

Practice

What Will Change in Nursing Practice Over the Next Five Years?

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The answer: “It depends.” The question in the title is by no means easy to answer. There are too many variables – independent, interdependent and dependent – all of which will affect the final outcome. I think a much easier question for me to answer would be “What *should* change”; but I digress. My task is to reflect on what *will* change in nursing practice over the next five years.

Since the early 1990s, healthcare has undergone major reform in order to reduce or maintain costs while attempting to increase the quality of outcomes. Such strategies as downsizing, restructuring, rightsizing and re-engineering were utilized in order to achieve “system reform.” However, system reform requires an alignment of structure, process and outcome. All too often over the past 10 to 15 years, the focus of system reform has been on structure for example, the Sinclair restructuring commission and the reform of Community Care Action Centres. In addition, consumer knowledge and

expectations have increased, the client population has continued to age and technology has continued to outpace social norms, morals and values.

Issues identified in the 1980s by such groups as the Registered Nurses Association of Ontario (RNAO) and the Canadian Nurses Association (CNA) continue to be issues today. In 1981, the RNAO held a Think Tank on Nursing Leadership. In its report on the Think Tank (RNAO 1982), the RNAO identified issues that included educational entry level to the profession, specialization, changing roles in institutional and primary care, ethical decision-making, professional rights and responsibilities and adequacy of nursing manpower. The presence or absence of nursing leadership was also identified as having a major effect on the quality of client care. These issues made the need for strong and effective leadership a priority for the profession in the future.

The recommendations that arose from the Think Tank are still current.

For example, all of the following were issues in the early 1980s and continue as such today:

- Leadership forums for nurses are required to heighten their awareness of the problems and assist them in developing skills and strategies to influence the solutions.
- Sessions with nurse educators are needed to familiarize nurses with the issues and examine ways in which they can effect change.
- Staff development opportunities are imperative.
- Issues relating to working conditions for nurses, the changing and decreasing nursing population and other conditions that influence the career paths of nurses need to be addressed.
- Recruitment and retention strategies require ongoing monitoring.
- The chief nurse should be a member of the senior management team.

Another report of the RNAO (1983) regarding future directions for health-care listed suggestions for action to improve health services and economic efficiency based on strategies proposed by the CNA (1981). These changes included appropriate utilization of healthcare personnel, development of new points of entry to the healthcare system and greater emphasis on prevention of illness and health promotion.

A number of recent reports on the Canadian healthcare system, such as that of Romanow (2002), suggest that human resource issues, quality of work environment, access to information and access to services are all factors that

currently prevent high-quality, efficient delivery of care. These sentiments are echoed by others, including the Canadian Nursing Advisory Committee (2002).

In its report on the Think Tank, the RNAO (1982) reported that pervasive, free-floating anger, hurt and hostility were evident in the profession. In 2001, staff nurses reported burnout and dissatisfaction with their jobs and a concern about decreasing quality of care (Aiken et al. 2001). There is now a lack of trust, and increasingly one hears the phrase, "If you wait long enough, old will become new again."

There remains a significant disconnect between nursing education and practice, nursing research and practice, and nursing administration and practice. Rarely do we see conferences or workshops in which representatives from these four dimensions gather together in one location to discuss issues of mutual concern or solutions. The Ontario Hospital Association (OHA 2003) has suggested that currently there are no common platforms or forums for stakeholders to discuss issues, develop positions and coordinate activities. Its report further states:

that perceived professional silos, political subculture, and professional hierarchy continue to affect professional working relationships and collaborative practice in the organization. . . . Several professions reported a lack of reciprocal understanding between professional groups about each other's education background, skills, and roles in delivering care. This has been explained as

partially an issue with staff attitudes, and in particular leadership's recognition of allied health discrepancies ... Students revealed a number of questions and concerns around role clarity in the profession, specifically clarification around RN and RPN practice and staffing models, the perceived nursing hierarchy in hospitals and nursing education, and the different levels of preparation in the education system. (OHA 2003:8)

The healthcare industry today is written about frequently in newspapers in the context of staff shortages, patient safety, patient satisfaction, cutbacks, operating deficits, staff dissatisfaction, scopes of practice, recruitment and retention and other problems and issues. But very little information has appeared with respect to concrete, practical solutions or futuristic thinking to examine the most effective and efficient way to respond to the ever-changing healthcare environment. We need to change how we deliver healthcare; for example, we must stop "turf wars" both within and across disciplines and address issues from the client's perspective. Currently, solutions are addressed not from the standpoint of what is right for the client, but according to the politically correct response for the organization or provider.

