Time management strategies in nursing practice

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Background. With the increasing emphasis on efficiency and effectiveness in health care, how a nurse manages her time is an important consideration. Whilst time management is recognized as an important component of work performance and professional nursing practice, the reality of this process in nursing practice has been subject to scant empirical investigation.

Aim. To explore how nurses organize and manage their time.

Methods. A qualitative study was carried out, incorporating narratives (22 nurses), focus groups (24 nurses) and semi-structured interviews (22 nurses). In my role as practitioner researcher I undertook observation and had informal conversations, which provided further data. Study sites were five health care organizations in the United Kingdom during 1995–1999.

Findings. Time management is complex, with nurses using a range of time management strategies and a repertoire of actions. Two of these strategies, namely routinization and prioritizing, are discussed, including their implications for understanding time management by nurses in clinical practice.

Conclusions. Ignoring the influence of 'others', the team and the organization perpetuates a rather individualistic and self-critical perspective of time management. This may lead to a failure to address problems in the organizing of work, and the co-ordinating of care involving other health care workers.

Keywords: efficiency, prioritizing, routinization, time management, time strategies, work organization, nursing

Introduction

Individuals do not invent the concept of time, but learn about it, both as a concept and a social institution, from childhood onwards (Elias 1992). In the Western world, time has been constructed around devices of measurement, such as clocks, calendars and schedules, and these are a representation of particular symbolism (Elias 1992).

Time budget studies are one of the oldest approaches for investigating time (Adam 1990). From a nursing perspective, empirical investigation into nurses' time management has been overshadowed by this reductionist perspective, typified by task analysis (Waterworth *et al.* 1999). There is value in this research, as it illustrates the range of tasks and time taken, but the perspectives of nurses themselves have been ignored. This is particularly important when there is an increasing trend to emphasize the 'invisible' dimensions (Davies 1995) of nursing work.

A previous study (Waterworth 1995), exploring the value of nursing practice from the viewpoint of practitioners, has identified that time with patients is important, but raises the question of how nurses manage their time.

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Time management

Literature on time management in nursing is mainly anecdotal, providing a number of tips on 'how to' manage time, along with descriptions of processes or strategies. The order for thinking about the process varies, ranging from setting objectives as the first step (Brown & Wilson 1987, Noreiko 1996) to working out how time is being used with the aid of time logs (McFarlane 1991). Giving information to patients about the routine is the starting point for DeBaca (1987), while using written contracts negotiated with superiors is the advice of Jones (1988). Determining the importance of tasks or priorities is part of the process, although the stage at which this should occur varies between authors.

An overarching theme in this literature is the need for nurses to think about their own time management, with the main 'message' that individuals can manage their time. This is an individualistic view of time management.

Thus, time management in professional nursing discourse is presented as an externally-defined set of practices. However, the reality of this process in nursing practice has been subject to scant empirical investigation, although studies on nurses' work organization (Bowers *et al.* 2001) have found time management problematic, with nurses compensating for lack of time by developing strategies in an attempt to complete their work.

The study

Aim

The aim of this qualitative study was to explore how nurses organize and manage their time.

Methods

A range of different data collection methods, namely narratives, focus groups and semi-structured interviews, was used. All data were audio-taped to ensure accurate records of participants' accounts. I was in the role of practitioner researcher (Reed & Procter 1995), and used observation and informal conversations as further sources of data. I recorded these in field note diaries, as a form of professional journalling (Manias & Street 2000).

Each data collection method has strengths and limitations and use of diverse methods was an attempt not only to enhance the trustworthiness of the study, but also to minimize the difficulties associated with individuals thinking and talking about time. As time is so deeply embedded and taken for granted within our tacit knowledge base, it is difficult to think past the superficial and beyond common associations with clocks and timetables (Adam 1995).

Table 1 Numbers of nurses participating in the study by clinical area

Clinical area	Number of nurses
Acute assessment	1
Coronary care	3
Gastroenterology	3
Haematology	11
Intensive care	1
Intermediate care	2
Medical	10
Oncology	3
Orthopaedic	3
Palliative care	7
Rehabilitation	5
Surgery	19

Sample

The sample of qualified nurses came from five different health care organizations in the United Kingdom (UK) and a range of clinical areas (Table 1). Access to the health care organizations was gained by making use of 'friendly gatekeepers' (Reed *et al.* 1996). I was reliant on senior nurse managers providing the names of staff who might participate in the study. When contacting the nurses to discuss the study and elicit informed consent, their genuine interest in participating and their potential contribution to the sample could be determined. These initial background data were used to determine suitability, so that sampling could be purposive (Patton 1990), and achieve diversity in relation to organization, clinical area, roles and gender.

