-dimensional task and likened it to a “production line”; however, when showering was linked with patient assessment, education, and total patient care it was an enjoyable and stimulating nursing intervention. Conversely, Sandra viewed holistic care in a different way because she believed she could assess and get to know the patient through means other than attending to ADLs and total patient care. This idea is expanded in the renegotiating patient proximity sub-theme. The opposing ideas of Sandra and Laura highlight the subtleties of nurses’ experiences and how these experiences impact on personal ways of practicing in the emerging acute care environment. It was interesting to note that it was the more experienced nurses, both RNs and ENs, who felt comfortable with delegation of ADLs.
I don’t need to be showering every patient to know what they need and what they don’t. As long as I am able to spend some time with my patients, I am usually pretty good at working it out. (Sandra, RN: Page 11)

For less experienced staff, the development of assessment and clinical judgement skills occurred when they saw the “whole big picture”. Critical thinking skills were hindered when they were only doing bits and pieces and mainly attending to hygiene cares. The decreased ability to critically analyse the patient and their care resulted in feelings of reduced patient proximity.

I feel empowered when you can check your patients blood results, page the doctors and get a Warfarin dose. Sometimes on this ward you can feel like an over paid [HCW] when all you do is basic cares. [Checking blood results] are just little things that we should be making part of our day, going through their charts, doing the whole big picture, not just hygiene cares. (Meagan, RN: Page 14)

Patient proximity, and the holistic care it allowed when practice was not divided up, was seen as a time saving benefit by some participants. For example, attending to a patient’s hygiene needs saved time because other activities could be carried out in conjunction with ADLs. Mobility assessment and patient education were two examples that participants provided when asked what other activities they carry out when attending to patient ADLs. Specifically, assisting patients with ADLs, allowed staff to assess patients’ mobility, which meant that they didn’t need to spend time completing a physiotherapy referral. Understanding patients’ capabilities meant they were not kept immobile while waiting for a physiotherapy review. It appeared that nurses wanted patients inconvenienced as little as possible, so this ability to determine their needs in a short period of time was important. Participants were multi-tasking and performing activities on a number of different levels when they were able to provide total patient care. Many believed that if they were to delegate activities to HCWs they would still have to find time to manage the other activities that they would normally do while attending to their patients ADLs. This was a typical comment:

…you can assess their mobility, you then don’t have to go to the physio to get a physio referral to see if someone is mobile, you can actually assess them yourself…and there’s a chance for some patient education and communication. (John,
Close patient proximity and total patient care were viewed by participants as an essential part of their everyday practice. Determining which facets of their practice should be prioritised to ensure this aspect of their role was maintained, in spite of the changes occurring in skill mix, were under debate. The reasons why participants strive for close patient proximity are discussed in the following sub-theme.

**Proximity allows for control and builds trust and rapport with patients**

*Proximity allows for control and builds trust and rapport with patients* was the second sub-theme. Many participants viewed close patient proximity and subsequent provision of holistic care as a way to develop a trusting relationship with patients. Participants believed it allowed nurses to build rapport with patients, with some participants linking treatment compliance to good nurse-patient rapport. Interpretation suggests that the development of a therapeutic relationship was threatened when staff were unable to remain in close proximity to their patients throughout their shift. The utilisation of HCWs in direct patient care was seen to limit close nurse-patient proximity that resulted in limited rapport building and communication with patients. John’s comments exemplify the comments of many others.

> …If all you do is dish out the tablets, that patient doesn’t know you from a bar of soap, whereas if you are personally washing them, you get to know them a little bit more and they trust you, so if you’ve got an [HCW] doing it, you lost that trust. I’d rather just do it myself. It builds a rapport with the patient…and for someone to let you shower them, that’s a big sense of trust (John, RN: Page 6)

Participants believed maintaining control was a benefit of close patient proximity because they were aware of what was happening to their patients, and any reviews occurring. It was believed patient care was disjointed when the time spent providing hands-on care was limited. This implied that participants did not trust others to inform them of their patient plan or changes to the proposed plan. It also suggested that the communication pathways between staff needed improvement if staff were to accept assistance from HCWs. “I like to know what is happening” and “being in the loop” were comments that exemplify this sub-theme.
I am really happy to do all of it and I like the fact that I can go in and give my patients their oral pills, that I can plan and control my day by looking at their care plan. I know when their fluids are due, if they need re-signing, if I need to get the RN to give them their antibiotics...so when I don’t get to do all those things, I feel more disjointed with the care, I like being in the loop and in control. (Annette, EEN: Page 7)

Maintaining control was about having a day that could be planned from the start of a shift and completed autonomously. This is interesting to note because Annette states how she enjoys being in control, however, as an EEN she does not have complete autonomy. Annette must rely on RNs to perform some activities for her patients however just knowing when these activities need completion enhances feelings of control and provides her with adequate practice autonomy. The degree of importance that participants placed on autonomous nursing care suggested they struggled to see value of other levels of nursing staff in the acute care setting. Many participants stated that there was no need to incorporate HCWs into the acute health care system, rather there should be a reduced patient-nurse ratio. A reduced patient-nurse ratio would mean nurses could provide total patient care and patient care could remain in the domain of licensed nursing practice.

There’s so much to do in every shift...some people think that they can just delegate a shower to the [HCWs] but I really don’t think that is safe. [HCWs] shouldn’t be thought of as a solution to the problem here. More registered and enrolled nurses would mean that patients would receive better care...I mean down south they have a mandated nurse-patient ratio...that would be so much better than employing all these new [HCWs] to try and fix it... I mean one day we had lots of sick leave and we were short one RN. After hours [nurse manager] wanted to give us two [HCWs] in substitute for the RN. I was so pissed off. (Sally, RN: Page 5)

Accepting help from HCWs was seen as reasonable as long as they were not performing the task completely unaided. Licensed nurses were then able to remain in control and close to the patient while still undertaking all the essential aspects of their role that were inappropriate for HCWs, such as performing a full patient assessment. This comment exemplifies a number of others:
I want to do it all…[HCWs] can actually help with the showers but…at least [I] know what’s been happening if I give all the care to my patients with the help of [HCWs].
(Annette, EEN: Page 5)

Many participants discussed their aspirations to remain in close proximity to their patients because it meant that they were able to control how and when patient care activities were attended to. Being in control of all patient activities meant that delegation wasn’t required. Delegation, although not new in nursing, was something that staff struggled with because many believed it undermined patient trust and limited rapport building.

I know I wouldn’t like it if I had all these different people looking after me…for patients to really communicate their concerns with you, they need to trust you and how can you gain that trust when there are five different nurses looking after the one patient? (Derrick, CN: Page 11)

When participants discussed their goal of remaining in control of patient care, frustration usually surfaced when they spoke of occasions when they were unable to do so. They disliked having insufficient time in a shift to provide all the care that they wished to. Rather than seeing HCWs as a means to provide care, they often spoke about how the licensed nurse-patient ratio should be increased in order for nursing staff to remain “in control of the whole patient situation”.

Recognising a new clinical reality

Recognising a new clinical reality was the third sub-theme and describes the actuality of working in acute hospitals. Participants’ expressed feelings of frustration and confusion as they struggled with what they would like to be able to do for their patients and what could actually be achieved given the time allowed, resources, and ward in which they worked. Because of the increased pressure being experienced by acute nursing staff, the need to find a satisfactory compromise between patient needs and staff capacity emerged. On one hand, participants were holding onto the historical notion that “good” nurses provide all care to their patients. On the other hand, participants stated they were feeling increased pressure from time constraints, high patient acuity, decreased length of stay and increased use of HCWs, which were limiting their ability to provide total patient care. As a result, these influences were causing participants to examine what it meant to provide safe, efficient and effective
nursing care. This resulted in an internal struggle as participants recognised that total patient care and close patient proximity were not always possible.

Well…I don’t know how to feel about the way nursing is going…sometimes I think it should stay the way it always has with RNs and ENs giving all the care but now with [HCWs] coming in it really mixes things up. I love it when I am the allocated nurse for six patients but sometimes there is just too much going on to maintain that level of input with your patients…it’s hard to know what’s best. (Sally, RN: Page 7)

Before nurses were able to accept that total patient care was not always possible and recognise the new clinical reality, rushing through their work was viewed as the next solution; however, hurrying in an attempt to alleviate the frustration related to the poor patient proximity generally resulted in nurses feeling as though they were not providing safe nursing care. Adequate time to assess patients, both physically and psychosocially, was important to participants and when it was not available “something ha[d] to give”. The realisation that total patient care is not always the safest option was reached by some participants.

Ideally, to have four patients that you can provide full care to. ADLs, medications, social aspects if that patient is coping, if they understand what we are doing for them in hospital. Ideally, I guess, and that’s what we try to do here, but it’s just…in a rushed manner. And that probably isn’t the best for our patients. So, I guess, we can’t always be doing everything for our patients when there are other more pressing and acute activities that we need to be doing. (Amy, RN: Page 4)

HCWs were being more readily employed within public hospital systems in Queensland, possibly in an attempt to assist with licensed nurse shortages. Many participants seemed willing to integrate HCWs into their practice because they recognised that total patient care was not always possible; however, they were unsure of the principles of delegation to HCWs. Some participants could see the potential benefits of these staff members; however, they needed to be able to accept that use of HCWs did not mean they were being lazy if used appropriately. Analysis of the data relating to the provision of care established that close patient proximity was given less priority as the acuity of patients increased and the other demands placed on nurses became less about patient contact and more about patient management. The sheer
necessity of attending to patient management activities appeared to be one of the driving forces behind the acceptance of HCWs in the acute hospital environment.

…maybe it isn’t necessary for RNs to be showering when they could be doing more antibiotics, and get the [HCWs] to do [the showering]. Sometimes the RNs just have to leave the ADLs to the [HCWs] because there are so many dressings and IV drugs to be given…it’s working out what others can do that is the tricky part. (Annette, EEN: Page 5)

Accepting that total patient care was not always possible or appropriate during times of high acuity, allowed recognition of a new clinical reality. This recognition moved participants towards developing a workable and achievable level of nursing care for patients that ensured all patient care activities were attended to without causing undue stress or pressure for nursing staff. Understanding which situations required the skills of a licensed nurse and which only needed a HCW, was an important step in the realisation of what constitutes a ‘good’ nurse in the new clinical reality. The consideration of alternative ways to manage patient care is expanded upon in the developing teamwork strategies theme in chapter five.

Renegotiating patient proximity

Renegotiating patient proximity was the final sub-theme. It is understood as the changes participants were proactively initiating in their nursing practice that resulted in patient proximity being achieved through other means. Acceptance of the fluid nature of nursing work ensured nursing staff were not burnt out by attempting to provide care that was unattainable given the highly demanding nature of the acute care environment. Renegotiating patient proximity meant participants were managing competing demands while developing a new type of proximity that was considered appropriate and adequate given their need to attend to competing demands. On one hand, they were ensuring that all technical activities were attended to; on the other, they were also ensuring that all basic nursing activities, such as ADLs, were also completed. Derrick discussed the importance of good critical thinking skills in situations where patient proximity was not possible. He believed critical thinking skills improved his ability to practice holistic care from afar because it meant he didn’t require close, continuing patient contact to get the best outcomes. Critical thinking allowed him to piece together aspects of care that were provided by other
nursing staff. This afforded him patient proximity without the need for close, continuing patient contact.

…as the in charge nurse on the ward on [late shifts] I feel that I am still able to provide holistic care to my patients even though I am still running the rest of the ward and helping the juniors out. It’s a different way to nurse, [being in charge and also having a patient load], because you really use your critical thinking skills to ensure each aspect of your patients’ needs are being met and managed… because you haven’t got the ability to stay in your room and spend eight hours with your patients because you are constantly being called away for some thing or another (Derrick, RN: Page 12)

Ensuring that patients still received timely, holistic care when being tended to by multiple care providers raised the issue of prioritisation. Prioritisation meant that participants addressed more immediate and important tasks first. Immediate tasks included the administration of medications and the management of acute conditions such as chest pain and fluid overload. Tasks that took second priority, due to the acute nature of their patients’ other needs, included the management of ADLs. While many participants cited the importance of attending to patient ADLs, they realised that the acute health care environment meant that prioritisation was a necessity and that these activities tended to slip behind more acute management issues. However, because participants were learning how to achieve proximity through other means, the need to prioritise one activity over another was becoming more acceptable. It was previously thought that the best way to achieve close proximity was through ADLs; however, participants were starting to consider that any activity related to a patient’s care provided some degree of proximity.

…as important as doing the little things for patients is, you still need to do the antibiotics and medications. And I guess that is probably more important for them than making sure they are clean. (Annette, EEN: Page 5)

Understanding there was a need to renegotiate proximity became easier for participants because of the need to prioritise and delegate activities. Participants managed their feelings of inadequacy and came to appreciate other ways to achieve proximity by stating that there was a certain immediacy that made prioritisation, and the subsequent delegation, essential and accepted. Delegation generally arose when participants were attending to more ‘acute’ or higher priority nursing activities.
Analysis revealed that rationalising the delegation of one activity to ensure that another patient was attended to in a timely and effective manner appeared to be a coping strategy for participants. Participants stated that while it was important for patients to be properly assessed and to trust their nurse, it was also necessary for some nursing activities to take precedence over others. Competing demands in the acute care sector were inescapable, which meant that participants were redefining what they realistically could, and could not, achieve in a shift. As delegation becomes better understood and the ability to find new ways to maintain proximity becomes easier, the need to rationalise their actions may diminish.

Sometimes there are things going on that just have to be done right this instant, like if someone has chest pain or something like that. You can’t tell the person who has chest pain ‘Sorry I will be back soon, I just have to go and shower Mr such and such.’ (Victoria, RN: Page 6)

Being time poor was encouraging some participants to “think outside the box” when it came to maintaining patient proximity. Time constraints were caused by reduced length of stay, high patient turnover, and increased patient acuity. This meant that staff were managing sicker patients over a condensed hospital stay. While participants believed they should be involved in all patient care activities, many were starting to recognise other ways that the patients’ needs could be attended to through improved use of all staff members. Licensed nurses from this study perceived there was an expectation that they were required attend to every aspect of patient care with many struggling to realise that their inability to manage all aspects of patient care in an eight-hour shift was not related to their incompetence, but rather was because of changing patient characteristics and staff grade mix. Being time poor has resulted in many nurses considering new ways of practicing and redefining ways to achieve patient proximity that was both safe and encouraged holistic care.

You figure out other ways to do it. You have to be innovative, think outside the box. We never used to get the volunteers up here at all but now we use them all the time to do things like chat to the patients, make cups of tea…things you can’t do when you are flat chat…on [the other ward] they now use the volunteers to sit with the patients who keep wandering… (Melissa, RN: Page 15)
In Melissa’s discussion, she made note of utilising the services of the hospital volunteers. This showed that she was attempting to maximise the services and skills available to her by using every member of the team to assist in meeting patient needs. The development of new teamwork strategies to achieve this is described in detail in the developing teamwork strategies theme in the following chapter.

In summary, the theme striving for close proximity to the patient centered on the main idea that when nurses were in close contact with patients, nursing care was holistic and improvements were noticed with patient trust and rapport and feelings of being in control. It was seen as the best way to assess patients and monitor pressure sores, skin integrity, breathing status, and mobility. Frustration with poor proximity commonly occurred when participants couldn’t stay close to their patients; however, feelings of frustration and time constraints were forcing participants to redefine the bounds of close patient proximity. Recognising a new clinical reality and renegotiating patient proximity ensured that nursing staff were able to safeguard their patients from adverse events, an aspect of the nursing role viewed as essential for everyday practice, which is discussed in the following section.

**Safeguarding patients**

The changes in the organisation of nursing practice, as a result of the renegotiation of patient proximity, triggered participants to consider the core roles of nursing. The articulation of these core roles allowed participants to determine which nursing activities could be delegated and which needed to remain in the domain of licensed nursing practice. One of the core nursing roles that emerged from participants’ discussion was safeguarding patients. For participants, safeguarding patients improved their outcomes.

Safeguarding patients was the second theme and describes the actions that nurses perceived improved patient safety and patient outcomes, and reduced the likelihood of adverse events. Participants stated that safeguarding patients from others’ errors and omissions, or the patients’ own illness should be one of an RN’s main goals.

I would think that the registered nurse’s role is as a safety intervention. As a safeguard against multi-faceted incidents such as medication errors, falls, aspirations, failure to rescue, failure to pick up signs in observations that would lead to a
patient decompensating further and having an arrest. A registered nurse’s role is so multi-faceted to prevent failure of human systems. (Derrick, RN: Page 15)

The importance of ensuring safe patient outcomes was an aspect of nursing care that participants stated was encouraged and reinforced by hospital executives. *Synthesising cues and visual observations in assessment, tempering assessment with gut instinct, ramping up critical thinking and piecing it all together* were the core behaviours that participants carried out to safeguard their patients from harm. Each of these core behaviours is a sub-theme of safeguarding patients.

**Synthesising cues and visual observations in assessment**

*Synthesising cues and visual observations in assessment*, the first sub-theme, was discussed as one step toward improving patient safety. All participants agreed that patient assessment was an activity that could not be delegated. Assessment techniques, such as interpreting vital signs, were greatly enhanced when used in conjunction with nursing staff’s acute visual assessment skills. Assessment using visual observation to determine patient needs often occurred unbeknownst to the patient and was performed in many ways—for example, when watching a patient mobilise, supervising a hygiene session, watching them swallow at mealtimes, monitoring skin integrity and granulation of wounds. Other participants discussed the importance of visual assessment when patients’ observations were stable and within normal limits but the nurse could sense that something was “just not right”. In situations such as these, participants underlined the importance of the assessment being performed by a licensed nurse because unlicensed staff may not pick up on subtleties associated with abnormal patient observations. For example, medical equipment can malfunction and provide inaccurate readings, which meant nursing staff needed to be aware and observant for the physical manifestations of patient deterioration. Maria provided the example of a patient who had stable observations, but who appeared unwell and subsequently arrested.

…I think you are looking at their colour…are they comfortable, how is their breathing, are they using accessory muscles, are their shoulders hunched up, just their face, what emotions are they showing, are they grimacing in pain, are they looking relaxed and peaceful, are their brows furrowed, have they got flushed cheeks, are they pale and sweaty, clammy, those sort of things? Do they have that massive
distending jugular sticking out pounding away…you need to be able to put the symptoms or signs that someone is displaying together with what the observations are doing with the patient diagnosis and history. And if those things don’t fit, then being able to say ok something is not right here, or you might look at the patient and they look crap, but their obs are pretty good or they look pretty good but their obs are terrible. (Maria, CN: Page 8)

Learning the skills of accurate visual assessment takes time and experience.

Participants stressed the importance of visual assessment; however, many noted that junior staff did not have these skills with one participant remarking on how difficult visual assessment was to teach. John stated that the practice of nursing was not simply about performing tasks, such as taking a blood pressure, rather it is a complex collection and synthesis of test results, observations, interventions and responses.

[Patients] come in and they’ve got cardiac history, and you need to watch their output and their input to ensure they are not going into failure, and you can physically look at them as well as do the math…got 3 litres in, got 100mls out, and physically you can also then look and hear the patient wheezing [with] their moist chest and [see they are unwell] without even looking at the fluid balance chart…some of the junior staff don’t do it, so you spend your time educating them on the importance of visual assessment, which is a basic skill that they should come out of university knowing. (John, RN: Page 8)

Participants reinforced that only licensed nurses should be performing vital signs.

The use of HCWs to perform physiological observations was believed to be unsafe because these workers had no accountability for their actions and may not have reported or understood an abnormal result. One participant noted that in the United Kingdom unlicensed workers were used to perform physiological observations which she believed was unsafe. Understanding that ‘normal’ differs among patients was seen to be as important as being able to obtain an accurate reading. Maria discussed that HCWs did not have the educational background to interpret visual changes in patients’ condition. She also noted that if a patient’s observations were outside normal limits she would check the blood pressure manually, something a HCW would be unable to do. The importance of understanding physical signs and symptoms, taking accurate measurements and synthesising the information gathered was evident in Maria’s discussion.
...I think if you have someone who really isn’t responsible for a whole lot doing your patients’ observations...they really don’t have the responsibility or accountability for it, so if I’m doing the obs and I think that result is a bit out of the norm or quite unusual for this patient then I’ll go and check it or if I’m not sure I’ll check it manually, I’ll do a manual pulse rather than just read it off a machine somewhere. And I will look at them to see how they are behaving and if it doesn’t fit then I will investigate it further. (Maria, CN: Page 8)

Inaccurate readings obtained by improper technique or broken equipment could lead to the wrong diagnosis, which may result in unnecessary, inappropriate or no treatment being initiated when required. The findings from this study showed that nursing staff looked beyond the spoken word of the patient and investigated abnormal readings even if patients stated that they felt fine.

I guess that’s where the RN’s skill and knowledge comes into it by being able to assess the patient, their base knowledge rather than just going this is how you do blood pressure because anyone can do a blood pressure and anyone can say it’s 120/70 but actually looking at the patient and assessing them at the same time is another skill altogether I guess. So a [HCW] may not be the best person to take observations. (John, RN: Page 8)

Visual observations were considered as important as physiological observations; however, ‘gut instinct’ was also a frequently used term by participants. The use of gut instinct in patient assessment is discussed in the following sub-theme.

**Tempering assessment with gut instinct**

*Tempering assessment with gut instinct* was the second sub-theme and was considered by participants to be important for good patient outcomes. This sub-theme is understood as the use of gut instinct during patient assessment when participants thought “something was just not right”. In these instances, the patient’s technical observations did not suggest any problems; however, participants “felt” the patient’s health was deteriorating through listening to their own gut instinct. A number of participants stated that intuition and gut instinct improve with experience and knowledge and become an essential aspect of holistic patient assessment. As nurses gain more experience, they process information through their senses so rapidly that they often are unaware of individual thought processes. Interpretation suggests that
listening to gut feelings or intuition allows nurses to envisage what might occur and access help earlier to prevent further escalations.

Sometimes you just know something is wrong, even without taking their blood pressure. I’ve had it happen before when a patient of mine was all sweaty and uncomfortable but his obs were fine and then the next minute he arrested. But I knew something was up even before it happened. Nurses’ instinct maybe. (Susie, RN: Page 4)

Patients who “don’t make sense” was a term used by one participant when discussing the use of gut instinct. This signifies a situation that is abnormal but cannot be categorised as being the result of one specific problem. Being aware of these situations and acknowledging gut feelings was seen as just as important as understanding what step to take next. If nurses ignore these situations because they cannot grasp the concept of gut instinct, then patient care is potentially undermined.

I remember when I was a student and my preceptor telling me how important it is when you have patients who don’t make sense…how important it is to tell the nurse in charge if you have a funny feeling about someone. (Jennifer, EEN: Page 8)

While the significance of using gut instinct was expressed by a number of participants, Maria raised the idea of “learning” to listen to gut instinct. In the event Maria described, her patient experienced a cardiac arrest and subsequently died. Prior to this occurring Maria requested a medical review because she was concerned about her patient even though their vital signs were stable. Interestingly, despite the doctor being unable to detect any problems, Maria continued to closely monitor the patient. Despite the poor outcome, Maria stated that had she not listened to her gut instinct then the patient would not have received a medical review.

…Yeah but that’s where you often get those gut feelings from, when you see people who don’t make sense and you learn to interpret those feelings because you can have someone who all night looks crap and you’ve had [the on-call doctor] up there and I know of one specific instance where I just had a feeling and I did obs all night, they just didn’t look comfortable and at 6am arrested and she had meningococcal but we didn’t know. If things don’t fit, then it important to be able to say ok something is not right…that’s where you often get those gut feelings from when you see people [who are unwell] and you learn to interpret those (Maria, CN: Page 8)
An important phrase she used was “learning” to use gut instinct. When questioned further about gut instinct, participants stated that little was taught about intuition or gut instinct during undergraduate training. This highlights the importance of promoting the acknowledgement of gut instinct to new graduates to ensure they understand the possible ramifications of ignoring warning signs. Even if nurses do not understand why they feel concerned, getting help from senior staff should always be encouraged.

Using gut instinct to challenge others’ opinions was also discussed. Rather than blindly accepting others’ plans, participants discussed how nursing staff must use their gut instinct when they believed an incorrect decision had been made regarding patient care. Tanya discussed this topic when she spoke of closely monitoring a patient who she believed was fluid overloaded as a result of excessive IV fluid rehydration.

I guess with this particular scenario, we had actually been watching her because she was elderly and they’d been giving her fluids for three days, six hourly to eight hourly, they weren’t slow fluids but the [medical staff] kept on saying she was dehydrated but we didn’t think so, so we were watching her and she did eventually become gurgly. (Tanya, RN: Page 2)

Tempering assessment with gut instinct was believed to be important for good patient outcomes. Gut instinct often surfaced when patients “didn’t make sense” and motivated nurses to access help earlier to prevent escalations; however, gut instinct was enhanced with experience and on the job “learning”.

