DOI: 10.12923/pielxxiw-2024-0049
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The concept of routine in nursing care: methodological reflections

Koncepcja rutyny w opiece pielęgniarskiej: refleksje metodologiczne

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A – Development of the concept and methodology of the study/Opracowanie koncepcji i metodologii badań; B – Query - a review and analysis of the literature/Kwerenda – przegląd i analiza literatury przedmiotu; C – Submission of the application to the appropriate Bioethics Committee/Złożenie wniosku do właściwej Komisji Biotycznej; D – Collection of research material/Gromadzenie materiału badawczego; E – Analysis of the research material/Analiza materiału badawczego; F – Preparation of draft version of manuscript/Przygotowanie roboczej wersji artykułu; G – Critical analysis of manuscript draft version/Analiza krytyczna roboczej wersji artykułu; H – Statistical analysis of the research material/Analiza statystyczna materiału badawczego; I – Interpretation of the performed statistical analysis/Interpretacja dokonanej analizy statystycznej; K – Technical preparation of manuscript in accordance with the journal regulations/Opracowanie techniczne artykułu zgodne z regulaminem czasopisma; L – Supervision of the research and preparation of the manuscript/Nadzór nad przebiegiem badań i przygotowaniem artykułu

STRESZCZENIE

KONCEPCJA RUTYNY W OPIECE PIELĘGNIARSKIEJ: REFLEKSJE METODOLOGICZNE

Wprowadzenie. Rutyna jest zjawiskiem powszechnym w praktyce pielęgniarskiej. Choć często postrzegana jako powtarzalna, jest niezbędna do zapewnienia skuteczności i spójności w świadczeniu opieki zdrowotnej. Rola rutyny jest złożona, gdyż balansuje pomiędzy gwarantowaniem pewnej struktury a utrudnianiem zapewniania spersonalizowanej opieki.
Cel pracy. Niniejszy artykuł bada pojęcie rutyny w wielu dyscyplinach naukowych, w tym w socjologii, psychologii i badaniach organizacyjnych. Podkreśla także jej implikacje dla opieki zdrowotnej, pielęgniarstwa i badań naukowych.
Metody. Przegląd literatury.
Wnioski. Biorąc pod uwagę brak jasności pojęciowej jeśli chodzi o koncept rutyny, co może wpływać na rozwój pielęgniarstwa, zaproponowano zalecenia dotyczące dalszych badań.
Słowa kluczowe: **rutynowa opieka, zwykła opieka, standard opieki, praktyka pielęgniarska**

ABSTRACT

THE CONCEPT OF ROUTINE IN NURSING CARE: METHODOLOGICAL REFLECTIONS

Introduction. Routine is a common concept in nursing practice, often perceived as repetitive yet essential for ensuring efficiency and consistency in care delivery. However, its role is complex, balancing between providing structure and hindering personalized care.
Aim. This paper explores the concept of routine across multiple disciplines, including sociology, psychology, and organizational studies, highlighting its implications in healthcare, nursing, and research.
Method. An overview of the literature.
Conclusions. Given the lack of conceptual clarity in the concept of routine, which may affect the development of nursing, recommendations on research are offered.
Key words: **routine care, usual care, standard of care, nursing practice**

INTRODUCTION

"Routine" is a concept of immediate meaning, easily understandable, which singularly marks the reality of daily life. Commonly, "Routine" means practice, experience and skill, but also mode, rhythm of life and activity that is repeated day after day, like a norm. It is sometimes associated with monotony [1], but can also acquire a qualifying value, when something has become usual, normal, customary, regular and common [2]. Routine can also be described in generic terms as a repeated behavior aimed at performing a temporary task and requiring little conscious thought [3,4]. In nursing, the concept of Routine has always been present, sometimes from a negative perspective (when, for example, it reflects an uncritically repeated practice), others in a positive light, when capable of providing certainty [5]; however, a first conceptual definition of it was developed only in 2007 with a concept analysis [6]. No methodological considerations have been produced since then, despite at least two reasons stimulating renewed interest in the concept of "Routine":