Focus groups

Focus groups can generate group interaction and insight (Morgan 1997). Group discussions enabled nurses to talk about how nurses managed their time. Initial questions on time were broad, such as 'How does time influence nurses' work?' Kitzinger (2000) identifies another strength of focus groups: the ability to study 'forms of communication' that participants use, allowing observation of interactions and emotions generated. Four focus groups were held, with 24 participants overall. On completion of each group, I reflected on the group process to evaluate my facilitation of the discussion. The skill of the researcher as a group facilitator is critical in achieving maximum interaction and adequate data (Morgan 1997).

Time with patients	Time effects
Controlling time	Frames of temporal reference

Figure 1 Initial themes from focus groups.

Semi-structured interviews

Interviews were conducted with 22 participants who had not been involved with focus groups or narratives. The aim of the interviews was to understand further the themes that had been identified from analysis of focus group data (Figure 1). They provided an opportunity for more in-depth interaction with participants on an individual level and minimized any possible influence of a group effect.

Narratives

Narratives are a means of representing experience of social reality (Geist & Hardesty 1990). In this study, a narrative was used as a story (McCance *et al.* 2001). Twenty-two narratives had been obtained in a previous study (Waterworth 1995). It was during this research that the issue of time had been identified as important and worthy of further study. I made the decision to return to this data set when nearing completion of the main study, as a means of testing out the usefulness of the conceptual framework in providing more understanding about the taken for granted and invisible meanings of time in nursing practice. Thus, secondary analysis of this narrative data was a means of making comparisons and confirming or challenging the ability of the emerging conceptual framework of time management to reveal how complex time is and how it is embedded in nursing practice in myriad ways.

Data analysis

Data were managed using the qualitative data analysis software package Atlas.ti (Scientific Software Developments, Berlin, Germany) Prior to transcription all data were anonymized. The approach was inductive, using line by line analysis (Strauss & Corbin 1998) to derive codes and, highlight words, sentences or paragraphs that reflected a meaning of time. Case analysis meetings (Miles & Huberman 1994) took place with research supervisors. Peer review by colleagues was used to check the analysis and interpretation of a sample of transcripts, and this confirmed but also challenged my coding and categorization of themes, which was modified accordingly.

Findings

The findings demonstrate that time management is complex, with nurses using a range of time management strategies.

In accounting for time management as described and discussed by nurses in this study, six time strategies (Table 2) have been identified. There are also repertories of actions and interactions (Table 3), suggesting that a nurse may need to use a combination of actions and interactions in order to decide on a strategy. In effect, nurses have to define the meaning of a situation in order to determine an appropriate strategy. Situations can be extremely complex, and nurses may have to pursue several strategies at the same time to control overall performance. Time strategies also involve engaging in actions and interactions that enable management of tensions produced by time pressure. Strategies may involve not only the individual but also the team and organization.

Some of the performance strategies and actions identified can be classed as representing an acceptable face of time management. This means that they are not only expected, but are also promoted as a means of managing time, for example, setting priorities. Strategies may be viewed as indirect or direct. An indirect strategy may resolve an immediate time problem the nurse is encountering. A direct strategy may prevent the time problem from arising in the future. As an example, a charge nurse reflects on the problems he is encountering:

Sickness – people phone up sick. You can say 'Right, I will stick eight on the off duty this morning.' You need eight this morning and you

Table 2 Time strategies identified

Prioritizing
Routinization
Concealment
Catch up
Juggling
Extending temporal boundaries

Table 3 Repertoire of actions

Controlling interactions
Focusing
Avoidance
Selective attention
Short cutting
Saying no
Making compromises
Delegation
Synchronizing

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can bet your bottom dollar the next morning there will be five there. And what you planned to do with Mrs X and Y and see relatives – you are ringing up cancelling, saying 'I am very sorry we cannot see you this morning.' And it all boils down to crisis on the day. There is very little planning we can do.

