PRIMARY NURSING

A CONTEMPORARY NURSING RESOURCE BOOK

a reader consisting of eight articles
especially selected by
The Journal of Nursing Administration
Editorial Staff

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Primary Nursing

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Planned Change: A Quest for Nursing Autonomy

by Donna Nehls, Verona Hansen, Patricia Robertson, and Marie Manthey

Donna Nehls, B.A., M.A., is chairman of Nursing Services, University of Minnesota Hospitals.

Verona Hansen, B.S., is clinical director in Pediatric Nursing, University of Minnesota Hospitals.

Patricia Robertson, B.S., M.S., is director of Nursing Services, Methodist Hospital, St. Louis Park, Minnesota.

Marie Manthey, B.S., M.S., is assistant administrator for United Hospitals, Inc., St. Paul. This article is reprinted from JONA, January-February, 1974.

Through a process of planned change, emphasizing staff participation and involvement, the Nursing Services Department, University of Minnesota Hospitals, reorganized to meet the practice goals identified by its members. The concepts of authority, responsibility, decentralization, and staff development were primary considerations in the reorganization changes made. These changes, together with strong staff commitment, have promoted professional development to the ultimate benefit of the patient.

Planned change is the technique management uses today to reshape organizations and make them better suited to their tasks and more responsive to the needs and desires of their members. With clear objectives, an environment of open communication, and encouragement of staff participation, an organization has a good chance to achieve both administrative and staff goals and to become stronger in the process.

Two summers ago we participated in such a process and helped to reorganize the nursing department in a large university hospital. The process, which began with an administrative invitation to change and which was strongly supported by staff members, concluded with the implementation of a plan that embodied the best ideas of the entire group of persons who would be working under it.

Interest and commitment to change is emerging both within individual organizations and in the nursing profession as a whole. Nurses are in the throes of reassessing their place on the health care team, and careful evaluation of their contribution to health care has persuaded them that their opportunities for service and independent action are, or could be, greater than at present. At the same time, they have begun to realize that they must depend on their own initiative to bring about the changes they envision.

Thus, nursing school curricula are being revised. Nurses are beginning to meet with physicians to consider together the changes in practice that will bring the greatest health benefits to the largest number of people as well as professional satisfaction to both groups of practitioners.

The problem of professional advancement for hospital nurses is being tackled with the aim of giving highly skilled clinicians the opportunity to assume greater clinical responsibilities. Leadership skills are being developed in the realization that bedside nursing experience alone is inadequate preparation for a supervisory role and, indeed, that bedside nursing experience may not be necessary for administrative service in a department of nursing.

Many nurses working toward solutions of these problems are convinced that the presently ambiguous concept of nursing authority causes some of the most serious and frustrating problems that hospital nurses face. A degree of authority is necessary to be able to determine a patient's needs, support his life processes, prepare him for the task of maintaining his health after he leaves the hospital, and provide an environment which will allow such actions. Hospital nurses are seeking nothing less or more than clear-cut authority to practice within the full scope of their preparation and at their level of competence. Level of competence, of course, will differ from nurse to nurse and from time to time, and it may be influenced by variations in the educational preparation and professional experience of each nurse.

The changes in the nursing department at University of Minnesota Hospitals, Minneapolis, were intended to increase opportunities for use of judgement and to provide support for the nurses as they exercised the decision-making powers available to them. We are confident also that the groundwork has been laid for an increasingly responsive and flexible organization which will be able to cope with the inevitable changes ahead in hospital nursing practice.

We offer this report of our experience in the hope that specific guidelines for the accomplishment of changes in the authority structure, as well as a description of the new relationships developed, may be of use to those who wish to bring about a more satisfying and effective role for nurses in their institutions.

FRAMEWORK FOR ACTION

The administrative structure at University Hospitals was a typical hierarchical form, with authority concentrated at the top. Under this system, the decision-making power of the nursing department was severely limited. A change in philosophy occurred with the appointment of a new administrative staff several years ago. The new emphasis was on long-range planning, development of innovative concepts of health care and delivery, and decentralized operation of hospital departments. This new approach initially had a rather unsettling effect. No one seemed sure how to deal with this unfamiliar receptivity of the administration to change or, more basically, how to approach change within individual departments.

The nursing department made a few hesitant tries at policy and reorganizational changes, yet despite the frustrations everyone had experienced under the autocratic system, uncertainty about where to go and how to get there made people reluctant to try. The nursing staff at the station level seemed least afraid to experiment, and the first major change therefore was the development on one station of a new form of nursing practice, which we named *primary nursing*.

Under this arrangement, one nurse is given complete responsibility for the nursing care of a small group of patients who become "her" patients. She personally attends to their needs as completely as possible, but her written care plan can include the delegation of some tasks during her own shifts and direct the care to be given when she is off-duty. Twenty-four hours a day, seven days a week, she is held accountable for the care given to her assigned patients.

To facilitate this plan of nursing practice, a new organizational pattern was worked out for this one station. It was not long before several other stations adopted the primary nursing plan, and its continuing success suggested the desirability of a hospital-wide nursing organization that would provide a better supportive framework for primary nursing and enable nurses in every area to assume a more responsible and professional role.

