The connection between nurses working at top of licensure and patient care

By Stephanie Allen, PhD, RN

All too frequently nurses perform tasks that detract from patient care and diminish their overall effectiveness. Have you ever seen a nurse searching for the supplies needed to carry out an ordered treatment? How about the nurse who needs to document an immunization in three different records so the pharmacy, billing, and electronic medical records are complete? Lastly, you see two nurses on the same unit in a hospital. One nurse looks overwhelmed and in a rush. The other nurse has an assignment that seems “easier.” How did that happen?

Now picture the nursing unit where all nurses are engaged in nursing tasks the whole shift. They are focused on patient care—and are productive. These nurses are practicing as defined by their licensure. And nurses who perform at the top of their license save time and money, and deliver better patient care. Nurses save time when they are not searching for missing supplies or waiting for equipment—time that can now be devoted to direct patient care. When non-nursing tasks are delegated and adequate support staff is available, nursing wages are not wasted.

Understanding the work of nurses on our patient care units is a key piece of overall unit assessment and the development of strategies to maximize patient, staff, and financial outcomes. Nurses who work at the top of their licensure provide better care and are more satisfied.

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How nurses spend their time

The primary role of the nurse is caregiver. Additional nursing roles include: communicator, teacher, counselor, leader, researcher, advocate, and collaborator. Based on those roles, nurses spend their time performing a variety of tasks, including:

- **Assessment**: Patient assessment, surveillance
- **Teaching**: Teaching about medications, treatments, discharge instructions
- **Treating**: Medication administration, wound care
- **Psychosocial engagement**: Emotional support, spiritual support
- **Care coordination**: Care planning, care discussions with providers, pharmacists, etc.
- **Clinical record management**: Documentation of care
- **Other**: Meals, breaks[1]

How much time a nurse spends on each task varies based on the environment or type of nursing unit. The higher acuity of patients in an intensive care unit correlates to the highest percent (26%) of nursing time spent in treatment while patients on a medical-surgical unit typically need more care coordination than other units.

Percentage of time spent on each task[2]

Task	Medical-surgical	Intensive care	Labor & delivery	Average
Assess	15%	17%	24%	18.7%
Teach	6%	6%	12%	8%
Treat	16%	26%	15%	19%
Psychosocial	5%	6%	8%	6.3%
Coordinate	26%	16%	17%	19.7%
Clinical record	19%	15%	19%	17.8%
Other	13%	14%	6%	11%

Another study found that nurses in a neurological rehabilitation unit spent their time in the following way:[3]

Activity	% of time spent
Direct patient care that includes hands-on interaction and/or care provision with specific patients	46%
Indirect patient care activities related to a specific individual patient but not hands-on care (e.g. team meetings, patient documentation and telephone liaison)	25%
Unit-related activities pertaining to the normal daily management of the ward environment (e.g. ordering supplies, ensuring a clean and safe environment)	10%
Personal time facilitating nurses to work more confidently and productively (e.g. rest periods, continuing professional development, and staff appraisal)	19%

The research illustrates that nurses are not always engaged in patient care activities. These activities were listed as "other" and "unit-related activities" and showed that nurses are engaging in non-nursing activities. So, what did the nurse researchers find when they specifically looked at those activities that nurses engage in that do not fall under the nursing role?

How nurses' time is wasted

Each of the tasks that nurses are expected to perform is compounded with some form of insufficiency. The nurse is administering medications and the medication is missing. The nurse places three calls to the provider in order to get a lab test reported and a medication changed. The nurse must document care in more than one area of the medical record or click through six or seven screens to input all the data from a single assessment. Wound care supplies are not stocked in the patient's room, and the nurse must hunt them down. These tasks are considered non-value added.

Nursing tasks can be broadly categorized as value-added (VA), necessary, or non-value added (NVA).

Value-added (VA) tasks—"Patient centered actions that directly benefit the patient," such as assessments and treatments.