**Ramping up critical thinking**

*Ramping up critical thinking* was the third sub-theme. It is understood as the escalating level of critical thinking that occurred during situations where patient care issues required immediate action. While there was a certain level of consistent covert critical thinking, there were many occasions that triggered nursing staff to “consciously critically think” about patient care issues. Occasions that required heightened critical thinking skills included deteriorating patient conditions, poor medical staffing, poor nursing grade mix and skill mix, high levels of agency staff, and high patient acuity. Participants discussed the importance of ramping up critical
thinking because plans and orders from other team members were constantly handed on to nursing staff and it was up to them to be able to work out which ones took priority. Many participants stated that critical thinking skills assisted with prioritisation, which was essential for being “a safe nurse”.

You know people might be attracted to the field of being a nurse for different reasons, but I think in a busy medical ward say, you have to be a good critical thinker, have to work well under the pressure of time and have a lot of instructions and be able to prioritise quickly and re-change it and that’s what you need to be a safe nurse and if you are not that, then you probably shouldn’t really be here because [errors] are going to get through. (Derrick, RN: Page 18)

Critical thinking skills were thought to be difficult to learn, because the process required ongoing experience with exposure to varied clinical conditions. Possessing high quality critical thinking skills was believed to be the first step towards having the ability to practise holistic care from afar, rather than requiring close, continuing patient contact, as discussed in the renegotiating patient proximity sub-theme. Some participants noted the importance of critical thinking skills because of the dynamic nature of the human body. In participants’ experience, medical and allied health staff assessed patients and devised plans of care; however, deterioration of the patient’s condition could render these plans ineffective and even unsafe and it was up to nursing staff to use their critical thinking skills to make this assessment to ensure patient safety. One participant argued that inexperienced nursing staff did not possess satisfactory critical thinking skills with many believing that the input from each allied health area was to be “followed as ordered”. Interpretation of this suggests that experienced nurses see inexperienced nurses following orders “blindly” rather than analysing care plans to ensure they are still appropriate given the patient’s fluctuating condition.

As you gain experience, you also gain confidence to question plans of care. When you first start out you tend to accept plans and follow them as ordered. But as you start to see how everything fits together, it’s easier to see when wrong decisions are made that need to be rectified. (Neville, CN: Page 10)

Discussion of this topic also centred on ramping up critical thinking in response to patient condition changes after assessment and planning by medical and allied health
staff. Specifically, participants stated that patient conditions could change so rapidly that critical thinking skills were ramped up to determine if the proposed patient care plans were still appropriate, despite some plans being made only hours before. Participants stated that they needed an overarching knowledge base to understand and assess all human systems because they were at the bedside, caring for patients 24 hours a day, and sometimes days after medical care plans had been made. Derrick provided the example of a patient who received a physiotherapy review. In his discussion, he stated that even though a physiotherapist states a patient is safe to mobilise, a nurse must ascertain on a daily basis if this review is still relevant because of medical condition fluctuations and environmental changes such as the addition of IV poles.

I think that probably the role that nurses should take, should be about overseeing patients as a whole. So you might have a physio working with the patient all the time, but I actually think we should work with the patient too. They might say mobilise this patient but you might actually see that they have three IV poles. The assessment was done a few days back but they’ve now deteriorated since that medical assessment was done and you won’t mobilise them, you won’t just follow what’s written as an order. You have to use your critical thinking so as an RN I think you should be a critical thinker and have a holistic point-of-view for the patient and I think that’s a role that should be pushed and there is a fair bit of research to say that that could be significant. (Derrick, RN: Page 15)

Meagan discussed a scenario where her patient received a speech pathology review. If the patient was noted to choke or cough on swallow, Meagan stated that she would not feed them “just because the speech pathologist has stated they had a safe swallow reflex”. This reinforced what Derrick stated, in that nurses must constantly use their critical thinking skills to ensure care plans remain valid.

But as your knowledge increases, you realise how much you have to think critically for yourself. An example would be when I had a patient who was reviewed by [speech pathology] on a Friday and then on Sunday he was choking on his thickened fluid. You can’t just keep following plans, because patients change so quickly and you have to be ready to make the assertive decision to say ‘no I won’t do that’. (Megan, RN: Page 9)
Derrick’s idea of preventing adverse events by using his critical thinking skills provided the visual picture of nursing staff as an overarching safety umbrella that kept patients protected against errors, falls, and other adverse events. Improving patient recovery and expediting discharge from hospital appeared to be Derrick’s main reasons for stating nursing’s main role was to safeguard patients.

Participants noted that some unlicensed staff did not appear to use, or even possess, critical thinking skills. This lack of critical thinking skills was discussed in relation to the failure to report abnormal readings. Participants stated that failure to report abnormal results was extremely dangerous because the patient’s condition could deteriorate very quickly to a point where more serious intervention was needed. John experienced this when he was working in the United Kingdom and a HCW was taking vital signs. The HCW didn’t have the appropriate critical thinking skills to understand the implications of an abnormal reading, which resulted in them failing to report a hypotensive patient to the nurse in charge. Understanding the implications of physiological observations and getting timely medical reviews before further patient deterioration was the main benefit that John discussed as to why licensed staff should take vital signs.

I know in England they do, they have [HCWs] trained to do obs and they just come and tell you the results, they do the whole lot and come back and say patient in bed one has got a BP of 80/40 and you say ok then you go back and check and find out they’ve done every other patient obs before they’ve come back and told you. It’s dodgy, they don’t have the critical thinking skills to be doing work of that calibre…if you had of gone and done it straight away who knows, you would have gotten on top of [the problem] a lot easier. (John, RN: Page 8)

Ramping up critical thinking skills improves patient safety and is believed to help prevent adverse events. Critical thinking skills allow nurses to assess patient care plans and determine their appropriateness at the numerous stages along the patients’ recovery pathway. Knowing when critical thinking skills need ramping up was seen to be as important as just possessing the skills.
Piecing it all together

Another method for improving patient safety was through piecing it all together. *Piecing it all together*, the fourth sub-theme, involved nursing staff pulling together the diagnosis, treatment and symptoms to get an overall picture of the patient’s health and response to nursing and medical care. Being able to piece together aspects of patient care was one way that participants believed reduced the likelihood of “[errors] getting through”. In particular, one participant saw it as a way of preventing adverse events and likened the nursing skill of being able to piece it all together as that of a “safety intervention”. The hospital setting is meant to be a place of healing and recuperation; however, many participants saw it as a high-risk environment where harmful events needed to be “fought off” by nursing staff. It was this multi-faceted role that nursing staff fulfilled that allowed them to successfully manage and guide their patients safely through the hospital system.

In [actual] fact, I’m in control of all of this and [allied health] are giving input from their disciplines and that’s all they do because I am in control and I am putting it all together. I probably think there’s a knowledge deficit for most RNs in that field and a lot of new RNs might not be able to add it all up, and put it all together. (Derrick, RN: Page 15)

“I’m in control of all this” was a strong statement made by Derrick. Some might believe that it is the medical staff who control patient care but as Derrick states, medical staff give their input, nurses connect it all together to establish how it fits with the patient at any one particular time and then implement their choice of action.

Being able to piece together acute symptoms “on the spot” was viewed as an important step toward safeguarding patients from adverse events. Tanya discussed a patient who became acutely fluid overloaded. Tanya was able to link the patient’s shortness of breath, his age, the regularity of his intravenous fluids and the need for medical attention. When Tanya “added up” the patient’s symptoms, history and treatment, she made an assessment of the patient that was reinforced by the reviewing doctor. Knowledge of potential risk factors was also noted by Tanya, which made it easier for her to make her an informed decision to notify medical staff. Piecing together the signs and symptoms of this patient’s condition safeguarded the patient from further deterioration.
So a patient, an elderly man, was short of breath, he had heart failure and he had had [IV] fluids going for a few days. When I put it all together I was worried. It was clear he was becoming overloaded, so I called the doctor, and the doctor came and said he was over loaded and needed some Lasix. An IVC was inserted, and the Lasix was given. I think it was significant that I assessed the patient in this instance. (Tanya, RN: Page 1)

Licensed nurses’ overarching knowledge and the ability to piece it all together meant they were a “safety device” for their patients in being able to fend off possible harmful outcomes sometimes associated with the fluid nature of the human body.

Piecing it all together to be a patient advocate was also discussed. Participants spoke of the importance of piecing together the patient’s needs to get appropriate reviews from allied health for discharge planning and to ensure patients were receiving all the appropriate care and intervention. Kathy stated that nurses act as a patient advocate to ensure safe decisions are made about their care and believed her ability to piece together different aspects of patient needs improved this advocacy role.

There is a lady there at the moment, she’s not safe to go back to her own room at the hostel because she’s having falls so I liaised with social worker and OT to get them to assess her and she is going back to where she came from, but they are getting a little bit more care and they are going to [assess her suitability for a nursing home]…and then put her into a high care [nursing home facility]. OT did a mini mental [state assessment] to see how she is going with showering and the physio assessment for her mobility because she is not walking too well and is refusing to use her frame. Being able to put together all their complaints to work out their needs is so important when you work in a medical ward like this. (Kathy, RN: Page 3)

As already discussed, piecing together patient information was also seen as a way to negotiate patient proximity when care was divided between nursing staff. Synthesising cues and observations in assessment, tempering assessment with gut instinct, ramping up critical thinking and piecing it all together were the core behaviours that participants carried out to safeguard their patients from harm. The importance of maintaining close patient proximity and safeguarding patients from adverse events was discussed by many participants; however, this discussion was contradicted during discussion of the following theme, privileging patients without
mental illness or cognitive impairment. While the next theme still encompassed many discussions around improving patient safety and maintaining close contact with patients, it was more often discussed in relation to patients without mental illness or cognitive impairment. While not all participants were noted to be privileging particular patients, the participants who had strong ideas that could not be overlooked. The importance that participants placed on holistic care in their discussion of the benefits of patient proximity was not carried into their discussion of caring for mental health patients or those suffering from cognitive impairment. This theme is discussed next.

Privileging patients without mental illness or cognitive impairment

The third theme to emerge from the data was privileging patients without mental illness or cognitive impairment. This is understood as the actions and attitudes of participants that gave benefits to medical and surgical patients over others who were suffering from some form of cognitive impairment or mental illness. Patients without mental illness or cognitive impairment were seen as more deserving of nursing care in the acute medical and surgical environment because participants perceived they fitted the mould of what an acute care patient should be. When patients were labelled as ideal acute medical or surgical patients, care was considered easier to provide because the ward facilities and nurses’ abilities were aligned with patient needs. Some participants commented that mental health patients should be cared for in mental health facilities even if these patients had acute medical or surgical conditions. Specifically, if patients suffered from behavioural changes such as agitation or wandering, they were seen to be out of place in the acute care setting. While not all participants discussed this issue, those who did expressed such aversion to caring for patients with cognitive impairment or a psychiatric illness that it could not be ignored. All the events discussed in relation to this theme involved patients who were suffering concomitantly from a medical or surgical issue and a mental illness or cognitive impairment.

[Mental health patients] just cause more problems for us than it’s worth to have them…I shouldn’t have to deal with the aggression and I mean it’s our role to calm down the other patients…but they shouldn’t be there in the first place, the calming down shouldn’t have to happen, that patient shouldn’t be on a medical ward. (Derrick, RN: Page 19)
The management of physical conditions was seen to be within the customary practice of participants who were working in acute medical or surgical wards. Move outside of this and introduce mental health or cognitively impaired patients and some acute medical and surgical nurses feel uneasy. Participants felt uneasy for many reasons: lack of time to be able to “talk them down”, lack of specialised skills, reduced contact with their medically unstable patients, and a knowledge deficit related to specific mental health procedures for particular situations. Tanya’s comment was typical of those who discussed this topic.

You know I just don’t think they should be on [this ward]. Half your night is gone if one patient decides to go off because you have to sit with them and calm them down…and goodness knows what is going on with the other six patients I am meant to be looking after. (Tanya, RN: Page 12)

Providing one-on-one nursing to medically stable but mentally unstable patients, managing behavioural flare-ups, and transporting these types of patients between facilities were the most commonly discussed activities within this theme. It is interesting to note that unstable mental health patients were not seen as ‘sick’ and participants stated that providing nursing care to these patients should not be part of their customary practice.

I had to transport a patient to the [dental hospital] once…they were a psych patient who had a dental abscess. It really annoyed me…I thought to myself that I wouldn’t have a clue what to do if they went off in the taxi or anything. (Elena, EEN: Page 12)

Caring for the cognitively impaired or mental health problems challenged participants’ ideas on what customary practice encompassed. This challenge then presented itself as a decision point for nursing staff. While there were a number of courses of action to take at this time, the majority of nursing staff tended towards the declaration that physical problems encompassed the majority of their practice and anything that challenged this should be avoided. This notion of cognitive problems being outside of nurses’ customary practice is interesting as it contradicts many participants’ discussion of their desire to provide holistic care as discussed in the good nurses work in proximity to the patient theme. This indicated that participants had their own personal understanding of how holistic care should be delivered and to whom.
I don’t even know why we are having to nurse these patients in the first place. I’m just not sure even if they need our care…they get specialised by [HCWs] who aren’t even nurses, which says to me that it’s a waste of time having them on the ward because they aren’t even getting nursing care. The sick patients get specialised by RNs and ENs so what does that say when they get specialised by [HCWs]? (Tanya, RN: Page 13)

Multiple responsibilities, which cause conflict between the activities nurses had to perform and what nurses thought they were employed to do, appeared to cause frustration for participants. For a number of participants, providing nursing care to patients who were suffering from mental illness, in addition to the care they must continue to provide to other patients, caused conflict. Participants believed they were employed to provide nursing care to a particular cohort of patients and stated they experienced inner conflict when these patients took “second place to patients who were going off”. For example, when medical patients required care, the needs of the other patients could be managed and juggled at the same time, meaning they did not require exclusive, prolonged intervention by nursing staff.

I chose surgical nursing because I want to provide care to patients undergoing surgical procedures. If I wanted to be a psych nurse I would have gotten a job in [that ward]…it’s just not fair when you have post-op patients wanting some pain relief but you can’t get to them because the patient in bed four is trying to abscond, it happens so often…it means that both patients aren’t getting the care they need. (Tanya, RN: Page 14)

The pressures on nursing staff to manage sicker patients who were pushed through the system more rapidly meant that some participants thought mental health and cognitively impaired patients were not receiving the care they needed and would be better managed in an environment suited to their condition. Additionally, they believed their skills were being wasted because the nursing care they were providing wasn’t aligned with their acute medical or surgical nursing skills.

There were three sub-themes within this theme: (1) prioritising physical conditions; (2) disrupting ward routines; and (3) decreasing quality of care.

Prioritising physical conditions

Prioritising physical conditions, the first sub-theme, was the precedence that nursing staff gave to conditions that had physical signs and symptoms, such as pneumonia or
myocardial infarction. Participants prioritised physical conditions because they saw these as “more acute”, requiring them to be managed first. Additionally, physical conditions were prioritised because they generally took less time to complete. For example, dressing a leg ulcer or administration of Anginine for a patient suffering from chest pain was easily initiated and completed; however, the time it took to establish a trusting therapeutic relationship with a patient suffering from an acute psychotic episode so that interventions could be implemented was viewed as somewhat longer and more “frustrating mentally”. Participants prioritised quick treatment over mentally exhaustive prolonged psychiatric treatment, such as trying to “talk down” mentally unwell patients.

Nursing is all about prioritisation, especially when it’s ridiculously busy…a day can be organised when you know how long every job will take, like 20 minutes to do the dressing, 15 minutes to change the sheets and 10 minutes to organise a physio review. But it’s hard when a patient is agitated and you know it will be an indeterminable time before they are settled…I personally don’t know how to manage that with all the other jobs I have to get done in a shift. (John, RN: Page 17)

The mental fatigue related to managing patients with mental health problems or cognitive impairment was a struggle for some participants. Participants who discussed this topic believed that one wrong word spoken to cognitively impaired patients could make them “go off” so they were constantly on their guard to be aware of their language, their actions, and other possible stimulants.

…heavy stroke patients are physically demanding but trying to calm down an agitated patient really takes it out of you because you are constantly searching in your head for the right thing to say to make them go back to their bed and calm down. (John, RN: Page 17)

Area of expertise influenced the prioritisation of physical conditions. Participants discussed how mental health nurses received extra training on how to manage behavioural disturbances and most had postgraduate qualifications that resulted in an endorsement as a mental health nurse. Participants were of the opinion that if they were going to continue to care for these types of patients, extra training would be required to prevent unnecessary events where patients were managed inappropriately. Improving knowledge and de-escalation skills may influence acute medical and
surgical nurses’ perceptions of the types of patients they should be caring for because they would be better equipped with the necessary management and de-escalation skills.

My friend who works in [mental health] has done post-grad studies…the stuff we get taught as students really doesn’t help. (Tanya, RN: Page 6)

Prioritising physical conditions often meant less time was available for the management of behavioural disturbances or other mental health issues. This resulted in participants trying to quickly manage these situations, which often had the reverse effect requiring extended nursing time to “start from scratch”. Participants stated that they did not have the time for these events because they had other medically acute patients, which was the nurses’ first priority. Mental health patients were seen to require more one-on-one time, which participants’ thought was over and above their already brimming workload.

If that patient becomes violent and aggressive, all of a sudden your attention goes to that patient…while that person over there is having chest pain…you then have to spend time calming the other patients down. You got a chest pain, chances are this person over here calling out abuse is going to set off a chest pain, so you’ve got to go and sort that out. In a ward like this you just don’t have time for it. (John, RN: Page 16)

The one-on-one time required for patients with mental illness or cognitive impairment was difficult to justify given the environment in which participants were working. However, the one-on-one time needed for a patient suffering from chest pain was seen as warranted. “All of a sudden all your attention goes to that patient” was a comment that exemplified the feelings of many participants. The extended time needed to treat psychiatric patients meant that no other patients received nursing care during this period; however, when medical patients required care, the needs of the other patients could be managed and juggled at the same time, meaning they did not require exclusive, prolonged intervention by nursing staff.

A lack of collaboration between hospital departments was also noted during the interviews. Each unit appeared to be a separate, distinct department working to provide care only for patients who fitted neatly into their diagnosis related group.
Provision of care to patients outside of this group frustrated participants because they were limited in the care they could provide to their “own” patients. “This is what I have been employed to do” was a comment from Tanya that exemplifies this notion. This was also reinforced by another interesting comment by Elena who spoke of caring for patients from other departments:

I don’t like it when [they] admit patients from other wards onto our ward. Why should I have to care for their patients? …and generally they always give us the crappiest patient [of theirs]...and we have to manage them and we don’t really know what is the best way to manage that type of patient because we are medical nurses. (Elena, EEN: Page 7)

The differing patient loyalties, reinforced by participants’ job titles, was interesting considering the comments made by many participants earlier in the interview when they stated they wanted to provide holistic patient care. This showed that participants wanted to provide holistic care to patients of their choice, namely the patient type commonly associated with the participants’ ward of employment.

I didn’t choose this ward to care for psych patients, I chose it because I enjoy orthopaedic nursing. (Melissa, RN: Page 6)

For some participants, providing one-on-one nursing care to mentally ill or cognitively impaired patients was viewed as “non-acute nursing”. For example, one participant stated that a patient with pneumonia was more acute than a patient with cognitive impairment who had the potential for an acute behavioural disturbance at any time. Interestingly, the cognitively impaired patient with the potentially unstable mental health condition was seen as a waste of nursing time because their immediate nursing needs were not as great as the patient with pneumonia. Monitoring of potential mental health problems was not viewed by acute medical or surgical nurses as being within their accepted daily practice.

Sure you could send a [HCW] special in because you don’t really have to do much for them but you are still responsible for that patient, you still have to oversee what the special is doing…it’s got to be a lot easier to manage rather than worry about that person running away, while the sicker person over there is having chest pain. (John, RN: Page 15)

The inability to see the significance of being available for potential mental health problems was in contradiction to participants’ earlier comments about the importance
of synthesising cues and visual observations for safe patient care. This appears related to some participants’ belief they had a knowledge deficit related to cognitive and mental health illnesses. It is possible that participants underestimated their ability to detect slight changes in these patients, which translated into many participants making blanket statements that they were ill-equipped to provide appropriate care; however, it is also possible that participants were making sound judgments related to their scope of practice and safety in practice. It is an essential aspect of nursing practice to understand ones own limitations and participants may be voicing valid concerns with regards to managing cognitively impaired and mental health patients in the acute setting.

Participants did not see that the mental health patients’ potential to deteriorate, which can often occur quite rapidly, as being a sound enough reason for their skills being used to “special” patients. Rather than “hanging around waiting for them to go off” participants believed that they should be involved in direct nursing care to patients who were “actually sick”. John’s discussion of being a “human alarm” exemplifies the idea that mentally ill or cognitively impaired patients’ potential for deterioration was not important enough for acute care nurses to be used in their care.

I shouldn’t have to be chasing patients bringing them back to the ward…human alarms basically and that’s what we are… but as an RN, I just shouldn’t have to be chasing psych patients. When we have a special here and they go off…our whole attention then goes to that one patient that’s going nutbags…I mean that’s more of a psych nurse’s role (John, RN, Page 17)

Being a “human alarm” indicated that in deteriorating situations, nursing staff alert others so that they are able to step in and take over. The term ‘alarm’ infers that nursing staff do not have the skills to manage behavioural disturbances, rather they are only present to alert others to behavioural changes. John’s comments were reflected by other participants. Many stated they were merely there to raise the alarm should a situation arise. There were no participants who believed they were a solution to the problem. Analysis of this reinforces the notion that medical and surgical nurses do not have, or do not feel they have, the skills to effectively manage acute mental health conditions.
...when patients really get aggressive and agitated we have to call the [medical officer] to get some diazepam written up and then if that doesn’t work, security has to come up and restrain them to the bed...then it’s a waiting game to see if works. (Tanya, RN, Page 7)

All participants who discussed this topic placed emphasis on undertaking nursing tasks not nursing supervision. Interestingly, patient allocation was also determined by the number of interventions patients required rather than the actual acuity of the patient or the potential for problems; therefore, nursing staff were expected to ensure that patients were adequately supervised while still attending to all technical tasks for their remaining patients. It was their view that taking time out to manage a behavioural disturbance was precious time taken away from acutely unwell medical or surgical patients. They did not see it in reverse. This indicates that potential problems or potential deterioration in a patient’s mental condition is not given the same importance as actual medical problems when patient allocation occurs.

In the mornings the [in charge nurse] will ask night duty if [the patient] has had a quiet night. If it’s been a good night then [the patient] will be allocated like any other patient on the ward, no matter if yesterday at 2pm they went off. (John, RN, Page 17)

Interestingly, participants did not discuss how nursing staff have highly developed assessment skills that could be used when caring for mental health, cognitively impaired or seemingly medically stable patients. In all the examples provided, there was potential for health deterioration. Licensed nursing staff possess patient assessment skills that may assist in identifying the early signs of agitation and aggression in mentally unstable patients, which may go unnoticed if HCWs were attending to them; however, if HCWs are used in this manner, specialised training may assist in the management of patients under their care. Participants wanted to provide holistic care; however, they believed they didn’t have the skills, the time, or the staffing numbers to provide this type of care to cognitively impaired or mental health patients as well as ensuring that all patients on the ward received safe and timely care. The time limitations placed on acute medical and surgical nursing staff demonstrated that participants perceived the physical aspect was all they had time to care for.
Disrupting ward routines

*Disrupting ward routines* was the second sub-theme. There were accepted activities and accepted time frames that participants stated should be adhered to in the acute care setting. Admission of patients who were cognitively impaired generally disrupted these accepted routines because of their unexpected behavioural disturbances, which caused stress for nursing staff and impeded the care of other patients.

…he was admitted and then the rest of the night was insane. I didn’t get a chance to do half my work, or even have a break…even with the help of [the in charge nurse]. (Melissa, RN: Page 7)

Another reason why the routine was disrupted, aside from the increased patient needs related to behavioural disturbances, was because grade mix and skill mix did not appear to be taken into account when acuity changed as a result of these patients being admitted. Participants from both hospitals stated that acuity was determined by the number and types of patient care activities that nursing staff had to perform. This meant that patients whose conditions required less measurable intervention (e.g. developing a trusting relationship), compared to measurable intervention (e.g. administration of antibiotics), were not seen to increase a ward’s level of acuity. As a result, the workload was not acknowledged and extra staff were not provided, which forced nurses to attempt to manage the increased workload associated with the admission of cognitively impaired and mental health patients. This resulted in many participants stating that the ward routine was “turned on its head” when these patients were admitted.

It’s so hard to get anything else but a [HCW]…usually we need an extra RN or an EN but they don’t give it to us, it’s so frustrating. (John, RN: Page 16)

The management of aggression was one of the most commonly discussed issues that disrupted the ward routine. The disruption that was created when patients became unsettled was viewed as detrimental to the health of the other acutely unwell patients with the lack of appropriate facilities to effectively manage aggressive mental health patients within an acute medical unit causing even more frustration. One participant discussed a patient with schizophrenia who was withdrawing from non-prescription medications. The nurse was particularly distressed because of the effects it had on the
other patients. One patient located in the same room had a pneumothorax with an intercostal catheter connected to suction. John spoke about how this patient wasn’t even able to leave the room when the patient “went off”; she just had to sit through the chaotic situation. In this instance, the notion of “going off” is understood as aggressive, threatening behaviour towards staff and other patients, yelling and throwing of items around the ward.

