Patterns of nursing: a review of nursing in a large metropolitan hospital

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Summary

- In this Clinical Practice Development (CPD) project we set out to identify and describe current approaches to the management and delivery of nursing care in an Australian Metropolitan Teaching Hospital.

- Using a simple descriptive design, data were collected to elicit patterns of care provided by nursing teams. We sought to demonstrate patterns described by nursing teams (interviews) and actual patterns of care (observation).

- As expected there was a degree of incongruence between the espoused and actual patterns of care.

- Interview data revealed that most study wards had a view of nursing that emphasizes meeting the total care needs of patients and their families through offering biopsychosocial and educative care. The observational data revealed that a relatively large proportion of time was expended on activities that were not regarded as important by staff when interviewed (e.g. documentation) while relatively small amounts of time were observed to be spent educating patients or communicating with relatives of patients.
The identification of this type of gap creates a dissonance in clinicians that can be used to stimulate change through CPD.

Clinicians used the information to stimulate discussion and to rewrite team value statements.

Keywords: Clinical Practice Development, nursing philosophy, patterns of care, work sampling, work systems.

Introduction

As a result of the introduction of generic management principles into health care systems in most Westernized countries, staff in contemporary hospitals and health systems have developed mission statements to provide a focus for both strategic planning and the delivery of services. This paper reports on a clinical practice development (CPD) project in a large metropolitan tertiary referral hospital following the formulation of a ‘Nursing Vision Statement’ based on an agreed position statement on the philosophy of the nursing service. This statement is both widely disseminated and prominently displayed throughout the hospital. Essentially, the agreed hospital-wide vision statement was designed to allow for variation and scope in interpretation by individual ward staff according to their function, patient population; the skills and preferences of ward leaders and their nursing teams; and the multidisciplinary goals of each ward. As is the case in most large institutions, the application, at the operational level, of the principles embodied in the statement was varied and its impact on service delivery uncertain. Commissioned by the Nursing Executive of the hospital in 1998 and conducted during 1999, the team from the University Department of Clinical Nursing, situated in the Hospital, set out to determine and report the patterns of nursing service delivery in general wards in the hospital. The study was completed in 1999 and presented to clinicians (Pearson et al., 1999).

Background

The pattern of nursing care delivery in a given ward or unit is determined by the organization of nursing work which is, in turn, developed by a nursing team according to the values and beliefs held by the ward leader and the nurses. The approach to the management of nursing care in a ward is also influenced by the focus of patient care and nursing priorities specific to that ward.

In theory, making these values and beliefs explicit can be a powerful tool to help any team move forward in a determined direction (Pearson, 1983; FitzGerald, 1989, 1991). However, statements of team philosophy do not always remain current. Neither are the sentiments contained in them automatically discernible in practice. On the whole, useful philosophies are dynamic documents that serve to remind nurses of their purpose, roles and ambitions for the team. Pearson (1983) contends that nurses working in teams generally work towards a tacitly agreed philosophy that is manifest in their daily routines and manner. In this CPD project the team set out to uncover the tacitly agreed philosophies revealed by the nurses’ words and actions in order for the nursing staff of each ward to review their ideals and practice.

Project design

The guiding project question was – What are the current approaches to the delivery of nursing care in wards located in this hospital?

The aims were to:

• identify and describe current approaches to the management of nursing care in wards located on the health authority’s major site;
• assist Clinical Nurse Consultants (CNCs) (charge nurses) to articulate the approach taken to nursing care delivery on their wards; and
• promote the development of new approaches to the management of nursing care by CNCs.

Specifically the objectives were to:

• identify the existing philosophy of nursing and the norms of nursing care delivery in each of the project wards as perceived by the ward nursing team;
• identify the existing norms of nursing care delivery in practice in each of the study wards; and
• develop, in collaboration with CNCs and ward staff, a revised explicit, agreed, ward based statement of care delivery in the study wards.

The proposal was presented to the Nursing Executive as a CPD project. The Nursing Executive gave approval for the team to proceed with the study. Members of the team made appointments with all the CNCs individually to explain the study and ask them to participate. Participation in the interview and observation was on a voluntary basis. No names were recorded on the
documents and findings were reported to ward teams. Only aggregated data were available to other areas. One ward could compare their data with those collected in the whole service centre or hospital but they could not compare with one other ward.