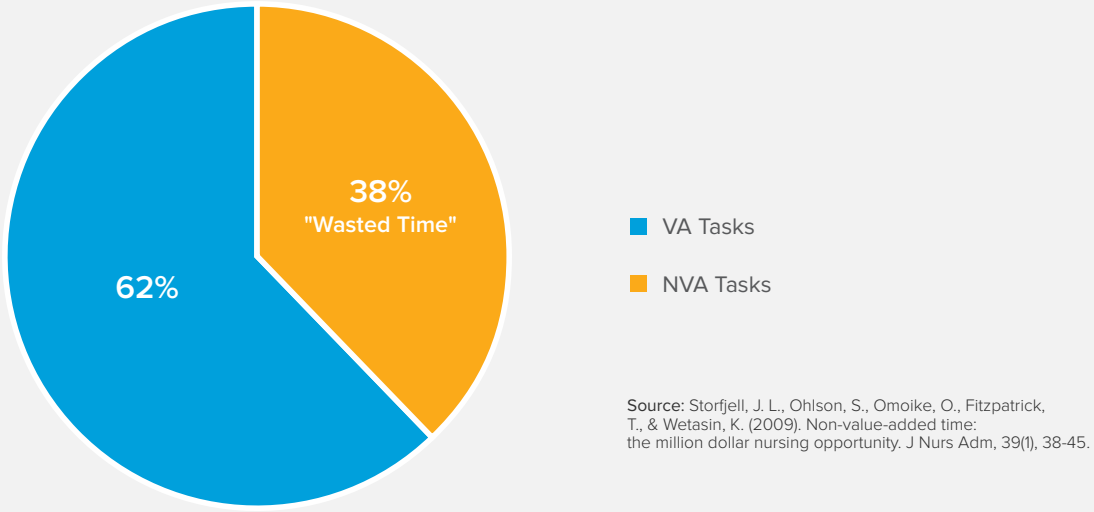
Necessary tasks—"Essential activities to deliver patient care, but have no direct benefit to the patient," such as documentation and transcribing orders.

Non-value added (NVA) tasks—"Actions performed by the RN that do not benefit the patient and are not necessary to delivering patient care," such as looking for equipment, retrieving equipment, and waiting for a return call from the provider or equipment.[4]

One study observed nurses on two telemetry units and a medical-surgical unit to determine how they spent their time. They grouped tasks and activities as Necessary, VA or NVA in order to capture time-wasting activities. Between 17% and 20% of their time was wasted.[5]

Type of activity	% of time spent
Value-added	55% to 61%
Necessary	20% to 23%
Non-value added	17% to 20%

More recent data suggests that nurses are engaging in almost 38% NVA time.[6]



Source: Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

What drives NVA time with nurses?

There are five key drivers of NVA time: handing off, searching for items, fixing things, waiting, and reworking.[7] These drivers impede processes across the shift and unit.

- **Handing off**—Communicating information from one staff to another; shift report, speaking to provider
- **Searching for things**—Acquiring materials needed for patient care; finding treatment supplies, medications
- **Fixing things**—Fixing inoperable equipment; broken diagnostic equipment, such as monitors, computer failures
- **Waiting**—Waiting to proceed with activities; waiting for housekeeping, waiting for medications and supplies
- **Reworking**—Repeating a task; changes in patient assignment, multiple calls to staffing office

Seven major processes or systems are most affected by these process impeders.

They include

1. Patient admission, transfer, and discharge [ATD]
2. Shift report
3. Access to equipment and supplies
4. Access to appropriate and timely medications—especially during night shifts
5. Scheduling, waiting for and transporting to diagnostic procedures
6. Clinical record management
7. Interdisciplinary communication
8. Nurse assignments and staffing