This nurse is attempting to manage his time by shifting priorities for that day. This will deal with the immediate problem and is an indirect strategy, but does not resolve the underlying problem of sickness and absence in the team which, if resolved, would be a direct strategy.

Emotion is produced by temporal demands (Fine 1996), and nurses may have to manage the emotion engendered. Complexity is added when noting the assertion that an individual can 'engage in time work to either promote or suppress a particular kind of temporal experience' (Flaherty (1999, p. 153).

Time is not autonomous (Fine 1996) and there are connections between time strategies, repertoire of actions and other skills and knowledge that nurses possess. When learning a skill such as taking a blood pressure measurement competence develops over a period of time. This competence involves accuracy in determining the measurement of blood pressure and ability to perform the measurement at a certain speed. As Benner (1984) found, expert nurses can respond rapidly to situations, whereas a novice's pace would be slower. Competence of nurses in completing skills will affect the other building blocks of the temporal organization of work. These building blocks comprise the speed of the worker, duration, synchronicity or timing and sequence (Fine 1996). The following staff nurse's account illustrates the problems she had with speed:

When I was first qualified I would not have had much experience or had much confidence. So I would have probably taken a lot longer over tasks and different things and probably would not have been confident about talking to doctors or talking to other people and pushing other people, so that would have slowed everything down.

Workers can put pressure on each other to keep up the speed of work (Novek *et al.* 1990), and nurses in this study made frequent reference to the speed of their work. Faster skill performance may reduce time pressures, especially when this is part of the speed of the team itself; therefore, the nurse does not feel she is delaying the overall team performance.

Routinization

Nurses in this study had a routine, which was their temporal plan of work and brought with it a sense of order. Routines are habituated ways of responding to occurrences in everyday life (Strauss & Corbin 1998), and are part of our normative experience. As such, they are taken for granted unless they are disrupted in some way. Understanding routines is important, because they demonstrate actions that have previously been worked out to maintain order (Strauss *et al.* 1998). In complex organizations, the synchronization of people's routines is important for overall continuity (Zerubavel 1979). Routines can provide a form of time supervision, not only for individual nurses but also for the team and organization. Systems such as critical care paths, which provide a plan of the routine management of a specific diagnostic group of patients within a time frame, function in a similar manner.

Routines bring with them a set of expectations and, for nurses in my study, the time slots for activities that they needed to complete. Routines can decrease the thinking time needed in time management. Thinking about activities that need to be completed and the sequence of these is a time-consuming activity. Having a routine can reduce the time pressure nurses' experience, and may be one of the reasons that they attempt to protect their routines from changes in practice. This is despite the arguments for them to reduce their routines to promote individualized care (Audit Commission 1992).

Others' routines

Nurses may have their own routines but this is influenced by others' time. Routines exist at different levels, as a staff nurse explains in the following extract:

You do sort of have your routines. It is just organizing your time. If the physio starts at 9 a.m. you have to have some sort of routine.

As a component of nurses' routine, there is a need to complete activities within certain time frames. A sense of timing about the duration of activities and sequence of when these need to occur is required to synchronize an individual routine with others, so other people's time management can influence time and routine. Routine is not just about what activities need to be completed, but incorporates sequencing, timing, and speed. The ability to synchronize one routine with others is important. This is in order to be efficient, not only as an individual performer, but in working with others involved in the overall provision of care. A staff nurse illustrates the difficulties encountered by other's routines as follows:

Someone else is asking 'Can you take a patient down and then collect him from Gastro?' Somebody else needs collecting from theatre.

If this is likely to be problematic, altering a routine by making shifts in the tempo, duration and timing of work may be needed. Nurses may use other strategies and actions in situations in which the timing within routines becomes problematic. In learning time management, other people's routines are incorporated and become accepted as a new routine. This then becomes taken for granted as a way of managing time. In a focus group, discussion took place about how nurses' practice had changed:

> There was an incident the other day. We had an elderly gentleman who became very confused and the doctor suggested that we should give him thioridine. Now it is ages since that situation happened here. In the old ward, it was quite often given to patients because they were not quiet or because they were rambling or wandering.

Routines can often be invisible (Bowers *et al.* 2001), unless they are exposed or attempts are made to change them.

Zerubavel (1981) states that routine is essentially antithetical to spontaneity, but nurses' routines can be responsive to the contingencies inherent in clinical practice as a ward sister explains:

> There are all these people talking about time management, but they are usually people who work in an office nine to five. They are not dealing with all the unpredictable things that can happen.

