Tasks and routines in 21st century nursing: student nurses' perceptions

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Abstract

The aim of this study was to explore final year nursing students' views about their clinical experiences. This was the second of three studies using a grounded theory approach overall with theoretical sampling of final year student nurses being chosen as a result of the initial study's findings. The sample was of a volunteer nature. The data collection tool was an open-ended questionnaire, with themes arising from the first study helping to form the questions. It was anticipated that more clinically experienced students would confirm, refute and perhaps provide 'new' information about the reality of clinical nursing when compared with the sample of neophyte nurses from the first study. Data were analysed through initial coding of responses and then compared and contrasted to the data of study one. Findings included categories of views about the nurses' roles and tasks, clinical priorities of qualified nurses, holistic care, and care plans. The conclusion suggest that despite nursing theory proclaiming the advent of 'new' nursing with hallmarks of holistic care and movement away from tasks and routines, the student nurses did not find this to be the case. Indeed, tasks and routines are what seemed to structure the work of nurses, with little evidence of holistic, patient centred care occurring clinically.

Key words: Student nurses ■ Clinical experiences ■ Nursing: process

Changes in nursing have been abundant over the past 30 years in terms of the development of a theoretical knowledge base, ostensibly to improve patient care and to achieve professional status. However, what about the reality? There may be what Porter (1992, p722) claims as the 'theoretical construction of the occupational position of nurses outstripping the reality'. Penney and Warelow (1999) also highlight this by claiming that despite nursing theory being removed from the medical influence the 'social world in which nurses practice is not' (p260). Wright (2004, p22) suggests that expansion of nurses' roles may undermine and efface the core values of nursing; he suggests we are 'seduced by a hierarchy of professional values' and that 'the technical, managerial and powerful are more important than the hands on, "being there" aspects of care'.

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Accepted for publication: January 2007

With this in mind, this current study was undertaken to explore the clinical situation through the perceptions of student nurses. The findings suggest that tasks, routines, the medical model of care and prolific documentation seem to govern nursing work, with the notion of holistic care not evident in practice. These views are reaffirmed by survey results from the *British Journal of Nursing* (2004) in which 905 qualified nurses felt there was 'not enough time to care for patients properly' (p351). It is anticipated that the findings of this study will add to the literature in terms of relating rhetoric to reality in clinical nursing.

'New' nursing

The drive for professionalization necessarily involved the discarding of old practices and assimilating new ones. The advent of 'new' nursing in the 1970s held the tenets that:

- Nursing needed to move away from the medical model of health that viewed patients as a set of physical symptoms, and instead patients were to be viewed holistically as persons
- The nursing process and decision making were proposed with an emphasis on direct patient care
- Basic nursing care was deemed just as important as the 'scientific' tasks given to nurses by doctors with an emphasis on nurse–patient relationships
- There was to be an emphasis on the process rather than the product
- The nurse was to be seen as an advocate for the patient
- Promotion of health was to be considered in addition to cure of illness (Reed and Ground, 1997).

'New' nursing was proposed as an improved way of working, however, there has been critical examination and discussion within the literature (Inglesby, 1992; Salvage, 1992; Porter, 1994; Savage, 1995; Reed and Ground, 1997; Rose and Marks-Maran, 1997; Woods, 1998; Libster, 2001). For example, Salvage (1992) suggests that the development of a one-to-one relationship between nurse and patient faced barriers from the outset, including recruiting sufficient numbers of staff.

Theory

Reed and Ground (1997) present a philosophical discussion on what the fundamentals of nursing used to be and what they purport to be now. They question the implication that 'new' has in fact replaced 'old' and this is particularly interesting when considering that providing an illusion, or perhaps delusion, of what 'new' nursing is (and that it is tacitly better than 'old') provides an unquestioning approach

that precludes further discussion. Reed and Ground (1997) suggest holistic care may be more useful as a concept to nurse theorists than to patients. Indeed, they make the point that patients may not want to be viewed 'holistically' at all. Most of the literature cited provides commentary and analysis of some of the principles of 'new' nursing, but there is little in terms of empirical research. This study was an attempt to explore nursing from those involved in it and present an inside view.

This study was the second in a series of three; the overall aim was to explore the clinical world of nursing, in an inductive way. This study generated many findings which contributed to an emerging theory, however, the focus of this article is to highlight one key finding: tasks and routines remain a large part of clinical nursing work.

Methodology

Design

The design was descriptive, using elements of grounded theory. Data collected were used to provide further depth and ratification of codes and categories identified from a previous study with first year students. A pure approach to grounded theory, in terms of theoretical sampling, constant comparative analysis and theoretical saturation, particularly in terms of theoretical sampling, was not achieved. Theoretical sampling was used, in a broad sense, to identify a group that might add to and confirm the data from study one, and final year students seemed appropriate.