**PHASE 1: SURVEY**

Two methods of data collection were used to obtain a description of current practice: interview and observation of nursing staff in the clinical setting. The methods were used to obtain a description of both espoused theory and theory in practice regarding patterns of nursing care delivery from the perspective of each level of nurse in the team. Twenty-four CNCs, 24 Clinical Nurses (senior staff nurse), 24 Registered Nurses (RNs) (level 1), 24 Graduate Nurses (first year out of university) and 24 Enrolled Nurses were interviewed.\(^1\) This is a cross section of nurses on each ward.

A structured interview consisting of 33 items was developed by the project team to guide the interview. The questions posed were fixed (e.g. ‘who evaluates the patient’s care?’). The respondent was then allowed to answer without prompting. The facilitator had a list of most likely responses that could be filled in with ease. For example, ‘who evaluates the patient’s care – (a) team leader, (b) nurse assigned to the patient, (c) CNC, (d) senior nurse, (e) RNs only, (f) other describe.’ Questions were asked under the following headings: the usual routines; methods of work allocation; methods for providing continuity of care, mechanisms for accountability, roles and responsibilities and priorities. These interviews were intended to reveal participants’ espoused theories of nursing. Responses were recorded by category for data analysis purposes. Each interview lasted approximately 30 minutes.

An observation schedule using work sampling was used to determine the frequencies of nurses’ activities and thus gain a view of theory in use. An observation tool was developed by the team based on expert opinion and review of examples of previous work sampling studies (Scherubel & Minnick, 1994; Cardona et al., 1997; Pedersen, 1997; Urden & Roode, 1997). Six hours of observations per shift were made by five nursing staff from the hospital who attended a training day. The training aimed at familiarizing the nurses with the observation tool and enhancing interobserver reliability. Fourteen observations, each of two nurses per hour, were recorded at randomly predetermined intervals. Each of the wards was observed on three shifts; an early, a late and a night duty shift. Selection of participants for observations was based on two factors; firstly, on agreement by the nurse and, secondly, geographical convenience for the observer, thus resulting in a convenience sample. A total of 144 nurses was observed over 72 shifts. Five observers were trained in this technique of data collection to establish consistency. The tool was slightly modified after piloting by both the project assistant and the observers.

The large quantity of data collected from observation were sorted according to meaningful and manageable categories. The categories were selected based on expert opinion and a literature review of studies using work sampling as a method of determining nurses’ activity (Urden & Roode, 1997). Each observation was allocated, according to team agreement, to one of the following:

- direct care (medication administration, procedures, vital signs, bathing, toileting, assistance with eating or drinking, mobilizing, assessing, talking, counselling and education);
- indirect care (bed making, medication preparation, discharge planning, pan room, phone conversations, washing hands and conversations with family);
- personal time (reading, meal break, toilet, conversations with staff, unofficial break, conversation in office and personal phone conversations);
- professional interaction (staff supervision, conversations, staff conference, medical review and ward round);
- family interaction (discharge planning, counselling, education and social);
- documentation (charting in office, Exelcare, referrals, documentation in office and charting with patient);
- unit related (cleaning, tidying, jugs, etc., stores, pharmacy, collecting blood, equipment); and
- others (official duties, looking for a person, looking for equipment, walking with no apparent purpose and professional reading).

Frequencies for the observation data were presented in percentages for individual wards. Reports combining data from wards in a service and for the hospital were compiled for the wards to make their own comparisons.

**Results**

**PATTERNS OF CARE – THE ESPoused VIEW (PHASE 1)**

The interview data were summarized by two members of the research team into narrative summaries for presentation to the ward staff. These summaries were not collated as their primary purpose were as feedback to the ward

\(^1\)Enrolled Nurses in Australia are those whose training, which is shorter than the undergraduate degree for Registered Nurses, places an emphasis on practical nursing.
team and to act as catalysts for critical debate amongst the ward team. However, when reading all the summaries there are similarities in the beliefs and values that underpin nursing care delivery across services and wards. There is also marked agreement between the team members in terms of the importance of service and attention to the needs of individuals. They all experience difficulties with pressures on their time and the severity of patients’ illnesses. Although acknowledged as important, continuity of care is predominantly provided for by verbal and written reporting, rather than by the allocation of patients to the same nurse each shift. Nursing teams in all but two wards expressed satisfaction with prevailing patterns of care and all espoused a valuing of comprehensive approaches to care; the importance of patient education, multidisciplinary teamwork, and the need to involve families in care. Such findings are not surprising. The basic constellation of values constituting the current rhetoric in international nursing and nurses, like most professional groups, are more likely theoretically to espouse dominant values. However, this does not necessarily translate into the actual application of such values in practice.

