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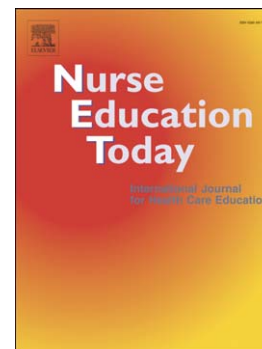
'Doing the writing' and 'working in parallel': How 'distal nursing' affects delegation and supervision in the emerging role of the newly qualified nurse

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‘Doing the writing’ and ‘working in parallel’: How ‘distal nursing’ affects delegation and supervision in the emerging role of the newly qualified nurse.

Developed from a ‘core’ paper presented at the Nurse Education Tomorrow Conference, Cambridge University, UK, Sept 3rd to 5th 2013.

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Abstract***Background***

The role of the acute hospital nurse has moved away from the direct delivery of patient care and more towards the management of the delivery of bedside care by healthcare assistants. How newly qualified nurses delegate to, and supervise, healthcare assistants, is important, as failures can lead to care being missed, duplicated and/or incorrectly performed.

Objectives

The data described here form part of a wider study which explored how newly qualified nurses recontextualise knowledge into practice, and develop and apply effective delegation and supervision skills. This article analyses team working between newly qualified nurses and healthcare assistants, and nurses' balancing of administrative tasks with bedside care.

Methods and Analysis

Ethnographic case studies were undertaken in three hospital sites in England, using a mixed methods approach involving: participant observations; interviews with 33 newly qualified nurses, 10 healthcare assistants and 12 ward managers. Data were analysed using thematic analysis, aided by the qualitative software NVivo.

Findings

Multiple demands upon the newly qualified nurses' time, particularly the pressures to maintain records, can influence how effectively they delegate to, and supervise, healthcare assistants. While some nurses and healthcare assistants work successfully together, others work 'in parallel' rather than as an efficient team.

Conclusions

While some ward cultures and individual working styles promote effective team working, others lead to less efficient collaboration between newly qualified nurses and healthcare assistants. In particular the need for qualified nurses to maintain records can create a gap between them, and between nurses and patients. Newly qualified nurses require more assistance in managing their own time and developing successful working relationships with healthcare assistants.

Background

This article explores newly qualified nurses' (NQNs) increasing delegation of hospital-based bedside care to health care assistants (HCAs), whose role is also called, in different international contexts, Nursing Assistant, Nursing Auxiliary, Care Assistant, Care Aide, Health Aide, Support Worker. The role of the modern hospital nurse has moved away from the direct delivery of patient care, and more towards the management of its delivery. This is for several reasons, including: rising healthcare costs, the need to maximise resources and

balance skills-mixes, and the general expansion of both nurses' and HCAs' roles (Standing & Anthony 2006; Weydt, 2010; Gillen & Graffin, 2010).

Delegation is 'the transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome' (ANA, 1997: 4). Several authors suggest that nurses, urgently need to improve their delegation skills (Curtis & Nicholl, 2004; Weydt 2010), especially NQNs, (Gillen and Graffin 2010; O'Kane 2012). This is difficult when 'nurse education does not prepare students for the practicalities of this role' (Hasson, McKenna and Keeney 2013: 231). Inadequate delegation can result in inefficient workload distribution, insufficient supervision of delegated tasks and key aspects of care being missed, duplicated and/or incorrectly performed (Standing & Anthony 2006; Anthony and Vidal 2010). This has implications for the patient experience, patient safety (Cipriano 2010) and patient outcomes (Mohr and Batalden 2002).