- during the pandemic and thereafter, there were numerous studies reporting among the outcomes some major changes introduced into departments that generated the ‚disruption of routines' [7]. Healthcare services modified and reduced the functioning of facilities, generating new ways of working, services, sometimes improvised, altering existing practices, sometimes resistant to change [8]. Nursing practice itself, with nurses moved from one department to another, has disrupted routines built over years, generating uncertainty due to the lack of reference points. Even in the daily lives of people, patients, and family members (e.g., the custom of visiting someone in the hospital that has been defined as forbidden), who have seen their life routines profoundly altered [9].
- nursing research initiatives studying the effects of interventions versus routine practice have increased: describing the features of what is routinely offered to patients is much easier in medicine because of the presence of practice concerning drug treatments, unlike what happens in nursing [10], which therefore has to reflect on what ‚usual care' or ‚routine practice' is. In fact, in research measuring the effectiveness of an intervention, the one used for comparison is usually referred to as ‚routine practice' or ‚usual care', but without explaining what is meant.

This brief methodological contribution aims at offering a summary of existing definitions in other disciplinary fields and in the healthcare and nursing contexts, as well as in the field of research, in order to identify the priorities on which researchers might focus their attention.

The concept of routine in other disciplines

In the sociological field, routine is often associated with the term "ritual", but the definition is not unambiguous and universally accepted [11]: the most widely agreed upon indicates a series of ritual and repeated actions giving meaning and stability to daily life, providing a sense of security and continuity [12]. However, Fiese [4] and Spagnola [13] point out that routine refers to an action requiring a simple and momentary commitment, repeated over time; in contrast, rituals imply a temporal involvement and continuity that may extend beyond the specific time and place, sometimes including a generational transition [14]. Routines refer to instrumental and pragmatic aspects that are easily observed [4,13]; conversely, rituals imply a more symbolic and psychological connotation, involving the emotional sphere and concealing hidden meanings that can only be understood in their fullness by those who participate in them [4,13,14].

Tab. 1. Difference between some concepts: routine, standard of care, usual care

"Routine". Practice, experience (skill that is acquired through experience and not through rules and study) [1], regular performance of an activity that allows the acquisition of competence. Monotonous and repetitive rhythm of life and activity, of practice.
It can be described in generic terms as a "repeated behavior aimed at performing a temporary task and requiring little conscious thought" [3,4,40].
In the MeSH term search, 28 contain the word "routine", including: [Nursing, Practical], the practice of nursing by licensed and unregistered individuals who are qualified to provide routine care to patients; [Licensed Practical Nurses], healthcare personnel who do not hold professional degrees or credentials but have completed training and are qualified to provide routine care to patients under the direction of registered nurses and physicians; and [Implementation Science], the study of methods to promote the adoption and integration of evidence-based practices, interventions, and policies in routine health care and public health settings.
"Standard of care". Level, grade, usual standard; Model, type, norm to which all products and processes, all activities and performances of the same series must conform, or to which they conform; model of a particular phenomenon widely accepted as being in agreement with experimental observations. [41]
Treatment that is accepted by medical experts as an appropriate treatment for a certain type of disease and that is widely used by health professionals. Also called best practice, standard medical care and standard therapy. [42]
In fact, this term refers to the level of care, competence, and treatment that, considering all relevant circumstances, is deemed acceptable and appropriate by similar, reasonably prudent health care providers [27,28]. Level of care, competence, and treatment that, considering all relevant circumstances, is deemed acceptable and appropriate by similar, reasonably prudent health care providers [34,35].
Standards of care play a relevant role in safety (e.g., "The Second Global Patient Safety Challenge-Safe Surgery Saves Lives," aimed at defining some "standards of care" related to the safety of surgical practice [36].
In MeSH term search, [Standard of Care] appears to be defined as the minimum acceptable patient care based on statutes, judicial decisions, policies or professional guidelines.
"Usual care". Normal, usual, conforming to habits; that is such by habit, by custom [43].
The term "Usual care" is widely used in many clinical trials, including randomized controlled trials (RCTs) to refer to the control group receiving the standard or conventional, or usual, or routine treatment, as opposed to the group receiving the experimental intervention being evaluated to determine its efficacy. In fact, some synonyms are "standard of care," "control case," "Routine care," "best current," and "standard treatment" "treatment as usual" [44].
In the MeSH term search, 42 contain the word "usual." In none of the terms does the word "usual" describe concepts related to the meaning of habitual.

