

How are Nursing Roles and Nursing Work Organised?

This article focuses on acute care nursing so the single professional term is used.

An article which addresses the specific issues of midwifery, mental health, community nursing and country nursing is planned for Article 5.

This is the third in a series of articles to encourage discussion about nursing and midwifery career structures in South Australia. Each article looks at different issues affecting professional career structures. It is hoped that these articles will stimulate workplace discussions, challenge nurses and midwives to ask further questions, and become a way of collecting feedback from as many people as possible. Your views are not only welcome, they are crucial.

What has Influenced Acute Nursing Work and Nursing Roles?

In developed countries around the world, in interstate health systems and within South Australia the calls for change in the way health care work is organised are gaining momentum.

Nurses seem to agree with many of the calls for change – particularly those that suggest that many activities, processes and clinical decisions that have traditionally been restricted to doctors could be undertaken by registered nurses.

However nurses seem not so supportive of changes that suggest that some of the activities traditionally undertaken by registered nurses could be done by enrolled nurses or other work groups without nursing qualifications.

How has the current organisation of nursing work come about? What influences it?

In 1950, industrial workers were the majority of workforce in every developed country.

“Here is what I think nurses do. Using their considerable knowledge, they protect patients from the risks and consequences of illness, disability, and infirmity, as well as from the risks and consequences of the treatment of illness. They also protect patients from the risks that occur when illness and vulnerability make it difficult, impossible, or even lethal for patients to perform the activities of daily living -- ordinary acts like breathing, turning, going to the toilet, coughing, or swallowing.

Although many studies, conducted by nursing, medical, and public health researchers, have documented the links between nursing care and lower rates of nosocomial infections, falls, pressure ulcers, deep vein thrombosis, pulmonary embolism, and deaths, most promotional campaigns and many nurses themselves ignore these data.

I believe the public knows that nurses are kind, caring, and compassionate. People don't know, however, that nurses have medical knowledge, participate in cures, and have technological know-how. The public needs to know that nurses -- regular, ordinary bedside nurses, not just nurse practitioners or advanced practice nurses -- are constantly participating in the act of medical diagnosis, prescription, and treatment and thus make a real difference in medical outcomes.

What do nurses do? They save lives, prevent complications, prevent suffering, and save money.”

Suzanne Gordon 2006

By 2000, developed countries had less than 1/6 of the workforce in industrial roles. The Industrial Age had great influence over healthcare systems. Industrial models of work were built on linear processes and hierarchal authority and control structures. The healthcare systems that developed during this era have all the features of the industrial model.

Nursing also developed during the Industrial Age with functional divisions of labour, departments, and control mechanisms. Educational structures supported discipline specific learning environments. Institutions that housed healthcare developed organizational structures, chains of command, policies and roles that promoted separate and distinct departments.

Now that we are leaving the Industrial Age, and moving toward the Information Age, what changes should be made in our organisational structures? (Wiggins 2005)

Another influence has been the geography or building structure of hospitals. Most hospital care is ward or unit based: surgical wards, medical

wards – most have fairly similar structures.

How are these wards determined? Mainly by the allocation of beds to various medical specialists. In this physical structure, nursing has developed roles that focus on a person being in charge of a ward rather than in charge of nursing care and staff allocated to wards rather than to a group of patients with similar nursing needs.

What Influences the Daily Work Routine?

Nursing routines have stayed fairly similar over many years. The acute nurse's day is largely arranged around the times of meals, the times of medical specialist visits, visiting hours where these are restricted and the “traditional” hygiene structure of morning bath or shower.

These types of routines are so entrenched they have become what is called ‘mental models’ – thinking that is so ingrained, people believe they are ‘natural’ or immovable.

Changing mental models is very difficult – particularly if they are not even recognised as controlling or influencing one’s behaviour.

Nursing has fought a long battle to move from exclusively medical models of health care. In the acute services, nurses try to balance illness and health by focusing on the patients experience rather than the disease process. And yet much of nursing work is organised around the disease treatment processes of medicine and surgery.

If the future is to be different then a major change of thinking will be needed. Making changes within the current knowledge and mental models won’t be sufficient. Changing and rearranging our knowledge and mental models to generate radically new ways to do things will be needed.