An interesting feature of these results is the non-differentiation of nursing roles between the CNC (charge nurse) and Clinical Nurse (senior staff nurse) and, more significantly, between the role of the RN and the Enrolled Nurse. The Clinical Nurse role is seen largely as a Deputy Clinical Nurse Consultant and, thus, a training role, rather than the performer of an identifiable advanced clinical function.

While patients may be allocated to the same nurse for a few shifts, allocation to one nurse for the entire hospital stay was not popular. Some of the reasons offered by nurses for this were:
- nurses found it stressful (‘boring’ and ‘difficult’);
- geographically difficult as patients get moved around the ward;
- causes problems in terms of work allocation; and
- patients become over dependant.

Nurses reported that the most common means of allocating work is the matching of nursing skills to the severity of the patients’ illness rather than preserving continuity. Patient allocation was usually determined by the most senior nurse on duty at the beginning of the shift.

PATTERNS OF CARE – ACTUAL PRACTICE (PHASE 1)

The observation frequencies of each of the eight categories were:
- percentages of the hospital average;
- individual ward percentages; and
- a service average.

A total of 144 staff was observed. Each ward had two staff per shift observed for three shifts. In total, approximately 432 hours of nursing time were observed resulting in 10 741 recorded observations hospitalwide. The data collected from observation, including ward description and work sampling, were entered on Filemaker Pro (Apple Computer Inc., Cupertino, CA, USA) and frequencies determined using SPSS (SPSS, Inc., Chicago, IL, USA) (the latter used for convenience rather than statistical computations). The frequencies were presented as pie charts for each of the 24 wards. The hospital and service centre mean values are presented in Figures 1 and 2. The individual ward distributions do not differ significantly from the aggregated data. Comparisons between wards or services were not made as this was not the purpose of the project. There was no intention of setting one area up against another. Data for individual wards were only presented to that ward. Collections of Service and Hospital data were reported so that the ward team could relate to average figures themselves. Individual ward results are not reported in this paper.

Figure 1 Patterns of nursing care: all wards.
PHASE 2: DEVELOPMENT OF EXPLICIT CARE DELIVERY STATEMENTS

This action orientated component of the study consisted of:
• a meeting with the CNC of each ward to report the results of phase 1;
• a nursing staff meeting on each ward presenting the results of phase 1 for that ward and action planning; and
• the redevelopment of value statements with each ward team.

The CNC of each designated ward was presented with the project findings by the research team member allocated to that ward. Following this preliminary feedback session there was a ward meeting to disseminate and discuss critically the results with the nurses. Each member of the academic team works with four teams of nurses to facilitate their interpretation of the findings and relate them to their nursing work.

At the meetings the researcher discussed the interview data and showed nurses the work study results. The staff were asked to reconsider their values and to justify practices they wanted to preserve (see Box 1). For the purpose of rewriting the philosophy statement of the ward the nurses confirmed the things they valued the most and justified some of their practices that matched the value. An example is a ward where education of older patients was not observed (see Box 2). Health education is important for patients and their families, particularly regarding the safe use of medicines. The need for information differs between patients and it is the responsibility of the nursing staff to give patients or family members the information they require to make healthy choices and follow treatment regimes. It is acknowledged that some patients may not find an acute episode of illness in hospital the most conducive to their learning. In these cases the information will be given to the appropriate person before discharge. Nevertheless the nursing staff will give patients information that they require immediately for peace of mind and to make decisions relating to their care and treatment.

The nurses wanted to keep values in the philosophy but as the observational data did not show evidence of some values in practice, the team agreed to reassess their work in these areas. Such areas of dissonance were used as

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Box 1 Extract from philosophy

Continuity of nursing care is provided for by verbal and written reporting. It is every nurse’s responsibility to read care plans and to ensure that they deliver care according to patients’ written plans. In order to provide support to colleagues throughout a shift we use a buddy system when allocating work. This ensures that patients are moved safely with two nurses and that the correct level of supervision and feedback is given to newer members of the team.
catalysts for change. The observation data were not presented to the staff as facts. The team acknowledged that the data were a crude snapshot of ward work and produced for the staff of each ward in order to stimulate critical reflection rather than to be a report.