Malone developed the concept of 'distal nursing' in which, she argues, nurses are increasingly driven away from proximity to patients (Malone, 2003). She suggests nurse-patient proximity is of three kinds: 'physical,' 'narrative,' and 'moral.' 'Physical' includes the traditionally important acts of washing, taking people to the toilet, as well as the ceremonial, but now discarded, 'back rub' in which nurses came to know their patients, which Malone calls 'narrative proximity.' Out of these come 'moral proximity,' in which the nurse learns to 'be there' and, arguably, advocate for the patient. Malone argued that nurses' proximity to patients is being lost along each of these dimensions, concluding:

'If we want educated practitioners who engage with us on a human level, as opposed to merely processing our bodies, we must consider how spatial-structural power relations further or obstruct relationships between patients and healers' (Malone, 2003, p 2325)

Psychodynamic theorists propose that in stressful situations, individuals may distance themselves psychologically by cutting off ('splitting,' Klein 1959). In the context of nursing, Menzies (1960) argued that 'institutional defences' distance staff from patients, in order to protect the psychological security of nursing staff in the face of suffering and death. Retreating to administrative tasks and avoiding direct patient contact, might constitute one such defensive action. Twigg (2000) has also argued that personal care ('bodywork') is regarded in health care contexts as 'dirty work' and is relegated to the most junior staff because of its cultural devaluation. Drawing these theoretical perspectives together, then, it is possible that the gap between NQNs and patients arising from distal nursing, could be exacerbated by psychological and cultural factors which exaggerate distancing from patients. It could also create a divide between nurses and HCAs, the former having 'clean' administrative work tasks, the latter having 'dirty' bodywork tasks.

Aims

The primary research aim of the Aark research project (Magnusson et al 2014) from which the data subset described here was drawn, was to understand how newly qualified nurses (NQNs) recontextualise the knowledge learnt in university to enable them to delegate to, and supervise, healthcare assistants (HCAs). This article addresses how NQNs negotiate their role in relation to that of HCAs, particularly in relation to conflicting demands upon their time.

Method

Ethnographic case studies (Burawoy 1994) were undertaken in three hospital sites, using mixed methods, namely: participant observations; and semi-structured interviews, with NQNs, HCAs, and Ward Managers/ Matrons. See Table 1 for full details of data collection from the three hospital sites, and Table 2 for profiles of each hospital site.

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Observations and interviews were designed to explore: how NQNs delegate and supervise patient care delivered by HCAs; NQNs handling of concerns regarding HCAs' performance; how NQNs learn or acquire relevant competencies; what other factors affect how NQNs organize, delegate and supervise care. Data were analysed using thematic analysis (Guest et. al. 2012), aided by the qualitative software NVivo.

Findings

In this section we explore three inter-related themes relating to NQNs delegation to, and supervision of, HCAs, in conjunction with the other demands of their role, particularly the regular maintenance of patient records. The three themes are: working together; working in parallel; and doing the writing.

Working together

On some wards there was a strong collaborative element to team working. Team members knew and understood their respective roles but there was an expectation that both registered nurses and HCAs should be involved in the delivery of bedside care.

We have a very close knit team and everybody works really well together and the support workers are as big a part of the team on here as the trained nurses are, we all have our own roles but we all work together and I think it's quite evident when we have NHS bank nurses come from other wards, they actually, they do say to me how well support workers work with the team here and we should go on other wards the trained nurses do one thing, the support workers do another, we all work as one on here, we all do the bed baths together, we all do the patient care together, and then we all have our own duties that we go off and do afterwards but we actually all sort the patients out together. (AINTWM2)

As can be seen here, this ward manager shows an awareness that everyone has their particular roles, but also that there is shared responsibility for the physical care of patients. In this ward culture, there is no splitting off of personal care to the HCAs.

Skills and confidence levels of NQNs and HCAs were also central to effective team working.

I always try with my healthcare assistant to go through my handover sheet and say 'this needs to be done, this needs to be done and this needs to be done,' 'can we do this sometime throughout the shift,' for example, weighing a patient who needs to be weighed, I'll say 'this needs to be done'... they know how I work now anyway, so I say 'if I start with the medication and then we'll do some washes together and then if we can do some observations and then we'll see how much time we've got left before lunchtime' say for example to weigh a patient, to dip a patients urine, to do something that the doctors have asked us to do or we need to do. (CINTNRS5)