Just feeding a sub-optimal health care system with more bodies to carry out old practices doesn’t strike one as the most adaptive response. Using the looming crisis in health workforce to drive innovation to make more efficient use of professionals seems a smarter way to approach the issue.
O’Neil 2005

Nursing work in the future

We have many questions about what the future will require, but we cannot wait until we have all the answers. We must begin to experiment and act now. One of the most important tasks is to define the health work of the future, and then we can identify the roles and competencies that will be needed to do that work.

The American Organisation of Nurse Executives proposes seven ‘Guiding Principles for Future Patient Care Delivery.’

1. That the core of nursing is knowledge and caring and that patient care tasks must be prioritized during a shift to ensure that the work requiring the skill and education of the nurse is achieved as a priority.
2. That care is user-based rather than institutionally-based. Care will move to and with the patient, bringing closer links between ‘hospital’ and ‘home’ care.
3. That knowledge is access-based: Nurses will need to shift from “knowing” a specific body of knowledge to “knowing how to access” continually evolving knowledge.
4. That knowledge is synthesised. The work of the nurse will shift from critical thinking to “critical synthesis” - co-ordinating care across multiple levels, disciplines, and settings.
5. That the relationship of care will be with individuals and populations and will be multidisciplinary. Nurses must redefine points of intersection with other disciplines.
6. That there will be both a “virtual” and “presence” relationship of care: Nurses will need to know when they must be present, and when virtual (for example through tele-health) will work.
7. That the work of the nurse in the future will be to manage the journey for the patient, client, or population. This is the role of the coordinator/advocate at its highest level. This is the role of assisting patients in navigating the complexity and confusion of healthcare. (Thompson 2004)

Do these principles seem relevant to the future of nursing in South Australia? What might be the ‘Australian’ guiding principles for future patient care delivery?

What might these likely changes mean for nursing roles?

What are the care delivery models that will best link with these principles? How will nurses make their clinical thinking, judgment and decision-making more explicit? How will nurses integrate principles such as these with team work models?

What will need to be different in the work environments of the future to support nursing work? What new leadership competencies will be needed? What technologies and infrastructure will be needed to facilitate the transition to this future?

One follow on from the implications of workforce shortages and published views of future health delivery is that the work of registered nurses, medical doctors and allied health professionals would be redesigned to allow more flexible work sharing and work allocation.

It also follows that some work currently done by registered nurses would move to enrolled nurses, and that some of the work of both levels would move to appropriate support staff within nursing teams or in other departments. However logic does not always drive workforce decisions, or responses to them.

How might nursing accommodate changes in work roles while ensuring that the core of nursing – the type of work that drew people into the profession – is not compromised, or indeed, is retrieved?

What types of role redesign should the profession consider?

We see an urgent need for major workforce reform. The health workforce and workplace practices must be modernised. Workplaces need to capitalise on current professional capabilities and not be bogged down by 19th century professional boundaries.
Black 2005

Role redesign

In the UK, the National Health Service (NHS) is experimenting with the redesigning of public sector health roles. The way in which the NHS has clarified what workforce redesign may mean is useful to consider.

According to the NHS, role redesign has a set of fundamental principles and any changes must ensure clarity, accountability and safety for the patient and staff. All role redesign should take account of the need for continuing personal and professional development and lifelong learning. Experience and training from one role should be recognised and accredited and used for development into other roles (NHS 2005).

Moving a task or individual up or down a traditional skills ladder

Examples could include Enrolled Nurses undertaking tasks usually done by nurses higher up the nursing 'skills ladder', such as medication administration 'tasks'. (Figure 1)

Extending the breadth of a role

Examples include nurse led clinics. For example, nurse led wound clinics might include wound reviews previously done by surgical rotation interns and heat applications previously done by physiotherapists. The goal of integrating these tasks is to provide a more seamless and efficient outcome for patients. (Figure 2)