Legend. MeSH, Medical Subject Headings

Tab. 2. Guidelines for protocol, studies, and reviews development and reporting

Resources for protocol development or review of reporting guidelines	Control exposure: how to report
Reviews Reporting Guidelines	
The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2020 statement [45]	a) *(Data Items)* List and define all other **variables** for which data was collectedt (e.g., participant and **intervention characteristics**, funding sources). b) *(Synthesis method)* Describe the processes used to decide which studies were eligible for each synthesis (e.g., tabulating the study **intervention characteristics and comparing against the planned groups** for each synthesis.
Reporting of new Cochrane Reviews [46]	a) *(Background and objectives)* A description of the experimental intervention(s) should place it in the context of **any standard or alternative interventions**, remembering that standard practice may vary widely according to context. The role of the **comparator intervention**(s) in standard practice should also be made clear. b) *(Methods)* Eligibility criteria for interventions and **comparators** should be stated also, including any criteria around delivery, dose, duration, intensity, co-interventions, and characteristics of complex interventions. c) *(Results)* In the Results section, a brief narrative summary of the included studies should be provided (by specifying the number of participants and summarizing characteristics of the study populations and settings, interventions, **comparators**, outcomes and funding sources).
Experimental Studies Reporting Guidelines	
Consolidated Standards of Reporting Trials – CONSORT [47]	*(Methods)* The **interventions for each group** with sufficient details to allow replication, including how and when they were actually administered.
CONSORT Pragmatic Trials [48]	*(Methods)* Standard CONSORT item plus: Describe extra resources added to (or resources removed from) **usual settings** in order to implement intervention. Indicate if efforts were made to standardize the intervention or if the intervention and its delivery were allowed to vary between participants, practitioners, or study sites; Describe the **comparator** in similar detail to the intervention.
CONSORT stepped wedge cluster randomised trials [49]	*(Methods)* The intervention and **control conditions** with sufficient details to allow replication, including whether the intervention was maintained or repeated, and whether it was delivered at the cluster level, the individual participant level, or both.
Reporting Guidelines for relevant aspects of medication adherence research – EMERGE [50]	a) *(Measurement-method section)* Describe **routine** care related to the management of medication adherence, if applicable (e.g., **routine** assessment of medication adherence, adherence support programs, and provider training). b) *(Intervention-method section)* For intervention and **comparator** groups, describe each relevant level of the medication adherence intervention (e.g., healthcare system, organization, and provider and patient/caregiver).
Better reporting of interventions: template for intervention description and replication – TIDIER [51]	***Scope of TIDieR:*** TIDieR can be seen as a guide for reporting the intervention and **comparison** (and co-interventions, when relevant) elements of a study. We emphasise that our definition of "intervention" extends to describing the intervention received by the **comparison group/s** in a study. **Control interventions** and co-interventions are often particularly poorly described; "usual care" is not a sufficient description. When a controlled study is reported, authors should describe what participants in the **control group** received with the same level of detail used to describe the intervention group, within the limits of feasibility. Full understanding of the **comparison group** care can help to explain the observed efficacy of an intervention, with greater apparent effect sizes being potentially found when control group care is minimal. Describing the care that each group received will usually require the replication of the checklist for each group in a study [51].
Feasibility And Quality Improvement Studies Reporting Guidelines	
Reporting for intervention development studies – GUIDED [52]	Understanding **the context in which an intervention was developed** informs readers about the suitability and transferability of the intervention to the context in which they are considering evaluating, adapting or using the intervention. Context here can include place, organisational and wider sociopolitical factors that may influence the development and/or delivery of the intervention.
Revised Standards for Quality Improvement Reporting Excellence – SQUIRE 2.0 [53]	*(Methods)* Contextual elements considered important at the outset of introducing the **intervention(s)**.
Standards for Reporting Implementation Studies –StaRI [54]	a) *(Introduction)* Description of the **problem, challenge or deficiency** in healthcare or public health that the intervention being implemented aims to address. b) *(Methods)* The **characteristics of the targeted 'site(s)'** (e.g., locations/personnel/ resources etc.) for implementation and any eligibility criteria.
Observational Studies Reporting Guidelines	
Standards for Reporting Diagnostic accuracy studies – STARD [55]	*(Methods)* **Reference standard**, in sufficient detail to allow replication; Rationale for choosing the **reference standard (if alternatives exist)**; Definition of and rationale for test positivity cut-offs or result categories of the **reference standard**, distinguishing pre-specified from exploratory; Whether clinical information and **reference standard** results were available to the performers/readers of the index test.
STrengthening the Reporting of Observational studies in Epidemiology – STROBE [56]	a) *(Methods)* *Clearly define all outcomes, **exposures**, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable. Cohort studies: For matched studies, give matching criteria and number of exposed and **unexposed** Case-control studies: For matched studies, give matching criteria and the number of **controls** per case b) *(Results)* Give characteristics of study participants (e.g., demographic, clinical, social) and information on **exposures** and potential confounder.