This nurse is describing a confident and efficient delegation style, involving the HCA in the tasks for the day, sharing handover information in an organised way, and then prioritising tasks for them both. The nurse also plans to participate, alongside the HCA, in the provision of personal care to patients. On wards with well-established routines and experienced HCAs, there was also a sense of a minimal need/opportunity for delegation:

'A lot of them don't [delegate], or they don't need to if they've got our regular staff on that like myself have been here quite some time. We know our role and we sometimes will delegate to them in a way, we will say 'come on we need to do...' I mean obviously if they need bloods getting from the labs then they'll say 'will you just run to the labs' but that's just part of the day to day work and so in a way that is delegating because they can't always themselves go, but it depends on the staffing levels again, if there are enough nurses on and there's maybe only one support worker they will go.' (AINTHCA3)

This HCA recognises the respective responsibilities of a nurse and an HCA, yet also describes a strong sense of co-working and collaboration. Participants also described an interaction between NQN and HCA skills and confidence levels:

'All my healthcare assistants are self-starters and they're pretty proactive and know what they should be doing so there's not much for a trained nurse to tell them to do, I guess that's partly because they've done their NVQs and they're quite skilled up anyway, yeah there's, I mean most of my healthcare assistants could easily go on and become trained staff.' (BINTWM1)

'I think, what I've noticed is these support workers know more things than we do, they know a lot, it's like you think all they do is making beds but when you're doing a ward dressing, they will do best dressings, because they've been here for long time ... better than us, and... as a newly qualified I found a lot of help from the support workers.' (AINTNRS8)

This ward manager and NQN are both describing highly capable HCAs who require limited amounts of delegation and supervision. By contrast, other HCAs were far less experienced:

'Some of the healthcare assistants even in this department they never worked anywhere before, they're very keen, they're very enthusiastic to work, but because they haven't met certain situations... and the nurses [play a key role] to identify that and to teach them because at the end of the day the nurses should be directive and directing them you know, working together but pointing out what needs to be done next on the planning I think.' (CINTWM3)

'We have had some HCAs that have not been very good but I think it depends on, we're working with them on the doubles, you actually understand how they work and how quickly they are and that's like a test for me in a sense, seeing how good they are, because we do a double first and I'll watch, if they're actually doing it correctly like, raising the bed up, making sure everything's fine, everything's with them, then I have more like a sense of safety

in them, saying 'yeah you can go do the double' or the 'single on your own for me', so I know, I feel more confident in them and that relationship kind of builds up a bit more and they'll come like ask me 'is there anything you want me to do?' (AINTNRS3)

The ward manager and NQN here are both describing HCAs who are less experienced and/or require a greater degree of delegation and supervision. The NQN explains how she adapts her style accordingly, in order to be able to support and supervise the HCAs' work. The NQNs time management and delegation skills are crucial,

'... I was really worried about delegation, you know telling people twice your age what to do. But then I quickly realised that if I didn't delegate I was never going to get everything done and was never going to go home on time. I was leaving shift at 9.00 when I should have finished at 7.30, just catching up on all me paperwork, and even then I'd have forgotten to do things, I'd be going home in tears, I'd take keys home and have to bring them back, it was ridiculous, it was harder than the whole of the three years as a student. And so I talked to my preceptor, and she suggested how I could ask people to do things... and gradually it got better. Now I don't have a problem asking people to do things, and I'm getting home on time, and everything's getting done.' (AP4M)

This participant highlights both the challenges of delegation for the NQN during the transition from student to fully operational qualified nurse, and how important delegation is to becoming a safe, effective and confident nurse. So, working together, as seen here, involves: a collaborative ward culture; nurses and HCAs knowing their respective roles; there being some mutuality and reciprocity in terms of how they perform their roles; nurses being able to adapt their delegation and supervision style according to the skill level of the HCA; and nurses having being confident and competent in delegation and supervision.