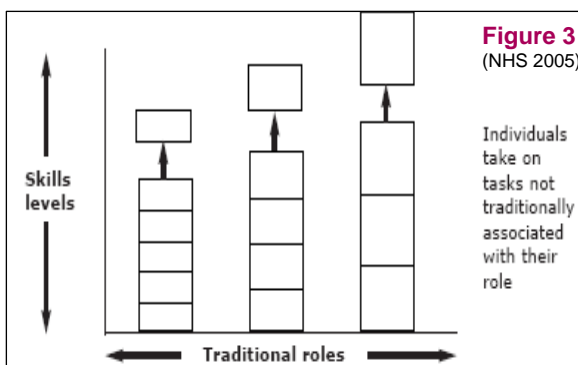
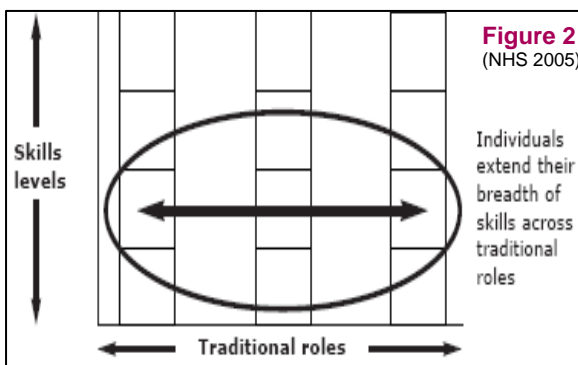
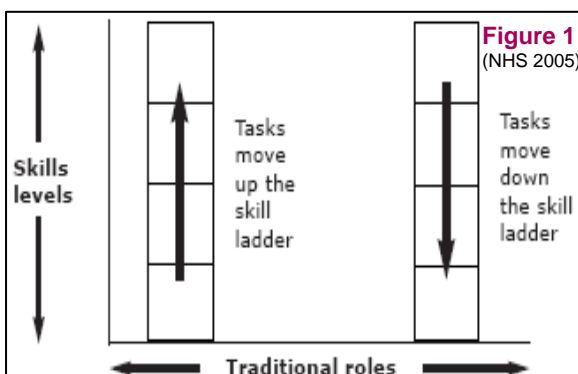
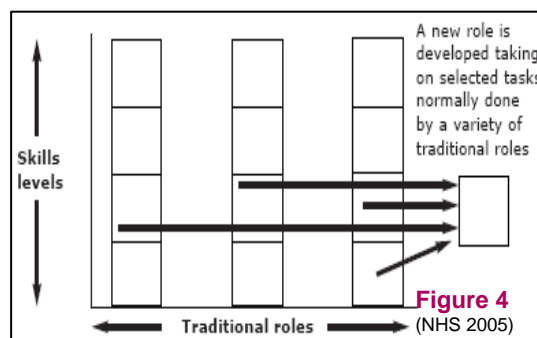
Increasing the depth of a role

For example a busy Diabetes Clinic may use an assistant to welcome and organise clients. With education, such a role may be redesigned to include undertaking routine testing of urine, inspection of feet, etc. Adding such tasks increase the depth of the assistant role and allows the

professionals time for the more complex assessments and patient education. (Figure 3)

Developing new roles

New roles such as ICU Outreach Nurses have been developed to follow up all patients discharged in the previous 24 hours from ICU. This role decreases patient stress, assists adjustment to the ward, and supports ward nurses with any procedures with which they may not be familiar. (Figure 4)



These examples may suit various sites but one point that the NHS makes clear is that redesigning roles should take account of local requirements.

Ideas about moving major traditional professional boundaries have been proposed by some commentators, but in reality this may not be immediately feasible.

However, the ideas of ways in which work can be realigned are useful as nursing and midwifery consider their career structure arrangements for the next decade.

"Future health care models should envision having the right health professional in the right place, at the right time, with the right skills, competencies and training" (Mancini 2004).

One goal in the Nursing and Midwifery Career Structure Review would be to move towards the goal of right person, right place, right time, right skills, and right preparation.



Some Role Redesign Issues in Nursing

There are several issues in nursing that need to be considered in relation to ideas about role redesign.

Is it the Role or the Behaviour that Needs to be Changed?

Sometimes the persistence in working in traditional systems creates wasted work and can reduce effective care for patients. For example, if the documented admission observations of nurses are not read and used by medical and allied health staff, considerable time is wasted and patients are subjected to unnecessary repetition. Processes that include combined patient notes and attitudes that are respectful of the observations and contributions of other professional groups may be the changes needed, rather than new or different roles.

Similarly, some registered nurses unnecessarily increase their workload with an "If I don't do it myself, it won't be done properly" approach. Again, this issue may need a change in approach rather than changed roles.

