Much of the work nurses do is unseen. Recognition of this work would help shape education and practice, and ensure society has an accurate view of the profession.

Making visible the unseen elements of nursing

In this article...

- Views about nurses and nursing
- The key elements of organising work
- How organising work impacts on healthcare

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The traditional image of nurses as caregivers needs revision but this is challenging as much nursing work cannot easily be explained. This article summarises the main findings from a large-scale study of a relatively invisible, but everyday, element of nursing practice – “organising work”. This has always been a component of nursing but has recently been seen as a distraction from patient care. More must be done to recognise and communicate its value and the demands it places on staff to shape education, professional development and how nurses are viewed.

The world of work is always changing, and none more so than healthcare. The last century has seen nursing roles evolve in response to a host of technical, economic and social factors but, despite vast changes in the structure and content of their work, for the last 40 years or so, nurses have been widely understood to be caregivers: “The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.” (Henderson, 1966)

“[The nurse’s role involves the] use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.” (Royal College of Nursing, 2003)

Recent concerns about modern nursing, most notably in the aftermath of the Francis report on care failings at Mid Staffordshire Foundation Trust, suggest this image is in need of revision. This is not because nurses are “fallen angels” as some would have it, but because understanding nursing purely in terms of caregiving is increasingly at odds with the reality of their work in today’s healthcare systems. In both hospital and community contexts nurses care for patients with complex conditions, requiring specialist intervention and coordinated input. Pressure on resources makes it increasingly challenging to provide ongoing support for families in the community and to discharge people from hospital, while increased patient flows in the acute sector mean activities previously extended over several days must be compressed into shorter timeframes (Duffield et al, 2007). At the same time, the workforce has shrunk, the number of support workers has increased, and tasks have been passed to nurses from doctors.

In this climate it is unsurprising that research regularly shows contemporary nursing practice to bear only a fleeting resemblance to its patient-centred image (Allen, 2004). It is not simply that nurses are increasingly distant from direct care delivery (Cavendish, 2013), they also undertake a range of activities that remain hidden from view (Allen, 2004). A brief glimpse inside today’s health service reveals that nurses contribute significantly to everyday delivery processes and, as

Organising work is vital, but often invisible

5 key points

1. The societal image of nurses as caregivers needs to be revised
2. Nurses carry out organising work, which is vital to good-quality healthcare
3. Little is known about organising work and nurses can find it hard to describe this
4. Organising work includes four practice domains: creating working knowledge; articulating patient pathways; matching patients with beds; and care transfers
5. A better understanding of organising work will affect workload, education, recruitment and how nurses are viewed by society
such, the quality of patient care. Although some estimate that this work – referred to here as “organising work” – accounts for more than 70% of that done by nurses (Füraker, 2009), it has never been studied in its own right and remains a poorly understood element of nursing practice.

**Literature review**

Organising work is a classic example of what social scientists call “invisible work” (Nardi and Engeström, 1999). Work is made invisible in several ways: some is done in invisible places (ie, the behind-the-scenes work of librarians); some is considered routine, even though it actually requires skilled problem solving and knowledge; and some is done by “invisible people”. As an example, Hart (1991) described working as a hospital domestic and how, despite working in public areas, she was “unseen” by passersby.

Public claims about the nature of a role may also bring certain aspects to the fore – some work may be invisible therefore because it sits uneasily with how members think about themselves.

Nursing has many features that make visibility problematic. It is often assumed to rest on the natural caring talents associated with women and it involves bodywork and engagement with intimate aspects of people’s lives and death, making it difficult to talk about. The work of nurses is also extremely varied. Another factor contributing to its invisibility – or the invisibility of certain elements – is the challenge faced by the profession in communicating the diverse activities that are undertaken.

Nurses’ work has always included a wide range of background activities that do not entail direct care delivery. "Bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse. But the art of nursing ought to include such arrangements as alone make what I understand by nursing, possible.” Nightingale (1860, reprinted in 1969)

However, recently, nurse leaders have focused on strengthening patient care delivery – by developing a range of nursing models that put patient relationships at their centre – to the neglect of these other dimensions of nursing practice. One result of this is that nurses themselves are uncertain about the value of those elements of their role that do not involve direct patient care, and find it difficult to describe their work.

**Aim**

A study to examine the “organising” aspect of nursing was designed. It aimed to:
- Describe nurses’ organising work as explicitly as possible;
- Tease out the associated knowledge and skills;
- Understand the circumstances that made this work necessary.

The findings are reported in detail elsewhere (Allen, 2015) but summarised here.