Nonetheless, routine, which brings about a sense of predictability, sense of time control and familiarity, is relevant to time management. A routine not only comprises a sequence of activities or tasks that need to be completed, but also the duration of these activities and the speed with which these are carried out. A routine has a pace that can be altered as the situation demands.

Some events or activities are amenable to temporal relocation, others cannot be easily extracted (Hassard 1996). Possibility of disruption to others' routines is a reflection of the connections between power and time management. Some health care workers' status means that it is their routine that will be established as the priority routine. On one of the study wards, despite there being set times for ward rounds, one consultant in particular would change the time or even the day, giving minimal notice to the ward team.

There is reliance on patients playing their part in supporting nurses' performance of time management. Goffman (1959) refers to protective measures that are used by the audience and others to assist the performers. For example, it is important for the maintenance of routine and time performance that patients take their medication at the times allocated. Patients who disrupt this may be labelled as 'difficult' (Stockwell 1972).

Prioritizing

Time is one of the principles that can best allow people to establish and organize priority in their lives, as well as to display it symbolically (Zerubavel 1981). The ability to prioritize is a prerequisite for effective work performance and is an expected strategy. The assumption is that priorities can be determined, and decisions made as to what is most important, and that this can be followed by appropriate nursing actions.

Prioritizing provides a structure for the temporal ordering of work. In this study, prioritizing forms a complex picture, unlike the rational process evident in the literature. Prioritizing has paths of connectivity (Strauss *et al.* 1998) to different levels of routine. Priorities may be determined by those of the organization and the resultant organizational routine. A staff nurse relates the problems encountered as follows:

> It is all dictated by outpatients. Five outpatients come in an ambulance, so put back the patients on the ward. The patients on the ward at the moment are sometimes being treated at 10 o'clock at night, so they could be treated at 8 o'clock one night, 10 o'clock the following morning and so it is very difficult. When you ask them for a schedule, they say it is not possible to give you one. So basically you get what you are given as far as time. Even talking to a patient and then they are taken away and what they were going to tell you or what you were trying to establish is either broken off because they have gone for treatment.

The team may determine priorities and, as such, there is an expected team routine, as a ward sister explains in relation to changing a routine:

> We used to do an MST (morphine slow-release tablets) round 10 [o'clock] and 10 [o'clock] but we found that, because there are only two trained night staff and an auxiliary, by the time they finish the ordinary drug round and settle the patients who desperately need commodes and whatever, quite often it was nearly 12 o'clock before the MSTs were done. And then lights were going off very late. So it makes the night very short for the patients. So I thought about it and said to the staff what about if we do the MSTs at 9 and 9. There is a problem in the morning with our patients because they are going off for treatment. So, when you come to do their MSTs at 10, half of the patients were missing, because they had gone for treatment or you found half the drug sheets in pharmacy. Quite often it became 11 before you had finished. If you are doing something in a morning you have to concentrate and think 'Has anybody done the MSTs?'.

There is evidence of tension between the ward routine and other departments' routines. If nurses are not 'on time', that is they have not got their timing of medications right and

synchronized this process, patients may have left the ward or there may be delays in patients' transfer to other departments.

Patients are admitted to wards with their own time frames, their routines incorporating the times to take their medication. Individual patients' medication times and routines may have to adapt to the ward routine. Decisions about priorities may be taken with reference to the ward routine, rather than individual patient needs (Procter 1989). Meeting individual needs not only requires knowledge of the patient, but an acknowledgement that this is a responsibility, a commitment and a priority. The delegated authority and responsibility associated with work organization systems, such as primary nursing, may allow the priorities of the individual to co-exist with some of the priorities of the team and organization. However, this creates tensions for nurses because the needs of one patient compete with those of another in terms of urgency. This is reflected in one staff nurse's account:

> When you have taken your report the most important thing is to assess which one out of your team requires that ultimate care – the most in need of your 'hands on care' first. I like to go along and say 'hello' to everyone and then I go to them all and if I can't offer them any assistance with hygiene or care I will explain why – because I have got somebody else who is poorly at the moment and needs my attention. But if there is anything I can do for them first, if not I will be back as soon as possible. So I go and say 'hello' and check whether there is anything vital within that first 15 minutes. If not, I explain would they like to wait and I go and see to the poorly ones and they usually say 'fine' and I say for them to buzz in the meantime should they need us.