Encouraged by the enthusiasm of the primary nursing staffs and by the desire of the administrative group to decentralize operations, nursing management set its course on an organizational format that would foster self-direction for the department, be democratic in its operation, and facilitate and encourage independent decision-making for nurses to the extent that existing constraints made this possible.

PROCESS OF PARTICIPATION

The timetable for development of an organizational plan was deliberately made short. A commitment by the acting director of nursing to take another position made it desirable to complete the reorganization within three months; the tempo of action was therefore brisk. This accidentally determined time span seemed in retrospect to have been an effective factor in the success of the project.

A major consideration of nursing management was the need to involve a large part of the hospital staff in working out the new format. The first step taken, therefore, was the appointment of a communications consultant* to direct the planning process and develop a smooth working relationship between the management staff and supervisory personnel in the departmental hierarchy.

With the assistance of the acting director of nursing, the consultant planned a questionnaire which was sent to the supervisory, clinical, and inservice directors. The questions were planned to elicit the feelings of staff members about their present work situations, to engage their interest in the reorganization process, and to seek out their desires and ideas. Some of the questions were:

What do you like most about your position?
What do you feel you do best in your position?
What is most frustrating to you about your position?
How would you like to participate in the new nursing services organization?
What are you most concerned about?

As results of the questionnaire were awaited, a committee on reorganization (COR) was appointed to study the information developed and to use it in making recommendations for the new design. Summarized by the communications consultant, the answers to the questionnaire indicated some firm opinions on the characteristics the respondents wanted to see incorporated into a new structure:

Clear allocation of nursing responsibility at the level of action, with commensurate authority to make and implement decisions.
Assistance to current and potential leaders in the development of management expertise.
Opportunity to develop individual potential in nursing skills.

*Ms. Coellen Kiebert-Jones

Integration of responsibility for clinical and managerial decisions at all levels of operation.

Opportunity to participate in major decisions affecting nursing practice.

Clear role definition and clarification of job responsibilities.

Pleased by the strong response to the questionnaire, the committee members decided to sponsor an event that would provide concentrated opportunity for management personnel to share their feelings and enlarge upon their ideas in the search for an "ideal" plan. They chose a one-day workshop away from the hospital as the event to provide this opportunity, and several important goals were set for it: to collect the data regarding the interest of supervisory personnel in the reorganization; to engage the active participation of each person in the process; to encourage an honest appraisal of individual strengths and weaknesses; to clarify career aims; and to prepare for staff acceptance of the changes ahead.

Interest was sustained throughout the day through the use of various techniques of meeting, and the relaxed atmosphere of a gathering free from the distractions of the hospital contributed to a general willingness to communicate. The written responses to the questionnaires were clarified and reinforced; the group began to achieve a consensus on the values they considered essential as a basis for the new organization; and COR members gained a better understanding of the attitudes and problems with which they must deal. This informal workshop also gave the COR members an opportunity they very much wanted—the chance to establish rapport with the other members of the nursing management staff.

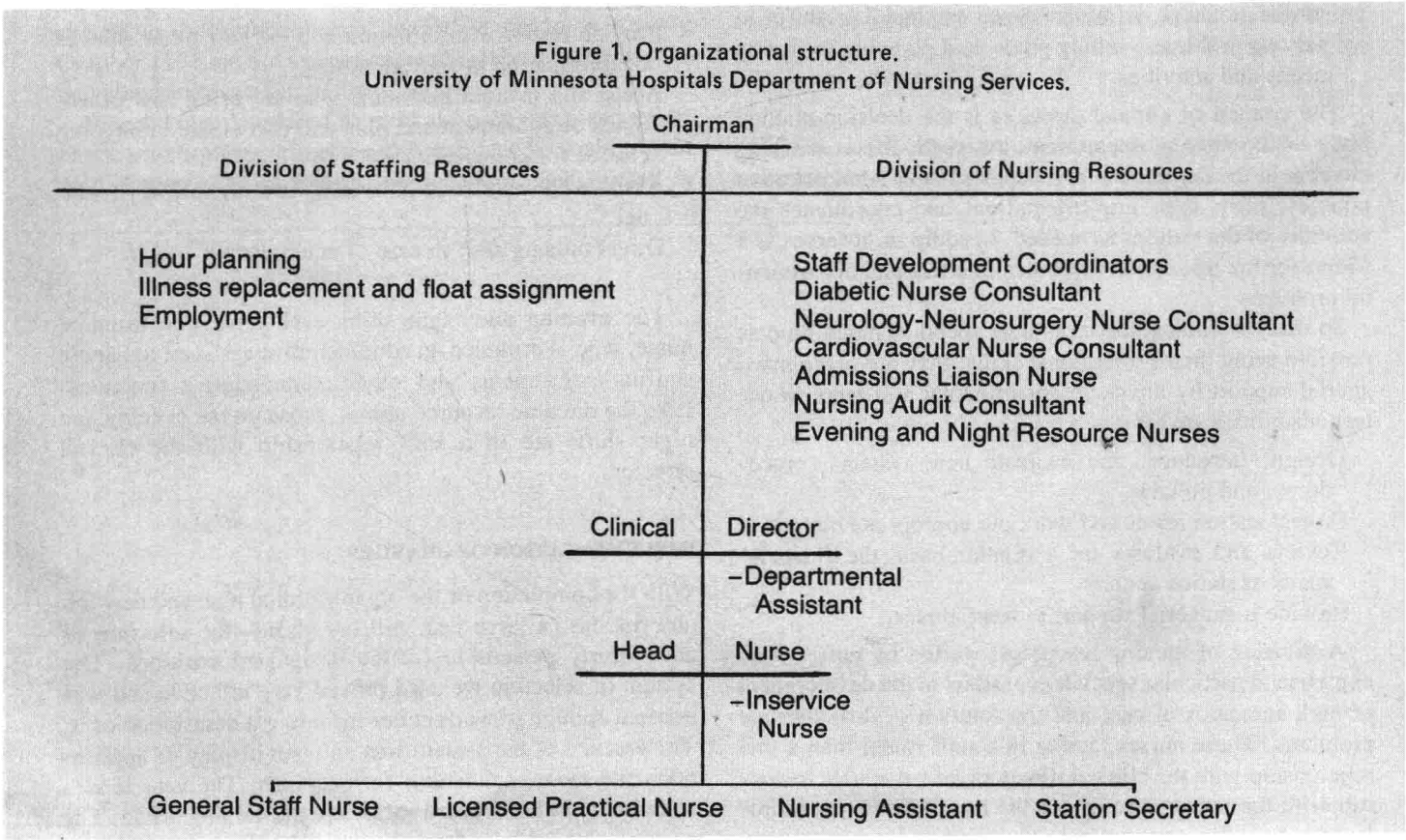
Following the workshop, COR widened its contacts to include such groups as evening and night supervisors, in-service staff, head nurses, and unit managers. Through questionnaires, meetings, and personal interviews, additional concerns and suggestions were solicited.