Ironically, if one asks a nurse, "What is it you do?," the response will invariably include descriptions of tasks. It is not surprising that nurses have difficulty moving beyond the task orientation of their scope of practice. During periods of restructuring, efficiency and down-

sizing, the first positions to be eliminated were those representing the unique areas of practice within a nurse's scope – those of education, research and leadership. Further, it is difficult to quantify and describe the concepts of clinical resource, mentorship and clinical leadership, which are all components of nursing's scope of practice.

Tasks have traditionally been the focus of nursing workload measurement tools. As a result, these tools (although utilized by administration in decision-making) are not valued or considered valid by nurses. In my experience, and in conversations with nurses, there is acknowledgment that the information submitted by nurses when considering workload is often "fudged" or overquantified. There is also no acknowledgment in the tool for the numerous interruptions that nurses encounter, for the demographics that affect their workload (such as non-English-speaking clients and families) or for the "turnover" and movement of clients that occur over the course of 24 hours. This flaw in measurement adds credence to the nurse's feeling of being undervalued and provides only a small snapshot of nurses' total workload.

The increased utilization of unregulated care providers, particularly in the community and long-term care sector, adds to nursing workload and risk. The ever-increasing complexity of clients with multiple diagnoses requires a higher-level knowledge worker, not a diminished one. Decision-makers in organizations may unknowingly place their employees, their clients and the organization at risk when they instruct

caregivers to work beyond their scope and knowledge base. This risk is increasingly evident when applied to the unregulated care provider.

Student nurses often have their initial clinical placements in long-term care or complex continuing care. I would suggest that these are more appropriate placements for students towards the end of their study program, when they are better able to integrate and synthesize the complexity of care into their practice.

Recognition needs to be given that families or significant others are becoming primary caregivers in the community and in institutions. A primary role for nurses in these circumstances is to educate rather than to “do for,” and to perform a coordinating role in relation to care provider and other health professionals.

Evaluation and evidence-based best practices are discussed but inconsistently applied. Nurses are knowledge workers, but there is not a great deal of literature about knowledge transfer. Nurses are not given enough time in the environments within which they work to think critically, plan and implement the care to be provided.

Hayes (1994) concluded that non-nursing functions continued to be a professional nursing issue. Nurses assume more non-nursing functions, and as a result spend less time with clients.

Where I think nursing practice *will* be and where I think it *should* be are two very different places.

Nursing leaders in all sectors must be on the same page and must influence

decision-makers and administrators in organizations to change their ways of thinking and concepts regarding health-care delivery. Nurses and nurse leaders must have a shared commitment to meet the standards for professional practice and to advocate for systems with practice settings that facilitate professional practice and quality outcomes for clients.

Nurses will need to be skilled at critical thinking, which has been defined as “sound judgment and wise action in complex, unique and uncertain situations” (Citizen Advocacy Centre 2000). In addition, nurses need skills in direct care and management for both acute and chronically ill care, the capacity to adjust when things don’t go as planned, skills in collaborating with other providers of health services and the ability to work independently without readily available support. Nurses will also need skills in managing other registered personnel and unregulated care providers, allocating resources within the care setting, and computer literacy. They need to view leadership as a component of everyone’s role, not just of those individuals with an official title.

In order for nurses to practice in ways that will deliver satisfaction in the next five years, leadership is crucial. Leaders from all dimensions of nursing need creativity and vision. They need to discuss complex issues and reach decisions, yet speak with one voice. It is important that they be aware of the issues, but not continue to dwell on them. We need to move forward and create environments that will allow us to be creative and try a variety of solutions.

Porter-O'Grady (2003) has suggested that today's leader makes it safe to question, to risk and to stretch staff into new ways of thinking and being, congruent with the opportunities and emerging demands of transforming clinical practice. The nurse must be aware that assessing the appropriateness of all current rituals and routines of practice is the work of the time. Value now demands that everyone examine his or her efforts closely and collectively to determine what should be retained and what should legitimately be left behind because it is no longer appropriate.

A recent review of the literature confirms that the issues and recommendations of the last 25 years are remarkably similar to those of today. We are still reiterating the same concerns and postulating the same solutions. However, little collective action by the profession has been taken to date. The time to try new solutions is now. I would suggest that unless nursing leaders approach leadership from a totally different paradigm, nursing practice will remain as it is today. Nursing will continue to fractionalize and will not harness the power we have within our professional community.

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