There was no where for her to go on the ward…so we had three security guys come up and they grabbed her and took her downstairs and put her in the isolation room in A&E…you have the other six patients just in that bay and it’s loud and distressing for them…she ended up having to come back up to us because there was another patient admitted to A&E who needed the isolation bay. It’s just not acceptable to care for these types of patients on general wards without the appropriate facilities. (John, RN: Page 17)

Some participants discussed their annoyance when ward routines were disrupted because of mental health and cognitively impaired patients. Participants stated that these patients should not be admitted to medical and surgical wards because they believed mental health wards were better equipped environmentally and professionally because the nurses had the training to administer IV antibiotics, whereas medical nurses did not have the training to manage acute psychotic situations. John stated, “they are quite happy to send [mental health patients] to us.” John then went onto say that mental health units were reluctant to accept a medical or surgical patient to their area. It appeared that participants were overlooking that a mental health patient would be admitted to an acute medical or surgical ward because they required acute medical care in addition to acute psychiatric care.

**Decreasing quality of care**

*Decreasing quality of care* due to poor skill level and knowledge deficits, in the field of mental health and cognitive impairment, was the third sub-theme. Participants believed quality of care was declining because nursing staff were spending increased time attending to behavioural disturbances rather than providing effective and efficient care to all patients. It appeared that when basic nursing roles (such as being able to attend to wound dressings or provide care for a patient with a tracheostomy) were disrupted as a result of poor management of behavioural disturbances, job strain
developed. The resulting reduced quality of care for all patients—mentally ill patients included—added to the stress that nurses, like John, were experiencing.

We can’t give them the proper attention they need. We haven’t got anywhere to take them away if they are causing problems. It just takes away the nursing hours from the other patients and you don’t need it. It increases your workload heaps…there’s another five patients as well. (John, RN: Page 16)

One particular incident, discussed by John, exemplifies the knowledge deficit and resulting poor quality of care for mental health patients. In this scenario, a patient absconded because ward staff were unfamiliar with mental health paperwork. The patient was on an inpatient involuntary treatment order, which meant that they were unable to leave the ward unless escorted by a licensed nurse or medical officer. The patient did manage to leave and John believed it reinforced his argument that most RNs require further training to understand the legalities and needs of psychiatric patients. In particular, John stated he needed education on the types of psychiatric treatment orders, their related paperwork, and nursing interventions needed relative to each type.

…we had one patient come over from [the psychiatric ward] that was voluntary, anyway we thought she was voluntary… anyway the psych consultant came over and said where is such and such and we said don’t know, she’s gone down for a smoke. [The psych doctor] goes she’s not voluntary, she’s on a community treatment order and we go well this is what we were told on this bit of paper and it said they were voluntary so then we had to go through calling the police and calling their home…had we had more knowledge of the paperwork to look for, we could have said no you can’t go off the ward (John, RN: Page 18)

Patient outcomes have the potential to be jeopardised when nursing staff are unfamiliar with mental health diagnoses, related paperwork and management strategies. The resulting poor patient outcomes appeared to influence participants’ decisions in determining which activities they believed were outside of their scope of practice. Analysis has shown that if nursing staff believed they could not provide adequate, patient-specific care then they felt they shouldn’t be involved in these activities. In the example that John provided, there was potential that the patient who had absconded could have come to harm. When John discussed this, he appeared
quite upset at the thought of a patient under his care being harmed. Had John been aware of the mental health paperwork and behavioural management skills, his idea that caring for this patient was outside of his scope of practice may have changed.

Analysis of the data established that the use of acute medical and surgical nursing personnel to provide care that was more closely aligned with mental health nursing was detrimental to the job satisfaction of acute medical and surgical nurses. All participants who discussed having to attend to mentally ill or cognitively impaired patients commented on the immense amount of frustration that it caused. The continued use of licensed nurses to special patients implies there is a potential for acute deterioration in these situations. Increased frequency of lawsuits in health care means organisations are trying to prevent possible patient incidents and improve patient safety. The use of licensed staff with specific training to special the types of patients discussed by participants is one way of achieving this; however, participants were less attuned to considering the potential for actual mental health problems resulting in medical and surgical patients being prioritised because their needs were perceived to be more immediate and urgent.

**Summary**

This chapter described three themes that emerged from the data that related to direct patient care. These were (1) **good nurses work in proximity to patients providing total patient care**; (2) **safeguarding patients**; and (3) **privileging patients without mental illness or cognitive impairment**. The importance of maintaining close patient proximity and safeguarding patients from adverse events was discussed by many participants; however, many believed they did not have the skills to safeguard patients with mental illness or cognitive impairment due to knowledge deficits. The next chapter will describe the final two themes related to indirect patient care.
CHAPTER FIVE
Indirect patient care

Introduction

Chapter four presented three themes related to direct patient care and the constructions between nursing staff, nursing activities, and patients. This chapter presents the final two themes related to indirect patient care. These two themes—developing teamwork strategies and picking up the slack to ensure patient safety—emerged from the constructed working relationships between staff, both nursing and allied health.

There were many non-clinical activities that RN participants discussed as undertaking on a daily basis. These included managing other levels of staff, allocating patient loads and activities, and staff education. All the activities discussed were managed concurrently with direct patient care, and were causing stress as participants struggled with how to manage their workload. In response to their expanding workload and changing grade mix of staff, participants were developing teamwork strategies, which is the first theme discussed here. Picking up the slack to ensure patient safety, the second theme discussed, describes the feelings that participants experienced, and strategies they employed, when they were involved in activities that they believed should have been undertaken by other hospital employees.

Developing teamwork strategies

The developing teamwork strategies theme describes the tactics that participants developed to manage the changing mix of patient care providers in the acute setting. The importance of developing effective teamwork strategies evolved as licensed nurses examined what it meant to work in nursing teams where members had differing levels of knowledge, skills, and responsibility. The development of teamwork strategies grew out of participants’ acceptance of the changing acute health care environment. This acceptance and movement towards the development of innovative teamwork strategies appeared to alleviate the frustration that was commonly experienced when unrealistic workloads were placed on nursing staff and was another way that participants were able to maintain patient proximity.

Developing creative teamwork strategies assisted in the maintenance of patient
proximity and good patient outcomes regardless of mix of patient care providers. In this environment, working alone and avoiding teamwork in an effort to be seen as a “good” nurse who does everything for their patients was detrimental to patient care as described in the theme good nurses work in proximity to patients providing total patient care, described in chapter four. Being willing to accept help and respecting the input from other levels of staff ensured that good patient outcomes were achieved in a timely manner. While teamwork limits the provision of total patient care by individual nurses, it encourages the uptake of various types of nursing workers. Teamwork also ensures that when the RN picks up activities the EEN and EN cannot do, they will gain help from the EN in other areas in return. When participants spoke of working in teams, they usually spoke of a team that included an RN, EEN or EN. In the following example, Melissa spoke of administering all the medications, while she asked an EN to check and record the vital signs of those same patients. Between them, they provided all the care to one group of patients.

Usually if I’m struggling I’ll ask an EN to do my obs for me…and if I’m helping someone else out, then I’ll always ask them if they can help me out in return. Most of the time they do. It can get quite hard when you’ve got two ENs on and three RNs or whatever. Everyone needs to get in and help out. We are getting better at this. (Melissa, RN, Page 12)

There were three sub-themes within ‘developing teamwork strategies’: (1) delegating activities; (2) trading tasks; and (3) valuing others. Licensed nurses have had to learn the process of delegation. While delegation was not a new concept, participants stated that previously the opportunities to practise it had been scarce; however, it appeared that with greater numbers of HCWs in the acute health care system, delegation was becoming increasingly necessary. Valuing other team members and staff approachability were also linked with delegation. Each of these is expanded upon in this section.

**Delegating activities**

*Delegating activities* was the first sub-theme of *developing teamwork strategies*. Following assessment by RNs, aspects of care were delegated to EENs, ENs and HCWs. Delegation also occurred between RNs; however, the most commonly discussed situation was delegation from RNs to HCWs. Data analysis established that if staff were unclear about the process of delegation, or the way to manage other
levels of staff as they provided delegated patient care, they were less likely to see delegation as a solution to increased workload pressures. It was for this reason that delegation emerged as an area of contentious findings. A number of participants spoke of how delegating activities such as hygiene cares, taking observations, and feeding patients caused guilt because they believed they should have been able to manage these tasks independently. The idea that nursing staff should be able to attend to all nursing needs for their patients was mentioned by several participants and characterises the good nurses work in proximity providing total patient care theme; however, accepting assistance from HCWs and working towards a common goal with colleagues was the common idea throughout the teamwork theme.

Sometimes it takes two of you to shower somebody. It could be you and a [HCW] which would mean that you aren’t tying up two registered nurses. Now that we have more [HCWs] on the ward it means that the RNs can focus on the important activities and the [HCWs] can help with the basic ADLs. (Karen, RN: Page 8)

Many understood that delegation was an essential step towards achieving a realistic, practical, and safe workload but were unclear how to incorporate it into their practice. It is possible that delegation caused such a quandary because the opportunities to practise it had previously been minimal due to the small numbers of HCWs employed in the acute system, and, as comments from participants implied, that delegation from RN to EEN or EN was uncommon. It would be expected that as the numbers of HCWs increase within the acute health care system and the processes of delegation are learnt and practised, delegation and the associated supervision will become customary and result in staff being more comfortable with the practice.

The difficulty of delegation was noted in many participants’ stories. It was common for participants to discuss “asking for help” from HCWs, indicating they were aware of the value of teamwork and the utilisation of all levels of health care workers, but were uncomfortable with the act of delegation and unsure of how to maximise the role of HCWs. The findings associated with HCWs also reflected that the data collection period occurred during a time when there was a sharp rise in the numbers of HCWs in acute wards and nurses were struggling with the integration of these workers into their practice. Previously licensed nurses didn’t have the assistance of HCWs, which
resulted in staff being more likely to battle on through their work without utilising the newly introduced roles.

…sometimes I even forget that I can ask the [HCWs] to help with showering and other stuff. We usually just get on in and do it because for so long we haven’t had anyone around that was free. (Annette, EEN: Page 8)

Battling without assistance indicated participants were not only unused to the HCW role, but that they were also uncomfortable with delegation. Rather than risk being perceived as lazy, participants continued to be involved in the care of their patients even when HCWs were capable of attending to the activity. This reinforced the belief that many participants were struggling to overcome, that total patient care should be the goal of all nurses. John’s comment was typical of many others.

I’d ask for help, I wouldn’t just say ‘can you wash that patient?’ I’d say can you give me a hand with washing this patient…there are plenty of people who would say ‘just wash that patient’, but I just don’t feel right about it. It feels like I’m just palming off my slothy work, the work I don’t want to do. But it doesn’t bother me if I have to do it or not, I just have other things the [HCW] can’t do. It’s just not me. (John, RN: Page 6)

Relationships and knowledge of the person accepting the delegated task greatly influenced what was assigned to them. Participants spoke of how trust builds up over time and through working with each other, colleagues begin to know each other’s capabilities. The idea of delegating tasks then becomes less unreasonable and more accepted. Experienced staff members were more comfortable with teamwork and delegation than newer staff members. It appeared that length of service influenced work relationships with new graduates and unlicensed nursing staff. Sandra, who had over 20 years of experience, felt very comfortable with delegation:

I have nothing against ENs and the new grads ‘cause I love them dearly, but they just don’t get how it all works…I really learnt how to delegate when I started to be in charge…there’s just no way that I can manage the whole ward without help and if I don’t delegate certain things then the day goes to shit. (Sandra, RN: Page 11)

Delegation was becoming an inevitable practice for many participants. The ability to ensure that patient care was attended to in a timely manner rested partly on the
motivation and knowledge of how to delegate. The realisation that delegation didn’t
equate with laziness or simply being bossy was a common hurdle for participants.

Trading tasks

Trading tasks when others provided help constitutes the second sub-theme. Trading
tasks between nursing staff was a strategy that some participants used to ensure the
workload was evenly spread among colleagues. Initiated when RNs were asked to
assist with activities that EENs could not undertake, such as administering IV
antibiotics, trading tasks resulted in RNs asking their colleague to complete an
activity for them. For EENs, trading tasks commonly consisted of undertaking patient
observations for the RN in return for assistance with their IV medications. Trading
tasks enabled EENs to return the favour, and was important because of the positive
effects this reciprocity had on team morale and job satisfaction. The principle of
trading tasks was not discussed in relation to RNs delegating to HCWs, rather it was
in relation to EENs asking RNs to administer IV medications to EENs patients in
return for EENs completing another activity for the RN.

If I need to get the RN to give them their antibiotics, I’ll write
them up and get them ready, but I don’t mix them or
anything, I know I’m not allowed to but I wish I could
because then it wouldn’t be such an ask for the RNs…I mean
they have so much other stuff to get on with. Even then I
always try to help out…like do their feeds or stuff like that.
(Jennifer, EEN: Page 5)

A number of EEN participants stated they felt guilty when they asked RNs to assist
them, knowing they already had many other responsibilities to attend to. Moreover,
one RN participant spoke of EENs avoiding asking for assistance because they didn’t
want to add to the RNs workload. Specifically, she noted this with regard to the
administration of PRN or ‘as required’ medications. Legally, EENs were not allowed
to authorise the administration of PRN medications, and were required to discuss
patient needs with an RN who would then assess the patient and the need for the
medication. Some EEN participants believed their inability to dispense all forms of
medications was a burden on other staff members; however, if they were able to
return the favour by undertaking another of the RN’s activities, they felt less
burdensome to their colleagues.
…I saw everything that happened because the patient had asked me for some Panadeine. I said I would come back but when I did I saw that he’d already been given it. I asked the two other girls on and neither of them had been asked about it, so only [the EEN] could have given it. I guess she was just trying to placate the patient and the rest of us were so busy but it makes you think what else goes on that you don’t know about. (Melissa, RN: Page 4)

Trying to “placate” the patient might have been the reason behind the EEN stepping outside of her scope of practice; however, had the other nurses not been as busy she may have been more inclined to ask for assistance. Such extreme busyness may make the RNs seem unapproachable and may result in EENs and HCWs making unsafe decisions for fear of adding to the workload of RNs. If the EEN had offered to trade a task, then the request may not have seemed too much for the RN to handle in conjunction with her already full patient load.

Trading tasks not only attempted to reduce tension between staff, but improved the timeliness of patient care. For example, when an EEN had a patient that required IV antibiotics they would seek out an RN to assist with this. Because the RN already had many other responsibilities, the RN would trade a task that the EEN was able to help with, such as taking a patient’s observations or attending to hygiene cares. This trade of tasks increased the likelihood that each patient received safe and timely care regardless of what type of licensed nurse was responsible for their care.

…we have heaps more [EENs] now than in the last couple of months, it’s getting really, really difficult for the [junior RNs] who try to get their work done but then get asked by the EENs to do their IV stuff. The only way they can manage it is by giving the [ENs] some of their stuff to do. (Sandra, RN: Page 11)

From participants’ comments, it was apparent that tension surfaced when there was a higher proportion of EENs to RNs on a shift. In these instances, the RNs assumed responsibility for all activities that were outside of the legal scope of practice for EENs, such as administration of IV medications and care planning. Tension built up when the RN wasn’t willing to accept help from others, or the EENs weren’t willing to return the favour by trading a task with the RN. From participants’ accounts of these events, it was apparent that the increased amount of work that RNs must attend to when working with ENs was not considered in workload allocation. Conversely,
EENs also stated their skills were not always taken into account during allocations, with one EEN participant stating that she was often allocated patients with multiple IV requirements that she was unable to manage. However, with patient acuity increasing, it be would be expected that the majority of acute hospitalised patients would have some needs that could not be managed by an EEN. Nonetheless, it appears that omitting to consider skill mix, when determining patient loads, contributes to tension and frustration among both RNs and EENs.

It can be really tough when you are on shift and there are lots of ENs and EENs. It means that as a registered nurse you know that you will have more responsibilities on that shift and that it is probably going to be really busy. Staffing allocation don’t always take into account what staff we already have before handing out the agency staff. It’s rough. But if they are willing to help us out and do things in return then it definitely makes it a bit easier. (Victoria, RN: Page 11)

Trading tasks was commonly initiated to ensure that workloads were evenly spread among nursing colleagues. RNs traded tasks with EENs and ENs when they were required to complete activities that the EENs and EN was not authorised to perform. ENs and EENs then returned the favour when they received assistance from RNs with activities they were unable to complete.

Valuing others

*Valuing others*, in particular HCWs, was the third sub-theme. With the rise in numbers of ENs and increased use of HCWs in the hospital, it was critical that all nursing team members were given the opportunity to practise to their full potential. The data suggested the relationships that nursing staff had with other health care employees influenced their decision to work in teams. If participants did not understand the role of HCWs or if they failed to work well together, then participants were less inclined to accept them as part of the nursing team and became more likely to strive for close patient proximity through total patient care. For team nursing to be readily accepted, participants stated that they had to have good relations with the HCWs and feel secure that they were competent and would not “jeopardise patient care” and safety.
…you pick things up along the way and you talk to them and you ask questions and you find out where they have come from and why they have chosen to be a [HCW]. I think I knew what to expect from the [HCW]s when they first started on [this ward] because I had worked as one when I was a student…but the older nurses who didn’t really know what they could do or what knowledge they had were more sceptical of the whole situation. (Melissa, RN: Page 8)

Relationships among nursing staff, particularly between licensed nurses and HCWs, played a significant role in participants’ decisions to delegate. Permanent HCWs who were linked to a particular ward were more frequently called on to assist with patient care than casual HCWs. Additionally, if the HCW was studying to become a licensed nurse they were given more opportunities in the ward and were more commonly called on to provide hygiene care than HCWs who were not studying. Nursing students were frequently provided with extra avenues to gain experience on the ward because nursing staff allowed them to sit in on procedures; however, these opportunities were not given to non-studying HCWs. Participants spoke of their increased trust in HCWs studying to become nurses because they were slowly building on their nursing knowledge base and were “wanting to learn”. One participant differentiated between them by saying that nursing students were an “investment”, which indicated that extra time was spent educating and guiding these staff members.

The ones we have on the ward have been around for a while and they are older. They have both come from completely different jobs…and we know them…but when we get agency [HCWs] you don’t know what they are capable of so we generally just get those ones to restock and they don’t have much to do with the patients. (Sally, RN: Page 4)

Participants spoke of how student nurse HCWs were allowed to be “doing other things”. Positive attitudes to specific levels of nursing staff appeared to influence the use of these staff—in particular, the positive attitudes towards HCWs who were studying meant they were commonly called on to participate in direct patient care. Encouraging undergraduate nursing students to work as HCWs could be a way that these unlicensed staff could be positively integrated into the current health care system. The following comment was typical.
...I think patient care should be a part of an [HCW]’s role...because I was an [HCW] when I was a nursing student and since I’ve been a nurse, I haven’t seen many [HCW]s that are nursing students, they are mostly older [HCW]s that maybe used to be wardsmen or used to be cleaners and so they are not as interested in learning new skills as a younger nursing student [HCW], so I sort of see the two different, so if there was a nursing student [HCW] that said hey is it alright if I look in while you are doing that wound dressing, then I would say definitely yeah, but the older [HCW] that’s not studying, wouldn’t put their hand up to do that sort of thing so I definitely think there are two types of [HCW]s, but they all have the same job description. (Sally, RN: Page 7)

Participants believed there was an improved transition from undergraduate to licensed nurse when the amount of time spent in the clinical environment was lengthened through employment as a HCW. All participants who spoke highly of nursing student HCWs had been employed as a HCW during their own undergraduate degree. Most had been employed in nursing homes because previously HCWs were not allowed employment in acute care hospitals; however, changes had occurred and nursing students were exempt from having to complete a TAFE certificate to be employed as a HCW as long as employment commenced in their second year of study. Participants saw this as a positive step towards the uptake of HCWs into acute nursing teams. The need to differentiate between the two different types of HCWs via job description was another topic discussed. This was interesting to note because in other Australian states undergraduate nursing students were employed in acute care hospitals. They received a patient allocation and were assisted by licensed nursing staff. Employing undergraduates as HCWs increases their exposure to patients, clinical conditions and time management practices, and positively influences the decision of some licensed nurses to incorporate HCWs into their practice. However, it should be highlighted that it may be their distinction of being a student nurse rather than a HCW that actually encourages their uptake.

If the input from all levels of staff was not valued, teamwork declined and unhealthy staff relationships developed. Some participants spoke of delegating only basic care to ENs even if they knew the ENs were capable of managing more. Melissa spoke of not delegating medication administration to an EN even when that EN was medication endorsed because she believed, as an RN, she was more qualified to administer medications. She stated that she disliked delegating patient observations but still
continued to do it, thus maintaining her status distinction by controlling the activities delegated to ENs. By doing this, RNs may unintentionally undermine the role and purpose of other levels of workers in the acute care sector by limiting their scope of practice in the workplace.

When [we haven’t] got…enough RNs on the ward…we are having to teamwork…to delegate to the ENs. Usually when I’m in that circumstance, I will just say that I’ll do all of the medications, even if they are endorsed. If you want to do all the obs and then we’ll meet in the middle when it comes to bedding down, that sort of stuff. I hate giving all the shit jobs…but there’s no point in them doing the meds because they’ll only have to come and get me for the subcuts and IVs.

(Melissa, RN: Page 2)

The comments of Melissa and many others reinforced that some nursing staff were not aware of the process of delegation. To Melissa, it involved “giving” tasks to other staff members. However, delegation should involve discussion with the staff member to whom the task is being delegated to ensure they were comfortable with the activity. Open discussion between colleagues appeared to be enhanced when all team members were valued. This process was not discussed by any participant.

While Melissa classified patient observations as a “shit” job because she saw it as routine and mundane, data related to delegation included a high frequency of expressions such as “shit”, “crappy”, “dirty” or “slothy”. These were also used to describe attending to patient hygiene needs and toileting patients. The use of such language was disturbing, because it suggested that participants didn’t value these activities and saw them as worthless and mundane. Interestingly, all of the participants who used these expressions also discussed how they strived to provide holistic patient care. This was contradicted when such language was used to describe pertinent ‘holistic’ nursing activities. However, use of this language appears to be related to the notion of a production line, which was discussed in the patient proximity theme, where certain activities, when they were not linked to patient diagnosis or treatment, appeared to be one-dimensional and viewed as “crappy”; however, when these activities are linked with patient assessment, education and general holistic nursing care practices they are considered enjoyable and stimulating.
Some participants were already considering the practicalities of working in teams of nurses with differing responsibilities. One participant was exploring the allocation of one licensed nurse and HCW to a group of patients who required similar numbers of nursing staff to attend to their needs. This was considered a viable solution to increasing patient acuity and dwindling numbers of licensed nurses. Staff allocation decisions could then be made taking into account the need for a second person to assist with the performance of activities of daily living. Neville discussed the allocation of an RN and HCW to eight or nine patients, which was different to the ideas raised by other participants striving for close patient proximity who wanted a 1:4 nurse-patient ratio. By using the nursing team in this innovative manner, Neville saw the benefits as being to free up a licensed nurse who was more skilled to assist others.

…sometimes I start considering allocating an RN and [HCW] to 8 or 9 patients. If you put an [HCW] with an RN in that area, you’ve actually freed up another staff member who’s probably more skilled and qualified in that critical incident situation than having a [HCW] floating around doing odd jobs…I think it depends on the situation but I mean we currently use [HCW]s to do odd jobs and assist with cleaning but I think we all need to think about using them differently because if they can be used for less acute patients, being supervised by someone then you’ve freed up a more skilled member of your staff. (Neville, CN: Page 3)

Developing effective teamwork strategies was a common discussion point for many participants. The changes currently occurring in the acute health care system meant teamwork was becoming a central part of nursing work, with it often including team members of varying grades. However, for nursing teams to work efficiently a number of factors need to be considered, including the act of delegation, trading tasks, and valuing others. Each of these can impact positively or negatively on the team and it is up to all nursing team members to ensure that teamwork affects all staff and patients in a beneficial way. The level of teamwork and collaboration among staff was influenced by education level and professional development motivation.

I think some of the [HCW]s that were coming in from the agency…were level 1’s, I don’t know what the difference is, but they didn’t seem to have a clue about a lot of things that were going on…They were mainly looking after our wanderers and not much else, but a level 3 is fairly
comfortable where everything is, especially if they’ve been on the ward working as a regular [HCW]. It’s a whole lot easier working with the level 3 [HCWs], the shift flows better because everyone knows what they should be doing and we help each other out which is so important when there’s so many full care patients. (Derrick, RN: Page 2)

While it emerged that nursing staff were developing new teamwork strategies to assist with managing workloads, it appeared from participants’ accounts that allied health, medical, and support staff were not putting in a joint effort towards patient care and general ward operation. The feeling of picking up the slack for these hospital staff was discussed by many participants and was the second most prominent theme in this study.