In accordance with the nurses, the researchers re-drafted the ward philosophies for them using the data and notes recorded at the meetings. The drafts were sent to the wards for consideration and changed by the teams. The final documents were returned to the wards. Although these have been laminated they are not petrified. Reassessment of a ward’s philosophy should be undertaken regularly.

Discussion

Differences between espoused and actual patterns of care were evident to varying degrees in all the wards. The phase 1 interview data revealed that, predominantly, study wards espoused a view of nursing that emphasized meeting the total care needs of patients and their families through offering biopsychosocial and educative care. These views reflect the dominant rhetoric of modern nursing and a response to evidence that holistic patient-centred nursing is of importance to clients (Gardner & Wheeler, 1987; Taylor et al., 1991; Grady et al., 1993; Ersser, 1997; McCormack, 2001). However, in the case of the study wards, these views did not accord with observed patterns of care in relation to the provision of psychosocial care, patient education and the involvement of families in care giving and care planning. Although hospital wide 33% of time was observed to be spent on direct care, only a small proportion of this time was dedicated to either educating or talking with patients (see Fig. 1).

Similarly, a relatively large amount of time was seen to have been expended on activities that were not regarded as important by staff when interviewed. The areas of activity that were frequently observed in practice but rarely referred to in the interviews include documentation (13%), unit-based activities not directly related to care giving (8%) and personal time (13%). This is a common finding in practice, so it was not a surprise. It remains to be seen whether, considering the importance of physical/therapeutic nursing and the power of the presence of the nurse (Pearson, 1989; Ersser, 1997), and the apparent agreement with this by the nurses in this study, a concerted effort to increase bedside nursing by RNS may be achieved. Nurses using these data to reappraise their current practices and consider the roles and patterns of their nursing could achieve this, although the current pace and acuity of nursing work hamper such developments.

The dissonance between espoused philosophy and practice is by no means confined to nurses. Indeed it is a human trait that characterizes most aspects of our lives. We have long held aphorisms that epitomize this phenomenon (e.g. practise what you preach). There are many explanations in the literature – particularly in psychology – as to why it occurs. What is important – and what makes this study relevant for nursing practice at the study hospital – is the necessity not merely to recognize the existence of such dissonance but to identify its precise nature. For as long as we believe that what we espouse is what we practice, we will perceive no need for review or change.

Limitations

This was a CPD project that was intended to inform nurses locally and stimulate critique of the status quo. It is an example of a value setting exercise on a large scale in one hospital. The data collected provide a ‘snapshot’ of patterns of care at a particular time. It was only intended to be a description of work at one point in time.

The observation tool was too detailed and later categorization may have introduced bias. However, the findings from individual areas were remarkably similar to the aggregated scores for the whole hospital and therefore add a degree of credibility to the crude patterns. The team encouraged the nurses to challenge the findings and to find different concrete examples of their values in practice. The data were presented to the nurses to make them more critical of the status quo rather than to provide a definitive description of their work.

Conclusion

The overall findings of this study suggest that a high level of expert physical care is provided by nurses to patients in the hospital and that patterns of nursing

care vary between wards but that differences between services are not apparent. Although patient care is not compromised by these factors, the quality of care could be improved if patterns of care were more closely aligned to the Nursing Vision Statement and to the values and beliefs espoused by the nurses. Greater role clarity for Registered and Enrolled nurses is also likely to lead to more effective utilization of nursing staff resources. The rewritten philosophy statements are the results of this project and they represent the knowledge gained from the exercise.

The project team recommended that the Nursing Executive:
- resource an Action Research Study on two or three volunteer wards to explore discrepancies between the espoused values and actual practices of nurses and to plan, implement and evaluate a programme of change in each of these wards to develop an explicit ward philosophy that is reflected in actual practice;
- resource a programme of Action Learning and Action Research to clarify the role of Registered (levels 1–3) and Enrolled Nurses;
- develop strategies to operationalize clearly identified, appropriate role functioning of Registered and Enrolled Nurses; and
- promote the development and prominent display of explicit statements of beliefs, values and patterns of care strategies in all wards and nursing units.

The findings of the observations and interview were, on the whole, received constructively by the nurses. It is a mark of these nurses’ professionalism and commitment to quality nursing that they had the confidence to join in this study that enabled them to critique their work so closely.

References