Enrolled Nurse Roles

One of nursing's traditions has been to limit the role of the enrolled nurse. While once this could be based on the limited education for enrolled nurses, such is no longer the case. The current Enrolled Nurse Diploma course in South Australia has more hours than the old RN hospital certificate that remains the only qualification of many currently practicing registered nurses.

Enrolled Nurses may undertake most procedural tasks within the scope of nursing. The main exception is in the area of S8 medications due to current legal requirements. The clear delineation between the Registered Nurse and Enrolled Nurse roles is in the activities of clinical decision-making, professional judgment and

accountability, not in who does the physical tasks.

So for example, the enrolled nurse can administer medications and is expected to report signs of side effects or allergy etc. However, the registered nurse is responsible for decisions to withhold medication, contact medical practitioners about concerns, assessing the patient's response to the medication in terms of expected and unexpected outcomes and provision of discharge education to the patient as part of the total education for continuing care.

RNs Attachment to Procedural Work

One of the current problems in nursing is that allocation of nursing work on a shift-by-shift basis is often focused on routine procedural work – the manual tasks of patient care or on the number of patients or beds in various segments of a ward. Assessment of clinical workload by managers and management tools needs to be further refined to better identify the clinical decision making, consultation between health professionals, networking to manage the patient's care, liaison with other staff and with family members and the many other interpersonal therapeutic roles and thinking roles expected of registered nurses.

The focus on visible procedural work may well have contributed to a decline in registered nurses undertaking the non-visible "knowledge work" that should be a major portion of the professional nursing role. It may also have shifted the emphasis for some nurses from a professional role to an hourly paid employee role.

This situation is further exacerbated by the measuring of costs per DRG or per patient only in terms of manual, technical or procedural work. It seems that in today's economically obsessed world, only what is visible is measured, and only what is measured is valued.

In nursing, the lack of value attached to interpersonal therapeutic work, thinking, decision making, and emotional work is well recognised. It is part of what makes nurses themselves feel unrecognised and unrewarded.

However, is it possible that nurses themselves devalue non physical work in the way they allocate work within a ward, and in what they believe to be equity of workload?

How does your team allocate work? Are patient numbers allocated only on the basis of their physical care needs? If RNs are given more "complex" patients, is this because these patients have more procedural or technical work associated with their care? Do nurses in your team consider the number of showers or sponges as the measure of equity of workload?

Many types of work allocation and work measurement tend to ignore the knowledge work required, particularly of the RN role. Two things may result. Registered nurses themselves, too busy doing procedural and technical work, stop thinking and making clinical decisions and judgments. Or, under time pressures of trying to do work that is measured and work that is not, the RN becomes burnt out, exhausted and frustrated by some sense that this is not the nursing they wish to do.

Absorbing the Work of Other Work Groups

A similar problem is the frequency with which nurses absorb the work of other work roles. This may occur within nursing itself with RNs not delegating sufficiently to ENs.

A commonly heard response to delegating nursing work to ENs or to other categories of worker goes along the following lines. "I have to do the patient showers – I use that time to assess the patient's walking (movement, skin etc)".

Why can't there be other options? For example, the RN going to the patient



and making such assessments speedily without engaging in the additional time of activities of daily living that could be managed by others. In part perhaps this is because it is the visible and routine work that is counted and recognised.

There are many examples of nursing absorbing the work of others, and indeed being expected to do so by the organisation. When a department declares that they will no longer be doing 'x', the impact of this work reduction is often absorbed by other groups. Since nursing has a 24/7 presence in a hospital, it may well be nursing that picks up the work that has been reduced by another group.

A more "efficient" process in one department under budget pressure may increase the work in other roles.

"Substitution When it Suits" – After Hours Miracles of Role Redesign

One form of role redesign is to move tasks from one group to another. Many submissions to the Productivity Commission (2005) sought to remove some of the restrictions by various professions on what work can be undertaken by a professional group. One of the suggested ways of dealing with the medical doctor shortage was to allow nursing and allied health professionals to undertake tasks traditionally undertaken by doctors. The AMA has opposed these suggestions – using the term "substitution" as a negative concept and warning of major issues with quality if doctors do not keep doing all the tasks they claim as theirs.