**Picking up the slack to ensure patient safety**

The picking up the slack to ensure patient safety theme was characterised by nursing staff performing work that someone else had forgotten to do, stopped doing temporarily or ceased to undertake at all, but which still needed to be done to ensure patient safety. Generally, these activities were within the customary practice of other hospital staff and not regular work for nursing staff; however, some also fell into ‘grey areas’ where no hospital employees took responsibility for the activity. In these instances, nursing staff picked up these activities because no one else did and patient safety required it. For example, participants spoke of the need for nursing staff to follow up on jobs that the medical staff did sporadically, which lead nursing staff to think that the doctors had forgotten.

…the patient needed a troponin level at 8pm but the slip hadn’t been written up. But then again they never are. It’s really frustrating because we aren’t technically meant to write them up but it’s impossible getting ward call up here when they are busy just to write the slip up. I don’t think I should have to do it because they’ve forgotten, I’ve got enough on my plate. (Helen, RN: Page 1)

Two common examples provided by participants of activities medical staff attended to sporadically were checking of pathology results and completing of pathology requisitions. Other activities included obtaining continuing IV fluid orders and orders for variable dose medications, and following up on plans that were made on ward rounds but were never followed through by medical staff.
Warfarin and insulin. They drive me crazy. They know they need to be written up, but do they do it? No. They changed the warfarin time to 4pm to prevent ward call from having to prescribe warfarin after the teams had gone home but it hasn’t helped. (Karen, CN: Page 3)

Non-medical activities included the transportation of medications between departments, cleaning, and making refreshments for patients. When participants discussed these activities they commonly stated that they were outside of their scope of practice. Scope of practice in this sense referred to the customary practice of each professional rather than the legal standards to which staff members must adhere. When discussing picking up the slack, participants understood scope of practice to mean the completion of activities that were established practices for other workers, but could still be performed by other staff members. Picking up the slack was described as a “constant frustration” and “huge waste of time”.

I just feel that as a nurse I am just picking up after everyone else. I mean I do that enough at home! Whether it’s checking to make sure an INR has been done or making sure the [wardsman] has changed the curtains after the last MRSA patient. (Sarah, RN: Page 6)

The main reason participants continued to perform these activities was related to the effects it had on patient care. Participants stated that if all staff ignored these tasks patient safety was jeopardised. Their main concern was for the patient and, while other hospital employees also had patient needs as their top priority, it was the nursing staff who were in close contact with the patients for the longest period of time each day. Therefore, they experienced, first hand, patient anguish if these activities were not completed. Improved patient safety was one of the main motivations for participants to continually pick up the slack.

Technically it’s not my job but I’m looking at the bloods for my own interest. I think it’s a safeguard. Removing one other thing that could possibly go wrong. We are just little sieves, stopping some of the crap going through. (Maria, CN: Page 8)

Improving patient safety appeared to be the main reason why most participants were picking up the slack rather than challenging other staff or hospital management about the activities they believed were outside of their customary practice. Improving patient safety was a top priority, even if ensuring it forced participants to perform
work that was the established practice of another health care employee. For example, some staff stated that checking pathology results was not part of their role, and established hospital policy confirmed this; however, they continued to perform it because of the improvements they perceived it had on patient outcomes. When asked why they believed that this activity equated with picking up the slack, participants said they couldn’t personally make any changes to a patient’s course of treatment as a result of the pathology results, but because surveillance improved patient outcomes, they continued to do it.

Checking pathology results is important for nurses, maybe not for diagnosing or changing a course of treatment, but I think for trying to achieve a safer patient outcome, it’s worth having a look, us checking their blood. (Maria, CN: Page 6)

John provided the example of how checking a critical potassium result improved his patient’s outcome. Had this result gone unnoticed, the consequences could have been fatal. The medical team did not check the potassium result but John detected it. John’s story was typical of many others.

Pathology. I think it’s a thing on this ward checking up pathology results… it’s a culture on this ward, we do it as the in-charge coordinator, [level two RNs] go through every pathology of the day checking patients results and then notifying the results to the doctors… it’s not [our job] it’s the doctors…it’s good in that it helps the patient’s outcome… if they’ve asked for bloods to be done on someone, they need to go and check them… the patient could be here another day, [they] actually could die, potassium’s can quite often be low and the team goes home and you have to ring the evening RMO to come and do something [about it]. (John, RN: Page 11)

Understanding the possible implications of a blood result going unnoticed overnight was an important issue raised by participants. Many participants noted that it was “senior staff” who were checking the pathology results. It appeared new graduates were less likely to check pathology results, but as they increased their knowledge base, improved their time management skills and started to see the “bigger picture”, they also saw this activity as important for patient safety rather than viewing it as outside of their customary practice.
Certainly more senior staff will check labs regularly because they realise the implications of the doctors not checking it. I remember being a new grad and there was no way that checking bloods came onto my radar because I was just focusing on getting my basic cares done. And if I remember right, the in charge nurses never expected me, to but when I started to be in charge it became an expectation. (Sarah, RN: Page 3)

While some participants believed they were picking up the slack by checking pathology results, others stated it was appropriate when relevant to patient diagnosis. Determining when checking was appropriate required some degree of critical thinking. Checking the blood results of a patient with anemia was an important nursing activity and could be likened to attending to the dressing of patient with a surgical wound; however, checking the pathology results of a patient who has been admitted with an eye infection would take a lower priority.

I suppose it’s checking bloods when relevant to the patient and their care. So if someone with a leg ulcer [had] a FBC [full blood count] done, I probably wouldn’t make sure I looked at their bloods…whereas if I had someone who had anemia and had a full blood count done, then I would look at it…well it’s not our responsibility, I have been told that it’s not our responsibility to review the bloods. I think it is a safeguard. (Maria, CN: Page 6)

Chasing up orders was similar to checking pathology. Many believed that if they were to refrain from requesting continuing orders, patients would miss out on pertinent treatment, in particular, vital medications. Despite many nurses feeling frustrated because of the time spent chasing up medical staff, they continued to do it because of the positive effects it had on patient safety. While many participants pointed out that medical staff also had patient safety at the top of their priorities, it was the nursing staff that experienced first-hand the effects of other’s omissions. Derrick’s discussion exemplified many others.

I know it’s our role to ensure that [the] administration of drugs and doctors orders are carried out, and that it’s our role to double check all that stuff because we are administering what’s been ordered, but it shouldn’t be our role to chase them down to write it when they’ve written it [in the notes] and they should be looking at the charts and looking at whether they need to write more fluids, they should be looking at whether they need to write a prednisone dose or a
gentamicin dose, we shouldn’t have to be sitting there checking our INR and then ringing them and reminding them to write up warfarin. But we do it because otherwise our patients would get everything late or not at all. (Derrick, RN: Page 7)

In every event that participants discussed where they believed they were picking up the slack for medical staff, patient safety was at the centre of their discussion. The importance of maintaining patient safety, as discussed in the safeguarding patients theme, was considered one of nursing’s core roles. There were four sub-themes within the picking up the slack theme: (1) role blurring; (2) nurses impeded by doctors omissions; (3) working beyond job description; and (4) working below expertise level. Each of these is expanded on in the following sections.

Role blurring

The first sub-theme was role blurring. Role blurring, in the context of this study, was discussed in relation to the organisation of continuing medical orders and the associated grey area of practice between medical and nursing staff. Amy pointed out that medical staff were very busy and may believe that because nursing staff were administering the IV fluids, and were aware of when orders were getting low, that they should also be responsible for requesting further orders; however, she also stated that medical staff should attend to this activity because the writing of orders is their responsibility. This indicated that there was a certain amount of role blurring occurring in relation to particular patient care activities. Interpretation suggests that chasing up orders tended to stem from differing professional priorities, outcome expectations, and views on each profession's contribution to patient outcomes. Unclear professional boundaries and the increasingly blurred role boundaries between medical and nursing staff was also a likely source of the perception of picking up the slack.

…we are asking the doctor, we all work as a team but it can be a bit frustrating when they’ve come and seen the patient, they should have written it up then…so there’s that part missing, that grey area between doctors and nurses where who’s job is it? (Amy, RN: Page 7)

The continued chasing by nursing staff seemed to be perpetuating the idea that if medical staff made omissions then nursing staff would pick them up. The pressures
already on nursing staff to ensure patient care was provided in a timely manner, accompanied by the feeling that they were also responsible for the inactions of medical staff, seemed to be causing job strain. Participants stated that they often finished their shift dissatisfied because they hadn’t been able to do all that they wanted to do for their patients due to the need to follow up on the responsibilities of others.

I can spend so much time chasing up orders that I don’t get around to doing all the nursing stuff that I have to do. (Victoria, RN: Page 5)

The actions of nurses may have been perpetuating the blurring of boundaries between medical and nursing staff. Comments from participants such as “I mean we will do it if we have time” show a situation that seemed to be creating confusion for medical staff. Kathy’s discussion of a scenario where a request form was left for nursing staff to deliver to radiology exemplifies role blurring. She spoke about how it wasn’t her job, which she also told the doctor, but then went on to discuss that if nursing staff have time then they’ll do it. Such inconsistency may have been confusing to medical staff because nursing staff were not definite on this issue. This may influence medical staff to ask nursing staff to assist with these tasks because they know that nurses will do it if time permits.

Today a doctor had left a CT form here for the nurses to finish filling out and then for us to organise a CT so I just rang him and said look you have got to finish off the form, get the patient consent, and he did all that and he still leaves it in the folder so then I have to ring him back again and say look you actually have to take this down stairs to CT and explain to them why this CT has to happen. Oh can’t you do that? I said no that’s not our job, it’s your job to do that…I mean if we have time we’ll do it (Kathy, CN: Page 5).

A number of participants mentioned how performance monitoring of medical staff was left up to nursing staff. In particular, they were referring to the resident medical officers (RMO) who were supervised by registrars. In the public hospital system, registrars were the first point of support for the RMOs; however, registrars were also very busy and sometimes didn’t have adequate time to be able to guide and educate the RMOs. Therefore it fell to the nurses to assume the teaching role and highlight their omissions. This caused angst for participants who stated it should not be their
responsibility to monitor the work performance of medical staff; however, they continued to do so because of the positive effects it has on patient safety.

…the doctors had just rotated that week…so it’s expected that they won’t really know what to do. It’s usually a busy time when we get the new ones because we have to pick up on things they don’t know about or forget to do. I think it should be the registrars who do this, but I know they are busy too, but sometimes I feel uncomfortable telling them what they should be doing, I mean, I’m not a doctor. (Victoria, RN: Page 6)

Role blurring was also discussed in relation to EN roles. One EN participant discussed an occasion where she was expected to monitor a patient’s blood transfusion. She felt uncomfortable with it at the time but has since done this on many more occasions and feels more at ease. It appears that using ENs to perform the duties of RNs, has crept into the acute health care system as a consequence of time pressures and fluctuating grade mix.

It’s usually to do with IV therapy…where they don’t have good staff. And that’s a shame that that happens but [its usually] through shortness of staff and maybe not the right mix so. There was an expectation that I watched their blood [transfusion]…yeah I had to keep an eye on it. (Annette, EEN: Page 3)

One participant described the act of checking and chasing up as balancing a set of scales. In Derrick’s discussion, he believed medical and nursing staff should be equally “checking” to ensure their associated responsibilities were met and patient care was provided safely. When the scales started to tip towards nurses with all chasing left up to them, it caused frustration.

…and while some of that is your job as the in-charge nurse I suppose when I was talking about chasing down medications etc, that’s your advocacy role and your role for safety for the patient, but sometimes the scales tip so far over that you find yourself always doing this and you are saying well bring it back, I’m still going to be checking it, but bring it back so I’m not chasing it as much. (Derrick, RN: Page 20)

Unclear role expectations and the contradictory actions of nursing staff appear to be causing some role blurring between nursing and medical staff. It is these increasingly
blurred role boundaries between staff that appear to be perpetuating the feeling of picking up the slack for many participants.

**Nurses impeded by doctors’ omissions**

*Nurses impeded by doctors’ omissions*, the second sub-theme, describes occasions where nursing staff were restricted from providing safe patient care because of doctors’ omissions. It was the responsibility of medical staff to prescribe medications, fluids and most other patient orders; however, it was nursing staff that action these orders. When nursing staff were restricted from providing patient care because medical staff hadn’t authorised or prescribed appropriately, they became anxious about the possible effects it had on patient safety.

…their relatives were standing there and the patient desperately needed some morphine but I had to wait for [the on call doctor] to come up. I would have been annoyed if I was in their shoes but there wasn’t anything I could do. (Laura, CN: Page 1)

Participants stated that they often knew what needed to be ordered but couldn’t administer the medications without authority from medical staff. This resulted in nursing staff feeling limited in providing care to patients. Participants spoke of having to explain to patients and family members why medications were being given late or fluids running out before another order was written up. Participants believed this reflected poorly on their nursing care, which caused deep frustration because it was through others’ omissions, that nursing staff were made to look incompetent. One participant’s discussion exemplifies this sub-theme. In addition to managing the clinical concerns, Tanya also had to assuage the patient’s family because they were anxious over why a decision had been made earlier for a blood transfusion, but as yet, their relative hadn’t received it.

…an oncology patient came up…and all it said in the notes for the plan was have two units [of blood]. They had fluids going which had run out and there were no more orders so we had to run around and ring the doctors and organise [for them to] assess the low BP which was done over the phone and then [more fluids] were ordered then after that start the blood, so when we rang down for the blood, the group and hold had expired, so then I rang the [registrar] back, and then had to ring the RMO to tell them from the [registrar] to do the bloods and to order the blood…they never did their bit for us
to complete ours. The family were worried and I felt bad because I couldn’t give the patient what he needed. (Tanya, RN: Page 7)

It was clear from Tanya’s discussion that the time it took to pick up the slack of medical staff caused frustration for nursing staff because they were prevented from providing the care the patient needed. It was also clear that it generated frustration for other staff as indicated by Derrick’s when he said

…you are just troubleshooting and nagging them from the time they walk in the door. (Derrick, RN: Page 9)

The use of the term “nagging” suggested that medical staff also experience frustration when they are constantly reminded of what they haven’t done. Interpretation suggests that nurses sense this frustration and feel as though they are nagging, which they want to avoid, but are unsure how to unless doctors attend to all their responsibilities.

The time wasted “nagging” meant less hands-on time for patients, which participants believed decreased the quality of nursing care. Many thought that this time could be better spent providing better nursing care and “getting more quality control happening”. Many participants stated that time was already an issue because they had to manage sicker patients over shorter admission periods. If participants didn’t have to chase down doctors for continuing orders or similar, then more time could be spent providing hands-on care. Participants stated that this would improve patient safety and reflect more favourably on the nursing staff. One participant discussed that they would frequently spend up to two hours per shift chasing up staff.

…you could be spending a lot more time actually getting discharge planning organised and making sure it wasn’t a mad rush when time came to discharge them home…there are tons of other more productive things we could be doing. (Derrick, RN: Page 10)

Specifically, participants viewed confirming orders and picking up the slack was wasted time because it delayed patient care. It required paging doctors to come back to the ward, or after hours, talking to the on-call doctor who did not write the original order and was unsure of the patient’s diagnosis or treatment needs. The time spent finding patient details was also wasted time for doctors. During this time, no one was productive because nurses were on the phones trying to find doctors and doctors were
answering multiple pages. This meant treatment, sometimes in life threatening situations, was delayed. Participants believed that if medical staff were able to follow through with plans made on a ward round and not be constantly called or paged then this gave caregivers more time at the bedside with patients and would help increase patient satisfaction with care. It was also thought to save time for medical staff because they would not be retracing their steps and writing orders for plans written earlier in the day. Derrick’s comments were typical of many others:

…you really could spend an hour or two chasing up stuff with doctors, where you could be spending a lot more time actually getting discharge planning organised, just getting more quality control happening. Very frustrating and really time consuming because you end up paging three or four times, sitting there trying to critically think whether this is important or not important enough to page again. All the while patients are sitting there waiting for their nurse to come out of the office. (Derrick, RN: Page 9)

When nursing staff were restricted from providing patient care as a result of others’ omissions, they felt uneasy and frustrated. Restrictions to nursing care usually occurred because medical staff hadn’t authorised or prescribed appropriately, which caused participants to pick up the slack and remind medical staff of their omissions.

Working beyond job description

The third sub-theme was working beyond job description. This sub-theme involved participants performing activities that they stated were outside of their individual scope of practice but inside the scope of practice of a nurse employed at a higher level. Participants called it “scope of practice” but what they were actually referring to was job description. Not being paid the higher rates that the senior nursing staff would get if they were undertaking these activities seemed to contribute to participants feeling as though they were working outside of their job description. Most frequently discussed activities included education of other nursing staff, locating staff to cover leave, and managing knowledge deficits of other staff members. Each of these activities, meant participants were “taken away” from their patient allocation but were essential because patient safety required it. Working away from their patients seemed to be a source of frustration for participants because they believed their main role should be close patient contact and hands on treatment. “You just
don’t have the time. You get caught up, the workload is too heavy,” was a comment from Maria that highlights the frustration surrounding this sub-theme.

I have patients who need their meds or dressings done and I have to go next door and do a grasby because there isn’t any grasby competent people down there…I’m not a clinical facilitator and I don’t have time for that on a busy early shift. (Maria, CN: Page 4)

Staff education was an activity commonly discussed by participants when asked about what they believed was outside of their scope of practice. While this activity was once seen as the domain of senior nurses, participants stated that it was now left up to the RNs on the ward. Many discussed the lack of support given to new graduates and how it was difficult when staff had a patient load and were approached by junior staff for assistance. “It can’t be left up to ward staff” was a common statement. Because participants perceived staff education to be the role of a Nurse Educator, it left them feeling as though they were picking up the slack for these staff members. Participants discussed that while it was important for the new graduates to continue their education after their formal university training, the acute hospital setting didn’t always allow for it because of time constraints. With the high number of graduates employed within each hospital, it also appeared that the support provided to them by graduate coordinators wasn’t enough, compounding the ward staff’s perceptions of picking up the slack. Participants stated that it was time pressures and their other ongoing responsibilities, such as continuing to provide adequate care to their patients, that made it too difficult to provide education to other staff. Lack of exposure to clinical conditions during training was seen as one of the reasons that new graduates require extensive education after graduation. John’s comment was typical.

…it’s [education] left up to the ward nurses to then get out and educate them as well and we also have to oversee our sick patients, so I guess that’s another thing that really shouldn’t be left up to RN nurses is staff education. (John, RN: Page 19)

In addition to staff education, picking up the slack in relation to nurse colleagues clinical decision-making skills was also an issue. In particular, participants who were classified as senior RNs on their ward were frustrated by the lack of critical thinking that was occurring. Many stated that it was an important skill for licensed nurses to be
able to “critically think” and analyse problems to find solutions, as discussed in the *safeguarding patients* theme. A number of participants discussed how frustrating it was when junior staff members approached in-charge staff with acute changes in patient conditions. They would pass on the changes with an expectation the issues would be resolved by the nurse in charge. It appeared that critical thinking was an important skill for nurses to possess so they could make sense of changes to a patient condition and be able to proactively manage their patient load. Reliance on senior staff to manage patient condition changes, as noted by a number of participants, is hard, time consuming, and impossible to sustain. Nursing staff must take responsibility for their patients and go to the senior staff with solutions to their problems but be willing to listen to advice on whether their proposed solution is the best course of action.

…there is too much emphasis on if you are my senior and I tell you, that’s my job done. They come up and say ‘I’ve got a blood pressure of 80/40’ and then they go away they don’t critically think…I say to them what are you going to do? Come to me, tell me they’ve got the blood pressure, that this is what I’m doing. That saves so much time because they’ve already started the critical thinking, they’ve started the process and that’s what I want. I don’t want to have to go down and call the doctor, because then I have got more or less 30 patients and I don’t get paid enough for that. That’s an experience thing they pick up, it makes it hard [when you’re in charge] (John, RN: Page 9)

Locating staff to cover leave was another activity discussed that participants stated was beyond their scope of practice. Having “just one more thing to deal with” was the comment made by Maria when discussing this topic. The ward environment was not static, and participants stated it was a huge expectation when staff had a patient load and were expected to locate additional staff via phone lists. Maria noted that the people who were usually responsible for this task were the Level Four RNs who manage the hospital after hours. Being taken away from the patient and being asked to perform duties of someone of a higher level seemed to be the main reason why Maria stated it shouldn’t be her job.

If I’m in charge of a ward and I’ve had one of my colleagues ring in sick for the next shift and I ring the after hours nurse manager or the staffing person and they say to me there’s no
staff, you’ll have to do something, I don’t perceive that to be within my scope of practice. If I’m already with a patient load and coordinating what’s going on within a ward, I then don’t have a lot of free time to be going ringing part timers or trying to source staff from other wards. I’m not paid the NO4 wage for that and I just don’t believe that’s my scope. (Maria, CN: Page 3)

Working beyond job description where participants performed activities that were outside of their individual role description but inside the role description of a senior nursing employee was an everyday frustration; however, working below expertise level also evoked similar feelings.

**Working below expertise level**

The fourth sub-theme was working below expertise level. This sub-theme is understood as the performance of tasks that participants stated fell below their level of competence and job description. Common issues discussed included running medications between departments, restocking the medication cupboard, cleaning, moving beds, making refreshments for patients, answering phones and other clerical work. Participants stated these activities required no judgment or critical thinking and could be performed by other less skilled employees. Completion of the above activities was viewed as wasted nursing time because there were other hospital employees who should have been performing this work.

I reckon we would spend about an hour on late shifts running back and forth from pharmacy with meds that weren’t brought up earlier…doing this in conjunction with answering the phones because the receptionist goes home at 4pm is just ridiculous…we don’t have time but because there isn’t anyone else around to do it, we get lumped with it. (Kathy, CN: Page 9)

All participants who discussed these activities were frustrated that no other staff appeared to be concerned if the activities were not attended to. For example, participants spoke of running medication charts, discharge scripts and discharge medications between departments. Many thought this job should not be completed by licensed nursing staff; however, continued to undertake the activities because there were no designated people for this job, which if ignored, would compromise patient care. Participants believed too much time was taken away from patient care through
participating in an activity that “could be performed by any idiot off the street”.
Kathy’s comments were representative.

…yesterday pharmacy rang [because] we had a patient in the discharge lounge and pharmacy said ‘well the discharge lounge people can’t get here you just run down here and pick it up and take it to discharge lounge’…because the ambulance was on it’s way, I said ‘I’m not going to leave the ward, [if] I come down there, I’ve got to hang around and wait around while everybody gets organised. But I did, because otherwise the patient would have missed the ambulance. (Kathy, CN: Page 10)

The degree of knowledge needed to perform the activities listed above was a big source of frustration. Many stated that the tasks did not require the services of licensed nurses and could be performed by a HCW. Interpretation suggests that with nursing staff already feeling stretched trying to manage direct patient care, any activity that they were expected to perform that didn’t directly require their services was viewed as wasted nursing time. Interestingly, no participants discussed asking the HCWs employed on the ward to assist with activities, such as delivering discharge scripts to the pharmacy department. As discussed in the delegating activities sub-theme, previously nurses didn’t have access to HCWs in the acute setting. Lack of understanding of the purpose of the newly introduced roles may be have been the reason why they were not utilising these staff.

…any idiot would be able to walk in off the street and restock a medication cupboard or order new medication. Instead they pay the CNs $30 an hour to grab the barcode reader and reorder stock and put away hundreds of boxes of medication. It’s stupid and it’s a waste of money and a waste of an educated person’s time. (John, CN: Page 5)

Interestingly, there were no participants who viewed restocking as a safety issue. If medications were put away in the wrong areas, staff may accidentally select a medication from a pile that normally contains one type of drug and administer it to a patient. The risk of medication errors may be greater despite the rules of medication administration being very stringent in checking the drug, the dose, the patient, the time of the order, and the route.
And it is just another job that we have to do in between looking after our sick patients. It drives me nuts. (Karen, CN: Page 15)

Participants also discussed their frustration when relief administration officers were not provided when regular administration staff were sick or on leave. During these periods, nursing staff were required to pick up the slack and answer phones, file paperwork, and book appointments while still managing their patient load. Participants stated that the provision of clerical assistance allowed for more direct patient care and was greatly appreciated. When administrative assistance was limited it was the patients who were disadvantaged. One participant’s story stood out as a prime example of how patient care can be negatively affected if nursing staff have multiple extraneous responsibilities placed upon them. In this example Neville was drawn away from the bedside of an acutely unwell patient. Licensed nurses are expensive telephonists and participants stated they should not be used in this way. Stress was noted by Neville when relaying the event which highlights how damaging unfair expectations, can be to nursing staff.

...I had to answer phones, direct visitors...and I think there was a point where bed management rang and I was...in the middle of this gentleman with the chest pain nearly being in full arrest and I just kind of blurted this is not the right time to be ringing me. (Neville, CN: Page 2)

It is interesting to note that the ringing phones drew Neville away from the critical patient situation. Neville was torn between thinking that the phone call could be related to critical blood results, and knowing the patient’s condition was central to his concerns. This often occurs in the acute care environment because many test results are phoned through prior to formal reports being available. It is also noteworthy that administrative staff were provided between Monday and Friday but not on weekends. While there may be less hospital staff on weekends there was usually an influx of visitors and calls from family members, which created more work for nursing staff and removed them from the bedside.