The acting director of nursing services met with each member of the management staff to determine her interest in the kinds of new positions that might develop and her commitment to the success of the reorganizational effort. These contacts were extremely helpful as COR sought to give form to a structure that would be optimally responsive to the expressed needs and desires of the nurses who would be working within it.

ORGANIZATIONAL STRUCTURE AND ROLE RESPONSIBILITIES

During this period a number of plans were sketched and submitted to the various groups for their reactions and suggestions. After further refinement, the final plan, as outlined in Figure 1, was submitted for approval by the total nursing management group. At this point only two months had passed since the initiation of the reorganization effort.

Figure 1. Organizational structure.
University of Minnesota Hospitals Department of Nursing Services.



According to the plan accepted, the department of nursing services is guided by a chairman, who is responsible to a senior associate director of the hospitals and who chairs a council of twelve clinical directors. Her functions include selection of these directors and other key personnel of the nursing department, encouragement of nursing staff in professional development, chairmanship of a division of nursing resources to assist in this activity, integration of long-term hospital goals with the aims, programs, and day-to-day operations of the nursing department, a liaison role in contacts with hospital administration, medical staff, and other hospital departments, and other usual administrative duties.

The twelve nurses who constitute the council of clinical directors each have responsibility for several patient care stations and have full authority in those areas to make all decisions pertaining to their operation, including the setting of nursing policies and procedures and determination of standards of patient care. The clinical directors' responsibilities are to:

- Establish and maintain quality standards of nursing care.
- Assess the clinical knowledge needed by staff members.
- See that needed continuing education is available to and obtained by staff members.
- Encourage and facilitate improved methods of nursing practice.
- Allocate their departmental funds effectively.
- Collaborate with hospital department heads and members of the medical, administrative, and nursing staffs in solving problems, setting goals, and planning for future needs and activities.

The council of clinical directors is the decision-making body of the nursing department. As such, it is a unifying element in the department and decides major administrative policies, plans their implementation, and coordinates the activities of the stations as needed. In addition, it serves as a forum for the discussion of clinical matters and departmental problems.

So that the clinical directors may spend as much time as possible using their professional skills, they are given managerial support by nonnurse departmental assistants whose responsibilities are to:

- Design, introduce, and evaluate new systems, procedures, and policies.
- Project station needs and work out appropriate budgets.
- Review and evaluate on a regular basis the financial status of station centers.
- Provide managerial support to head nurses.

A division of nursing resources, staffed by nurses with expertise in particular specialties, assists in the development of high standards of care and the solution of difficult care problems. These nurses, acting in a staff rather than a line relationship with the clinical directors, are available to consult with the nurses throughout the hospital and, on a limited basis, in the community.

The staffing function was made more comprehensive and a division of staffing resources was created. Its objectives are to:

- Provide a central staffing service seven days a week, twenty-four hours a day, with the advisory help of head nurses, who identify staff strengths and weaknesses and assist in establishing patterns of staffing.
- Investigate, develop, and evaluate new methods of staff utilization.
- Provide staffing data to the clinical directors.