"The models being put forward by COAG, the Productivity Commission, and the States are based on substitution – somebody else taking the place of a doctor. They want somebody other than a doctor to perform what they term 'low risk' or 'normal' tasks. Where human life is concerned, there is no such thing as 'low risk' or 'normal' (Haikerwal 2006).

Even in the acute care hospital setting there are numerous activities and decisions that are relatively low risk and routine.

In the hospital health care team, there are often registered nurses who have more experience and knowledge in a specific field than interns and registrars rotating through the speciality.

There are many interventions that may be undertaken by medical doctors or by registered nurses. The question of which person undertakes which task should be based on competency in the skill and having sufficient knowledge and understanding of the expected and unexpected outcomes.

At present however, it is more likely that the time of day in a hospital will dictate who undertakes some tasks. The "after hours" issue is a classic example of absorption of work by nursing.

There are many tasks that move from interns and registrars to registered nurses after 5pm and on weekends and public holidays. Similarly, many administration, clerical, social work, and physiotherapy activities are maintained by nurses when people normally employed in those roles are not available.

It remains to be seen how much role redesign and workforce flexibility will actually occur in the health system.

While nursing may welcome the removal of some of the current traditional restrictions to the "upper end" of its practice, the profession must also deal with the potential of removing some of its own restrictions on who undertakes the work at the "lower end" of nursing.

Nurses as Knowledge Workers

"The term "knowledge worker" was coined by Peter Drucker some thirty years ago to describe someone who

adds value by processing existing information to create new information which could be used to define and solve problems... Their main value to an organization is their ability to gather and analyze information and make decisions (Miller 1998).

Drucker (1998) says a knowledge worker is "a problem solver rather than a production worker, a person who uses intellectual rather than manual skills to earn a living".

The essence of knowledge work is to create the one-of-a-kind results that characterize craft products rather than mass production. In health, this may involve crafting a specific solution for a complex patient discharge, or putting together a "one off" wound dressing concoction for a specific problem, or interacting with a patient in a very particular manner to address the uniqueness of the circumstance.

One thing that differentiates knowledge work today from other craft work is that, except for the final product, knowledge work is essentially invisible. All the important stuff takes place inside the knowledge worker's head (McGee 2004).

Standardization, reproducibility and supervising workers to ensure they all worked in the same manner were key concepts in the Industrial Age. It is not feasible to use these approaches for knowledge workers or problem solvers.

If much of the role of registered nurses is "knowledge work", how might acknowledging this change work allocation and work roles in nursing?

Would this assist in making the knowledge, judgment and unique solutions developed by many registered nurses more visible? Could more of the routine procedural activities in nursing be undertaken by ENs? Could the manual activities of nursing be more clearly separated from the knowledge work activities?



The table on the next page outlines a way of dividing work according to the degree of knowledge work involved. It also considers work in terms of the continuum between standardisation (complete mass production) through to unique customisation. In terms of service rather than products, consider the following examples. A train ride is mainly a standardised service with very limited customisation. A taxi ride is customised – you can start and stop wherever you wish.

Neither of these services requires high levels of problem solving, judgment or intellectual knowledge. If the dimension of interpersonal or relationship skills is added to this view of work activities, the following example indicates different types of work role requirements. A woman cutting the hair of an elderly man will follow a fairly standardised process and does not need high level knowledge or advanced interpersonal skills.

The work activity is generally fairly public.

However when a female enrolled nurse gets an elderly man to take off all his clothes and shower in front of her, advanced interpersonal skills are needed to negotiate this normally private activity. The activity itself (showering someone) is fairly standardised and does not require a high level of knowledge. It is the additional interpersonal skill level that marks the difference.

Figure 5: Work Process Structure applied to Industry (Maccoby 1996), and to Nursing (Parkes)