**Method**

In the spring and summer of 2011, I shadowed 40 adult hospital nurses in a large university health board in Wales. The sample was informed by an expert reference group drawn from nurse education, service and policy. It included a variety of roles selected to capture the spectrum of nurses’ organising work (Table 1). On average I spent 12-15 hours with each participant.

The main sources of data were:
- Observations;
- Informal interviews;
- Analysis of the tools nurses used.

Ethical approval was granted by Cardiff School of Nursing and Midwifery Studies Research Ethics Committee.

**Results**

Data analysis revealed that, in the hospital context, organising work was made up of four related domains of practice:
- Creating working knowledge;
- Articulation;
- Bed management;
- Transfers of care.

Healthcare depends on specialist expertise but sharing this knowledge is challenging. Multidisciplinary team members make largely independent contributions to patient care and each works with a partial view of the patient. Patients’ care evolves too, often in predictable ways and, while ward rounds, board rounds and team meetings are important in supporting interprofessional communication, they are relatively infrequent and never attended by all involved those with a particular patient.

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**Table 1. Nursing roles of study participants**

<table>
<thead>
<tr>
<th>Role</th>
<th>Participants, n</th>
</tr>
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<tbody>
<tr>
<td>Discharge liaison</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Neurological rehabilitation</td>
<td>1</td>
</tr>
<tr>
<td>Patient access</td>
<td></td>
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<tr>
<td>Post-anaesthetic recovery</td>
<td>1</td>
</tr>
<tr>
<td>Scheduled surgery coordinators</td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>3</td>
</tr>
<tr>
<td>Respiratory</td>
<td>1</td>
</tr>
<tr>
<td>Vascular</td>
<td>1</td>
</tr>
<tr>
<td>Unscheduled care coordinators</td>
<td></td>
</tr>
<tr>
<td>Emergency unit</td>
<td>2</td>
</tr>
<tr>
<td>Medical admissions</td>
<td>1</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>2</td>
</tr>
<tr>
<td>Medical assessment</td>
<td>1</td>
</tr>
<tr>
<td>Surgical assessment</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2</td>
</tr>
<tr>
<td>Specialist unit coordinators</td>
<td></td>
</tr>
<tr>
<td>Short-stay surgery</td>
<td>1</td>
</tr>
<tr>
<td>ITU – general</td>
<td>3</td>
</tr>
<tr>
<td>ITU – cardiac</td>
<td>3</td>
</tr>
<tr>
<td>Triage</td>
<td></td>
</tr>
<tr>
<td>Surgical assessment</td>
<td>1</td>
</tr>
<tr>
<td>Emergency unit</td>
<td>1</td>
</tr>
<tr>
<td>Nurse specialists</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>1</td>
</tr>
<tr>
<td>Anaesthetic assessment</td>
<td>2</td>
</tr>
<tr>
<td>Colorectal</td>
<td>1</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1</td>
</tr>
<tr>
<td>Troubleshooting roles</td>
<td></td>
</tr>
<tr>
<td>Out-of-hours site manager</td>
<td>3</td>
</tr>
<tr>
<td>Hospital-at-night practitioner</td>
<td>1</td>
</tr>
</tbody>
</table>
A significant element of the nursing role observed involved facilitating communication between care providers. Trajectory narratives were central to this work; these stories, created by nurses when patients were admitted to the service, summarised the current status of a patient’s care and were shared through nursing handover. Trajectory narratives did not remain static but were reviewed and revised as part of nurses’ everyday activity, through:

- Scrutiny of the medical record;
- Attendance at meetings;
- Discussions with other care providers and family members.

This was intentional work and involved more than information gathering. Decisions had to be made about what to note and what to ignore, while the relationship between different sources of information had to be assessed and made sense of.

Nurses’ efforts in creating this working knowledge were woven through the fabric of everyday practice, with questions in one context transformed into answers in another almost continuously. While difficult to see, the summative information nurses generated was not available anywhere else in the formal record but was essential in supporting everyday service delivery in a fast-flowing environment.

**Articulation**

*Nurses run the place [...] That requires anticipating people’s needs and constantly being two steps ahead.* (Senior nurse)

The second domain of organising work is the work nurses do to ensure the various actions, people and materials required to support patient care are lined up in the right place at the right time. It is well recognised that gaps between service processes threaten care quality and that additional work is needed to manage these relationships. Strauss et al (1985) called this extra work “articulation work”; in my study this took three different forms (Box 1).

The “holy grail” of healthcare quality improvement is to ensure the right person is in the right place, doing the right thing at the right time. Nurses made an important contribution to this but, although the articulation work this entailed was demanding of their time and energy, it was largely taken for granted by their organisation.