The University of Minnesota Hospitals complex has many highly specialized units and its general orientation is inadequate. To improve the effectiveness of orientation, inservice nurses, reporting to the head nurse of the area, were appointed to each patient care unit to provide more appropriate, efficient, and complete guidance to new staff members.

Another aspect of the new plan is a completely altered role for evening and night supervisors. They function now as resource nurses, with the following primary responsibilities to:

- Survey nursing needs for their shifts, plan and coordinate service to the stations, and anticipate needs for nursing service on following shifts.
- To be available to assist in solving nursing care problems as needed.
- Provide resource information and suggest other sources of information to staff members.
- Assist and instruct personnel who are using new procedures or equipment and plan and participate in ongoing classes for permanent staff.
- Assist with orientation of evening and night shift personnel.
- Direct nursing staff in case of emergency.

The evening and night shifts each have one resource nurse, who is provided an administrative assistant to handle staffing adjustments and other administrative functions. Like the daytime resource nurses, those on the evening and night shifts are in a staff relationship with the clinical directors.

IMPLEMENTATION OF CHANGES

With the completion of the organizational plan and new job descriptions, a large task still lay ahead—the selection of about thirty persons to fill the designated positions. The system of selection we used proved very effective and was unusual enough to warrant our including a description of it. The essence of the system was an open display of applications and recommendations for positions. The vehicle was an ordinary bulletin board located in the nursing office. The positions available in the new organization were listed on it.

Each member of the nursing department who qualified for any of these positions was given three green, numbered name tags with which she indicated, in the order of her preference, the positions in which she was interested. Only the owner of a green tag could move it from position to position as her interests changed.

Persons who wanted to recommend others for positions were provided blank yellow tags, which they filled out and placed on the board under the suggested positions. Users of the board could also suggest additional positions they believed would improve the organization.

The board was open for action for a period of two weeks, which can only be described as an exciting period. As tags were moved from place to place the staff gave each other encouragement and support, and staff from other hospital departments, hospital administrators, and medical staff came to observe the action and discuss the preferences and recommendations. The appearance of the board was constantly changing while animated conversations took place ir every part of the hospital. A general feeling of openness and camaraderie prevailed throughout the process, greatly easing the task of the acting director of nursing, who made the final decisions on appointments with the assistance and counsel of other nursing management personnel.

Within three months the entire process was completed. A new structure was designed, roles were defined, job descriptions were written, and appointments to the newly created positions were made. A short pause gave staff a chance to catch their breath, and then one day in early October 1971 the old system came to an abrupt stop and the new one went immediately into action.

Planned change geared to meet strongly perceived needs has a health-giving effect on the people who make up an organization. The process of participative change itself is one of renewal. We have seen the changes in the attitudes and accomplishment of the nurses serving in our institution, and although we certainly cannot pretend that no organizational or personal problems remain, it has been encouraging to see nurses regain a vital interest in their work, ready to learn more about what constitutes good nursing care, comfortable with interdepartmental contacts, accept their increased responsibilities seriously and effectively, and able to concentrate more of their attention directly on patients.

The authority problem is still with us and will be for a long time to come, but the situation is unquestionably improved. The new structure has given nurses a chance to explore new opportunities for action and to find new resources within themselves as well as to use their nursing preparation with more confidence and assertiveness.

Some of the methods we found effective in the planning process are being used to evaluate the department's present strengths and weaknesses, and we now have both the attitude and the mechanism to facilitate further changes whenever inadequacies are identified.

The problems nursing faces today differ in detail from institution to institution, but the character of the problems is fairly common to all of them. The problems on which we focused in shaping our new organizational format must be acted upon, we feel, if nurses are to realize their potential for service. The character of the organization is an essential element in allowing nurses to develop and use professional judgment and clinical expertise. The University of Minnesota Hospitals have taken a decisive step in encouraging nurses to grow professionally in their own interest and for the benefit of their patients.

The authors acknowledge with thanks the assistance of Mrs. Jean Morton in preparing this material for publication.

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Primary Nursing: An Organization That Promotes Professional Practice

by Karen L. Ciske

Karen L. Ciske, R.N., M.S.N., was Consultant in Rehabilitation Nursing, University of Minnesota Hospitals, Minneapolis, when this article was written. She is now developing an independent nursing role as a consultant/instructor/facilitator for primary nursing.

Hospital nursing has been a difficult place to implement professional practice. In an attempt to find ways to improve the delivery of nursing care and the level of staff satisfaction, a group of nurses at the University of Minnesota Hospitals adapted the one-to-one assignment model to a small patient unit. Decision making was decentralized to the nurse who knew the patient best, the primary nurse. Because of her role in staff development, the head nurse was seen to be pivotal to the success of primary nursing.

The hospital as the agency that employs the majority of practicing nurses in the United States is often the most difficult place in which to practice nursing. Some of the frustrations experienced by staff nurses are reflected in surveys of graduate nurses working in hospitals. Kramer found a 20 percent potential or actual dropout rate from nursing for a group of nurses followed during a two-year period after graduation [1]. She reports that there is a continuing drop in the scores pertaining to professional role conception (beliefs and values about the nursing role), which would imply that nurses become less professional with continued employment [2]. Harrington and Theis and Sister Reinkemeyer also have studied the roles of baccalaureate nurses and point out dissatisfactions pertaining to employment in traditional hospital settings [3, 4].