Prioritizing is part of this nurse's routine, entailing the sequencing of her work and its duration. This is about the need to spend time with specific patients. With the exception of high dependency areas such as intensive and coronary care units were the nurse–patient ratios usually are 1:1 or 1:2, nurses, like the staff nurse quoted above, have several patients that they need to spend time with. It is notable that she gives other patients permission to interrupt her if necessary.

Prioritizing becomes an integral part of a nurse's routine. The latter is comprised of other routines, such as the ward routine. In effect, nurses are dealing with different priority systems:

> There are some things that are priorities that always have to be done, like medications. There are priorities to you and to the patient. So if it was a priority to the patient and they wanted something, I would see that as a priority.

There is complexity in this, as what patients might perceive as a priority may not always be recognized as such by nurses. For some specialist nurses, contact with patients may only arise because others' involved have identified this as as a priority. Tensions can arise if there have been differences in determining whether contacting a specialist nurse is a priority or not. Specialist nurses will also make judgements as to whether particular situations should be a priority for them. Differences in priority systems and time agendas exist. Nurses have to have local knowledge of whose priority systems, in fact, take priority and the way in which these can be influenced.

Interruptions to nurses' work can be accepted and taken for granted (Waterworth *et al.* 1999). However, this can be more complex, because team members, supporting team priority systems can function to provide time protection for other team members, as a ward sister's account reveals:

> It is very difficult because, if people need you specifically and they need you there and then, if I did not want to be interrupted – say I was talking to a patient or relative – I would say to S 'Look, I do not want to be disturbed unless it is very urgent'. So then, S would try to answer anything that would come my way. She would only get me if she could not cope with or someone specifically wanted me. So you sort of rely on your other colleagues to try and take the burden off you.

Provision of cover by other nurses can provide some degree of protection against interruptions, but for the team members involved, this will bring extra work and impact on their own time management. Providing support for the protected time needed with a patient or relative has to be viewed as important within the team's priority system. If team support is not available, nurses have to work around the situation and use other strategies to manage their time. Working as part of a team means getting to know the priority systems, what may be urgent and, therefore, when it may be appropriate to interrupt a co-worker. In order to maintain the team performance of time management, judgements are made about individual team members. If the time a team member spends with patients is viewed as excessive, this can create tension and disrupt team performance, as a staff nurse illustrates:

> I don't mind X spending time with patients, but there are his other patients to think of and we are doing his work. He has to learn that there is a limit to the amount of time he can spend with one patient like that. It is annoying the others, as they have to do his work, answer the call bells and then they have to catch up on some of their own work.

Nurses need to be able to sequence their work according to priorities and deal with conflicting priorities. Being able to compromise is an accepted part of prioritizing, and involves

understanding the need to compromise and the feelings associated with it. A charge nurse relates compromising and prioritizing to patient safety in the following extract:

> Ultimately, compromises are made along the way. As I said before, setting priorities [is necessary], but the patient needs to be safe. Hopefully, with working with experienced staff other staff learn and are educated as to what are the priorities.

In determining priorities, decisions are made as to what work should be completed and what work other workers could do, and integral to this process is delegation. Being able to delegate work to others can be problematic for nurses (Hansten & Washburn 1996). In some instances, there is no one to whom one can delegate, as illustrated by the following extract:

> You have to do it. If the ward clerk is off sick, within 48 hours you will have a pile of case notes that is taller than me. If you do not do it, you will not be able to find anything on that ward again.

Student nurses were valued in a number of ways, and this was, in part, because work could be delegated to them.

Duplication of workers' skills has become more prominent in health care. This is relevant to nurses and their expanding portfolio of skill development. Delegation is reliant on workers having certain skills that enable them to complete the delegated work. Walby *et al.* (1994), assert that nurses do not have the right to impose their priorities on junior doctors. The expanding portfolio and the development of advanced nursing practice roles, means that nurses will have to delegate work to medical staff. Although the language of 'sharing work' may be used in order to minimize some of the tensions between the professions, conflict may be anticipated and attempts to avoid this may cause nurses to complete the work themselves, as a staff nurse explains:

> It would be easier to get someone to wash and dress a patient and make a bed than it would be to come and take bloods and make up antibiotics. Well, it is more accessible to get a care assistant and help wash a patient and make sure a patient is comfortable in a bed or if you can get some care assistant or student to do the observations. Whereas it can be harder to get a doctor to come and help you do the antibiotics or come and take bloods, because they are always too busy doing something else.