Data collection tool

The tool for data collection was an open-ended questionnaire to generate qualitative data. The questions were based on data from a study with first year students and from the literature. The questionnaire was piloted with a group of students (n=10) not in the target group, but in the following cohort. As the approach was qualitative, this was to establish the credibility and appropriateness of the questions and the readability of the format. Following comprehensive feedback, changes were made to the format and further explanation of some details was provided. Questions included asking students: to describe the work of nurses; what they perceived nursing to be; and the perceived roles of nurses. There were additional questions about perceived priorities in the clinical setting and student descriptions of what caring meant and how it was manifested in the clinical area.

Ethics

Ethical issues, such as anonymity and confidentiality were made explicit. One reason for data tool selection was to ensure anonymity, as the investigator held a position as lecturer. There was assurance that if the students chose not to participate or chose to withdraw, it would not be held against them in any way and that all data analysis would be confidential to the researcher. This was given in a written information sheet, in which students were also advised to maintain the anonymity of any wards/staff they were discussing. The study was given Chair's approval by the Local Research Ethics Committee and approval by the faculty Ethics committee.

Sample

The target group were final year nursing students on a Diploma in Nursing course and a BSc in Nursing Sciences course. All of the target group were included as the questionnaires were distributed to all students in the Adult branch and 15 were returned. The total number of students from the combined cohorts was 64, giving a response rate of 25%. Sampling was therefore of a volunteer nature.

Data analysis

Data were analysed initially through coding to provide categories or emerging themes. Colour codes were initially given as concepts were identified. Constant comparative analysis was used; as data were analysed, comparison was made with previous data and with data from subsequent questionnaires, as an ongoing concurrent process. Some categories were evident from study one data, for example, paperwork, routines, communication, roles and auxiliary nurses, and these categories were compared with emerging data. In addition, new codes emerged within categories defined by the first study data.

Some of the students' views will be presented, discussed and related to the literature. The categories are: nurses' roles and tasks, nursing priorities, paperwork, and caring. These categories seemed to have reached saturation, although this was difficult to determine, particularly in light of the relatively small number of students volunteering. A limited amount of data were selected due to word limitation, however, all data presented are of a majority consensus. The findings are described in relation to some of the concepts underpinning 'new' and 'old' nursing, e.g. moving away from tasks, emphasis on interpersonal relationships, psychosocial as well as physical care and caring for people as individuals.

Findings and discussion

Nurses' roles and the 'tasks' of nursing

The advent of 'new' nursing advocated a move away from tasks and routines and independence from the medical model. The following data suggest this may not be a reality. The majority of answers focused on nursing as tasks with basic care forming part of the answers, either as what nurses do or do not do. Paperwork and technological care were also mentioned. Holistic care was a term used but with little evidence of explaining what it meant in reality.

One student stated that nursing was about:

'providing holistic care for a patient and looking to maintain or restore health' (student 1)

This phrase sounds familiar, particularly from an idealistic and theoretical perspective, but it is then followed by a list of tasks that are all physical in nature including:

'observations, wound care, hygiene needs, prep for theatre, documentation, mouth care, nutritional care, etc.' (student 1)

The aspects of listening, communicating and psychosocial support are not mentioned. This appears to be a case of

idealism (in the use of the term 'holism') mixed with reality (physical work). Because the student makes no comment or judgement about it she does not seem to see the dichotomy that is there.

Another student refers to the tasks aspect when describing what nursing is:

'Time spent by qualified nurses is to mainly care for patients' medical needs, for example medications, IVs, observation, discharge' (student 7)

Another student seems to agree, but does not happily accept it:

'I merely thought it was about caring for the physical aspects of a patient...now...more technical aspects IVs, catheters, and with such duties comes documentation. The core element of what I originally constituted as the role of the nurses is being delegated to junior nurses. I am unhappy that junior nurses develop closer and more bonding relationships with patients...' (student 3)

In answer to the question: 'describe what nursing is', there was not a consistent view or consensus. Holism was mentioned by several students, but in an idealistic way with no indication of whether they have seen it or whether they simply feel it should be mentioned.

Most of the students commented on basic caring but in a negative context 'just', 'merely', 'simply'. Some suggested this is the work of junior nurses. It seems these students have not witnessed 'personal' care being given by qualified nurses. Several of the students were unhappy about this but overall it seemed accepted and not questioned. The 'doing' aspect of nursing work was described much more than the 'being' of nursing or caring activities. This is an antithesis to the principle in 'new' nursing that promotes holism over task allocation.