Most common causes of NVA time and examples of the processes that drive them

Admission, transfer, discharge	Handoffs	Transfer of information to and from previous unit, bed placement, staffing office, physician, unit team
	Searching	Reports, orders, medications, supplies, equipment
	Fixing	Equipment
	Waiting	Data entry, orders, housekeeping, transport, bed placement, medications
	Rework	Duplicate assessments, changing nurse assignments
Shift report	Handoffs	Transfer of information to and from unit staff
	Searching	Reports, individuals to give and receive report
	Waiting	Clinical record system failures
	Rework	For individuals to give and receive report
Supplies, equipment	Handoffs	Requesting adequate supplies and working equipment
	Searching	Locating adequate supplies and working equipment
	Fixing	Broken equipment
	Waiting	Delays in obtaining supplies and equipment
	Rework	Time list when equipment does not work, multiple requests for supplies and equipment
Pharmaceuticals	Handoffs	Obtaining orders, transfer of information to and from pharmacy, physician, charge nurse, unit clerk
	Searching	Locating correct orders and medications
	Fixing	On-unit medication dispensers
	Waiting	Obtaining orders, pharmacy delays in stocking medications; access to unit
	Rework	Repeat requests for medications; access to pharmacy on night shifts
Diagnostics	Handoffs	Transfer of information to and from laboratory, radiology, physician
	Searching	Obtaining orders and reports
	Fixing	Nonworking equipment
	Waiting	Timely transport
	Rework	Repeat calls for transport, scheduling, reports
Documentation	Handoffs	Documentation requirements increase with every handoff
	Searching	Locating reports, working computer terminals, paper records
	Fixing	Computer terminals, fax machines
	Waiting	Access to computer terminal or paper records
	Rework	Interruptions, duplicate documentation requirements

Communication	Handoffs	Transfer of information among care team
	Searching	Locating physicians and care team; patient education materials
	Fixing	Computer system breakdowns
	Waiting	Lack of response
	Rework	Repeat requests for information
Staffing	Handoffs	Transfer of information for staffing changes
	Searching	Obtaining adequate unit staffing
	Fixing	Rearranging assignments midshift
	Waiting	Locating appropriate staff
	Rework	Repeat calls to staffing office, individual staff

Reprint of table.[8]

Impact of NVA time

What happens to patients when nurses spend NVA time

NVA time causes tasks to be left undone. Others call this "missed care" or "implicitly rationed care." These terms fall under the umbrella term "unfinished care." Researchers conducted a literature review (42 quantitative reports, seven qualitative reports, one mixed method report and four scientific reviews) where they explored the conceptual definition of unfinished care, its prevalence, and antecedents and outcomes.[9] Based on their review, between 55% and 98% of nursing personnel report leaving at least one task undone each shift. There were four predictors of unfinished care and six outcomes of unfinished care.

Predictors of unfinished care

- Perceived team interactions
- Adequacy of resources
- Environment that values safety
- Nurse staffing

Predicted outcomes of unfinished care

- Decreased nurse-reported care quality
- Decreased patient satisfaction
- Increased adverse events
- Increased turnover
- Decreased job and occupational satisfaction
- Increased intent to leave

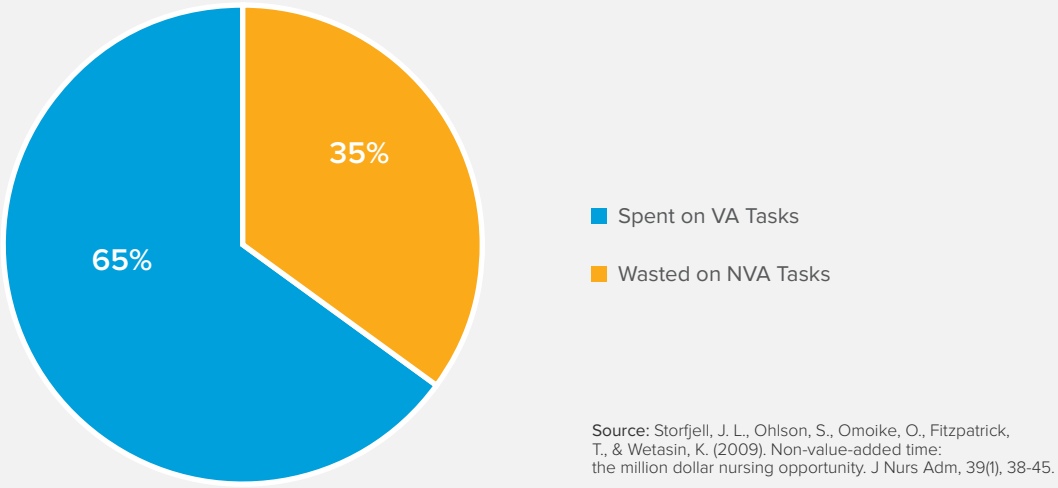
What tasks are left undone? The most common include fundamental elements of care, such as ambulation, hygiene, feeding, surveillance, patient teaching, discharge planning, and care documentation.[10] Often, the care is just not done. Sometimes, the care is completed by nurses on the next shift or on duty the next day. Incomplete nursing care puts the patient at risk for complications and, even, readmission, for example, because of poorly explained or incomplete discharge instructions.