...for me not having AO support or something like that,...it really stood out for me...because I think the end of my tether was phone calls and at least some one there to answer the phone would have just let me concentrate on the clinical scenario. (Neville, CN: Page 2)
Because nursing staff were seen to run the ward and were always in and out of the nurses’ station they stated they couldn’t ignore the ringing phones. Nurses cannot ignore phone calls because they are often vital for patient care, which meant in the event described by Neville, he was forced to pick up the slack of administrative personnel.

Filling in for the wardspeople was another issue raised by participants where they believed they were working below their expertise level. In particular, moving equipment and furniture around the ward was discussed. Picking up the slack for wardspeople occurred to reduce waiting times for patients. Participants stated that it was quicker for nursing staff to perform certain activities than wait because wardspeople did not see these activities as high priority and often there wasn’t enough wardspeople for the whole hospital. Waiting for these staff impeded patient flow, which was something participants wanted to avoid because of high patient turnover and increased patient numbers. It also caused inconvenience for patients if they had to unnecessarily wait around. It was for this reason that many participants expedited transfers by attending to these tasks themselves. Accusations of bed block from other departments occurred if patients weren’t moved in and out efficiently and was one of the reasons Karen provided when asked why she continued to undertake these activities.

Yes, bed moving. Like today we’ve moved about eight beds. We’ve moved furniture half of today. You know it’s quicker for us to do it than, you know the wardsmen are supposed to do it, but we can never get them here to do it, so it delays transfers for patients from other areas so we do it to expedite that transfer. Well I think it should be a priority because if you don’t do it quickly, you are accused of bed block. (Karen, CN: Page 4)

Cleaning was another activity participants stated was below their expertise level. In particular, Victoria spoke about nurses on her ward emptying bins and linen skips. Nursing staff pick up the slack for other colleagues, perpetuating the notion that work will get done even if the designated person didn’t or couldn’t.

Emptying linen skips and rubbish bins. I don’t have to do it. It’s like anything, if you are at home and your bin’s full, you are going to empty it. You just figure [that] no one else is going to do it so I’ll do it. (Victoria, RN, Page 3)
A few participants spoke of recent changes made to patients’ breakfasts that resulted in nursing staff having to pick up the slack for kitchen staff. Again, this caused immense frustration and resentment because nurses weren’t using their skill or expertise for these tasks. In one hospital, the nutrition department decided toast was not going to be provided for breakfast anymore. Patients’ continued to want toast as a part of their breakfast, so in order for them to receive it nursing staff had to toast bread using ward facilities. Additionally, breakfast time, when most patients wanted toast, was one of the busiest times of the day for nursing staff because they were receiving handover and starting on their morning medication round. Having other more immediate jobs that required nursing intervention was a common reason provided by participants when asked why they believed they shouldn’t be participating in the activities they discussed. One participant noted that there was no consultation between kitchen and nursing staff when the decision was made to remove the toast from the menu; however, instead of nursing staff consulting with kitchen staff on the changes, they picked up the slack and took on the tasks themselves. Better interaction and communication between departments may help prevent events like this from occurring. Interestingly, when discussing other departments that nurses pick up the slack for there was no discussion on whether nursing staff had provided feedback on their grievances. Karen provided the following example.

Yes making toast for patients because they don’t get toast anymore, they get given two pieces of bread, so nurses are making toast for the patients now. Yes they used to get toast and all of a sudden, and there’s no collaboration, there’s just no toast. They send up bread or bread rolls for the patient. I wouldn’t want a piece of bread first thing in the morning. You just don’t have time to do it. (Karen, CN: Page 11)

Picking up the slack appeared to be a common frustration for nursing staff. Nurses construct their world in relation to what is best for the patient and are seen as the link to the patient, which may be one of the reasons that they picked up the slack. Nursing staff take into account the needs of the patient and often do a lot of running around to ensure patient needs are met even though many of the activities may not be considered a part of their customary practice.
Summary

There were many indirect patient care activities that participants discussed undertaking. Some of these included managing other levels of staff, allocating patient loads and tasks, reviewing pathology results and education. All the activities needed to be managed concurrently with direct patient care, which often caused stress and frustration for nursing staff. While it emerged that nursing staff were attempting to develop effective teamwork strategies, it appeared from participants’ reports that allied health, medical and support staff were not putting in a joint effort towards patient care and general ward operation. In some instances, picking up the slack allowed participants to safeguard their patients from adverse events. Quite often participants were piecing together all the different aspects of the patients’ hospital care, which often meant they had to either follow up on or complete activities for their colleagues in order to ensure their patients’ safe passage to discharge. The feeling of picking up the slack for other hospital staff was discussed by many participants and was the second most prominent theme that emerged from the data.
CHAPTER SIX
Discussion

Introduction
As health care systems adjust and adapt to internal and external influences, demands on nurses are shifting. At the same time, changes are being seen in the profile and skill mix of nurses in acute care wards. The purpose of this research was to understand how medical and surgical nurses conceive their scope of practice in response to the available grade mix and skill mix of nurses and other health care providers in the acute hospital setting. Using a constructivist approach informed by the writings of Guba and Lincoln (1989), this study examined how licensed nurses constructed their nursing work on acute medical and surgical wards within a two large metropolitan teaching hospitals located in southeast Queensland, Australia. The constructivist paradigm provided a way to investigate and understand the nursing role.

Overview of findings
At the time of this study the nursing work environment was changing. A number of studies have suggested that better care and fewer patient adverse events are associated with care provided by RNs (Aiken, 2002; Aiken et al., 2003; Cho et al., 2003; Needleman et al., 2002); however, shortages of RNs and ENs are increasing both internationally (Buerhaus et al., 2005; Cho et al., 2003; Needleman et al., 2002) and nationally (AIHW, 2003; Cowin & Jacobsson, 2003; Creegan et al., 2003; Duffield & O’Brien-Pallas, 2003; Hegney et al., 2003; Morphet et al., 2008). With healthcare systems globally facing multiple simultaneous challenges—such as increasing patient acuity, rising patient turnover rates and greater demands for health care—nursing staff were questioning how patient care should be delivered in the acute care setting, particularly given the increasing numbers of HCWs. While some facilities were choosing to employ more HCWs, RNs were unsure of how these types of workers could be integrated into their practice. In the new work environment, “hands on” care did not always appear to be the best use of RNs time and delegation did not equate with laziness, but these were notions RNs struggled with.

The themes that emerged in this study from interviews with RNs and ENs were divided into two groups: themes related to direct patient care and themes related to
indirect patient care. The themes related to direct patient care were *good nurses work in proximity to patients providing total patient care, safeguarding patients, and privileging patients without mental illness or cognitive impairment*. The themes related to indirect patient care included *developing teamwork strategies* and *picking up the slack to ensure patient safety*. These final two themes related to the constructions of patient care delivery among staff, both nursing and allied health. In both theme groups, patients and their wellbeing were at the core of participants’ discussion. There were many aspects of the nursing work environment that influenced the realities of participants’ nursing practice; however, safe patient care was always cited as being the main goal and key reason for many of the decisions that were made during everyday practice.

This chapter discusses the findings of this research, compares and contrasts these findings with the relevant literature, and makes explicit the contributions of this study. A number of recommendations for clinical practice and education are outlined, and areas for further research are suggested. The limitations of the study are discussed and a conclusion to the study is provided.

**Scope of practice**

The Scope of Practice Framework developed by the QNC (2005a) is a principle-based document that states “the scope of nursing and midwifery practice is that which nurses and midwives are educated, competent and authorised to perform” (p.3). This professional framework forms the boundaries of nursing practice within which nurses constantly negotiate what it means to provide professional nursing care in today’s acute care environment. It would be facile to develop a list of tasks that prescribe the activities that nurses can and cannot perform within the framework because of the never-ending changes occurring in care contexts, individual capabilities, and patient needs. With this in mind, the purpose of this discussion is not to define what nurses should or should not be doing; rather, it seeks to show the complexities of nursing practice within the current system and QNC framework, and provide insight into what patient care provision currently means for today’s nursing staff.

While scope of practice was only occasionally discussed by participants, it always formed an unspoken perimeter around the activities they discussed. Participants
seemed aware of the activities they were legally allowed to perform and with the interviewer also being a nurse, participants didn’t see the need to explicitly discuss the official aspects of scope of practice. No participants discussed events where they overstepped the boundaries of their own scope of practice, but often spoke of finding new ways to practise to ensure the core needs of patients were met within the limits of the accepted QNC Framework. This discussion is, therefore, framed around the constant negotiation occurring in nursing practice to find new ways of practicing given the available grade and skill mix including negotiating nursing practice, negotiating patient safety, negotiating nursing domains, and negotiating patient proximity.

Negotiation

Negotiation is defined as “the process of achieving agreement through discussion” (Macquarie Dictionary, 2005, p. 1458) and is referred to by many synonyms such as bargaining, compromising, mediating, exchanging, and trading off (Strauss, 1979). “Negotiations occur when rules and policies are not inclusive, when there are disagreements, when there is uncertainty, and when changes are introduced” (Maines & Charlton, 1985, p. 278). Negotiation can resolve disputes, achieve agreement on proposed plans, bargain for individual or shared goals (Fisher, Ury & Patton, 1991), or accomplish outcomes that satisfy the group (Strauss, 1979). Negotiation involves three basic elements: (1) the negotiation process; (2) the behaviour of the negotiators; and (3) the substance being negotiated (Gulbro & Herbig, 1995). The process refers to how the parties negotiate. The negotiation process takes into account the context, the people involved, the tactics used by those involved, and the order in which the tactics are employed (Fisher et al., 1991). Behaviour refers to the relationships among these parties, the amount and type of communication between them, and the styles they adopt (Fisher et al., 1991). The substance refers to the item being negotiated (Gulbro & Herbig, 1995). In the context of this research, negotiation was shown to be an essential part of nursing practice due to the multidisciplinary nature of patient care and the numerous levels of nursing staff managing aspects of care. Patient care negotiation requires extensive collaboration and discussion among staff members in an attempt to help each clinician achieve their discipline specific aim; however, this is not always the reality. Negotiation assists in building a shared environment that can
improve trust among members of the multidisciplinary team; however, not all clinicians have the skills, or time, to successfully negotiate patient care. This was evident in some participants’ discussion of situations that may have benefitted from negotiation between care providers; however, instead of doing so the nurses involved chose to pick up the slack for another colleague.

Trading off, a common term used when describing the negotiation process (Strauss, 1979), was also used by participants. Trading off was only discussed between nursing staff and did not occur between nurses and members of differing professions. While there appeared to be plenty of discussion and interaction between nursing staff and other health care professionals, both of which are important for negotiation, it is unclear whether participants were unsure how to negotiate with members of other professions or they just chose not to.

The products of negotiation have temporal limits (Strauss, 1979). Products of negotiation in the health care context include proposed patient care plans, completion of specific activities such as wound dressings, and allocation of nursing teams to patient groups. The need for frequent review of these products commonly resulted from a change of staff, differing patient characteristics and diagnosis, and availability of support staff. Re-negotiation is required when one, or sometimes all, of these factors change to ensure patient and staff safety is not compromised. This was evident from some participants’ stories where it was discussed how the decision to negotiate a particular activity with another nursing staff member on one shift might not be possible, or even appropriate, on a subsequent shift. This highlights how negotiations need to be continually worked at, re-evaluated, and revised (Strauss, 1979).

Relationships and attitudes greatly affect negotiation in the hospital setting (Strauss, 1979). For example, participants discussed how time-consuming patient care discussions could be when medical staff rotated from one unit to another. Rotation meant new medical officers weren’t familiar with nursing staff and could sometimes be wary of their requests. The increased uncertainty when negotiating with people or contexts that are unfamiliar may limit the products of the process (Fisher et al., 1991). Interactions with strangers are accompanied by higher levels of anxiety, as the people involved in the negotiation process anticipate a wider array of possible negative outcomes (Gudykunst & Yun Kim, 1995), which can sometimes restrict interaction
altogether; however, as both medical and nursing staff become more familiar with each other, negotiations and discussions become easier. Gudykunst and Yun Kim (1995) suggest paying conscious attention to the communication process and gathering more information on the person involved in the interaction. While information sharing between medical and nursing staff occurs over the course of multiple interactions, paying specific attention to this process during medical staff rotation may limit the anxiety associated with this time.

Team familiarity was again highlighted by participants’ discussion on how smoothly a shift could progress when regular staff, who understood the intricacies of each other’s practice and the ward, were rostered. This shows that people who are in a positive and comfortable environment are more cooperative and open to the negotiation process (Fisher et al., 1991), increasing the possibility that all people involved will reach their goals. In the acute health care environment, such a process facilitates favourable outcomes for the patient. Positive negotiation has been linked to good decision making skills, flexible thinking, creative problem solving, and respect for others’ perspectives (Fisher et al., 1991; Keatinge, 1998), all of which are essential for health professionals in the acute care setting. Respect for others’ perspectives and flexibility were important to participants, especially when interacting with other health professionals who have their own priorities and practice habits; however, it seemed from the discussion of some events that flexibility in care delivery was not always appropriate or safe. For example, one participant spoke of being asked to deliver a radiology request form. An expectation of the delivery was that the purpose of the request be explained to the radiologist. Despite the participant having time to do this, it would have been unsafe to do so because she may not have had adequate knowledge of the patient or procedure. Understanding when practice flexibility was reasonable and safe required experience and advanced critical thinking skills.

Positive attitudes affect negotiation. Similarly, so do negative emotions such as frustration, anger and stress (Strauss, 1979). Negative attitudes can have detrimental effects on various stages in the negotiation process (Gulbro & Herbig, 1995) and can result in negotiation not occurring at all. Findings from this study show the link between the level of trust and negotiation with participants discussing how difficult patient care coordination became when staff were unsure of each other’s skills and
knowledge. Frustration, anger and stress can all affect the level of trust between people, and result in changing the central goal from achieving agreement to retaliating against the other party involved (Gulbro & Herbig, 1995). The emotions of frustration, anger and stress were evident in participants’ stories, suggesting that practice negotiation was, at times, limited by their emotions. Frustrated and stressed negotiators pay less attention to other’s interests, become blinded by their own goals and achieve fewer joint goals (Fisher et al., 1991), all of which could be detrimental to patient care.

The seemingly continuous need to negotiate care between nursing care providers also appeared to be a frustration for some participants. This usually stemmed from the inability to provide total patient care, a goal of some participants. Because these participants had no desire to consider other ways of working, negotiation wasn’t a part of their day-to-day practice; however, when they were forced to negotiate activities and practices—because they were physically unable to manage their workload—frustration ensued. This may have further limited negotiations and even caused some to avoid negotiating at all and attempt to manage patient care independently. While this option may be safe on one shift, the avoidance of practice negotiation with other nursing care providers may have detrimental effects on patient safety on another shift.

There were a great number of activities that participants discussed as being negotiated daily but not everything is negotiable at all times or negotiable at all (Strauss, 1979). Attempts to negotiate particular activities usually occur when protocols or rules are not conclusive (Svensson, 1996). This was sometimes the case for participants, however, at other times they were asked to complete activities that were clearly within the customary practice of other health professionals as described in hospital policy. This caused great frustration for participants because it left them feeling as though they were picking up the slack for the other health professionals. The following sections further explore aspects of negotiation, in relation to the findings of this study, including negotiated order, negotiating nursing practice, negotiating patient safety, negotiating nursing domains, and negotiating patient proximity.
**Negotiated order**

The concept of negotiation assists in understanding social organisations (Strauss, 1979) because one of the fundamental ways to achieve goals in organisations is through negotiating with one another (Svensson, 1996). Hence, some believe all social orders are negotiated orders (Svensson, 1996). Negotiated order is “the sum total of the organization’s rules and policies, along with whatever agreements, understandings, pacts, contracts, and other working arrangements. These include agreements at every level of the organization, of every clique and coalition, and include covert as well as overt agreements” (Strauss, 1979, p. 5). Negotiated order describes the social organisation occurring in and through people negotiating with each other (Strauss, 1979). In the context of this research, negotiated order was the interactions between licensed nurses, unlicensed nurses, medical staff, allied health staff, support staff, patients, and their families. The negotiated order approach has been proposed as a more suitable theoretical basis for illuminating the interplay of professionals in diverse hospital environments (Svensson, 1996) than the doctor-nurse game proposed by Stein (1967) in which frank and open communication between professionals was discouraged. The doctor-nurse game has been shown to be deterministic, limiting the interaction between professions and reinforcing the “prevailing power relations” (Svensson, 1996, p. 380). Further, evolutionary developments in the two professions may make this conceptualisation less applicable today. It is also simplistic to only consider the interactions between doctors and nurses when there are a variety of other health professionals now interacting to provide patient care, and increasingly complex interactions between various levels of nursing staff.

New patterns of interaction between nurses, licensed and unlicensed, and between nurses and other health professionals are a key feature of the changes currently occurring in acute health care systems. Previously, there wasn’t the need for nurses to negotiate care between licensed and unlicensed staff because the latter group of workers were rarely employed in acute hospitals; however, their increased use has resulted in the need for a new order to be negotiated. Similarly, the blurring of role boundaries between doctors and nurses, and availability of staff, have also created avenues for, and relationships that demand, negotiations between these workers, that
previously didn’t exist within the prevailing social conditions in hospitals (Svensson, 1996).

Changing organisational conditions have been suggested as the reason that “space” has been created to allow nurses more negotiation freedom (Allen, 1997, p. 500). For example, the social dimension of health care has become more prominent (Svensson, 1996), which places nurses in a powerful negotiation position due to the social knowledge they obtain through providing patient care. Participants often discussed having a more holistic understanding of the patient and their overall health profile than other health professionals. Other clinicians were believed to focus on their narrower area of expertise, which did not allow them to understand the patient in the holistic way that nurses were afforded. This placed participants in an advantageous position to negotiate patient care decisions, such as hospital discharge and proposed care plans, because of the overarching level of patient knowledge they possessed.

Negotiating what is possible and permitted varies. Availability of staff, patient acuity and knowledge of the attending staff continually changes, which mean the arenas for negotiation must be fluid and flexible. Over 10 years ago, Svensson (1996) discussed how the field of negotiation was widening as a result of the strong position and presence that nursing staff had in acute hospital settings (Svensson, 1996). Major changes have occurred since this time, which may mean even further space has been created allowing nurses more negotiation freedom. Understanding the importance of the negotiation role, and the impacts it has on patient safety, is extremely pertinent to today’s nursing workforce. Minimal literature has been published on the topic of negotiation in nursing practice, which suggests negotiation as a means to provide safe care may require further investigation.

Nurses negotiate continually. The main body of work on the topic of nursing practice negotiation originates from research undertaken by Allen (1997, 2001, 2002, 2004), Strauss (1979) and Strauss, Fagerhaugh and Suczet (1985). The study to which Allen (1997, 2001, 2002, 2004) refers took place in the United Kingdom during the mid 1990s. Its aim was to explore the ways in which nurses were managing the boundaries of their work and developing their scope of practice. Aspects of Allen’s work that examined the negotiation of nursing’s occupational boundaries, the relationships that nurses establish with clients and how these affect service delivery, are supported by
this study; however, the negotiation between nursing and medical staff suggested by Allen (2001) is not. Allen discussed nursing staff negotiating with medical staff according to the urgency of their work. This meant if they had time to negotiate with medical staff they did (Allen, 1997). For example, Allen (1997) discussed how nursing staff would discuss the completion of particular activities with medical staff to determine when and how they would be completed. This allowed nursing staff to manage their time more efficiently as they were aware of the actions of the medical staff. There were times of non-negotiation between medical and nursing staff, discussed by Allen (1997); however, not to the extent that was highlighted by this study. Participants from this study never discussed medical-nursing negotiation; rather, they spoke of negotiating their practice with other nurses to incorporate particular medical activities instead of negotiating directly with doctors. This concept of negotiating nursing domains, as opposed to negotiating with doctors, is expanded on in the section negotiating nursing domains.

The other body of literature originating from Strauss (1979) and Strauss et al. (1985) considers negotiation and negotiated order within hospitals. While this literature is helpful in being able to make meaning of the findings from this study, a number of changes have occurred in acute hospital organisations and staffing ratios since it was published. For example, Strauss et al. (1985) discussed negotiated order in relation to nursing, medical and other allied health professionals but did not directly discuss negotiated order between levels of licensed nurses or between licensed and unlicensed nursing staff, necessary now that HCWs are providing patient care in acute care settings. Therefore, the findings from this study extend the concepts raised by both Strauss and Allen and help to make sense of how nurses conceive of their scope of practice given the available grade and skill mix of both nursing care providers and other hospital workers.

**Negotiating nursing practice**

Greater numbers of ENs and HCWs in the nursing team (ABS, 2005; Duffield et al., 2007) are changing team dynamics and what it means to work collaboratively (Anderson, 1997a; Anthony et al., 2000). As a result, negotiating practice among licensed and unlicensed nursing staff has become a way to maintain patient safety when working with the varying levels of nursing care providers. Where previously
nurses in acute hospitals provided care in conjunction with other licensed nurses, currently patient care takes place in new territories (Allen, 1997) with negotiation occurring between licensed and unlicensed staff. It is easy to assume that there are only three levels of nursing care providers in acute hospital settings – RNs, ENs and HCWs; however, within these levels are numerous other categories that have created new domains for care provision. For example, there are HCWs who are undergraduate nursing students, ENs who are endorsed to administer some medications and RNs who have completed postgraduate courses to extend their knowledge, to name a few. The multitude of knowledge levels among nurses, increased patient acuity, and responsibility for more indirect patient care activities means negotiating nursing practice is unavoidable and requires flexibility and responsiveness.

Uncertainty and change were discussed by participants and appear to be two reasons why negotiation is unavoidable in today’s nursing practice (Maines & Charlton, 1985). These conditions are apparent in acute care contexts today (Allen, 2001) with nurses’ participation in patient care being highly variable and fluctuating depending on the grade mix and skill mix of the nursing staff and availability of other health professionals. With conditions always changing in uncertain work environments (Allen, 2001), such as acute medical or surgical wards, negotiating nursing practice between licensed and unlicensed nursing staff appears to be a way that safe patient care can be provided simultaneously to a group of patients in a multi-professional setting. The ability to work in this type of environment requires knowledge of each different role, an understanding of the principles of delegation, good communication skills, respect, and an ability to piece patient care together. It was these principles that many participants discussed, and that provide the context for the following discussion.

Practice negotiation is not an isolated nursing action or activity. Rather, it is a blend of nursing practices that are undertaken and negotiated depending on the clinical situation, the scope of practice of the attending nurse, and the available grade and skill of other nurses and health professionals. Practice negotiation ensures nursing workloads are manageable but, most importantly, that patients are safeguarded from adverse events and poor outcomes. Specifically, practice negotiation involves delegation, trading tasks, piecing it all together and communicating with colleagues. One, all, or a combination of these practices may be undertaken during practice
negotiation and it is up to nursing staff to determine which of these need to be employed on any one occasion. Each of these aspects of practice negotiation is expanded upon in the following sections.

Delegation plays an essential role in practice negotiation. Delegation assists in balancing out workloads among nursing care providers. For example, some participants spoke of delegating activities to their colleagues when they were managing a particularly heavy patient load. In these instances, nursing staff assisted each other when the patient acuity of their patient allocation was less than that of their colleagues. Negotiating practice in this way made workloads more manageable and ensured that patients received timely care, essential for good patient outcomes and safety.

Good delegation skills are needed to effectively manage the current grade and skill mix (Hayman et al., 2006). However, while some participants discussed delegation as a means to managing heavy workloads, it was a topic that caused concern for other participants because it appeared that they did not understand the process. While much has been published about the need for nurses to delegate, little has been written about how to perform it successfully or how the principles of delegation can be learnt (Kleinman & Saccomano, 2006). Participants frequently discussed their lack of understanding of the HCW role that many believed led licensed staff to have unrealistic expectations of how much direct patient care HCWs could actually provide safely. Negotiation of practice, in which RNs or ENs delegate activities to HCWs that are contrary to legislation, puts both the patient and associated staff at risk (Conway & Kearin, 2007). Unrealistic expectations can lead to frustration among staff, unsafe practices and, ultimately, compromised patient care. While this study did not access HCWs perceptions on delegation, it became clear from participants’ descriptions that the concept of delegation was indefinite in the acute care setting. This finding is consistent with a study conducted in New South Wales that found many RNs were unclear of the principles of delegation and were without a full awareness of HCW roles (Conway & Kearin, 2007). This caused difficulty because RNs were delegating activities without an understanding of the concept or person accepting the delegated act (Conway & Kearin, 2007).
With delegation playing such a crucial role in nursing practice negotiation, the need for further education on the topic was evident from participants’ discussion; however, teaching delegation to nurses—especially to those nurses who have mostly practiced primary nursing where they have been responsible for coordinating all aspects of patient care—has been shown to be challenging (Anthony et al., 2000). When RN participants from this study discussed delegation, they often commented on how they wanted guidelines on what they could and could not delegate to ENs, EENs and HCWs. However, it is not such a straightforward matter. While legislation and regulations provide guidance on what may or may not be delegated, often judgement calls made about what can be delegated require some level of critical thinking. Critical thinking is essential in learning the practice of delegation and in the provision of safe, effective care (Paul & Heaslip, 1995; Smith & Godfrey, 2002) that is negotiated among care providers. Critical thinking has been shown to improve with education and experience (Fonteyn, 2000; Paul & Heaslip, 1995), an idea that was discussed by participants. Delegation skills are learned and developed over time; however, the findings from this study suggest that greater emphasis needs to be placed on the teaching of delegation principles at an undergraduate level to improve these skills for new clinicians. Previously, nursing education focused on teaching students how to work in homogenous teams of RNs; however, the reality of the acute care environment is that of licensed and unlicensed staff working alongside, with varying education levels, and multiple job responsibilities. Additionally, HCWs need to be provided with appropriate avenues at the commencement of employment for learning how delegation affects their practice to ensure they only undertake activities appropriate for their level. Improved delegation skills and increased knowledge of how to incorporate delegated activities into practice should improve practice negotiation, teamwork relations, and ultimately patient safety.