Interpersonal relationships

An underpinning factor of 'new' nursing was the emphasis on patient contact and the role of nurses as patient advocates. However, the student nurses described something different. The main priorities mentioned were 'tasks' and routine: 'giving medications', and 'documentation'. Only one student answered that patient contact was a priority. These answers were viewed in relation to what the students perceived as important to staff.

'What seems most important, on initial view, is that nurses just see themselves "getting the job done". Priorities appear to be set to a nurse's own agenda, i.e. get tasks done so they can have a break. Other priorities are meeting targets.' (student 13).

And:

'When I started nursing I believed that it was a job where everybody worked towards the same goal, where the patient was the focus, but now I see nursing is more preoccupied with cost effectiveness, management and other new quirky phrases [so] the patient is no longer the true focus. Nursing is challenging but it's a challenge I want to take because someone has to fight for the patient so they receive the best from the hospital and the NHS.' (student 15)

This student seems to be implying that the qualified nurses she has observed have put the patient second to the 'system' and they feel that someone needs to address this and views it as a personal challenge. This demonstrates the emphasis is on the product as opposed to the process, again an antithesis of 'new' nursing.

Overall, the answers lacked depth and there were few examples given in most students' responses. Communication was not mentioned, although one student mentioned that 'cancer nurses' allowed the patient to talk. Individualism, communication, caring or holistic care were not mentioned by any student as being a priority. The answers seemed to reflect the routine nature of nursing and of getting the work done through completion of tasks. This is congruent with Kelly's (1991) work with undergraduate nurses. One of Kelly's interviewees claimed the biggest problem was 'the pressure to get through the work' (p870) and another suggested the hospital structure was not organized for people's benefit, but rather for the organization's benefit.

Most students were quite specific in listing things that nurses prioritize:

'Medications, carrying out technical jobs that health care assistants can't do; tasks, such as feeding patients and seeing to hygiene needs are also priorities seen to be left to health care assistants and students' (student 1)

One student mentions the 'time' element:

'Priorities seemed to be to get everything completed and documented as quickly as possible' (student 6)

Another student seems to have had similar experiences:

'Ensuring [observations] are done 4 hourly (whether needed or not), ensuring everyone is washed before 9 am etc.' (student 4)

Another student seems to have a commitment to caring about basic needs, illustrated by:

'What appears to be priorities are IV drugs, meds, discharging, bed management and ward rounds! I see patient care being a priority which, although includes IV drugs, meds, etc also includes a lot more, i.e. personal care, feeding and nutrition' (student 9)

One student suggested that staff deliberately stayed away from patients through completing tasks such as the medicine round:

'...I frequently see nurses back away from providing all cares (i.e. bathing, toilette, even making the beds) and using the excuse of the medicine round. Even though there is plenty of time to do some cares prior to the medicine round. I believe the medicine round is important but I also enjoy providing care to the patient, I get confused that some nurses shy away from this form of care and hope that it doesn't happen to me' (student 15)

Another student mentioned:

'Some focus on tasks, such as getting everyone out of bed...which I hated...it seems so much kinder to allow them to sleep until they want to get up' (student 4)

This supports the findings of Melia (1987), i.e. nursing becomes a matter of just 'getting through the work'.

Ritualism and care plans

'New' nursing was viewed as a move away from rituals and routines and proposed that successful nursing practice was the outcome to be achieved. The nursing process, and subsequent care plans based upon it, were one of the main principles. However, some students viewed care plans as a ritual that displaced creativity and impeded individual care:

'In my experience, care plans have not helped to plan care...they hinder creativity and individualized care. One person's experience of breathlessness is not the same as another, yet a care plan would be written for the same ritualistic tasks...people tend to follow the plan and forget (or never think) to add their own part or look for alternatives...having to document all steps of the daily routine is unnecessary and time-wasting' (student 2)

Another student confirms this by stating:

'I think care plans aim to be holistic but actually facilitate standardized and repeatative [sic] care planning, leading to unindividualized care...I have had positive experiences of care pathways on surgical wards, but there is always the risk of a 'tick box' culture' (student 11)

The care plan, as an entity in itself, is mentioned:

'I wished care plans worked as they ensure the patient care is done, as well as provide the nurse with documentation and proof of care. However, they are too much writing, not enough time or nurses for the care plan to be carried out (student 15)

There seems real cognitive dissonance here: the student feels the care plans ensure care is done well and it provides proof but, conversely, she suggests they do not work by stating she wishes they did. Allen (1998) provided an assessment of nursing records in which she used ethnographic data to interpret nurses' views of nursing records. She found that nursing records were shaped by new managerialism and consumerism and litigation consciousness that have 'distorted the purpose and content'. Interestingly, her results showed that nurses felt pressured to please the quality assurance managers and to include problems on care plans 'irrespective of whether they had any relevance to the patient concerned'. The findings from the current study support Allen's findings.