<p>High knowledge Standardised product Lower patient interpersonal skills</p> <p>In Industry:</p> <ul style="list-style-type: none"> - typically automated - high knowledge teams to respond quickly to problems, safety <p>In Nursing: Resuscitation? Acute episode interventions – fits, accidents, anaphylaxis etc? Immediate post op care? IV cannulation?</p>	<p>High Knowledge Customised product High patient interpersonal skills</p> <p>In Industry:</p> <ul style="list-style-type: none"> - experts from different functional areas work together as a team - composition of team depends on knowledge needed - heterarchy (leadership depends on who has key knowledge at different parts of the process) - collaborative communication - the hardest work process <p>In Nursing: Unusual ADLs? – e.g. mouth care after radiotherapy, feeding after oral surgery. Chronic care teams? Assess the impact of medications? Evaluation of treatment interventions? Discharge planning?</p>
<p>Lower knowledge Standardised product Lower patient interpersonal skills?</p> <p>In Industry:</p> <ul style="list-style-type: none"> - customer – supply or assembly processes - Deming and Toyota – eliminate waste/defects in process - Continuous improvement <p>In Nursing: Cleaning up messes/equipment? Collecting trays? Filling in food and drink taken? Electronic observations – eg BP taken with machine? Setting up equipment for procedures?</p>	<p>Lower knowledge Customised product High patient interpersonal skills?</p> <p>In Industry:</p> <ul style="list-style-type: none"> - information age services by phone or electronic; - based on protocols and templates; - employees respond directly to small variables in customer requirements but mainly process is set <p>In Nursing: Usual ADLs eg feeding, showering etc? Mobility activities? Standard observations? Getting medications from the container to the patient? Running standard IVs? Taking blood?</p>



The table attempts to list a few examples of how nursing work might be divided if this approach to work classification were taken. It may challenge some traditional assumptions.

For example resuscitation after a cardiac arrest requires quick and decisive action. It probably only requires high knowledge if additional measure such as intubation and IV medication are required.

In community circumstances members of the public can be trained to proficiency in skills for resuscitation and use of semi automatic defibrillators etc. In hospitals, it is reasonable to assume that the person may have other complications and that additional measures such as intubation and administration of IV drugs will occur. Thus higher knowledge is expected. The need for interpersonal skills is reduced by the condition of the patient. Most of the process of resuscitation is standardised.

Clinical assessment and discharge planning, on the other hand, usually are highly customised and require considerable interpersonal skills to achieve good outcomes. Both also require high levels of knowledge across a range of subject matter.

If you applied this model to the nursing activities in your ward or unit, how might it change the way you allocate work activities and the work roles you require?

Drivers of Role Redesign

Efficiency: Lean Thinking

Simply put, lean means using less to do more. Lean thinking is not typically associated with health care, but supporters say the principles of lean management can work in health care in much the same way they do in other industries, because it has to do with improving processes.

“One of the challenges of implementing lean in health care is that it requires people to identify waste in the work in which they are so invested. All workers want to feel their work is valuable, perhaps most especially health care workers. Recognizing that much about their daily tasks is wasteful and does not add value can be difficult for health care professionals.

A nurse who is hunting for supplies is doing it to serve the needs of patients. Nurses may not see this as wasted time, and may not stop to wonder why those supplies aren't where they need them every time they need them. But if the supplies were always readily available, the time nurses spend hunting for them would instead be devoted to something more appropriate to their skills and expertise” (Miller 2005).

The Flinders Medical Centre Redesigning Care approach is based on Lean Thinking ideas. The FMC approach sets the following goals:

- Seeing things through the patient's eyes;
- Finding a better way of doing things;
- Respecting the ideas and work of others;
- Giving staff the time and tools to tackle problems;
- Looking at the whole picture;
- Taking small steps as well as big leaps; and
- Improving the patient journey. (FMC 2006).

When these steps are followed some job role changes are likely to be one of the results.

Safety and Quality

“Quality and effectiveness in health care are much more difficult to measure than efficiency and partly for this reason managers are less accountable for quality and effectiveness than they are for

efficiency. Likewise the incentive structures within which managers work have traditionally focused their attention on efficiency and cost control rather than safety, quality and effectiveness” (Legge 2000).

Among the emerging trends in health are the issues of clinical governance and clinical risk management. One focus in current policy discussions is on how to make executive managers accountable for quality and safety as well as efficiency and cost control.

“No one is quite sure how this is going to be achieved but calculating risk may be part of the solution. What are the limits to speeding up the work of nurses? One limit is the point at which the nurses leave the system. Another limit is where managers can be made accountable for the shortfalls in patient care that will inevitably arise as nurse managers are required to do more with less.

It is not fanciful to speculate that effective nurse workload monitoring systems will enable health service researchers to draw tighter links between adverse events and the 'efficiency' of nursing rosters. If such links could be more clearly drawn then the accountability for efficiency could be balanced by a comparable accountability for creating the conditions needed for quality and safety” (Legge 2000).