Legend. CONSORT, Consolidated Standards of Reporting Trials

Tab. 3. TIDieR Checklist

- Brief name: Provide the name or a phrase that describes the intervention
- Why: Describe any rationale, theory, or goal of the elements essential to the intervention
- What: Materials: Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed (such as online appendix, URL); Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities
- Who provided: For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given;
- How: Describe the modes of delivery (such as face to face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group;
- Where: Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features;
- When and How Much: Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose;
- Tailoring: If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how
- Modifications: If the intervention was modified during the course of the study, describe the changes (what, why, when, and how);
- How well: Planned: If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them; Actual: If intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.

Legend. TIDieR, template for intervention description and replication (https://www.equator-network.org/reporting-guidelines/tidier/)

In the psychological field, routine is conceptually associated with "habit" [3], understood as a specific action or behavioral tendency that is implemented with little conscious awareness or reflection, in response to a specific set of associated conditions or contextual cues [15,16]. In fact, automaticity is considered a key feature of routines, defined as the limited awareness of an action carried out with speed, efficiency and little effort [17-19]. Like a routine, a habit requires limited conscious thoughts; however, unlike the former, an individual's habit is subject to modification [3].

In organizational disciplines, routine is defined as repeated behaviors aimed at performing a temporary task and requiring little conscious thought [3]. Organizational routines consist of interdependent, repetitive and recognizable patterns of actions, involving multiple actors [20] and accounting for much of what happens within an organization and influencing it [21].

Feldman and Pentland [20, 22] identify two components in organizational routines: the ostensive one defines their rules and principles, while the other, related to performance, emerges from individual actions and behaviors. According to Becker [21], organizational routines facilitate the coordination of work activities, improve the balance of behaviors, enable automaticity, and can contribute to the consolidation of knowledge, including tacit knowledge. Although routines in the organizational setting can be considered as stable processes, they have the potential for constant change over time [20, 23], especially when its participants do not achieve the expected results, or when new opportunities for change arise [23]. A recent systematic review of the literature has shown that the concept of "organizational routines" is not yet well defined and that it is often employed ambiguously [24]: research in this area is working to better define the conceptual framework of this phenomenon [24-26].

The concept of routine in the healthcare field

Health care settings are also characterized by more or less implicit routines, which may vary in form and complexity but are commonly always aimed at making the service efficient, while ensuring patient safety. In the United States, the term "standard of care" (Tab. 1) is commonly used in the field of forensic medicine, referring to the level of care, competence and treatment judged to be acceptable, appropriate and reasonably prudent [27,28]. Much research supports how care delivered following protocols based on standards of care and certain routine activities, such as "double-checking" and checklists, reduce adverse events [29]. When based on sound scientific evidence, standards of care provide uniform references and guidance to health care professionals, so they are also important elements in the training of professionals.

