

EDITORIAL

How not to argue against nursing associates

Some issues in nursing are almost guaranteed to generate more heat than light. The passion level in these discussions often needs the mythical amp setting of “11” from Spinal Tap. How should the curriculum be reformed? 11. Great nurses are made not born, 11. Things were better or worse in the “old days,” 11 and more. Added to this list is the whole vexed question of the “second level nurse,” nursing assistant or associate. I trained (if you can still use that word), back in the mists of time that were the 1970s in an “Institution” where nursing assistants were plentiful and some would say, where they ruled the roost by virtue of what seemed no more than their longevity and ubiquity. If you want to bring an old school nurse out in hives, just let them hear that oft-whined phrase, “I’ve worked here for 25 years, there’s nothing you can tell me,” or “It’s me who does all the REAL work around here, not those book-learned nurses with their paper qualifications” and so on ad nauseam.

As the world of nursing struggles with what to do about “levels of nursing,” having already shot itself in the proverbial foot by getting rid of the enroled nurse, it struck me that so many of the arguments that I hear against assistants in nursing or healthcare assistants are chillingly similar to exactly the kind of Neanderthal responses that some doctors have used against nurse practitioners for years. This comparison table might show what I mean.

Why some doctors think nurse practitioners are a bad idea	Why some nurses think that nursing assistants or associates are a bad idea
They are not “real” doctors, just puffed up nurses who think that they can step into doctors’ roles.	They are not “real” nurses, just puffed up healthcare assistants who think that they can step into nurses’ roles.
They are a clear danger to the standards of safety and quality. Safety and quality of health care are bound to suffer with a second rate and unqualified “doctor” in the role.	They are a clear danger to the standards of safety and quality. Safety and quality of health care are bound to suffer with a second rate and unqualified “nurse” in the role.
I have gone to medical school for “X” years to gain my medical knowledge and expertise, and these nurse practitioners have not. If they want to be “real doctors,” then let them go to medical school and become real doctors.	I have gone to nursing school for “X” years to gain my nursing knowledge and expertise, and these assistants or nursing associates have not. If they want to be “real nurses,” then let them go to nursing school and become real nurses.
It is cost-cutting, driven by shortages. They will not employ doctors, so they go for the cheap option—nurse practitioners.	It is cost-cutting, driven by shortages. They will not employ registered nurses, so they go for the cheap option—nursing associates.

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TABLE (Continued)

Why some doctors think nurse practitioners are a bad idea	Why some nurses think that nursing assistants or associates are a bad idea
We are being “deskilled,” pure and simple.	We are being “deskilled,” pure and simple.
We receive X ¹⁰ hr of training/supervision/clinical practice, and they receive only X. How can that be “acceptable” care?	We receive X ¹⁰ hr of training/supervision/clinical practice, and they receive only X. How can that be “acceptable” care?
Nurses are not doctors. Simple.	Nursing associates are not RNs. Simple.
If you want an ingrown toenail treated, use a nurse practitioner. If you are worried about a serious illness, see a real doctor.	If you want your flowers arranged or need help cutting up your food, use a nursing associate. If you are worried about a serious health or care issue, see a qualified RN.
No nurse practitioner should ever be let out alone without a doctor’s supervision and oversight.	No nursing associate should ever be let out alone without an RN’s supervision and oversight.
This has nothing to do with “patch protection” or professional self-interest. My only motivation is the welfare of patients.	This has nothing to do with “patch protection” or professional self-interest. My only motivation is the welfare of patients.
This is the thin end of the wedge and could be the end of medicine as we know it.	This is the thin end of the wedge and could be the end of nursing as we know it.

It should be a concern that some nurses are trotting out the same tired arguments that we have scorned and debunked when they came from doctors seeking to trash nurse practitioners. There must be better and more productive ways to discuss the arguments and issues involved in having various “levels of nurse” in our health systems. The issues are not merely academic, educational or professional. Our directors of nursing and service managers need to staff their wards, hospitals and services safely and acceptably this week-end, not in 5 or 10 years’ time when the witch doctors of “workforce planning” have finally divined something that we could do that might positively affect something about nurse staffing for the better sometime soon.

I can see clear pros and cons in any assistant in nursing or associate nurse role. It is difficult to argue that every single health need that a person or patient has can only ever be met by a qualified RN. It makes sense today and in future that we should have several “entry portals” into a nursing career and that not everyone will begin a nursing career by “doing well at school” and then “going to university.”

Nursing is by no means alone here in contemplating a broadening of its essential workforce. For many years, school teachers, for example, have watched as school support officers, healthcare assistants, teacher's aides and other "paraprofessionals" have joined their classroom team (or infiltrated their workplace, depending on your stance). This has not been easy and the issues, as for nursing, go far beyond questions of competencies, skills and reporting lines. This is not just a question of some extra warm bodies appearing on the ward to improve the staffing numbers or to "gain experience." Just as "Culture eats strategy for breakfast, every day of the week," so the social milieu and complex human dynamics of a ward or hospital will thwart every attempt to solve the nursing workforce problem via some HR department effort or with a new list of "approved tasks" or stamp-me-smart courses for the unqualified.

Even a cursory glance at some of the exemplary work on the everyday reality of the healthcare assistant (HCA) role (Hasson, McKenna, & Keeney, 2013; Spilsbury & Meyer, 2005) and the broader phenomenon of "role drift" (McKenna, 2004, 2005) in nursing and health care should, put at its mildest, give us cause for concern. When we learn that HCAs may already believe that they are providing a sizeable chunk of "hands-on, basic care" or "bedside care," (Spilsbury & Meyer, 2005) however, you care to demean it and when we learn that they already "play a major part in the education of student nurses," (Hasson et al., 2013, p. 1), by the time-honoured process of having them "sit beside Nelly," we can rightly ask "What could possibly go wrong?". We may not even have to ask this as Lord Willis has done it for us. The question is as painful as it should be rhetorical: "The question of core purpose was also posed: was nursing education preparing nurses to manage care delivered by others, or to nurse patients themselves, or a combination of both?" (Willis, 2012, p. 24) cited in (Darbyshire & McKenna, 2013, p. 306).

The human dynamics here, as in any field, are hugely complex, and expanding the "nursing team" in this way will have profound implications for the social ecology of wards, units, hospitals and services. I sat at a recent nursing research conference slack-jawed as a professor presented her research findings, suggesting that new graduate RNs have little idea of how to manage other staff, delegate, supervise or any of these other skills that would have come under "Ward Management" in another era and that are now assumed to exist in RNs to benefit the associate nurses and patients who will be promised such supervision. The new RNs worried about asking

people to do things, lest they appeared "bossy." They "checked" on care when the other staff were not looking in case they offended. They did not want to supervise others' work in case they stopped being "friends with them." I can barely go on.

Spilsbury and Meyer (2005) noted pointedly that: "In practice, HCAs reported, and were observed, working predominantly alone. They were providing bedside care to patients without the support and supervision of RNs" (p. 74). At some point, someone will ask: If RN supervision has not worked with or is invisible to HCAs, why will it now succeed with associate nurses?

These are truly tough questions for nursing to grapple with, but at the very least, let us enter this world and engage with the issues with our eyes wide open and with our "knee-jerk reaction dials" set not to 11, but closer to zero.

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