How might the work of Level 3, 4 and 5 nurses be changed by these approaches? How could the impacts of budget levels be more closely and accurately linked to clinical outcomes?

Will reflective practice and development roles such as clinical supervisors and clinical teachers be more clearly recognized as contributing to the quality of clinical outcomes? Will practice development roles be recognized as a sound investment in risk reduction and improved quality?

What is the best way of providing care to the patient?

What skills and resources are required to deliver this care?

What is the best way of constructing a workforce or team with the required skills?

(Quotes from Qld Health 2005)

Concerns about Role Redesign

There are some issues that nursing needs to consider in terms of possible impacts of ideas about role redesign.

Work Intensification in Nursing

Work intensification can mean working longer hours (extensive work effort), and/or working at a faster pace or with fewer down times (intensive work effort).

In hospital settings the hours of work are non-standard, usually with a reduced number of workers as the shifts move across the twenty-four hour day from morning to night and through the five days of the standard working week to the week-end. In the past this arrangement has assumed that workload reduces in the evenings, at night and on week ends. "These assumptions are no longer guaranteed although many hospitals still operate according to this model ... there has been considerable increase in work intensification in the health sector. It has not been restricted to nurses or doctors, but is system wide" (Willis 2005).

Re-designing the health workforce will involve more than removing some roles or shifting some work from one group to another. It requires maintaining staffing levels or increasing them where workload levels increase. "It also demands recognition that the intensity of work for one occupational group will impact on other groups where the work is highly structured around teamwork and where all are committed to the service of care" (Willis 2005).

Recent National Health Service (NHS) changes have brought shifts in the ideals, pace and physical location of work, with significant consequences for staff. Hospital nurses have experienced increased devolution of managerial responsibility and are under pressure to ensure a faster throughput of more acutely ill patients and simultaneously contain service costs.

In the UK, two other factors have also significantly increased nurses' work pressure: stepping in to fill the vacuum left by junior doctors working fewer hours and the concept of multi-skilling. The latter has been introduced as 'patient focused care' and emphasises the desirability of health professionals developing wider sets of multi-professional skills, to enhance patients' experience of 'seamless' care.

The net result of these changes is that health service managers have had to reappraise the nature of nurses' work and the skills required to accomplish it. (Adams 2000).

Known effects of skill-mix changes for nurses are enlarged managerial, medical and therapeutic remits and increasingly devolving bedside nursing to non-professional staff.

"Within this context, broad categories of skill-mix changes involving nurses were characterised by: (i) *multi-skilling*, where both professional and non-professional care staff undergo additional training to provide a broader range of care *skills*, but where recognition of the primary nursing role and responsibilities remains unchanged; (ii) *role extending*, where nurses take on new *tasks*, substituting for another professional group; (iii) increased *managerial functions*; (iv) the *development of specialist roles* within a particular discipline, and (v)

changes related to *nursing grade dilution*, i.e. employing more health care assistants and fewer nurses. As a result of service re-structuring and skill-mix initiatives, nurses are also increasingly asked to supervise larger numbers of support staff and students" (Adams 2000).

How it's Done: the Way Change is Managed

Trust within organisations facilitates co-operation and is essential for good economic performance and innovation. Trust reduces costs and improves the flow of information, and thus has direct economic effects as wider outcomes. It aids innovation by improving communication flows and the diffusion of knowledge, within and between organizations (Asgeirsdottir 2005).

Nurses' experience of structural change has not always been good. Accurate information has not always flowed well. Trust has not always been developed. Reasons for changes have not always been explained clearly.

Too often in health organization restructures changes are imposed without the involvement of the people who do the work, understand the work and who will have to bear the major impact of the change.

There are many good reasons to consider changes to work practices and to roles. However, the processes used to implement changes need to be honest in their intent and respectful of those being asked to change.

The Career Structure Review allows nurses to actively participate in discussions about role change and is one means for the profession to interact with system management to effect changes that address both patient and staff outcomes.



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For further information contact:

Nursing Office
Department of Health
PO Box 287
Rundle Mall
Adelaide SA 5000
Telephone: (08) 8226 6409
Email: robyn.parkes@health.sa.gov.au

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