Allen (1997) argues that nurses undertake medical work, because it is less time consuming than trying to get a doctor to do it. In the study reported in this paper, the idea of 'time consuming' was also present in the effort required to delegate work to others. This involves determining whose representation of busyness takes priority.

Discussion

Whilst having time to spend with patients has been perceived as important to nurses (Waterworth 1995), how time is managed is not only highly problematic but reveals how time itself has become so deeply embedded in issues relating to care. Therefore, attempting to understand how nurses manage their time reveals not only the complexity of what is involved but also some of the invisible dimensions.

An ability to manage time in an acceptable way is an important performance standard and reflects competency in organizing work on an individual basis. The emphasis is on individual performance. As Nicholson states:

> If you find yourself saying I just don't have enough time, then it is probably your own fault (Nicholson 1992, p. 52).

A powerful image of personal inadequacy can be associated with the idea of time management.

My paper has focused on two time management strategies that, on the surface at least, present as an acceptable face of time management. The evidence suggests that one of these, prioritizing, is an expected time management strategy and that other actions such as delegation are given professional approval and considered important skills for effective management of patient care. As is evident from the analysis in my study, it is important to examine what lies beneath strategies (Hochshild 1997), what they reveal about the temporal demands on nurses as they attempt to organize their work, and the influence of the team and organizational routines and priorities. In my study, the importance of routine, which represented the nurse's temporal plan, was evident. The way in which nurses' routines have to take into consideration others' routines and the impact of this are also clear. Some of the strategies maintain a dysfunctional image, supporting management rhetoric that time can, in fact, be managed. The strategies used to manage time can also have adverse consequences for patients, as well as fail to address some of the underlying problems nurses face in attempting to organize their work in shifting health care systems. This is particularly so when the strategies are indirect and may perpetuate less effective care or at least limit its effectiveness.

With the increasing emphasis on efficiencies in health care, management of time becomes central. Shifts in organizational temporal frameworks, such as rapid throughputs and decreased lengths of stay in hospitals, are increasing and there is an expectation that people will work harder. Warhurst and Thompson state:

> The combination of increased competitive pressures for cost reduction in public and private organizations, with expanded means for

What is already known about this topic

- Time management is an expected component of nurses' work organization.
- Emotion is produced by temporal demands.
- Interruptions to nurses' work are taken for granted.

What this paper adds

- It challenges the individualistic construction of time management.
- It shows how two time management strategies – routinization and prioritization – are influenced by others (team and organization).
- It shows the connections between power and time management.

reducing and recording 'idle time', are leading to substantial work intensification (Warhurst & Thompson 1998, p. 9).

In my study, work intensification was experienced as time pressure.

Whether time management has become more problematic for nurses because of the concern with improving efficiency and productivity, is largely unknown. Few studies to date, with the exception of mine and that of Bowers *et al.* (2001), concerning long-term care, have focused specifically on time management. The changing temporal structure in health care affects, in a negative way, how nurses perceive their work when standards cannot not be achieved. Time pressure can also have a negative effect on decision-making (Hunt & Joslyn 2000), impacting on its quality, because reflection and consideration of alternatives can be perceived as time wasting processes, as nurses attempt to work quicker.

In this era of the specialist knowledge worker, there is more need for horizontal co-ordination (Warhurst & Thompson 1998). In health care, the increasing division of labour means that more specialists can be involved in a patient's management. The co-ordination function, largely viewed as a nursing responsibility, becomes crucial but also problematic. This is particularly so when there are different interpretations, resulting from a number of influences, as to whose time is a priority. This creates more tension, not only for nurses attempting to manage their own time, but in relation to attempts to influence the time management of other health care workers.

Conclusion

Examining the two time management strategies of routinization and prioritizing exposes the contradictions that nurses face in their attempts to organize work within temporal boundaries. The taken for granted notion of time management has been challenged, revealing the influence of 'others', the team and the organization. Ignoring these perpetuates a rather individualistic and self-critical perspective of time management, and may lead to failure to address some of the problems in organizing nursing work and co-ordinating care involving other health care workers.

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