Working in parallel

In contrast with the above picture of effective team working between NQN and HCA, we also identified a less joined-up approach. This often involved: a less collaborative ward culture; role confusion between nurses and HCAs; inadequate communication between nurses and HCAs; and problematic delegation and supervision styles among NQNs. One ward manager described a ward culture where the NQN-HCA teamwork was contingent upon the preferences of individual NQNs:

'The care is divided between the healthcare assistants and the nurses because they work as a team and in theory they should all help each other out and the nurses should help the support workers to wash, bath, feed patients, I have to be honest that again is down to individual nurses as again into their time management as to who does what.' (AINTWM4)

This more individualised approach, reliant upon the registered nurses' personal style, made the quality of team working much more variable. With effective nurses this was not a concern, but inadequate delegation and supervision could lead to problems. For example, on some wards HCAs were observed arriving for a new shift and, with a minimum of handover or opportunity for detailed instructions by qualified staff, beginning their routines, e.g. sitting patients up, washing patients or giving out bowls, turning patients, and helping with meals. NQNs were observed receiving a report about a fraction of the patients on the ward and then begin doing observations, administering medicines and 'doing my writing' (see below). Whilst possibly a demonstration of confidence in the support staff and a seemingly appropriate use of qualified nurses expertise, this effectively meant that the two grades of staff rarely worked together, except occasionally to manage challenging patients, or those requiring two staff by protocol ('doubles'). This HCA describes a lack of communication:

Our handover system at the moment is we come in in the morning and the person who's being co-ordinating will hand over all the patients, whether they've eaten or drinking and such and after that the nurses will go off and they'll get a bedside handover from the other nurses in the rooms. What I don't agree with is how that's being done basically because whatever the nurses are telling the other nurses could be something important to us and we don't get, we know we're not involved, so we don't get that maybe... We'll be doing stuff like [breakfasts] and we might have missed something. It could be something 'oh they've had a fall today' or 'that person needs feeding' or something's happened or they're due for an x-ray or we could be planning stuff and then that patient could go off the ward. So I do think the handover system needs to change... because we're with the patients more time than the nurses. (AINTHCA5)

The HCA highlights concerns about being provided with insufficient relevant information about patients, despite being the person who has the most direct contact with them. Inadequate information can lead to mistakes being made unknowingly, and can pose risks to patient safety and outcomes, as well as the patient experience.

It wasn't a clear handover so to where, like 'this has got to be done by a certain time' or, so we've been behind then when a patient's coming down from HDU because we didn't know the bed needed doing... there's a bit of lack of communication there. (AINTHCA1)

This HCA is giving a very clear, simple example of how there was no bed for a patient arriving from another ward, because they had not been told of the patient's imminent arrival.

'The anaesthetist came back and they said "the patient had a wrong wrist band on her leg, she had the patients name of another patient on her leg" and the care assistant had put [it] on her leg and I hadn't double checked it' (BINTNRS2)

This is an example of a more serious incident where parallel working meant a nurse had failed to adequately supervise an HCA. Parallel working was also identified in our analysis of NQNs' differing delegation and supervision styles (Magnussen et al 2014; Allan et al frth). The most common approach was that of the NQN adjusting to the transition from student to registered nurses was that of the 'Do-It-All' nurse. This is the NQN who lacks the skill or confidence to delegate care and so tries to complete all the tasks on their own.

'I'd rather do things me self as well because then I know that they're done and then, because at the end of the day it will come back on me if something's done wrong or not done at all.' (AINTNRS6)

'I didn't want to delegate to staff so soon, because... well, they, maybe, had been there longer than me and I didn't feel that I was in the right position to tell them what to do, even though I was, but I didn't want to tell them. So I've sort of took on too many jobs myself and maybe that led to me not prioritising my time really.' (CINTNRS2)

'Recently I've not been taking a break... I forget things and like with my delegating I don't think I'm very good so I'm trying to do everything at the minute and then realising that you know, I'm not really delegating ... ' (AINTNRS12).