Why does this situation exist? I believe it is because many hospitals tend to be bureaucratic organizations that place value on efficiency, predictability, rules, and authority. Malone has done a masterful job of describing the problem of a professional within a bureaucracy [5]. She suggests changes in the organization of hospital services so that graduate nurses who are committed to professional practice might implement what they have been taught in their educational programs as quality care for their patients. To a great extent this might help to prevent role deprivation resulting in disillusionment, bitterness, adaptation to other values, and unsatisfactory patient care.

With this concern in mind—to somehow make it possible to practice nursing at a higher professional level in our hospital setting—I became involved in 1968 in an experimental project designed to improve the delivery of services to patients on a small medical unit. I was nurse clinician on this unit and several others at the University of Minnesota Hospitals. I worked with other clinicians, administrative supervisors in nursing, inservice staff, head nurses, and faculty from the school of nursing as a member of the steering committee to determine the needs for change and implement them. The following is an overview of the process through which our group and the nursing staff of the 23-bed medical unit accomplished rather dramatic changes in the organization and delivery of nursing care.

One aspect of our project was the development of a ward manager position; another was the examination of existing systems in delivery of care by nursing and other hospital departments. Although we recognized that we might be freeing nurses to nurse by establishing a ward manager role, we were aware that this in itself might not improve patient care. The Iowa study, in 1960, had confirmed that increasing the time devoted to direct patient care had not automatically produced *better* patient care [6]. Thus, we began to examine our organization of nursing services at the unit level.

We were utilizing team nursing on most units, but our particular brand of team nursing seemed to perpetuate deficiencies in the acceptance of responsibility for care planning and follow-through on many of these units. Shared responsibility and accountability often became *no responsibility and accountability*. The team leader's goals of assessing each patient on her team and supervising the planning, implementing, and evaluating of care plans for ten to twenty patients were unmet.

In studying our situation we began to see how unrealistic were our expectations of team leaders. In our busy, acute care hospital we were asking a registered nurse, often newly graduated from any one of three kinds of educational programs and working rotating shifts to: (1) know and act upon

the critical information on her patients in order to plan their care, using the team conference whenever appropriate; (2) lead other team members, which involved assigning, supervising and teaching licensed practical nurses, orderlies, and aides; and (3) observe and constantly evaluate the care patients received. From the patient's point of view, care was extremely fragmented with as many as three or four of the nursing staff caring for him during one shift. As a clinician, I found it difficult to help the staff achieve comprehensive care for patients or to find satisfaction in their jobs.

In looking for alternatives to the team-nursing structure, we investigated what other nursing services were doing. For several years Loeb Center for Nursing and Rehabilitation in New York City had been working with organizational patterns other than traditional team or functional nursing. Their patients are assigned to professional nurses who are responsible for and provide the total nursing care throughout the patient's stay. A nurse is assigned a specific ''district'' of patients and plans with them for the achievement of their health care goals. She cares for them each day she is on duty; thus, continuity is improved with few aspects of the patient's care delegated to nonprofessional workers.

Other examples of this one-to-one assignment can be found in private duty, public health, and psychiatric nursing practices. The principle of a one-to-one assignment in our hospital had previously been adapted successfully to the rehabilitation units and we wondered if this method could succeed on acute care units as well.

The nursing committee described what we wanted to accomplish for patients in a ''job description for comprehensive care.'' The focus was on continuity of nurse-patient relationship wherein the nurse would: (1) encourage the patient to participate in his own care and to express himself; (2) be knowledgeable about the patient's medical condition, personal and family data, and implications for nursing care; (3) teach the patient and work with the family; (4) plan for other staff involvement through the kardex and other communications; and (5) refer the patient to other professionals when appropriate.

Since it seemed somewhat risky to remove the security of the team system before the staff had an opportunity to ''try on'' these responsibilities and/or learn how to act more independently than they had previously, we asked them to choose and provide care until discharge for a few ''comprehensive care patients'' in their teams. It was expected that the nurses would try to fulfill the comprehensive care job description, as well as continue their team nursing responsibilities. We introduced a new kardex form with more space for nursing evaluation, weekly classes on the elements of comprehensive care, and the concept of total care. Total care meant that the patient related with one nurse during any given shift for the care required —medications, vital signs, hygiene, treatments, teaching, etc.

After several months of what we perceived as a greater degree of comprehensive care within the team system than formerly, a rising level of staff frustration and anxiety became apparent. Nurses were not selecting patients for comprehensive care, and they were reluctant to write on the kardex or to talk about their plans for their patients. After examining what was happening, we found that we had inadvertently created an even more tense and frustrating situation than before. Team leaders were fulfilling their expected roles as they had before the project, but *in addition* they were trying to follow a few patients for comprehensive care. Because they were committed to its principles and felt unsuccessful in its accomplishment, they seemed to be blaming themselves as being inadequate nurses. The problem was the *system* we had introduced! As the planning and steering committee we had asked nurses to assume greater responsibility for individual patients than they had formerly assumed in team nursing, but we were not relieving them of any of their team-leading tasks.