The financial cost of wasted nurses' time

- According to the Bureau of Labor Statistics, the average RN makes $31.48/hour.[11]
- Up to 35% of nursing wages and $750,000 to $1,000,000 is wasted on each unit every year on NVA activities.[12]
- There are over 914,000 licensed beds in the United States.[13] If we assume each unit has approximately 30 beds, there are over 30,000 nursing units in the US. This extrapolates to over $30 billion wasted in wages each year.
- It is not economically sound to pay premium wages to nurses to complete tasks not strictly defined by the nursing scope of practice. It is a waste of money and a nurse dissatisfier.

Nurses are consistently ending their shifts with unfinished care. Nurses are prevented from completing all nursing care because of processes and systems impeded by handing off, searching for things, fixing things, waiting and reworking. Wasted time and unfinished care cause decreased patient satisfaction and increased adverse events. When nurses perform NVA tasks they are more likely to experience turnover, intent to leave, dissatisfaction, and may perceive that they are delivering lower quality care. Nursing units are losing up to $1,000,000 a year in NVA activities—or on a nationwide scale, up to $30 billion annually.[15] Health care organizations have an opportunity to improve patient, nurse and organizational outcomes when nurses perform fewer NVA tasks and perform at the top of their licensure.

Nursing unit wages.[14]



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Strategies to get nurses working at top of licensure

Review nurse scope of practice

It is important to review your state's nurse practice act to determine the scope of activities that fall within the nurse's scope of practice. There is often confusion as to what tasks and activities can only be performed by nurses and what tasks are not part of the nurse's role. Allow your nurses to perform tasks and activities to the fullest extent of the law. Nurses who perform at the top of their licensure (or those avoiding NVA tasks) are happier and are less likely to leave their jobs.[16]

Standardize job descriptions

A review of position descriptions is also a good idea. Standardized position descriptions that reflect current scope of practice and the expectations of the role clarify the activities and tasks of the nurse. Do not put tasks and activities in position descriptions that can be performed by non-nursing personnel. Job descriptions should be easily accessible to nurses and nursing supervisors. Have all unit employees review their job descriptions and the job descriptions of their colleagues. Knowledge of roles and role expectations will reduce confusion and potential unit conflict.

Clearly define support staff roles

Support staff roles are key to reducing time wasted by nurses on NVA tasks. Support staff roles and position descriptions should be clearly defined to cover all NVA tasks your nurses are currently performing. A seamless partnership between nurses and support staff is critical to enhancing patient care and reducing costs.[17] Sufficient support staff is needed to cover nursing NVA tasks and other tasks as delegated.

Foster a culture of delegation

Nurses should be encouraged and expected to delegate non-nursing tasks to support staff. A culture that empowers nurses to delegate appropriate NVA tasks to support staff frees nurses to focus on providing the nursing care only they are qualified to provide.[18] Nurse leaders serve as catalysts for organizational change and empower nurses to work at the top of their licensure.

Formalize and automate nurse-patient assignments

Nurse-patient assignments impact the ability of nurses to perform at the top of their licensure. The assignment is pivotal in patient, nurse, and organizational outcomes. Matching the right nurse to the right patient based on concrete, definable characteristics of the nurse, such as certification or experience, and patient, such as acuity and workload, enhances the nurse's experience and job satisfaction and improves patient outcomes.[19] The process should be formalized with set criteria for making assignments. Changes can be made in real time with a computerized assignment and tracking program. Assignment documentation is saved automatically, requirements are met and tracking outcomes related to specific assignments becomes possible.