The underlying theme in these three extracts is NQNs' lack of confidence, both in themselves and HCAs, and anxieties about delegation skills. In effect, nurses and HCAs again ended up working largely in parallel. The NQNs often struggled to finish their shifts on time and frequently felt overwhelmed, stressed, tired and even on occasions forgot some important work. The HCAs, in turn, felt excluded:

'Sometimes, sometimes you kind of just get left to your own devices so I'll just crack on with... the beds and the washes and just let the staff nurse get on with whatever she's doing but [I prefer] to have the little meeting with the staff nurse and split jobs between us.' (AINTHCA2)

This HCA highlights some of the problems of parallel working: a lack of awareness of who is responsible for what; not knowing what is expected of them; and a lack of a sense of collaboration and teamwork. This is associated with a lack of delegation, and a ward culture which does not promote effective team-working.

‘Doing my Writing’

Perhaps the most profound limits to the ability to supervise and delegate appropriately came from the pressures NQNs reported in relation to maintaining up-to-date records. Many NQN participants referred to ‘doing my writing’ as a key task to be completed frequently during a shift, and often for large parts of it. They also described this as creating tensions between themselves and HCAs at times:

I think a lot of the time they don’t realise, when they see us sat at a computer or on the phone they think we’re not doing anything or we’re just not bothering, when they’re running around but they don’t realise all these other little sort of bits and pieces that you’re always, you’re juggling so many different things and trying to pull so many things together a lot of the time it is on the computer or it is on the phone and I don’t think they realise that we’re doing that.
(AINTNRS7)

This nurse is highlighting her concern that HCAs may see them as not working equally hard because they are not on the move in the same way as the HCAs are.

Yes, I think it’s hard when you’re writing (and) you’re saying (to the HCA) ‘can you do this’ but it looks like you’re sat down... you’re doing something that needs to be done, but I was a support worker and so I know what it’s like when you see people sat there and you think you know.’ (AINTNRS1)

This nurse is suggesting that some support workers regard record-keeping as an avoidance of ‘real work’ as it involves sitting at a desk. Intriguingly whilst shadowing this thoughtful and diligent nurse we noted that she found a pool of dark brown faecal smelling fluid on the floor in a sideward. Initially she indicated that she would be asking a domestic member of staff or HCA to clear it up, but a few minutes later she was doing it herself. This could be seen as a failure to delegate, but it can also be interpreted as a caring act, one which showed the very ill patient in the room that the mess was unimportant and nothing to be made a fuss of. Rather than poor delegation this could also be understood as compassionate nursing at its best (Curtis et. al.2012).

Most HCAs thought that the administrative demands placed on NQNs made them less available to support the HCAs:

[If I need help] I tend to look for a support worker first and then I tend to look for a nurse if a support worker isn't available, because a lot of the time the nurses... are still learning all the paperwork because a lot of them are newly qualified ... especially if they've got a lot of admissions and a lot of paperwork to do [so] I only tend to ask the nurses if they look free basically. (AINTHCA5)

This HCA is highlighting how they feel that registered nurses' administrative tasks – especially as NQNs get up to speed - interfere with team working: HCAs tend to seek support from each other rather than from a registered nurse. This is potentially quite divisive. HCAs felt it also distanced nurses from patients:

I like the hands on care and no disrespect to the nurses because they're all fantastic but they're taken away from the hands on care so much now and when I first started it wasn't like that. But because they spend so much time on the computers... and paperwork and... the writing and the medication they don't spend so much time hands on care with the patients

anymore... it's not the trained staff's fault, it's not their fault, it's just the way things are now... I could never imagine doing that ... I like to sit down and talk to my patients and try and help them because a lot of it is psychological as well ... they do appreciate just a few minutes to talk about how they're feeling and how they can overcome their situation.' (AINTHCA2)

In a field-note one of the observers recorded an informal chat with a nurse:

'There's too much paperwork. It seems like there are new forms every day. Most of it's online, which is good in some ways when you get used to it, but it reduces one-to-one care a lot. I'm going to work on the community because I want one-to-one care again, I like sitting with the patients and talking to them.' (AOBSNRS12)

This section has highlighted the tensions which can arise in relation to record-keeping, in terms of the working relationship between NQNs and HCAs, and in terms of reduced contact time for nurses with patients.