Delegation, while a major part of practice negotiation between nursing care providers, is not the only consideration. Another aspect of practice negotiation included trading tasks. Trading tasks, although similar to delegation in that it is a way of sharing activities to manage the grade mix and skill mix, is the exchange of activities between nursing care providers. Trading tasks often occurred when an RN was required to complete an activity for an EEN or EN. Trading tasks assisted in ensuring the RN was not expected to manage an increased workload when working with multiple EENs or
Delegation differs in that it often means the person delegating the activity is required to complete another activity that may or may not be associated with direct patient care and probably cannot be undertaken by the person accepting the delegated act. Delegation was a ‘one way’ process of allocating activities whereas trading tasks involved a reciprocal process in which both nurses involved undertook an activity for each other. Hence, trading tasks more commonly occurs between RNs, EENs and ENs, while delegation is more likely to occur between licensed and unlicensed staff who cannot assume the responsibilities of the higher-level staff. Trading tasks, like delegation, ensured the workload was spread evenly among nursing care providers and was commonly initiated in an attempt to ensure patients received timely care when workloads became demanding.

Determining which activities can be safely delegated and traded between licensed and unlicensed staff is an important issue for nurses today. While it may be safe to delegate a particular activity to a staff member on one shift, the circumstances related to both the patient and the staff member may restrict the same act of delegation from being performed on another shift. It is for this reason that activities and abilities must be considered and negotiated on a shift-by-shift basis to ensure patient safety. The idea of “skill matching” has been proposed as a new way to configure the allocation of nursing staff to patients (Rischbieth, 2006, p. 397) and may also be appropriate when considering delegation. Skill matching is an innovative strategy that considers a nurse’s qualifications, duration of experience, demonstrated skill level, availability of support staff, knowledge of patient acuity, and nurse’s familiarity with unit specific technologies (Rischbieth, 2006). Knowledge of this information facilitates strategic nurse-patient allocation (Rischbieth, 2006) and may also be useful in reducing the risk associated with the delegation of activities to ill-prepared staff.

Delegation, trading tasks, and ultimately practice negotiation, is particularly difficult when working with casual or agency staff. Understanding the abilities and competencies of this group of staff members is complicated and time-consuming (Allan, 2000; Rischbieth, 2006; Richardson & Allen, 2001), which may be one of the reasons why many participants cited a preference for working with regular, permanent staff members. Another reason for the perceived extra burden associated with these types of casual workers is related to the practice of allocating patients who require
less skill and care to casual staff (Richardson & Allen, 2001). This practice was noted in a number of studies where the assignment of the most complex patients to regular staff was common because they were believed to be better equipped to keep patients safe (Richardson & Allen, 2001) and give continuity of care (Allan, 2000) than casual staff members. This practice could be reduced if the abilities and experience of casual staff could be easily ascertained at the commencement of a shift. Making the effort to discuss these matters, and skill match staff to patients (Rischbieth, 2006) could be time well spent and reduce the need to place extra strain on regular nursing team members.

The extent to which team members know the “strengths, vulnerabilities, and idiosyncrasies of all other members” has been shown to improve productivity and team efficacy (Kalisch & Begeny, 2005, p. 552). Kalisch and Begeny (2005) assert the importance of team familiarity lies in the ability to compensate for vulnerabilities and maximise strengths of each team member. Having this understanding enhances practice negotiation between nursing staff because the best person can be chosen to complete the activity, rather than the first available. Encouraging casual and agency staff to openly share their nursing experience and skills with senior staff at the start of each shift may assist in ensuring that appropriate activities are negotiated among the nursing team. A clear understanding of where each nursing team member is positioned with regards to experience and competencies not only improves safe practice negotiation but also makes public the skills that can be tapped into by other staff members.

Delegation and trading tasks improve the manageableability of nursing workloads and are essential for nursing practice negotiation; however, use of these practices required nursing staff to be able to piece together aspects of patient care to gain an holistic understanding of their patients when total patient care was not employed. Piecing it all together, which is elaborated on in negotiating patient proximity, is the ability to understand the patient as a whole through critically thinking about information that is gathered by the individual nurse or gleaned through conversation with other nursing staff or multidisciplinary staff.

Communication, another essential aspect of practice negotiation, underpins delegation, trading tasks, and piecing it all together. Without effective
communication, practice negotiation would be impossible. Effective communication allows goals to be articulated, which assists in team cohesiveness and movement towards a common objective (Kleinman & Saccomano, 2006). Effective communication has been linked with improved patient outcomes (Corazzini, McConnell, Rapp & Anderson, 2004), highlighting its importance in the acute health care system. With such a wide variety of health care providers in acute care settings, the need for communication lines to be open and responsive is more important than ever. Ensuring all staff, including HCWs, are provided adequate opportunities to discuss patient care with their colleagues is not only important for their professional development, but also crucial for safe, negotiated patient care.

With good communication being shown to be essential for patient care (Potter & Grant, 2004) and practice negotiation, it is interesting to note that HCWs did not have a recognised role in patient handover. With patient care more frequently being managed and negotiated between licensed and unlicensed nursing staff, the communication links between colleagues become increasingly important (Potter & Grant, 2004). Prearranged time for communication between HCWs and licensed nurses may improve communication between these workers (Jenkins, Abelson-Mitchell & Cooper, 2007). Participants discussed having to seek out HCWs to discuss particular patients because they were not forthcoming with information. This could be overcome by having as little as five minutes allocated per shift to handover the concerns of HCWs to licensed nurses. Allocating this time aside from the general nursing handover period would ensure HCWs are not spending excess time listening to the handover of information that does not relate directly to their work. Nurses are viewed as extremely busy professionals who often have little time for activities other than those directly related to patient care (Potter & Grant, 2004). As a result, HCWs may be apprehensive about approaching licensed nursing staff for fear of adding to their workload. Having a formal, allocated time to discuss their concerns (Jenkins et al., 2007; Potter & Grant, 2004) would alleviate this fear and encourage communication, which ultimately benefits both nurses and patients. Additionally, it would also give licensed nurses a chance to ascertain how HCWs were managing the aspects of patient care they were being delegated.
Making time to communicate does not automatically result in efficient information sharing among care providers. Understanding what needs to be communicated between nursing staff, licensed and unlicensed, is also important. The quality of communication between nurses has been shown to directly influence the delivery of care (Thurgood, 1995) with close to two-thirds of sentinel adverse events in hospitals being linked to poor communication (Haig, Sutton & Whittington, 2006). A number of studies have shown that the content of the information handed over was often inconsistent (Bomba & Prakash, 2005), subjective (Benson, Rippin-Sisler, Jabusch & Keast, 2006; Davies & Priestly, 2006; Payne, 2000), only comprehensive when the patient was considered unstable (Sherlock, 1995) and focused on handover of medical information with little reference to nursing care (Fenton, 2006). Ideally, nursing communication and handover should include handover of usual information such as medical diagnosis, pending results and investigations as well as information regarding continence, pressure areas, safety, self-care, hygiene, communication, nutrition and hydration (Fenton, 2006). Inclusion of patients in this information transfer between nursing staff has been shown to reduce fragmentation of care and promote continuity of care (McMurray, Chaboyer, Wallis & Fetherston (2008). Further, McMurray et al. (2008) encourage bedside handover because it has been shown to improve patient-centred information transfer, nurse-client interactions, and practice reflection. Moreover, exposing nurses to one another’s perspectives during bedside handover, improves teamwork (McMurray et al., 2008) and could be another avenue to encourage information sharing during practice negotiation among licensed and unlicensed nursing staff.

Practice negotiation demands open communication between nursing care providers. Education about handover and communication between staff should include both the content and process (Payne, 2000) with the use of role-play to provide this education being proposed by Jenkins et al. (2007). Role play would enable nurses and HCWs to understand how others involved in the handover process interpret their behaviour (Jenkins et al., 2007).

Nurses negotiate and adapt their practice on an individual, case-by-case basis (Lillibridge et al., 2000), which can mean that activities that are attended to on one shift by licensed nurses are not required to be attended to on the next shift. An ability
to understand when activities need to be undertaken, when they are not appropriate for completion by a nurse, when it is safe to delegate the activity to a HCW and when activities need to be shared among nurses is an important skill for nurses today and is the essence of negotiating nursing practice. Junior and senior nurses have varying abilities to negotiate practice and activities, both with their nursing colleagues and with other health care professionals. Junior RNs and ENs are more likely to ask senior RNs to negotiate activities for them because junior staff believe they do not have adequate negotiation skills and feel they could be pressured into completing activities they are not comfortable with (Allen, 1997). Moreover, senior staff have greater awareness of their scope of practice and time limitations, which enhances their ability to negotiate care to ensure the legislative boundaries are not overstepped and patient care is provided in a timely manner.

Practice negotiation among nursing colleagues creates a new teamwork dynamic between licensed and unlicensed staff. High performing teams improve patient care (Kaiissi, Johnson & Kirschbaum, 2003; Leidtka & Whitten, 1997), increase staff satisfaction (Horak, Guarino, Knight & Kweder, 1991; Rafferty, Ball, Aiken & Fagin, 2001), improve patient outcomes (Mickan & Roger, 2000) and enhance coordination and delivery of health care (Horak et al., 1991). Negotiating nursing practice among licensed and unlicensed nursing staff seems unavoidable because of the varying levels of nursing staff providing direct patient care. The ability to negotiate nursing practice in a team of such diversity requires effective communication skills, an ability to piece patient care together, prioritisation skills, and an understanding of the principles of delegation and trading tasks.

Safeguarding patients was a prominent theme in this study and, in conjunction with responding to increasing workloads, was the main motivation for nursing practice negotiation. Thus, negotiating patient safety is discussed in the following section.

**Negotiating patient safety**

With grade mix (i.e. the number of RNs, ENs and HCWs on any one shift), skill mix (i.e. the skills and experience of the staff within those grades) and practice negotiation fluctuating on a daily basis, maintaining and negotiating patient safety is an ongoing issue. Advocating and promoting patient safety is a nurse’s role (Aiken, 2002), with
detection and intervention when a breakdown in care occurs also an important aspect of nursing care (Ebright, Patterson, Chalko & Render, 2003). Patient safety was a prominent theme in this study, with senior RNs viewing themselves as patients’ safety nets. No junior nurses discussed patient safety as being an important part of their role with these participants focusing more on task completion rather than the overall responsibilities of the nursing role as others have noted (Gurbutt, 2006). As nurses gain expertise, they begin to see the bigger patient picture (Benner et al., 1996) and are able to both manage and deliver patient care. This was clearly articulated by experienced RN participants who discussed how new graduate RNs focus on the tasks they need to complete in their shift, often using a checklist for this purpose. They described that as they gain more experience, they start to see how their actions, and the actions of others, impact on patient outcomes and begin to view themselves as care managers, rather than just care providers.

Discussion of patient safety prompted a number of participants to consider activities that they perceived upheld patient safety. These activities could not be negotiated among licensed and unlicensed staff because doing so would negatively affect patient safety. For example, participants discussed how the everyday activity of taking vital signs must remain solely the responsibility of licensed nurses. Every participant who discussed the use of HCWs to collect physiological observations believed it was detrimental to patient safety and undermined the role of licensed nursing staff. Poor patient outcomes have been linked with the failure of nursing staff to comprehend the clinical implications of abnormal vital signs (Chaboyer, Thalib, Foster, Ball & Richards, 2008), something that could easily occur if HCWs were utilised in this way. Importantly, respiratory and pulse rates have been found to be independent predictors of adverse events (Buist et al., 2002; Chaboyer et al., 2008; Hillman et al., 2001; Kause et al., 2004). While the collection of patient observations, such as pulse rate, can be taught to HCWs, their lack of understanding and interpretation skills related to physiological observations increases the risk of unnoticed clinical deterioration and possible subsequent mortality (National Patient Safety Agency, 2007). Skills in time management, prioritisation, and communication are thought to be essential for any clinician performing patient observations (Hillman et al., 2001; National Patient Safety Agency, 2007). Thus, negotiating practice to ensure this activity remains in the domain of licensed nurses is crucial for patient safety.
However, complacency has been noted to occur when nursing activities become routine (Chaboyer et al., 2008; National Patient Safety Agency, 2007). With patient observations having the potential to become routine because the majority taken are normal (National Patient Safety Agency, 2007) it is possible this could result in HCWs being delegated the activity. Complacency related to vital signs was already occurring with a number of RNs discussing how they delegate the ‘task’ to ENs. On one hand, it was important; on the other, it was viewed as routine and just something to be ticked off a list. At times, observations were considered low priority, which participants often discussed as being their rationale for asking ENs or student RNs to perform the activity. Emphasising the importance of licensed nursing staff carrying out patient observations is essential for maintaining patient safety (Chaboyer et al., 2008). Becoming complacent about patient observations and seeing them as a task to tick off, not as a vital aspect of patient safety, is dangerous in the acute care setting and could lead to inappropriate staff being allocated this activity and deteriorating patients going undetected.

Negotiating patient safety required nursing staff to understand when to act upon patient condition changes. Understanding the significance of detecting and acting upon atypical vital signs in order to maintain patient safety in the acute care setting has been shown to be an important skill for licensed nurses (National Patient Safety Agency, 2007; National Institute for Health and Clinical Excellence, 2007). However, consistently identifying and acting on patient deterioration is multi-faceted, requiring clinical judgment and decision-making (National Patient Safety Agency, 2007) with several studies demonstrating suboptimal recognition and response (Chaboyer et al., 2008; Hillman et al., 2005; McGloin, Adam & Singer, 1999). Some areas that have been identified as possible points where patient safety is threatened in relation to patient deterioration including the inability to prioritise competing demands (Hillman et al., 2001), poor teamwork (Wallis, Davies & Shearer, 1997), ineffective leadership, communication breakdown, and lack of training in understanding physiological observations (National Patient Safety Agency, 2007). Ensuring that licensed staff are aware of the high level of interpretation skills required to determine the significance of patient condition changes (Hillman et al., 2005; McGloin et al., 1999) might assist in the negotiation of patient safety.
Negotiating patient safety by emphasising the importance of gut instinct for junior nurses is also important for nurses today. The use of gut instinct for the early identification of patient deterioration and for the maintenance of patient safety (Edwards, 2004) has been shown to improve with experience and on-the-job learning (Benner, 1994; Henderson, 2006; King & Clark, 2002; National Patient Safety Agency, 2007). Participants discussed how junior RNs were seen to make judgments from the readings of technology, such as electronic blood pressure machines, rather than reading the patient (Henderson, 2006) because they were yet to develop their intuitive patient assessment skills. Reading patients and listening to gut instinct involves assessing not only the physiologic parameters but also paying attention to the subjective aspects of the patient (Darbyshire, 1994; Henderson, 2006; James, Simpson & Knox, 2003; King & Clark, 2002). Encouraging the development of intuition through conversational education and discussion between junior and senior nursing staff may assist in highlighting the subtle aspects of the patient’s condition that are given attention by senior nursing staff.

Negotiating patient safety was perceived by participants to be difficult when caring for patients with mental health or cognitive impairment. Lack of educational preparation, in conjunction with the prolonged time it took to manage behavioural disturbances, were the main reasons why maintaining patient safety was difficult when caring for these patients. Interestingly, a number of studies have already found undergraduate nursing students are not specifically prepared for work in the mental health field (Armitage & McMaster, 2000; Clinton & Hazelton, 2000; Happell, 2007; Happell & Gough, 2007; Ramritu, Courtney, Stanley & Finlayson, 2002; Wynaden, Orb, McGowan & Downie, 2000). These findings are reinforced by another study conducted in Queensland that explored RN perceptions of their efficacy to care for mentally ill clients. The study authors found that three quarters of participants had limited knowledge of mental health problems and did not having the skills to identify, assess or treat patients with mental illness (Clark, Parker & Gould, 2005). Research also suggests that better care is provided and patient outcomes are optimal when similar patients are cohorted together (Aiken, Lake, Sochalski & Sloane, 1997; Czaplinski & Diers, 1998; Diers & Potter, 1997; Rimar & Diers, 2006); however, this is unlikely to happen when mental health and cognitively impaired patients suffer concurrently from acute medical or surgical conditions. Duffield et al. (2007) state
that nurses cannot be expert or even at ease when caring for a broad range of patient types. Improving knowledge and understanding of these conditions should improve attitudes towards this type of nursing care and improve the ability to negotiate patient safety when caring for mentally ill or cognitively impaired patients in acute medical and surgical settings.

Negotiating patient safety becomes increasingly important as the numbers of HCWs in acute care settings multiply. In the past, HCW’s roles focused on restocking, maintaining equipment, cleaning, and answering phones (McLaughin et al., 2000). Today, they are commonly being used to assist with patient hygiene, patient nutrition and even catheter cares, and are being provided with extra opportunities to learn and progress if they are undergraduate nursing student HCWs. Formal hospital policies outline the work that all HCWs are allowed to perform, but from participants’ discussion it appears that mainly it is the RNs who exert most control at the ward level. Many participants in this study discussed how they asked undergraduate nursing student HCWs to complete activities outside of their legislated scope of practice, such as apply a dry dressing to a wound. This potentially creates exploitation of undergraduate nursing student HCWs when they are used in ways that are beyond their role expectations and undermines patient safety. While work of this kind is outside of a HCW scope of practice, it recognises the skills and knowledge that undergraduate nursing student HCWs bring to the position. Not allowing undergraduate nursing student HCWs to perform these kinds of tasks could see many feeling de-skilled and frustrated; however, it is important for all HCWs to work within their scope of practice and be supervised when performing hands-on patient care to ensure patient safety.

From participants’ stories, there does appear to be some scope for the introduction of a revised scope of practice for undergraduate nursing student HCWs, depending on years of completed study. Negotiating the activities to be included in the revised scope of practice is complicated; however, it may alleviate the uncertainty surrounding the undergraduate nursing student HCW role. While a revised scope of practice for these workers may be a positive step, it raises the issue of reporting patient abnormalities. Changes in a patient’s vital signs could go undetected if undergraduate nursing student HCWs were involved in more complex patient care
activities. Additionally, HCWs can often get multiple requests for assistance from licensed staff (Potter & Grant, 2004) and, in an attempt to handle the busy workload, subtle but important patient changes may pass unnoticed or unreported. Being available and developing a two-way relationship is important for all nursing staff and can ensure that practice negotiation between licensed and unlicensed staff remains safe.

The negotiation of patient safety sometimes required nursing staff to perform activities considered within the customary practice of other hospital staff. Nursing staff were not always required to complete these activities; however, because of fluctuating patient contexts and staff availability, it was up to nursing staff to determine if they needed to negotiate the completion of these activities to ensure the patient was kept safe at all times and that legislative boundaries were not breached. This concept of negotiating the nursing domain to ensure patient safety is expanded upon in the following section.

**Negotiating the nursing domain**

Nurses have been shown to skillfully manage the hospital environment so that the organisation of others’ work does not impede nursing activities or affect patient safety (Allan, 2000; Allen, 1997; Tjora, 2000). One way that participants were achieving this was by undertaking activities believed to be outside of their customary practice. Examples of these activities included checking pathology results, chasing up continuing medication orders, cleaning, performing clerical work, and preparing food. The rationale that participants offered for completion of these activities was often that patient safety required the activity to be completed immediately rather than at a later time when the appropriate person was available for the job. Maintaining continuity of care, providing patient comfort, and that they had time to, were other reasons given for the need to negotiate the nursing domain; however, when participants were limited for time, these activities were not always undertaken. This lack of consistency puts the patient at risk because sometimes the doctors and nurses will each think the other has completed the activity. Allen (1997) explains that this way of managing their work emphasises the jurisdictional control of nursing staff. Nursing care is the priority; however, because of the need to ensure patient safety, negotiations regarding the allocation of work may be required (Allen, 1997). Allen (1997) goes on to
comment that the manner in which nurses make choices about whether to undertake work considered within the customary practice of other health professionals varies. Some nurses think they are being left to pick up the slack; however, for others, carrying out these activities makes sense given the constraints of the work environment and available staff.

For the most part, activities are negotiated according to the urgency of the work (Allen, 1997). This meant that when the appropriate staff member was not available, the greater the effect the activity had on patient safety, the more likely participants were to negotiate their occupational boundaries to include the activity. The activities listed above were seen to be within the domain of many other hospital staff members but predominantly were within the customary practice of doctors, wardspeople, administrative staff, and kitchen staff. The incorporation of these activities was double-edged (Allen, 1997; Allen, 2001). The benefits were obvious for patients; however, participants expressed concern that undertaking the activities made it difficult to create space to provide hands-on nursing care (Allen, 2001), which participants regarded as central to their work.

While the completion of activities considered within the customary practice of others may not have aligned with participants’ professional ideologies, the performance of devolved work clearly made sense within the constraints of the work context (Allen & Lyne, 1997). Completion of the activities listed previously often occurred when the relevant staff member was absent, which was often the result of time constraints and, at times, unfilled staff vacancies. The flexibility of participants’ in being able to slot into the role of other hospital employees at any time was admirable because of the benefits it had for patients and also because of the multitude of other responsibilities they still had to manage simultaneously; however, the flexibility of nurses’ work boundaries is not a new concept, with nursing jurisdictions being shown to shift in response to economic, social, technological, and organisational changes (Carpenter, 1977) and according to the demands of daily working practice (Beardshaw & Robinson, 1990; Davies 1995; Hughes, 1984). Interestingly, over 20 years ago Hughes (1984) suggested that a nurse’s place in the division of hospital labour was in essence “that of doing in a responsible way whatever things are in danger of not being done at all” (p. 308). This suggests that nursing’s jurisdiction, and the extent to which
this conceptualisation of nursing is applicable today, changes and requires negotiation depending on the availability of nurses, other health professionals and hospital support staff.

Negotiating nursing domains appears dependent on circumstances and who is available at the time. As previously stated, the products of negotiation have temporal limits (Strauss, 1979). The need to review negotiations may result from a number of factors, including a change of staff, differing patient characteristics and diagnosis, and availability of support staff. Nursing work is an in-between role (Bishop & Scudder, 1990) with negotiation occurring to meet the patient’s needs, nursing’s needs, and the needs of the attending health professional. Participants showed that in the absence of the respective health professional, it is more likely that nurses will move into the customary practice circles of others. Nurses are the ultimate flexible workers (Allen & Lyne, 1997; Davies, 1997; Hughes, 1984) and given their proximity to the patients, and their continuous presence on the wards, it is nurses who are essential for service delivery in acute care hospitals (Allen & Lyne, 1997; Duffield et al., 2005). Thus, while the nurse-patient relationship is an important aspect of nursing work and nursing's identity, Allen and Lyne (1997) assert the importance of recognising the contribution that nurses’ flexible working practices make to patient outcomes. Promotion of this concept may have enabled participants to view their work in what they considered the customary practice of others as within their scope of practice and an essential part of the nursing domain.

The different temporal-spatial organisation of nursing practice (Allen, 1997) creates differing perspectives and priorities for nursing and other hospital staff. Nursing is commonly ward-based with nurses’ priorities lying with the needs of ‘their’ patients (Smith & Godfrey, 2002). Conversely, doctors are connected to the patient needs of a much larger group and must systematically organise their work to reduce unnecessary time wastage spent traveling between departments (Allen, 1997). While other hospital staff, such as administration staff, are also ward-based, they are not in as close proximity to patients and are not directly exposed to patient suffering if care is delayed. Patient distress combined with an unavailable hospital employee often resulted in participants negotiating their practice to include certain activities that were considered outside of their customary practice.
The need for nurses to be flexible has been attributed to organisational turbulence (Allen, 2001). Turbulent work environments (Melia, 1979) have been shown to be a result of the centrality of the patient (Strauss et al., 1985), fluctuations in the pace of work (Allen, 1997), conflicting internal and external timetables (Zerubavel, 1979), and the diversity of occupational groups who each have their own culture and hierarchy (Allen, 1997). Consequently, nurses need flexible working practices to manage the organisational turbulence that characterises hospital wards (Allen, 2001). Participants spoke of many occasions when shifts were chaotic, which often required them to undertake activities they considered outside of their customary practice. If participants hadn’t slotted into these roles when required, continuity and timeliness of patient care may have been disrupted. It has been stated that hospitals need a point of flexibility in the system in order to function (Allen & Lyne, 1997) and nurses’ jurisdictional flexibility (Allen, 1997) places them in the best position to be this point. Hence, this concept requires emphasis so that nurses do not consider the negotiation of nursing jurisdictions as that of picking up the slack for other hospital staff.