The concept of routine in the nursing field

In the nursing field, routines, usual care, or standards of care may refer to a standard of practices and procedures guiding patient care [30] (e.g., routine procedures for preparing patients for surgery); or to the set of routine behaviors, sometimes not formalized at the organizational level [5,31], that may be conscious and subconscious, used to organize and coordinate activities along the axes of time, duration, social and physical contexts, progression, and order [6]. For example, how nursing care is delivered on the morning shift, by the different nurses on duty, to deliver what is deemed necessary. How medications are administered, how vital signs are taken [32,33] are concrete examples of nursing routine.

According to some studies, routine practices are an obstacle to the delivery of good care and can cause a lack of flexibility in nursing action [34,35]; routines often hinder personalizing care so much so that they generate among nurses (and patients) the loss of the sense of humanity and a violation of patient integrity [5]. At the same time, routines can help create a predictable and reassuring environment for patients, especially in chronic care settings: in some groups of patients, such as the elderly, maintaining routine and meaningful activities improves functional and cognitive status, as well as sleep quality and mental health [36,37]. As early as in 2007, Zisberg pointed out that the concept of routines related to nursing appeared to be insufficiently defined and used inconsistently and variably in the scientific literature, suggesting the need to study the concept further and help researchers, educators and experts in the discipline to better describe them. Since the first concept analysis was defined, no following reflections or considerations have been developed, suggesting the need to invest in this area in order to understand its antecedents and features, as well as the consequences of both 'good' and 'not good' or 'bad' routines.

The concept of routine in research

Routine, usual care or standard of care are often considered as the comparator in intervention or comparative research. In the EQUATOR website [38], where guidelines standardizing the methods of different study designs are listed, it is possible to get an idea of how researchers should describe and report such comparator. However, even here, variability emerges different concepts (e.g., intervention, exposure, control, usual care) that are used often interchangeably (Tab. 2). Moreover, while researchers are more careful in the description of the intervention in both educational and clinical research (e.g., [39]) by using, for example the Template for Intervention, Description and Replication system (Tab. 3), the traditional, usual care approach is less described and, therefore, it also becomes difficult to understand the external validity of the results in other contexts and countries. In addition, in the absence of an accurate description of the comparator, it is difficult to understand whether the intervention is effective because it is better than current practice or whether it is effective because it improved a suboptimal practice. Nursing practice appears to be more undefined, difficult to describe and variable, even when moving from one context to another, as it is characterized by values, habits, traditions. Therefore, especially when it comes to research, it is urgently needed to define a method describing what is routine, usual or standard when comparing methods, models or interventions, in order to determine their effectiveness.

Methodological challenges

The presence of routines in nursing care plays a crucial role: both from an organizational perspective, because it provides safety and a reference; and from the patients' perspective, for instance when they ensure safety in procedures (e.g., medication administration, effective management of protocols). For nurses, too, routine is an important point of reference: it offers a guide, conveys a sense of safety and represents a benchmark for students and newly-hired staff. However, excessive routine reduces attention and sensitivity to individual patient needs, with the risk of turning interactions into standardized procedures devoid of humanity. Therefore, routine can have both positive and negative interpretations, relevance and consequences.

In research, 'routine care' is often used as a comparator. Although other concepts, such as usual care or standard of care, are not always interchangeable, it is necessary to pay attention to routine and similar concepts, in order to cover the gap that may affect both research and clinical practice.

Efforts to conceptually define the routine, commonly known as "routine care" in the international context, could lead to a greater clarity in organizational and professional levels, as well as in research. These efforts may increase professionals' awareness of their own individuality, critical thinking in relation to both positive and negative meanings of routine, as well as improve the researcher's capacity to describe comparators when designing and conducting interventional studies.

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Manuscript received: 21.09.2024
Manuscript accepted: 06.10.2024