Limitations

This article is based on data drawn from a large qualitative study of nurses and their co-workers at three different hospitals in the South and North of England and reports on one particular aspect of our findings. Respondents mostly volunteered after being made aware of our study, but very few of those in the relevant population declined to take part if asked, so we have some confidence that our informants are credibly typical of people in similar roles elsewhere. Observation is necessarily selective, but we feel that our strategy of having six different, but well-briefed, observers added perspective to the fieldwork without overcomplicating it. Certainly 'shadowing' nurses allowed us to get critical insights both then and in subsequent interviews, which we consider to have been highly meaningful.

Discussion

Our research has highlighted the significance of the changing roles and worlds of nursing. Increasing emphasis on documentation, mostly on computers, is, in particular, a time-consuming priority for qualified nurses in a highly accountable nursing culture, and many NQNs feel this takes them away from the 'real' care of patients. This in turn means that they are increasingly reliant upon HCAs for more of the frontline care of patients, requiring NQNs to effectively delegate to, and supervise, HCAs. It also places greater emphasis on HCAs, not only to perform important aspects of patient care, but also to report back appropriately to NQNs about any significant changes in a patients' condition. This places increasing responsibility for patient well-being in the hands of HCAs.

Our analysis has identified a number of factors which inform collaborative nursing between NQNs and HCAs. Ward culture, personal working styles, skills and competencies, particularly effective communication, all play a role in determining the extent to which NQN-HCA team-working is safe, effective and efficient. Nurses and HCAs both perceived administrative tasks as limiting nurses' patient contact times. This was seen by many as a drawback to the new nursing role. It may also be that increased distal nursing is informed by avoidance of 'dirty work' on the part of nurses but our data does not indicate this. The ability of NQNs to prioritise tasks, manage their time, and that of the HCAs, and to not only effectively delegate, but also supervise, were understood to be crucial. We suggest that this should be addressed more fully in pre-qualifying education and post-qualifying preceptorship (Magnussen 2014; Allen frth).

Conclusion and Key Findings

NQNs increasing reliance upon HCAs for the direct delivery of bedside care places greater emphasis on the quality of NQNs' time management, delegation and supervision skills.

Greater attention needs to be given to how NQNs and HCAs work together and in supporting newly qualified nurses in developing the relevant skills to manage NQNs'. Further research is needed into the consequences for patient safety of nursing skills mixes, competence in delegation and supervision, and the most appropriate and effective methods for ensuring accountability.

5095 words

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Data collection method	Site A	Site B	Site C	Total
Observation of nurses (twice/nurse)	17 nurses 34 obs.	6 nurses 12 obs.	10 nurses 20 obs.	33 nurses 66 obs. (around 230 hours)
Nurse Interviews	16	4	8	28
HCA Interviews	6	2	2	10
Ward Manager / Matron Interviews	5	3	4	12
<u>TOTAL</u> <u>(Interviews and Observations)</u>	<u>61</u>	<u>21</u>	<u>34</u>	<u>116</u>

Table 1. Summary of data collected (November 2011 to May 2012)

	Site A	Site B	Site C
Ward specialities where participants worked	<ul style="list-style-type: none"> • EAU • Elderly • Medicine • Trauma • HDU • Surgical • Adult • General • EAU 	<ul style="list-style-type: none"> • Medical • ADU • Surgical • Adult • General 	<ul style="list-style-type: none"> • Surgical • Respiratory • Medicine • Gastro • Adult • General
Approximate number of beds	700	700	450
Preceptorship programme	Yes	Yes	Yes

Table 2 Overview of the three hospital sites which participated in the Ark study

Highlights

- The role of the modern nurse has moved away from direct delivery of bedside care.
- Nurses are under increasing pressure to delegate to, and supervise, healthcare assistants' delivery of bedside care.
- Maintaining records is time-consuming for nurses and can affect their teamwork with healthcare assistants.
- Greater attention needs to be given to newly qualified nurses' delegation and supervision skills.
- Further research is needed on nursing skills mixes, delegation and supervision.