After discussing this problem at a staff meeting, we made what was to us a momentous decision. We dissolved the team structure and assigned each nurse to a group of patients. We also identified realistic, minimum expectations for kardex information. The ''check-up'' system within the team was eliminated, and each nurse became responsible and accountable for accomplishing all that was necessary for her assigned patients during her shift. It was understood that the consequences of these changes would be evaluated and that the team or another system could be resumed if necessary.

At this time the label *primary nursing* was adopted. The basic concepts in this system of practice are:

1. Assignment of each patient to a specific (primary) nurse, who usually provides his care each day she is on duty until the patient's discharge or transfer.
2. Patient assessment by the primary nurse, who plans the care to be given when she is not on duty, when secondary or associate nurses care for her patients. Thus, 24-hour responsibility for care is actualized through the primary nurse's written directives on kardex and other communication tools.
3. Patient involvement in the care provided and identification of his goals relating to how the medical condition affects his life style.
4. Care giver to care giver communication—both in the nursing staff's daily reporting methods and between disciplines.
5. Discharge planning—including patient teaching, family involvement, and appropriate referrals.

Primary nursing is often confused with primary care, the latter being the mechanism by which a client enters the health care system. Usually this contact is in the community, and the health professional could be a nurse. However, primary nursing as defined in our project is a system

of hospital nursing services at the unit level with the components listed above.

In our experience with primary nursing we have found that the head nurse is the person most qualified to assign nurses to patients according to the care needs of patients and the abilities and/or case load of the staff nurse because, ultimately, she is responsible for the quality of care delivered to the patients on her unit. She is also responsible for evaluating staff and providing opportunities for their development. When the head nurse is aware that the patient's needs are beyond the ability of the primary nurse, she either chooses to work closely with her or assigns a second nurse to assist with specific aspects of the care to be given.

The upgrading of the unit secretary's job, the improvement of support systems (pharmacy, central supply, etc.), and the creation of the departmental assistant, whose functions are similar to those described for ward managers, were important factors contributing to changes in the head nurse and staff roles. Because the head nurse is now less obligated to supervise and perform desk activities, she is able to work more closely with her staff. Consequently, the staff benefit from her knowledge of patient care and gradually become more independent. After eighteen months of primary nursing, many of the head nurse's functions were observed to be consistent with the role of nurse clinician, when examined by Kramer and Manthey [7].

We had anticipated that the RN was the only level of nursing personnel prepared for the responsibilities of primary nursing. Therefore, the head nurse assigned each RN, including herself, to a group of patients. Most staff had three or four patients. However, several LPNs on the staff demonstrated excellent patient care ability and wanted a chance to be a primary nurse. We were reluctant but decided to assign them a patient along with an RN or the head nurse on a trial basis. We worked closely with these LPNs, as well as with many of the less experienced RNs, and were able to help them identify needs for additional skills and/or knowledge. After a few months we found some of the LPNs to be excellent primary nurses for certain patients, well able to establish care plans and make decisions with their patients. Nursing aides were not involved in direct care on some shifts and acted mainly as messengers. When they gave patient care, however, they worked closely with a primary nurse and received better instructions than previously.

Since staff members knew who was assigned to each patient, the quality of nursing care was more visible. An empty kardex versus clearly written instructions for care were evidences of the evaluative efforts and communication ability of the primary nurse. During the time in which the medical unit described has been using the primary nursing system, there have been a number of promotions to head nurse or inservice staff positions. These promotions may have been related to our being better able to *evaluate* the abilities of these nurses; the outcomes of their work with their primary patients were visible. This visibility of nursing judgments was frightening to many of the staff who felt some insecurity about being the main care planner and problem solver for a group of patients. They needed support, instruction, and encouragement.

Group meetings and classes were held on a regular basis. As needs for knowledge were identified, these classes were changed in content from assessment and care planning to a review of the medical diagnoses commonly seen on that unit. What came as a surprise to us was how much anxiety staff felt concerning the expectations of direct communication with the physician and more extensive patient teaching activities. They needed and wanted disease review. Classes on medical conditions and nursing implications were well received and used by the nurses.

There have been some exciting outcomes of our experiment. These are:

1. Staff enthusiasm toward patient care and a feeling of accomplishment with *their* patients.
2. Awareness of the strengths within the group for teaching and supporting each other—staff meetings were held regularly during the first year and periodically as needed.
3. Decrease in the turnover rate of RNs and LPNs.
4. Decrease in patient stereotyping by nurses as "difficult," "demanding," etc. with corresponding decrease in frustration and in staff/patient struggle for control.
5. Patients' and families' gratitude for having one nurse in charge of their care and coordinating other staff efforts.
6. Positive reports from nurses who "float" to primary nursing units.
7. Development of better systems of communicating with agencies following our patients after discharge, e.g., public health nursing, extended care, nursing homes.
8. Ten other units at our hospital have adopted the primary nursing structure.
9. Much interest in primary nursing has been shown by hospitals and schools of nursing in the community.