In addition, Moloney and Maggs (1998) completed a systematic review to determine the relationship between written care plans and patient outcomes between the years of 1987-1997, and found no studies that could be included in such a review and concluded there is, as yet, no empirical evidence to support the use of care plans.

Caring

'New' nursing focuses on the patient as a person and highlights the importance of the psychosocial aspects of care, in addition to the physical aspects. In relation to this, answers to the question of what caring was and examples of it, were brief with only a few limited examples. Some of the ways the students felt they cared were given, but examples the students had seen (indicating observing others) were very limited. Time was mentioned in several answers: in one way it was the giving of the nurse's time to show caring, and in another it was a causative factor for lack of care. Interpretation of these data suggest that, in several of the students' perceptions, a lack of care may be due to lack of time. Holism is again mentioned, as this seems to be an idealistic answer but no real examples of it are given. Students mentioning physical tasks and medical needs is still predominate. One student alludes to holism by saying caring is:

'...assessing a patient's physical, emotional and psychological needs and carrying out the necessary nursing tasks to meet these needs' (student 1)

The term 'tasks' seems to have replaced 'care' in this quote. It opens the question as to what tasks would meet emotional or psychological need?

Another student rationalises the lack of caring because of physical needs:

'A lot of time staff would probably like to spend more time "caring" for patients, however with staffing levels as they are, nursing priorities more to ensure that patients' medical needs are met first then if there is time the nurse can work on going beyond what is expected' (student 4)

The implication here seems to be that what is expected is the fulfilment of tasks, anything more is seen as 'extra' or going beyond. No evidence or description of observed caring in the clinical area was provided. Despite asking specific questions for examples of caring, very little data were collected on any specific, practical examples that

qualified nurses provided. Students suggested that it was the 'little' things or the 'extras' that denoted a caring approach. This supports the findings of Kelly (1991, p870) who stated that the senior students in her study referred to the 'taking time to do little things' and how important it was. The findings also corroborate Wiman and Wikblad's (2004) study in which video tapes of nurse–patient encounters revealed aspects of 'uncaring' behaviour.

One student epitomized this by saying:

'I think it can often be the little things that show patients that you care...fluffing up pillows, rather than many of the nursing tasks undertaken to meet their physical needs... Making sure they're comfy, just little things, like making sure their socks are not twisted when you put them on, as there's nothing more uncomfortable' (student 1)

This is a perfect example of a nurse 'being' as well as 'doing'; putting on the socks is a physical task to be done, but the feeling and empathy that goes with it indicate the affective or 'being' side of nursing, or perhaps just the human side. This may confirm Seedhouse's (2000, p62) definition of holism as no more than a general reminder to 'think broadly, deeply and as a consequence, kindly'.

Limitations

The use of open-ended questions provided useful data but the lack of opportunity to clarify and possibly expand brief answers could be seen as a drawback. However, the issue of anonymity was deemed too important to forego. An alternate solution may have been to use interviewers other than the author, but this was not a feasible option in terms of cost and time. Another consideration is that a relatively small selection of students volunteered to provide answers. However, as the intent was not generalization of findings, but exploration of an issue, this may not necessarily be seen as a drawback.

Conclusions

The social world of nursing may often be perceived as a dynamic, ever-evolving arena where theories, knowledge and professionalism dominate. The reality may be very different and student nurses have much to offer in revealing this. There could be a message here for nurse educators: the feasibility of the rhetoric of nursing theory needs to be considered. Does the social system allow anything more than a climate of 'getting through the work'? What do terms like 'holistic care', 'patient-centred nursing' and 'nursing process' really mean? New names for old ideas, 'new' nursing or a drive for professionalism? If students are taught that 'new' nursing is a much better way of working, what happens when the reality does not match the rhetoric? When holistic care is marginalized to meet targets? The adherence to tasks, routines and predominance of care of physical needs may then provide a safety net of working. Despite decades of theory building, research and a drive for professionalism, perhaps things really are just the same, in terms of getting through the work through completion of tasks. There may be an assumption in the literature, rather than any evidence, that the theoretical aspect of nursing has actually changed nursing clinically. It may be a case of talking about holistic care and 'doing' the nursing processes in the form of care plans but never actively believing in either of them. If this is so, describing nursing in terms of tasks and procedures becomes entirely understandable. BJN

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KEY POINTS

- Student nurses are well placed to describe and reflect on the reality of nursing work through their clinical experiences.
- The reality of the work of nurses may not match the rhetoric that is taught to student nurses.
- Terms such as 'holistic care', 'patient centredness' and 'nursing process' may be understood in a theoretical sense, but there may be limited use of them clinically.
- In nursing education, perhaps more attention should be paid to the realities of the social system that student nurses experience clinically, to help prevent dissonance leading to attrition.