Streamline documentation

Documentation should be intuitive. Systems must communicate seamlessly to prevent nurses from recording the same information in multiple systems. System navigation should use minimal clicking through screens to document nursing care. Systems should document information across platforms to enhance communication between the healthcare team and prevent redundancies in documentation.[20]

Maximizing your resources

Strategy	Benefits
Review scope of practice	**Nurse**: Working to top of licensure, higher job satisfaction **Patient**: Receiving the highest level of care **Organization**: Lower turnover and recruitment costs
Standardize job descriptions	**Nurse**: Fairness, understands expectations **Patient**: Receiving consistent, quality care **Organization**: Streamlined process, standardization
Clearly define support roles	**Nurse**: More time spent on direct patient care **Patient**: Receiving more care from the nurse **Organization**: Salary cost reductions
Foster a culture of delegation	**Nurse**: Happier, more satisfied nurses **Patient**: Receiving higher quality care, better outcomes **Organization**: Cost reductions in salaries and better patient outcomes
Formalize and automate nurse-patient assignments	**Nurse**: More equitable assignments, higher satisfaction **Patient**: Better outcomes **Organization**: Shorter lengths of stay, less adverse events
Streamline documentation	**Nurse**: More time spent in direct care **Patient**: Better outcomes **Organization**: Cost savings across areas

Making it work

Nurses are highly trained professionals and a valuable organizational resource. They have specialized knowledge and skills, yet this precious resource is wasted when nurses are not positioned to work at the top of their licensure and are expected to perform NVA tasks. Strategies to enhance nurse performance should consider the following: reviewing scope of practice, standardizing job descriptions, clearly defining support roles, fostering a culture of delegation, formalizing and automating nurse-patient assignments, and streamlining documentation. Nurses who perform at the top of their licensure positively affect nurse, patient, and organizational outcomes.

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[1] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[2] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[3] Williams, H., Harris, R., & Turner-Stokes, L. (2009). Work sampling: a quantitative analysis of nursing activity in a neuro-rehabilitation setting. J Adv Nurs, 65(10), 2097-2107.

[4] Upenieks, V. V., Akhavan, J., & Kotlerman, J. (2008). Value-added care: a paradigm shift in patient care delivery. Nurs Econ, 26(5), 294-300; quiz 301.

[5] Upenieks, V. V., Akhavan, J., & Kotlerman, J. (2008). Value-added care: a paradigm shift in patient care delivery. Nurs Econ, 26(5), 294-300; quiz 301.

[6] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[7] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[8] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[9] Jones, T. L., Hamilton, P., & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. Int J Nurs Stud.

[10] Bittner, N. P., & Gravlin, G. (2009). Critical thinking, delegation, and missed care in nursing practice. J Nurs Adm, 39(3), 142-146.

[11] Bureau of Labor Statistics, U. S. D. o. L. (2014). Occupational Outlook Handbook, 2014-15 Edition, Registered Nurses, from http://www.bls.gov/ooh/healthcare/registered-nurses.htm (visited June 23, 2015).

[12] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45.

[13] Allen, S. B. (2012). The nurse-patient assignment: Purposes, decision factors and steps of the process. Unpublished 3506483, University of South Carolina, Ann Arbor.

[14] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45

[15] Storfjell, J. L., Ohlson, S., Omoike, O., Fitzpatrick, T., & Wetasin, K. (2009). Non-value-added time: the million dollar nursing opportunity. J Nurs Adm, 39(1), 38-45

[16] Jones, T. L., Hamilton, P., & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. Int J Nurs Stud.

[17] Nursing Executive Center (2013). Achieving Top-of-License Nursing Practice: Best Practices for Elevating the Impact of the Frontline Nurse: The Advisory Board Company.

[18] Upenieks, V. V., Akhavan, J., & Kotlerman, J. (2008). Value-added care: a paradigm shift in patient care delivery. Nurs Econ, 26(5), 294-300; quiz 301.

[19] Allen, S. B. (2012). The nurse-patient assignment: Purposes, decision factors and steps of the process. Unpublished 3506483, University of South Carolina, Ann Arbor.

[20] Nursing Executive Center (2013). Achieving Top-of-License Nursing Practice: Best Practices for Elevating the Impact of the Frontline Nurse: The Advisory Board Company.

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