It was interesting to note that participants never discussed negotiating activities with their non-nursing colleagues; rather, they negotiated their jurisdictional domain to include the activity into their practice. For example, when they were required to undertake administration activities because of a lack of staff, participants’ discussed how they got on with the job because there was no other choice. Similarly, when they performed work of the kitchen staff, they just got in and did it and didn’t consult with relevant staff members because it was less time-consuming to complete the task than contact them. And while they discussed speaking to the doctors about activities that they didn’t believe they should be undertaking, they continued to perform them if they had time. Negotiation of patient care between doctors and participants did not appear to be occurring. This finding is similar to that reported by Allen and Lyne (1997), who stated that it’s easier for nurses to undertake medical work themselves than it is to negotiate from a subordinate position. This indicates that there are shifting nursing jurisdictions, based on availability of staff and patient need, rather than a creation of a negotiated domain of work between nurses and doctors. While this provides some insight into the non-negotiated boundaries between nurses and doctors, it is not congruent with the performance of other activities (such as cleaning) where if negotiation was to occur it would be with staff subordinate to nurses. Despite their
commitment to nursing care activities, participants who could negotiate their domain to undertake customary work of other hospital employees, did so irrespective of their other work responsibilities.

Negotiation of work boundaries was not always required of participants. When the respective clinician was present to attend to activities, negotiation was not needed on behalf of participants. This finding is consistent with Allen’s (1997) who stated that when doctors are present and available, nurses adhere to policy and legislation and ask medical staff to carry out tasks. An example of this provided by participants included the checking of blood results to aid in the ordering of variable dose medications, such as Warfarin. Participants stated that after hours, and when doctors were unavailable, they would routinely check blood results; however, during business hours and when medical staff were present on the ward they wouldn’t negotiate their practice domain to include the activity. This highlights how complex practice negotiation is and the fluid arena in which nursing staff must determine, based on staff availability and patient acuity, whether they need to negotiate their jurisdictional control to include particular activities in the nursing domain.

Maintaining the continuity of patient care has also been proposed as another reason why nurses perform activities considered within the customary practice of other hospital staff (Allen, 1997). This concept has been termed continuity-orientated boundary blurring (Allen, 1997). An example provided by participants that helps in understanding the concept of continuity-orientated boundary blurring is the act of following up with medical staff for ongoing fluid orders or plans made on ward rounds that were never documented or completed at that time. Completing these activities improved patient safety despite them not being considered a nursing responsibility by participants. Participants negotiated the need to chase the doctors for orders with their own nursing priorities and believed the completion of the former activity was justified given the effects it had on patient safety. In these instances, participants negotiated their own work domain because doing so promoted good patient outcomes. Allan (2001) describes this process as strategic multi-tasking. Strategic multi-tasking is understood as the completion of a task that falls outside of nurses’ formal jurisdiction but is carried out in order to complete another more complex activity (Allan, 2001). Both continuity-orientated boundary blurring and
strategic multi-tasking are ways that patient safety is enhanced; however, participation in these is negotiated depending on the availability of the appropriate health care employee and patient need.

Nursing work is intermediary (Allen, 2002). The ability of nurses to work flexibly and negotiate their jurisdictional domains is essential for the management of the organisational turbulence that arises from acute hospital settings. Participants' flexible working practices make an important contribution to patient outcomes and safety; however, without this understanding nurses are left feeling as though they are picking up the slack. Negotiation of nursing domains attenuates the fragmentary effects of modern health care systems (Allen & Lyne, 1997) and has been shown by the findings of this study to be important for patient safety, comfort, and continuity of care. Emphasising the benefits that nursing domain negotiation has on patient outcomes (Allen, 2002; Allen & Lyne, 1997) may help to reduce participants’ feeling as though they are picking up the slack for other hospital staff. Similarly, promoting the importance of this to other health professionals may also encourage them to appreciate the actions of nursing staff in gluing it all together (Thomas, 1983). Svensson (1996) describes work that nurses do not think they should do but is forced on them, because of the busy doctors, as “service work” (p. 392). Ensuring that nursing staff understand that the negotiation of their nursing domain is not an act of service work, or of picking up the slack as cited by participants in this study, and is considered a resource by all involved, may also be beneficial.

The seemingly relentless need to negotiate nursing practice and nursing domains to uphold patient safety and effect manageable workloads was leaving some participants feeling as though patient proximity was dwindling. By recognising this new clinical reality, a need emerged to develop ways to negotiate patient proximity that was satisfying for both nurses and their patients. *Negotiating patient proximity* is discussed in the following section.

**Negotiating patient proximity**

Nursing is a human practice (Malone, 2002). As such, relationships need to be formed and trust developed. To achieve this, nursing depends in part on maintaining some form of meaningful patient proximity. Participants struggled with what level of
patient proximity was adequate for safe patient care. Many discussed how their proximity to the patient was diminishing, creating the belief they were providing inadequate nursing care to patients. The positioning of nurses at the bedside 24 hours a day, seven days a week is believed to be the way in which nurses distinguish themselves from other healthcare workers (Peter & Liaschenko, 2004). Physical proximity to patients provides nurses with a sense of identity and purpose (Malone, 2002). Diminution of this aspect of the nursing role frustrated and worried some participants who believed that removal of direct patient contact from licensed nursing practice would have detrimental effects on patient safety. With total patient care provided by individual licensed nurses being shown to be difficult to sustain in the current acute care environment, practice negotiation to ensure some level of meaningful proximity is still maintained when using all levels of nursing care providers seems important. Negotiation of practice to maintain patient proximity mostly occurred between various levels of nursing staff rather than negotiation with other professional groups.

Hospital settings and organisational practice are increasingly disrupting close nurse-patient proximity (Malone, 2002). Shifts towards outpatient care, reduced length of stay and increased use of part time staff (Duffield et al., 2007; Gilmour, 2006) are just some of the ways that individual nurse-patient proximity is being reduced through changes to hospital settings and practices. Patients are leaving hospital sooner, meaning less time is available for direct contact between nurses and patients. Additionally, work redesign strategies are handing over nurses’ work to unskilled workers (ABS, 2005; Duffield et al., 2007) such as HCWs, with licensed nurses becoming care managers rather than care providers (Malone, 2002). Increased use of HCWs in the acute setting, along with other workplace strategies such as high numbers of casual staff, can result in patients having multiple nurses on a single shift. In this study, common constraints to close nurse-patient proximity included increased use of HCWs, handover of some medical responsibilities to nurses that took RNs away from the bedside, and increasing indirect patient care activities, such as attendance at administrative meetings. Collectively, these changes result in less engagement with patients, meaning nurses need to redefine what close patient care involves (Malone, 2002; Peter & Liaschenko, 2004) and investigate ways to negotiate
patient care to ensure all responsibilities, direct and indirect, are met and patient proximity is adequate.

Malone (2002) describes two types of patient proximity: physical and narrative. Physical proximity is defined as the “nearness within which nurses physically touch and care for patients’ bodies” (p. 2318). Narrative proximity occurs when nurses get to know the patient through listening, understanding and transmitting the patient’s story (Malone, 2002). Limitation of either type of proximity may result in nurses feeling distal to patient care. The inability of participants to gain close physical proximity to the patient had a flow-on effect to the narrative proximity that many experienced. Some participants discussed how they were not aware of many aspects of their patients care when activities they normally participated in, such as attending to ADLs, were delegated to HCWs. When physical proximity was limited through the delegation of ADLs to HCWs, participants were unable to discuss patients’ treatment, listen to patient concerns and develop a trusting relationship. As a result, narrative proximity was also limited. Malone (2002) confirms the interconnectedness between physical and narrative proximity, describing them as nested. Physical proximity sets up the possibility for dialogue between nurse and patient through which the patient’s narrative can be heard and discussed (Malone, 2002).

Practice negotiation seems to be an inevitable way forward for the nursing profession. With HCWs providing more direct patient care, and delegation and trading tasks becoming a daily occurrence, it is important to ensure the remaining time licensed nurses have with their patients is meaningful. One way that patient proximity can be negotiated to ensure time spent with patients is meaningful (Alliex & Irurita, 2004; Henderson, 2006), is by spending a number of short sessions of quality time with patients to let them voice any concerns and for nursing staff to communicate proposed plans. Alliex and Irurita (2004) described a similar process in their research into nurse-patient interaction in the presence of technology that they termed ‘maximising’. Maximising describes the added effort of nurses in trying to meet the humanistic needs of their patients and ensuring they maintained a patient presence (Alliex & Irurita, 2004). Colazzi explains that presence “requires encountering the patient, co-existing with him for some moments in time and space for the purpose of mutually illuminating the experience” (1975, p. 200). The need to maximise interactions
between licensed nurses and patients and maintain presence is increasingly important given the increased number of activities being delegated to HCWs and indirect care responsibilities being placed on nursing staff. In a recent Australian study, Chaboyer et al. (2008) found that RNs in medical units only spent a third of their time providing direct patient care, a finding that supports the need to maximise nurse-patient interactions as it appears to be this engagement with patients that keeps nurses connected to their profession. Findings from this study show that being able to achieve a patient presence without providing total patient care is a skill that requires experience and an ability to know the patient and their needs from only limited interaction. Acquiring this skill takes time and exposure to varied patient conditions, and also an ability to critically consider each piece of patient information.

Similar to ‘maximising’, Henderson (2006) described creating ‘situatedness’ for the purpose of creating an environment, sometimes only for momentary periods, whereby nurses are not influenced by the environmental or organisational pressures within the acute hospital environment. During these periods nurses require highly developed abilities to situate themselves and focus on the particular needs of the patient (Henderson, 2006). By situating themselves with the patient, nurses are not only being friendly but also seeking knowledge from patients with the aim of aiding their recovery and identifying the patient’s concerns and desires (Henderson, 2006). There were a myriad of distractions that participants discussed having to manage during an eight hour period, with many unsure how to get to know their patients if they didn’t provide total patient care. There was, however, one participant who spoke of being able to get to know her patients through spending short stints of meaningful time in their presence. She did not overtly discuss patient ‘situatedness’; however, from her description this appeared to be what she was doing. Henderson’s (2006) suggestion of temporary moments of situatedness then seems a plausible way forward for nursing staff within the existing constraints of care provision in the acute care setting.

Another approach to negotiate patient proximity is by encouraging open discussion of patients’ conditions and care plans between colleagues. This allows nurses to negotiate a new form of patient proximity. This proximity may not be as well-defined and distinct as the physical proximity or narrative proximity (Malone, 2002) discussed earlier, but it does provide a new way for nurses to re-define proximity in a
way that responds to the current work environment. For example, participants discussed the importance of ‘piecing it all together’ to ensure patient safety and safe nursing practice. This skill of being able to piece together aspects of the patients’ condition that they have cared for directly, read about in the patient’s progress notes, or discussed with other colleagues allows nurses to get to know their patients without the need to provide total patient care. ‘Piecing it all together’ provides an alternative way to ‘know the patient’ (Potter & Grant, 2004) that can be both satisfying and appropriate for nurses. ‘Knowing the patient’ has been described as the nurse’s understanding of the patient and their individual care (Radwin, 1996). The nurse’s experience with caring for patients and a sense of closeness between the patient and nurse are also related to ‘knowing the patient’ (Radwin, 1996). Contrary to Malone’s idea of physical and narrative proximity being nested (2002), this study shows there can be narrative proximity without actual physical proximity. ‘Piecing it all together’ is just one avenue for developing meaningful proximity and knowledge of patients when care is divided among care providers.

Gathering information from multiple care providers, both nursing and allied health, is important for negotiating proximity. Being able to critically reflect on the information and piece together the patient picture are essential for being able to maintain patient proximity without providing total patient care. Critical thinking has been described as “the cognitive processes and strategies that nurses use to understand the significance of patient data, to identify and diagnose actual or potential patient problems, and to make clinical decisions to assist in problem resolution and to enhance the achievement of positive patient outcomes” (Fonteyn, 2000, p. 108). In other words, clinical information, gathered through direct patient care or by discussion with other colleagues, and prior knowledge are considered, pieced together and nursing practice decisions are made. Clinical judgment has been thought to be the outcome of thinking critically (Benner et al., 1996; Brigham, 1993; Miller & Malcolm, 1990). It appears that the process of ‘piecing it all together’ reflects critical thinking and judgement.

Given that nurses’ critical thinking skills influence their ability to piece together patient information, enhancement of these skills in the nursing workforce may assist in the negotiation of appropriate patient proximity, and reduce the frustration associated with working alongside multiple nursing care providers. Thinking aloud
and reflection on action are just two ways that have been suggested to develop critical thinking skills in clinicians (Robbins, Millett & Waters-Walsh, 2004). Thinking aloud involves the presentation of a clinical scenario to clinicians who are then asked to verbalise their thoughts and decisions (Robbins et al., 2004). Reflection on action involves clinicians reflecting on a particular event and focusing on the clinical judgments made, feelings, and actions taken (Robbins et al., 2004). Both of these strategies could be employed to enhance critical thinking and the skill of ‘piecing it all together’, which could assist nursing staff in finding a level of patient proximity that is both appropriate and achievable.

Finding a nursing model that encourages use of all levels of staff and ensures meaningful proximity is achieved for nursing staff is important. The model needs to allow for meaningful proximity to be developed between nurses and their patients, and allow senior staff to assist junior staff to develop alternative ways of knowing their patients and negotiate proximity through means other than total patient care. Throughout the years, nursing has struggled to find the optimal nursing practice model (Fowler, Hardy & Howarth, 2006). At the time of the interviews, both sites employed primary nursing as their main nursing care model, with RNs also having to provide certain aspects of care to the EN’s patients. There was a general perception held by participants that nurses graduate from universities with the belief that they will practice independently, holistically and with the majority of their time spent providing hands-on care in close proximity to the patient. While this may still be the case in some hospitals, the responses from the participants from this study show that this is not the reality in many acute care environments. This mismatch between the perceptions of the nursing role and the reality of practice has the potential to further exacerbate nursing shortages and supports the need to promote practice negotiation to undergraduate nursing students. Delays in providing nursing care have been associated with insufficient nursing resources, high levels of casual and agency staff, and unexpected changes in patient acuity (Duffield et al., 2007). Some participants discussed using team nursing during extremely busy periods, which allowed the specialised knowledge of the team leader to be used in coordinating rather than providing hands-on care (Fowler et al., 2006).
The concept of using a ‘care manager’ type position was discussed by one participant who was considering new ways to practice given the increased numbers of HCWs and indirect care activities being expected of licensed nurses. The most experienced licensed nursing staff who possess a high level of critical thinking and reasoning skills (Smith & Godfrey, 2002) could be utilised in this position. The care manager could have primary responsibility for care coordination and oversight of the nursing care that is provided by a team to a predetermined cohort of patients. Coordination of care, by means of being an intermediary, has been discussed as an essential skill for nurses in the future (Allen, 2004). Care managers can provide initial assessment of the patient, reassessment as clinical condition changes, problem identification, care planning, multidisciplinary team coordination, and discharge planning (Smith & Godfrey, 2002). The care manager could also be used to mentor junior members of the team on subjects related to the patients’ condition but also related to the importance of developing meaningful proximity between client and carer. The care manager would be able to negotiate meaningful time with their patients and piece their care together with information provided by the team in order to maintain proximity while still meeting their other responsibilities. The care manager could be utilised, as many participants stated, as the “safety mechanism”, providing close supervision and surveillance of patient vital signs, without being taken away to perform tasks that can be undertaken by other care providers.

While experienced RNs could be used as care managers, care providers or newly registered RNs or ENs could provide direct nursing care under the direction of the care manager and with the assistance of HCWs (Smith & Godfrey, 2002). Junior nurses have been described as focusing on the technological needs of the patients (Henderson, 2006) and needing guidance to know “what to do next” (Alasad, 2002). This may result in junior nurses losing sight of the patient and failing to maintain meaningful proximity to the patient despite providing hands-on care. In these situations, task completion may outweigh the need to develop a close, interpersonal relationship, thus limiting meaningful proximity. This highlights how meaningful proximity is not afforded simply by providing total patient care; it requires a simultaneous awareness of the physical and emotional needs of patients for the development of a therapeutic relationship.
Some participants believed that patient proximity was eliminated altogether when HCWs were used to attend to basic patient cares and ADLs; however, experienced participants stated the opposite and believed it could be maintained with careful time management. Short stints of meaningful time spent with patients (Alliex & Irurita, 2004; Henderson, 2006) and learning how to ‘piece it all together’ become ways to maintain proximity when utilising the help of HCWs; however, junior nurses can get caught up with basic patient care activities (Alasad, 2002; Gurbutt, 2006) so it may be necessary for these workers to spend more time with patients until they can master meaningful patient proximity without the need to provide total patient care. Consequently, negotiation of proximity will always be a variable process across the nursing workforce as a consequence of the fluctuating experience, length of patient stay, and availability of other health professionals.

Some participants negotiated new ways to maintain patient proximity through delegating certain aspects of care that, because of competing pressures, could no longer be attended to by licensed nurses. Direct nursing care is an important component of nursing; however, the overarching care coordination role that is synonymous with nursing is also crucial to the success of the interventions of all health care providers (Allen, 2004). Without the coordination that nurses undertake each shift, health care delivery in the acute hospital setting could easily be disjointed (Allen, 2004; McCloskey, Bulecheck, Moorhead & Daly, 1996). Because of the importance of this coordination role and the ability of HCWs to undertake some aspects of patient care, delegation of care was occurring. This required nursing staff to ensure the remaining time that they did have with patients was as meaningful as possible.

Nurses needed to find ways to maintain a certain level of meaningful proximity to their patients. This meant negotiating aspects of their practice that they once considered essential, such as total patient care, in order to ensure patients received holistic care. Historically, holistic care was achieved by having an individual nurse provide total patient care. Holistic nursing care is still important; however, the means to achieving it have changed with it being delivered through practice negotiation among a team of nursing care providers. Negotiating activities with colleagues, both licensed and unlicensed, is now an essential way for meaningful proximity to be
achieved, holistic nursing care to be provided, and patient safety to be maintained. Negotiation of nursing practice is important for “getting to know patients” (Allen, 2001) and can make workloads more manageable, which gives nurses time to focus on the patient, rather than just the activities. The professional ideal of developing close, interpersonal relationships between nurses and their patients is then made easier because nursing staff are able to manage their time better and allocate a set period for being conversant with their patients.

**Recommendations**

The recommendations that flow from the implications discussed are as follows:

**Recommendations for practice**

That:

1. Ward-based or formal induction and education programs, introduced in the acute care setting, be provided to HCWs to assist them in better enacting their expected role in the team. These sessions could include an overview of the activities that may require completion by HCWs, activities that would be inappropriate for their role, and the importance of handing over patient information gleaned during patient interaction to the nurse responsible for the patient’s care.

2. Licensed nurses are assisted to develop skills to work more productively with HCWs. Some ways to assist cohesion among licensed and unlicensed nursing care providers could include involving all levels of nursing staff during handover, developing a clear role description for HCWs, and reflecting on practice.

3. Individual wards and units decide on a preferred nursing practice model that takes into account staff capabilities, scope of practice, patient acuity, and grade mix. It is likely that this model will require some flexibility when operationalised.

4. All levels of nursing staff, licensed and unlicensed, be provided with the opportunities to practise to their full potential, capabilities, and scope of practice. Limitations should not be placed on ENs or HCWs just because an RN is available at that time. For example, ENs should be allowed to administer medications if they are medication endorsed.
5. The safety aspect of the RNs practice be emphasised and developed in every acute setting. The importance of RNs as a “safety mechanism” is widely discussed in the nursing literature; however, its perceived importance in practice is somewhat limited. This could be achieved through focusing on the surveillance role of the RN in identifying patients at risk of deteriorating during staff education sessions.

6. Prearranged time for communication between HCWs and licensed nursing staff may improve communication between these workers. The use of whiteboards has shown some benefits internationally and could be explored locally at a ward level.

7. Nurses may require assistance to become better skilled at practice negotiation. The importance of negotiation in nursing practice needs promotion to all hospital employees to ensure they understand and appreciate how this ability of nursing staff to plug the gaps in practice is essential for modern healthcare provision.

8. Nursing staff be encouraged to develop and sustain relationships with their patients even when communication, may at times, be mediated by HCWs and when interactions are brief. This may be facilitated through understanding the skills needed to ‘maximise’ interactions and create patient ‘situatedness’.

**Recommendations for education**

That:

1. Academic and clinical educators implement activities to facilitate the development of nurses’ delegation and supervision abilities as licensed nurses increasingly work with non-professional staff. Continuing education involving simulation and role play may be effective ways for nurses to learn the skills required for changing models of patient care delivery and evolving professional roles. The role of the RN in coordinating patient care requires students to learn to take a leadership role in the multidisciplinary team.

2. Training and teaching focus on nurses gaining skills in screening and monitoring mental health problems to meet the increase in people with mental health problems in acute care areas. Training needs to be comprehensive and provided at a number of levels, such as crisis management and care for acute illness. Training in de-escalation of violent behaviour may also be beneficial.
3. Undergraduate nursing programs focus on nursing teamwork with opportunities to practice this in the clinical environment. Currently, undergraduates are taught how to work in teams of RNs; however, practice dictates teamwork must be negotiated between RNs, EENs, ENs and HCWs, thus education should be consistent with this.

4. Building on the previous recommendation, undergraduate programs need to provide opportunities for students to learn the coordinating care role that RNs must participate in. This should provide them with an understanding of what it means to work in a leadership role within the multidisciplinary team.

5. A change in emphasis is made in undergraduate nursing education to promote the intermediary and negotiating role of nurses as nurses currently appear to graduate from universities with the belief that they will practise independently with the majority of their time spent providing hands-on patient care.

6. Structured activities that improve team communication and functioning are required. Practical placements in acute care settings may benefit from the combined learning of nursing, medical, and allied health students. The opportunity to work together at an undergraduate level should improve communication and teamwork when all members eventually join the health care workforce.

7. Nursing students may benefit from being employed at the HCW level as undergraduates. The benefits for nursing students include improving time management skills, enhanced multidisciplinary team communication, and a better understanding of the nursing role and how it fits into the health care delivery team. Employing these workers would also positively affect the hospital if they were used appropriately and effectively.

**Recommendations for nursing management**

That:

1. Opportunities should be provided to all levels of staff to participate in nursing handover and patient care decision-making. Each nursing staff member, licensed and unlicensed, gains knowledge of the patient and their condition through their
interactions and contributes to patient care, which highlights the need for all levels to be included in the handover.

2. Respectful and collaborative relations are promoted throughout the nursing workforce to improve interactions between all levels of nursing care providers. While RNs are able to perform all aspects of nursing practice, this should not limit the activities performed by ENs or HCWs.

3. Senior nursing roles, such as coordinators of care, are required at a ward level. Team communication, mentoring of junior staff, promotion of patient safety, and orientation of the high proportion of casual staff are just some of the activities that could be managed by this staff member.

4. Coaching of nursing staff is a priority for nurse managers. Coaching, or mentorship, should focus on the importance of the patient safety role and how to maintain patient proximity while still working effectively with all levels of nursing care providers.

5. Patient allocation is considered in light of grade mix and skill mix of nursing care providers on a shift-by-shift basis. Patient allocation tends to be controlled by areas within wards (i.e. by room number); however, it should be based on staff abilities, experience, and patient acuity.

**Recommendations for research**

Further research should address:

1. The implications of HCWs who are undergraduate nursing students having increased responsibility and scope of practice compared to HCWs who are not student nurses.

2. The notion surrounding “good” nurses compared to “bad” nurses with regards to hands-on patient care and delegation and what nursing is in the 21\textsuperscript{st} century.

3. How practice negotiation can be taught to undergraduate nursing students and promoted as an important role for all nursing care providers.
4. The benefits and limitations of various nursing practice models given the increased numbers of ENs and HCWs in the acute care setting. Models should promote the leadership and coordination role of RNs while ensuring some degree of nurse-patient proximity.

**Limitations of findings**

Although it has been clearly shown that this thesis answered the research question and contributed to the evidence-based knowledge on nursing scope of practice, there are limitations to the findings.

First, the study is retrospective in nature and relied on the participants’ recollection of their nursing experiences. The events were discussed sometimes months after they occurred in practice. Previous studies have shown that the ability to recall events differs markedly among studies and over time; therefore, whether the accuracy of the recall may have been distorted as a result of the passing of time is difficult to determine. However, it was apparent from participants’ accounts of their events that they were vividly remembered and easily recalled (Kempainen, 2000). Additionally, the interview format was seen as an appropriate method of data collection because it allowed greater opportunity for discussion and clarification than other methods that may have collected data at the time of the event.