**Box 1. Forms of “Articulation Work”**

**Temporal articulation**

> Work directed to ensure things happened at the right time and in the correct order (Bardram, 2000). Here, nurses drew on their oversight of patient care and combined this with their organisational knowledge to anticipate future action so the necessary arrangements could be made.

**Material articulation**

> Directed at ensuring materials were available to support the work. Nurses did this by:

- Maintaining the clinical environment and making sure equipment was functioning and stores were in stock;
- Assembling materials to support specific actions.

This was necessary when people were working under pressure, action was time critical and/or staff were unfamiliar with the location of resources and equipment.

**Integrative articulation**

> Directed at ensuring the coherence of patients’ care. Actions that appeared reasonable in isolation might be questionable from a whole-pathway perspective. Nurses had an important role in supporting joined-up decision making, resolving contradictory elements and anticipating potential problems before they arose.

**Transfers of care**

In our highly specialised healthcare systems patients often travel across several services during an episode of care. A patient with a hip fracture will move from the care of ambulance services to accident and emergency, through to the wards, theatre, post-anaesthetic recovery, back to the wards and thereafter to rehabilitation services. The quality of communication at each of these boundary crossings can have important implications for the patient. While transfers of care are a shared responsibility, given their location in the sites of care, nurses take on the lion’s share of this work.

Transfers of care have retrospective and prospective elements: nurses must look back to make sense of the patient’s journey to date and forward to provide the information required to enable ongoing care. The demands this process places on staff is variable and affected by factors such as the:

- Complexity and certainty of patient care needs;
- Scope of care responsibility to be handed over;
- Familiarity of collaborating departments/professions;
- Extent to which the process can be standardised;
- Potential for verbal handover;
- Practitioners’ understanding of each other’s work purposes;
- Ease with which information can be accessed;
- Politics of transfer, such as disputes about the appropriateness of a referral and who should pay.
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Research

There is a growing appreciation of the importance of transfer of care for healthcare quality but less recognition of what it entails. Documents were key tools for managing transfers, but of varying value in supporting communication. Indeed, they often made work unnecessarily onerous and were the main source of paperwork about which nurses habitually complained.

Nurses also managed patient transfers in turbulent clinical environments and experienced constant interruptions, which undoubtedly affected the quality of the process. When dispensing medications they wore red tabards inscribed with "do not disturb" – an acknowledgement of the risks associated with this activity; completing paperwork for the purpose of transfers of care was not seen in the same way, even though the consequences of getting this wrong were no less significant. Indeed, in another example of nursing work being misunderstood, far from making the case for quiet places to undertake this work, there have been calls for the abolition of nurses’ stations and nursing work to be located more firmly in clinical areas.

Discussion
Doctors are usually regarded as the lead professional in healthcare but through their organising work, nurses have a huge impact on service quality. The findings of this study suggest very little happens inside healthcare that has not been influenced by a nurse. Nurses are what actor network theorists call the obligatory passage points in healthcare systems (Dear and Flusty, 2002). An obligatory passage point can be thought of as the narrow end of a funnel, which forces actors to come together around a certain topic, purpose or question. Through their organising work, nurses funnel, refract and shape all the activity that contributes to patient care. I have called this process "organising work" – a term I have extended to capture the nurse’s role in bringing together the nurse’s authority to undertake this work.

In addition, patients and their families not only have a view of their care, but are co-producers of it. As a result, as Strauss et al (1985) observed, much of healthcare is less like a closely controlled production line and rather more like the work of Mark Twain's celebrated Mississippi River pilot: “The river was tricky, changed its course slightly from day to day, so even an experienced, but inattentive pilot could run into grave difficulties; worse yet, sometimes the river drastically shifted in its bed for some miles into a new course.”

Disease processes are unpredictable and many patients have multiple needs that do not fit easily into standardised models. The care of individual patients also takes place in organisations responsible for entire populations and so, when resources are finite, patients are in competition with each other for access to services, facilities and the time and attention of health professionals.

Conclusion
It is important that we find ways to communicate the importance of nurses’ organising work. Such an understanding has implications for nurse recruitment, education and workload, as well as the tools and models used to organise and support practice. It also affects how nurses are judged. A student nurse, quoted in Willis’ (2012) independent review of nurse education, makes this clear: “The public’s experience of the NHS is greatly influenced by their expectations. If they don’t understand that what nurses do has changed, how can we expect them to believe they have had an exceptional service?”

The findings presented here sow the seeds for this debate. NT

References

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