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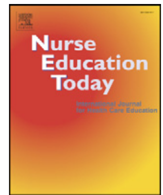

‘Doing the writing’ and ‘working in parallel’: How ‘distal nursing’ affects delegation and supervision in the emerging role of the newly qualified nurse☆

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SUMMARY

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.

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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, and 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 (Gillen and Graffin, 2010; Standing and Anthony, 2008; Weydt, 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 and 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 et al., 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 (Anthony and Vidal, 2010; Standing and Anthony, 2008). This has implications for the

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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 that 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, 1991) 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.

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; and what other factors affect how NQNs organise, 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

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

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 h)
Nurse interviews	16	4	8	28
HCA interviews	6	2	2	10
Ward manager/matron interviews	5	3	4	12
Total (interviews and observations)	61	21	34	116

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