Second, limitations exist in relation to the participants’ ability to express themselves and explain their practice. Some people have difficulty in expressing these meanings and it is for this reason that Twelker’s recommendation of collecting no less than 50 incidents was implemented. Some participants found it hard to answer when asked why they felt a certain way. A large number of incidents were collected to allow for the difference in participants ability to express themselves. The use of the I:R technique also helped to overcome this challenge (Chirban, 1996).

Third, the researcher was also employed as a RN at one of the sites. This only became an issue when some participants found it unusual when asked questions about basic patient care or where the participant thought answers would be self-evident to any nurse. Many commented that they felt strange answering the questions knowing that both parties (participant and interviewer) knew the answer because both were employed within the nursing workforce. Consequently, many participants were
reluctant to provide detail when asked about basic patient care, and felt it was a waste of time because the answers were apparent. Once this response was noted, the researcher reinforced that despite the answers being obvious to the participants themselves, it was important for the interviewer not to assume the answers from their own previous experience and that while it may be evident to the participant, it may not be to others. However, in some instances, despite encouragement, some events were not well discussed, which limited the amount of analysis that could be undertaken and meant these events, while considered during data analysis, were limited in the way they could be used. The idea of ‘obvious questions’ may advocate for the use of someone known to the profession but who is also detached. Using an interviewer who is detached may access information on ideas that are taken for granted by the participants; however, an interviewer with a background in the profession may elicit more complex information that may be withheld by participants from an interviewer who has no previous experience on the assumption that they would not understand (Irvine, Roberts & Bradbury-Jones, 2008). This notion is known as “researcher as insider” and has been shown to enhance rigour (Irvine et al., 2008).

Finally, previous knowledge or a background in the profession under investigation also influenced analysis of the events. It became impossible not to allow prior experience to inform the analysis of the events. This further emphasised the importance of rigourously questioning the data and ensuring that accurate representations were derived from the events. Critical discussion with my academic supervisors removed this potential bias. Prior knowledge, when used carefully and vigilantly managed, as was done in this study, greatly enhanced the study’s findings by enriching the interpretations and explicating the findings.

**Conclusion**

The nursing work environment is changing. Changes are being seen in the profile and grade mix of nurses in acute care wards and in the way nurses construct their practice. The purpose of this research was to understand how medical and surgical nurses conceive their scope of practice in response to the available grade mix and skill mix of nurses and other health care professionals in the acute hospital setting. Findings have shown that negotiation has become a fundamental aspect of nursing practice in
being able to provide timely patient care given the variety of nursing care providers currently employed in acute care settings. Negotiation is occurring on a daily basis with the goal of the negotiation process varying for each interaction. An ability to understand when, what, how, and with whom to negotiate practice presents new issues and skills to be learnt for the nursing workforce.

The new interfaces between nurses, licensed and unlicensed, and between nurses and other health professionals are the key motivating forces behind the changes currently occurring in nursing practice. Previously, there wasn’t the need for nurses to negotiate care between licensed and unlicensed staff because HCWs were not employed in acute hospitals; however, their increased use has resulted in the need for a new order to be negotiated. Similarly, the blurring of role boundaries between doctors and nurses, and the availability of staff have created relationships that necessitate negotiations between these workers where they didn’t previously exist within the prevailing social conditions in hospitals.

Negotiation in nursing practice has allowed nurses to redefine appropriate nurse-patient proximity. Previously, close patient proximity, gained through the provision of total patient care, has been linked with ‘good’ nursing practice. If nurses weren’t able to achieve close patient proximity they believed they were providing inadequate patient care. Findings suggest that this notion has arisen from the belief that holistic patient care can only be accomplished through total patient care; however, total patient care is becoming increasingly difficult to practise due to growing indirect care responsibilities, patient acuity, and the variety of employed nursing care providers. Negotiation in practice allows a new type of proximity to be afforded that allows nurses to ensure safe, and timely care is provided. Open communication between all care providers, an ability to piece together aspects of care gleaned through direct patient care or discussion with other team members, and maximising patient contact to ensure each encounter is meaningful, are ways in which nurses are achieving patient proximity through practice negotiation.

Negotiation of nursing practice also raises issues related to patient safety. Being a “safety mechanism” for patients was a dominant theme in this study and an issue that participants felt strongly about. As such, incorporating the practices of care negotiation meant knowing when it was safe to delegate activities, when the activity
required completion by a licensed nurse, and an understanding of when trading activities between care providers was safe. While it would be expected that most nurses would have this understanding, it became clear from the findings that this wasn’t the reality. Clear role articulation, knowledge of each role, and how to delegate were all issues that came to the surface when participants’ discussed practice negotiation.

The negotiation of patient safety led some nursing staff to find new ways of working in nursing teams. This resulted in participants negotiating patient care activities with their nursing colleagues when the grade mix and skill mix available at the time was less than optimal. Negotiating with nurses raised a number of issues for consideration including the importance of good communication between all levels of nursing care providers, clear role descriptions and having respect for each person’s contribution to patient care. Each of these aspects was believed to be essential for teams to function effectively and to their full potential.

And while participants from this study spoke of negotiating activities with their nursing colleagues, this practice was never discussed in relation to non-nursing hospital staff. Instead of negotiating with other hospital staff, findings have shown that a negotiation of nursing domains occurs with nursing staff determining the priority of the activity requiring completion, the availability of the relevant staff member, and the impact of delaying the activity on patient safety. Completion of the activities often occurred when a staff member was absent. The flexibility of participants in being able to fill these roles was admirable due to the benefits it had for patients and also because of the abundance of other responsibilities they still had to manage concurrently. While some participants likened the completion of work outside of their customary practice as picking up the slack, it clearly made sense to others because of the benefits it had on patient safety.

While this study has revealed the importance of negotiation in nursing practice, it is interesting to note the limited amount of literature on the topic. The literature that is available for review stems from research conducted internationally in the 1980s and 1990s. The majority of the findings from this study support this literature; however, the concepts have been extended to reflect the changes that have occurred in the acute hospital system since their publication. Practice negotiation will become a prominent
topic over the coming years as hospital administrators struggle to employ licensed nurses and instead use HCWs in an attempt to fill the gaps. Ensuring that the skills of practice negotiation are emphasised to the current cohort of licensed nurses and introducing the topic at an undergraduate level is important for ensuring that the nursing workforce is prepared to provide safe patient care in the current climate. Promoting and striving for outdated ideals, such as total patient care, not only frustrates nursing staff but overlooks the abilities that lie within the nursing workforce in becoming care coordinators, “safety mechanisms”, and practice negotiators.
References


Hovenga, E. (1996). *Patient Assessment and Information System (PAIS)*. Faculty of Informatics and Communication, Central Queensland University: Rockhampton.


APPENDIX 1

Information Sheet - Critical Incident Technique Interviews

Project Title: Developing Evidence-Based Workforce Models for Nursing Services in Acute Care Hospitals

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You are invited to participate in this important project, which is described below.

Background to the study:
The capacity of the Australian Healthcare system to provide care to patients is currently facing many challenges such as increasing patient acuity, rising patient turnover rates and greater demands for health care, cost containment pressures and nursing shortages. As the largest group of professional workers in the healthcare system in general, and in hospitals in particular, nurses' input is very important to finding innovative solutions to cope with these challenges. With quality and safety, not just efficiency, fundamental in delivering health care, it is vital that skills are matched to specific nursing work, and the requirements of particular workplaces, ensuring the appropriate mix of competencies for safe, high quality care. We think that the design of the nursing workforce in hospitals is of critical importance, however more information is needed about what nurses currently do, and what they should do.

Aim of the Study:
This study aims to identify and describe the activities undertaken by Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistants in Nursing (AINs) providing patient care in acute settings, and then determine the patient care activities that should be delivered or delegated by various levels of nurse in the acute setting. Gathering this information will then enable evidence-based policy guidelines for delivery of nursing services in acute care hospitals to be developed. To achieve these aims we are undertaking a three-part study that includes:

1. Observation – Work sampling study of nurses’ activities.
2. Interviews – Critical Incident Interviews about nursing activities.
3. Focus groups – Developing guidelines for nursing workforce models.

What participation involves:
We are inviting you to take part in Phase 2 - the Critical Incident interviews. Critical Incident interviews are a systematic way of collecting and analysing descriptions of specific situations, which help suggest solutions to practical problems. Information will be collected about work incidents that you regard as critical (significant or crucial, not necessarily of an emergency medical nature) examples of nursing activities. You are being invited to participate because you work in an acute care hospital setting and have important experience that can help
determine how the nursing workforce can best provide care for patients. You will be one of about 24 nurses we are asking to take part in the interviews. Your participation in this study involves an interview that will last approximately 1-1½ hours. The interview will be conducted at a time and place that suits you. The interview will be audiotaped so that we will be able to transcribe your descriptions of the incidents and analyse them. The information will be used, along with the data from the observation phase, by the focus groups to develop the guidelines for workforce design.

**What you will be asked to do:**
We will ask you to think of 4 critical incidents from your practice before you come to the interview:
- Two incidents when you thought you were undertaking patient care activities appropriate to your skills
- Two incidents where you thought you were undertaking patient care activities that should have either been delegated, or undertaken by a higher level of care provider.

Then, at the interview we will ask you to describe the incidents in as much detail as you can.
We will also ask you to read and check the transcript of your interview after it has been typed up from the tapes.

**Confidentiality:**
All information that is gathered at the interview will be treated in a confidential manner and your name will be changed to a coded number to ensure anonymity. The code will be kept in a separate file from the data. We will ask you to check the transcript to ensure that you approve us using all the information for the research. The tape will be destroyed following your approval of the written transcript. All information will be kept in a locked cabinet in the Research Centre for Clinical Practice Innovation at Griffith University during the study and for a period of 5 years after the completion of the research. Confidentiality will be maintained at all times. The research report will use code numbers and report aggregated data, to ensure that individuals cannot be identified.

**Consent to participate:**
Participation in this study is voluntary, so while we would appreciate your taking part in this study, we respect your right to choose not to participate. There will be no consequences to you if you choose not to participate, and this will not affect your future employment with the hospital. If you decide to participate and then later want to withdraw from the research, you may do so without the need to provide an explanation.

**The possible benefits:**
Although taking part in the research may have no immediate advantages for you, the findings from the Critical Incident interviews will provide valuable information that will contribute to the development of evidence-based guidelines related to skill-mix, staffing patterns, levels and allocation, and delegation of duties that will benefit future patients, and nursing and health care providers.

**The possible risks:**
There are no significant risks anticipated from taking part in this study. The observer is not judging or assessing your practice, but recording the critical incidents to be analysed along with information from other participants. However, if you find that discussing critical incidents from your practice is stressful, we will stop the interview, and if you wish, we will advise you of a counsellor you can talk to.

**Questions:**
If you have any questions or would like to discuss this study, I would be happy to talk with you, or if you would like to talk with another member of the research team, I will be happy to put you in touch with them. We will be bringing a summary of the study findings to your clinical area, and you are also welcome to discuss any issues relating to those results.

**Contacts:**
If you have any queries about any aspect of this study, or any concerns about the conduct of the study, please contact Professor Wendy Chaboyer.

or
If you prefer, you may contact either: the University's Research Ethics Officer, Office for Research, Bray Centre, Griffith University, Kessels Road, Nathan, Qld 4111, telephone (07) 3875 6618 or
The Pro Vice-Chancellor (Administration), Bray Centre, Griffith University Kessels Road, Nathan, Qld 4111, telephone (07) 3875 7343
or
the Gold Coast Health Service District Human Research Ethics Committee Administrator on (07) 5519 8010.

*The research team would like to thank you for your participation in this project.*
Professor Wendy Chaboyer (Chief Investigator)
APPENDIX 2

Information Sheet - Critical Incident Technique Interviews

Project Title: Developing Evidence-Based Workforce Models for Nursing Services in Acute Care Hospitals

Investigators:
- Professor Wendy Chaboyer (Griffith University)
- Professor Mary Courtney (Queensland University of Technology)
- Professor Christine Duffield (University of Technology –Sydney)
- Dr Philippa Seaton (Griffith University)
- Dr Kim Forrester (Griffith University)
- Professor Marianne Wallis (Griffith University & Gold Coast Hospital)
- Ms Kerri Holzhauser (Princess Alexandra Hospital)

Contact Person: Professor Wendy Chaboyer

Student Investigator: Ms Jessica Schluter

Address: Research Centre for Clinical Practice Innovation, Gold Coast Campus, Griffith University, PMB 50, Gold Coast Mail Centre, Queensland 9726

Phone Number: (07) 5552 8518 Email: w.chaboyer@griffith.edu.au

You are invited to participate in this important project, which is described below.

Background to the study:
The capacity of the Australian Healthcare system to provide care to patients is currently facing many challenges such as increasing patient acuity, rising patient turnover rates and greater demands for health care, cost containment pressures and nursing shortages. As the largest group of professional workers in the healthcare system in general, and in hospitals in particular, nurses’ input is very important to finding innovative solutions to cope with these challenges. With quality and safety, not just efficiency, fundamental in delivering health care, it is vital that skills are matched to specific nursing work, and the requirements of particular workplaces, ensuring the appropriate mix of competencies for safe, high quality care. We think that the design of the nursing workforce in hospitals is of critical importance, however more information is needed about what nurses currently do, and what they should do.

Aim of the Study:
This study aims to identify and describe the activities undertaken by Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistants in Nursing (AINs) providing patient care in acute settings, and then determine the patient care activities that should be delivered or delegated by various levels of nurse in the acute setting. Gathering this information will then enable evidence-based policy guidelines for delivery of nursing services in acute care hospitals to be developed. To achieve these aims we are undertaking a three-part study that includes:

4. Observation – Work sampling study of nurses’ activities.
5. Interviews – Critical Incident Interviews about nursing activities.
6. Focus groups – Developing guidelines for nursing workforce models.

What participation involves:
We are inviting you to take part in Phase 2 - the Critical Incident interviews. Critical Incident interviews are a systematic way of collecting and analysing descriptions of specific situations, which help suggest solutions to practical problems. Information will be collected about work incidents that you regard as critical (significant or crucial, not necessarily of an emergency medical nature) examples of nursing activities. You are being invited to participate because you work in an acute care hospital setting and have important experience that can help
determine how the nursing workforce can best provide care for patients. You will be one of about 24 nurses we are asking to take part in the interviews. Your participation in this study involves an interview that will last approximately 1-1½ hours. The interview will be conducted at a time and place that suits you. The interview will be audiotaped so that we will be able to transcribe your descriptions of the incidents and analyse them. The information will be used, along with the data from the observation phase, by the focus groups to develop the guidelines for workforce design.

What you will be asked to do:
We will ask you to think of 4 critical incidents from your practice before you come to the interview:
- Two incidents when you thought you were undertaking patient care activities appropriate to your skills
- Two incidents where you thought you were undertaking patient care activities that should have either been delegated, or undertaken by a higher level of care provider.

Then, at the interview we will ask you to describe the incidents in as much detail as you can.
We will also ask you to read and check the transcript of your interview after it has been typed up from the tapes.

Confidentiality:
All information that is gathered at the interview will be treated in a confidential manner and your name will be changed to a coded number to ensure anonymity. The code will be kept in a separate file from the data. We will ask you to check the transcript to ensure that you approve us using all the information for the research. The tape will be destroyed following your approval of the written transcript. All information will be kept in a locked cabinet in the Research Centre for Clinical Practice Innovation at Griffith University. Confidentiality will be maintained at all times. The research report will use code numbers and report aggregated data, to ensure that individuals cannot be identified.

Consent to participate:
Participation in this study is voluntary, so while we would appreciate your taking part in this study, we respect your right to choose not to participate. There will be no consequences to you if you choose not to participate, and this will not affect your future employment with the hospital. If you decide to participate and then later want to withdraw from the research, you may do so without the need to provide an explanation.

The possible benefits:
Although taking part in the research may have no immediate advantages for you, the findings from the Critical Incident interviews will provide valuable information that will contribute to the development of evidence-based guidelines related to skill-mix, staffing patterns, levels and allocation, and delegation of duties that will benefit future patients, and nursing and health care providers.

The possible risks:
There are no significant risks anticipated from taking part in this study. The observer is not judging or assessing your practice, but recording the critical incidents to be analysed along with information from other participants. However, if you find that discussing critical incidents from your practice is stressful, we will stop the interview, and if you wish, we will advise you of a counsellor you can talk to.

Questions:
If you have any questions or would like to discuss this study, I would be happy to talk with you, or if you would like to talk with another member of the research team, I will be happy to put you in touch with them. We will be bringing a summary of the study findings to your clinical area, and you are also welcome to discuss any issues relating to those results.

Contacts:
If you have any queries about any aspect of this study, or any concerns about the conduct of the study, please contact Professor Wendy Chaboyer.

or
If you prefer, you may contact either: the University's Research Ethics Officer, Office for Research, Bray Centre, Griffith University, Kessels Road, Nathan, Qld 4111, telephone (07) 3875 6618 or
The Pro Vice-Chancellor (Administration), Bray Centre, Griffith University Kessels Road, Nathan, Qld 4111, telephone (07) 3875 7343

or
or the Princess Alexandra Hospital Human Research Ethics Committee on (07) 3240 5856.

The research team would like to thank you for your participation in this project.
Professor Wendy Chaboyer (Chief Investigator)
APPENDIX 3

Developing Evidence-Based Workforce Models for Nursing Services in Acute Care Hospitals

CONSENT FORM
Critical Incident Technique Interviews

Investigators:  Professor Wendy Chaboyer (Griffith University)
Professor Mary Courtney (Queensland University of Technology)
Professor Christine Duffield (University of Technology –Sydney)
Dr Philippa Seaton (Griffith University)
Dr Kim Forrester (Griffith University)
Associate Professor Marianne Wallis (Griffith University & Gold Coast Hospital)
Ms Kerri Holzhauser (Princess Alexandra Hospital)

Contact Person:  Professor Wendy Chaboyer
Address:  Research Centre for Clinical Practice Innovation, Gold Coast Campus, Griffith University, PMB 50,
Gold Coast Mail Centre, Queensland   9726
Phone Number:  (07) 5552 8518  Email:  w.chaboyer@griffith.edu.au

By signing below, I confirm that I have read and understood the information package and in particular have noted that:

1. My involvement in this research will include participating in individual interviews using the Critical Incident Technique (CIT). This technique will involve the collection of information about work incidents that are regarded as critical (significant or crucial, not necessarily of an emergency medical nature). I will be asked to provide two examples from the following two areas of my practice experience:
   a. An incident where I undertook patient care activities appropriate to my skills
   b. An incident where I undertook patient care activities that I think should have either been delegated, or undertaken by a higher level of care provider.
2. My participation in this research will involve audio-taping the interview. I understand that the use of an audiotape recorder is to facilitate qualitative data analysis and that the information will be transcribed and placed on a computer using identification codes that do not personally identify me.
3. I have had any questions answered to my satisfaction and I understand that if I have any additional questions I can contact the research team.
4. I understand the risks involved.
5. I understand that although there may be no direct benefit to me from my participation in this research, this study will contribute to the development of evidence-based guidelines that may help improve nursing work and patient care
6. I understand that my participation in this research is voluntary and will not impact on my employment in any way, and that I am free to withdraw at any time, without comment or penalty.
7. I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3875 5585 (or research-ethics@griffith.edu.au) or Gold Coast Health Service District Human Research Ethics Committee Administrator on  (07) 5519 8010 if I have any concerns about the ethical conduct of the project; and
8. I agree that research data collected during the study may be published, on condition that no information that may identify me is used.

PARTICIPANT: _______________________________ (print name)
Signature:  _______________________ Date: _______________________

WITNESS:  _______________________________ (print name)
Signature:  _______________________ Date: _______________________

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APPENDIX 4

Developing Evidence-Based Workforce Models for Nursing Services in Acute Care Hospitals

CONSENT FORM
Critical Incident Technique Interviews

Investigators: Professor Wendy Chaboyer (Griffith University)
Professor Mary Courtney (Queensland University of Technology)
Professor Christine Duffield (University of Technology –Sydney)
Dr Philippa Seaton (Griffith University)
Dr Kim Forrester (Griffith University)
Professor Marianne Wallis (Griffith University & Gold Coast Hospital)
Ms Kerri Holzhauser (Princess Alexandra Hospital)

Contact Person: Professor Wendy Chaboyer
Address: Research Centre for Clinical Practice Innovation, Gold Coast Campus, Griffith University, PMB 50,
Gold Coast Mail Centre, Queensland 9726
Phone Number: (07) 5552 8518
Email: w.chaboyer@griffith.edu.au

By signing below, I confirm that I have read and understood the information package and in particular have noted that:

9. My involvement in this research will include participating in individual interviews using the Critical Incident Technique (CIT). This technique will involve the collection of information about work incidents that are regarded as critical (significant or crucial, not necessarily of an emergency medical nature). I will be asked to provide two examples from the following two areas of my practice experience:
   a. An incident where I undertook patient care activities appropriate to my skills
   b. An incident where I undertook patient care activities that I think should have either been delegated, or undertaken by a higher level of care provider.

10. My participation in this research will involve audio-taping the interview. I understand that the use of an audiotape recorder is to facilitate qualitative data analysis and that the information will be transcribed and placed on a computer using identification codes that do not personally identify me.

11. I have had any questions answered to my satisfaction and I understand that if I have any additional questions I can contact the research team.

12. I understand the risks involved.

13. I understand that although there may be no direct benefit to me from my participation in this research, this study will contribute to the development of evidence-based guidelines that may help improve nursing work and patient care.

14. I understand that my participation in this research is voluntary and will not impact on my employment in any way, and that I am free to withdraw at any time, without comment or penalty.

15. I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3875 5585 (or research-ethics@griffith.edu.au) or the Princess Alexandra Hospital Human Research Ethics Committee on (07) 3240 5856 if I have any concerns about the ethical conduct of the project; and

16. I agree that research data collected during the study may be published, on condition that no information that may identify me is used.

PARTICIPANT: _______________________________ (print name)
Signature: _______________________________ Date: ____________________

WITNESS: _______________________________ (print name)
Signature: _______________________________ Date: ____________________
SIGNIFICANT EVENT

Please recall and record four specific examples, two positive and two negative, where you felt that:

1. You were undertaking patient care activities that you should be undertaking;
2. You were undertaking patient care activities that should have either been delegated, or undertaken by a higher level of care provider.

Please be as descriptive as possible and include, where possible, the consequences of your actions, the surrounding circumstances, staff available at the time and any other important information that may help in the discussion of these events during the interview session.

SIGNIFICANT EVENT 1:

SIGNIFICANT EVENT 2:

SIGNIFICANT EVENT 3:

SIGNIFICANT EVENT 4:
APPENDIX 6
Contact Summary Sheet

Participant Number: 5
Campus: Hospital A
Interview length: 38:02
Interview date: 30/03/06
Today’s date: 1/04/06

1. What were the main issues or themes that struck you in this contact?
Holistic patient care that encompasses both physical and social needs is extremely important but there isn’t enough time in a day to do this. Experience correlates with improved ability to manage social issues and educate patients. Both EN and RN are able to assess patients for PAC etc. HCWs should not be able to do basic care unless they are supervised by licensed nurses. Assessment is a really big part of patient care and unlicensed people (wardies, HCW) are not able to do this.

2. Summarise the information you got (or failed to get) on each of the target questions?
- They were undertaking patient care activities that they should be undertaking
  Counselling of patients – managing patients social issues, mentoring of junior staff, being a source of knowledge and being approachable to other staff, any activities that promote patient safety both in and out of hospital, patient education, pressure area care (assessment of skin integrity, IDC, BO, alertness)
- They were undertaking patient care activities that should have either been delegated, or undertaken by a higher level of care provider
  Checking bloods or specimen results should be done by RMOs but nurses are constantly having to do it. Chasing up doctors for CT/XR results/ writing new med charts and bloods happens on a daily basis. Collecting a unit of blood from the blood bank or taking specimens to pathology. Collection of medication from pharmacy – very time consuming. Making of beds after they have been cleaned and when patient is an in-patient

3. Anything else that struck you as surprising, interesting, illuminating or important in this contact?
The participant was very keen to stress the importance of not just physical patient care. The lack of after hours social work was also an issue because not everything happens during business hours. Whilst PAC and hygiene is ‘just a task’ there is a lot more going on with patient. HCWs who are studying to be RNs are better/different to HCWs who are not studying – it was mentioned that maybe this could be brought in because HCWs who are studying are interested in learning and have a better background. “HCWs are a better investment for the industry”. Training for HCWs is not adequate. If nurses weren’t there 24hrs a day then lots of stuff wouldn’t get followed up and patients would miss out. Wardsmen should collect blood from the blood bank because two RNs are already going to check it at the bedside. Everything that takes you away from patients is less time can be spent providing good patient
care. Bed making is not a critical nursing job so it should be delegated. The participant that found it really hard to think of the situations/examples.

4. What new target questions do you have in considering the next contact with participants?

Nil at present