Many questions are still to be answered. Does the primary nursing system really facilitate the accomplishment of professional nursing as we think it has, or have improvements been related to the attention and support given to the group rather than from the changed organization itself? How can we help the head nurse to assume a different and very demanding role? How can we best develop the staff nurse's abilities and motivation toward functioning in a more independent role than before?

Primary nursing is not a panacea. It will not cure incompetent nursing practices or change staff attitudes about how much of themselves they are willing to give in relationships with patients or with other staff members. It demands knowledge of how to work within change in order to effectively utilize the group as the steps of change occur. And it requires clinical nursing leaders who are available as resources to the staff and head nurse when they face the problems and risks that come from entrusting the primary nurse with responsibility and accountability for patient care decisions.

There are indications from many disciplines that what one makes explicit to people as expectations of behavior affects what they can and will accomplish. This is true of hospital nursing. Our philosophy in primary nursing relates directly to individualizing patient care through a nurse-patient relationship wherein acceptance of responsibility and accountability is *expected*. We feel that professional practice has been promoted through our experience in primary nursing.

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Patients' Perception of Care Under Team and

by Reidun Juvkam Daeffler

EXPRESSIVE NURSING ACTIVITIES

Entrance into the health care system is more often than not related to stress factors. Nursing activities aim at reducing this stress. The instrumental activities of examining, diagnosing, and treating tend to provoke high emotional tension, embarrassment, anxiety, and pain, while the expressive activities of explaining, reassuring, understanding, accepting, and supporting the patient serve to lower the patient's tension level [1].

Patients express their basic insecurity in the health care system through their complaints about food, noise, never seeing a nurse long enough, and not getting their call answered promptly [2]. Studies reported by Leonard [3] supported his hypothesis that expressive nursing activities can reduce patient distress, confusion, and misunderstanding, and improve the patient's medical condition as well as cooperation and satisfaction. Meyers [4] found less tension created in patients when they were given specific information about a nursing procedure. In many cases communication skills are more efficient in providing relief from pain than pain medications are [5]. Several studies have shown that experimental nursing care stressing communication in terms of information, instruction, or psychological support, has improved patient welfare, measured by length of hospital stay and amount of pain medication needed after surgery [6, 7]. The reported studies indicate that expressive nursing activities reduce tension in patients, and because of the reduced tension these patients show more satisfaction and express fewer complaints than patients with a higher level of anxiety.

This article deals with the tension-reducing effects of expressive nursing activities and with primary care as an assignment system that gives more room for expressive nursing activities than does team nursing. Because patients with a high anxiety level are more likely to offer complaints about their care and their environment, it was hypothesized that patients in primary care units would be more satisifed with care than patients in team nursing units.

A study of perceptions of care in 82 hospitalized patients showed higher satisfaction and less omissions in care reported by patients in a primary care unit than in team nursing units.

Reidun Juvkam Daeffler, R.N., M.S.N., is a clinical nurse specialist in the Veteran's Administration Hospital, Phoenix, Arizona.

Primary Nursing

NURSE-PATIENT RELATIONSHIP

Despite an increased emphasis on the psychosocial aspects of nursing in educational programs, the gap between professional nurses and patients has increased during the last few decades. In many hospitals today nursing assistants do most of the bedside care, while registered nurses perform nursing activities that require skilled techniques, and coordinate and administer nursing care. The face-to-face contacts between patients and registered nurses are often of short duration.

Many complaints and much dissatisfaction have been expressed by both nurses and patients about the fact that registered nurses have become decreasingly involved with direct patient care. Today new nurse roles are developing to reverse this trend. Roles such as clinical nurse specialist and primary nurse practitioner are designed to ensure that patients have direct contact with well-qualified nurses. The direct nurse-patient relationship is reborn in primary nursing as a method of assignment of nursing care. This individualized care is expected to improve the quality of patient care.

Studies of patients' perceptions of nursing show that caregivers' attitudes influence patients' evaluation of nursing care, [8] that patients are unable to visually differentiate between registered nurses and licensed practical nurses [9, 10] and that patients give high priority to their physiological needs [11, 12, 13].

STAFFING PATTERNS

Studies of staffing patterns and nursing care show that number and type of personnel influence the quality of care as measured by number of omissions and completions of nursing tasks [14], number of unfulfilled needs as reported by patients and personnel [15], and waiting time for nursing service [16].

There are basically three methods of assignment of patient care in a hospital setting: case, functional, and team. In the case method the total care of the patient is assigned to one member of the nursing staff. The primary nursing pattern represents this method. In the functional method the emphasis is task oriented and jobs are grouped in the interest of time and expediency of service. In the team approach a group of caregivers work together to meet the needs of a number of patients. The team plan is a synthesis of case and functional methods.

TEAM NURSING

Team nursing, a popular concept during the last twenty years, has been practiced in many ways and not always in accordance with the principles emphasized by its developers. This assignment system evolved in an attempt to meet increased demands for nursing service, recognizing the changing role of the professionsl nurse in relation to the increasing number of nonprofessional nursing personnel [17]. The team leader, a registered nurse, assigns their duties to the members of the team at the beginning of the shift, plans and coordinates the care for each patient, and serves continuously as a resource person for the team members. The team members may be nursing assistants or licensed practical nurses. A licensed practical nurse frequently serves as a medication nurse. The team members perform most of the direct care under supervision by the team leader. If the team leader is the only registered nurse on the team, he or she also has to perform the nursing procedures that require R.N. qualifications, including intravenous infusions and medications. At the end of the shift another team takes over the responsibilities.

PRIMARY NURSING

Primary nursing is a pattern of care developed at the University of Minnesota Hospitals. Manthey, the initial innovator, explains that dissatisfaction with fragmented care and lack of direct patient contact was an impetus to work toward a change in the system [18]:

> Convinced that team nursing, as a care delivery system, prevented us from developing the kind of relationship necessary if we were to assume professional level of responsibility for the comprehensive care of patients, we began to consider the different organizational patterns that would permit

us to take increased individual responsibility for fewer patients and provide them with comprehensive care.

In primary nursing, as defined by Manthey, there are two kinds of personnel: primary nurses and associate nurses [18]. Each nurse is the primary nurse when she is responsible for the care of patients throughout their stay in the hospital; she is an associate nurse whenever she cares for a patient whose primary nurse is off duty. The primary nurse-patient ratio may be 1 to 4 on the day tour of duty, depending on the type of care needed and the rapidity of patient turnover. The primary nurse, usually a registered nurse, always does an admission interview with these primary patients, formulates a nursing diagnosis, and issues nursing orders. Licensed practical nurses may be associate nurses. Each primary nurse handles coordinating activities with other departments, physicians, and the patients' families, so that the head nurse is free to take care of maintenance of the system and teaching. Nurses' aides may assist the nurses in patient care, but most of their time is taken up with cleaning, dietary tasks, and transportation. The primary nurse does preparation for discharge and sometimes home visits, including the family in planning for the patient.

The quality of care depends on the individual nurses, whether team nursing or primary nursing is practiced. It seems that primary nursing would increase the contact between the patient and at least one registered nurse, and that it would ensure continuity of care better than would team nursing. The presence of the same nurse on a day-to-day basis, as the primary therapist, facilitates a sense of trust and a feeling of freedom on the part of the patient to express feelings and concerns about self [19]. Logsdon [20] believes that hospital nurses must move to the primary nurse concept in order to halt the fragmentation of care and to become full members of the health team.

THE STUDY

A study was performed to compare patients' perceptions of care under team nursing and primary nursing. Because the patient is the consumer of nursing care he is a valuable source of information about nursing practice, although he is not qualified to evaluate nursing.

The problem under investigation was: Is there a difference in identified omissions in care as perceived by patients on medical-surgical units under two different patterns of care: team nursing and primary nursing?

Setting

The study was conducted in an acute medical-surgical 160-bed hospital in a retirement community in the southwestern United States. All patient units in the hospital were circular with semiprivate rooms. Non-nursing functions on the unit were reduced to a minimum.

Sample

Patients from all medical and surgical units in the hospital, with the exception of intensive care units, were included in the study on the following criteria: (1) mentally alert and oriented, (2) able to read and write English, (3) well enough to respond to the checklist, and (4) admitted at least two days prior to data collection. The final sample consisted of 52 patients who received care on one of the five units where team nursing was practiced (Group I), and 30 patients who received care on a recently opened medical-surgical unit where primary nursing was practiced.

The age and sex distribution in the two groups was the same, with a majority of women and a majority of patients over 60 years of age.

Data-Gathering Instrument

Patients' perceptions of care were measured by means of a checklist developed by the Division of Nursing Resources of the U. S. Public Health Service [21]. The checklist, intended to measure feelings of inadequacies of nursing service, consisted of 50 items representing situations that might have occurred during hospitalization. All except three of the items represented omissions in care. There were three alternative checkboxes: (1) This happened today, (2) This happened some other day, and (3) This did not happen.

The items could be grouped into seven categories: (1) events indicating satisfaction with care; (2) rest and relaxation; (3) dietary needs; (4) elimination; (5) personal hygiene and supportive care; (6) reaction to therapy; and (7) contact with nurses.

A score was developed for each category of each group, based on predetermined weights of the event [21]. Category scores represented percentage of maximum possible scores; the higher the score, the more omissions in care or the greater the dissatisfaction with the nursing service provided.

Data Collection

The investigator administered the instrument to all respondents, with an oral and written orientation following the checklist. A pilot study resulting in about 40 completed checklists from another hospital gave useful experience in data collection and led to changes in method and to the addition of five open-ended questions to the checklist in order to cover some areas central to expressive nursing activities.

The anonymity of the respondents was emphasized to all the patients and to the staff. Most often the checklist was picked up by the investigator on the same day or a couple of days after the delivery. From the patients' charts the investigator obtained information about demographic, medical, and nursing data in order to determine the relationships between perception of care and the variables age, sex, diagnosis, duration of hospital stay, and dependency on nursing activities. This part of the study is not reported in this article.

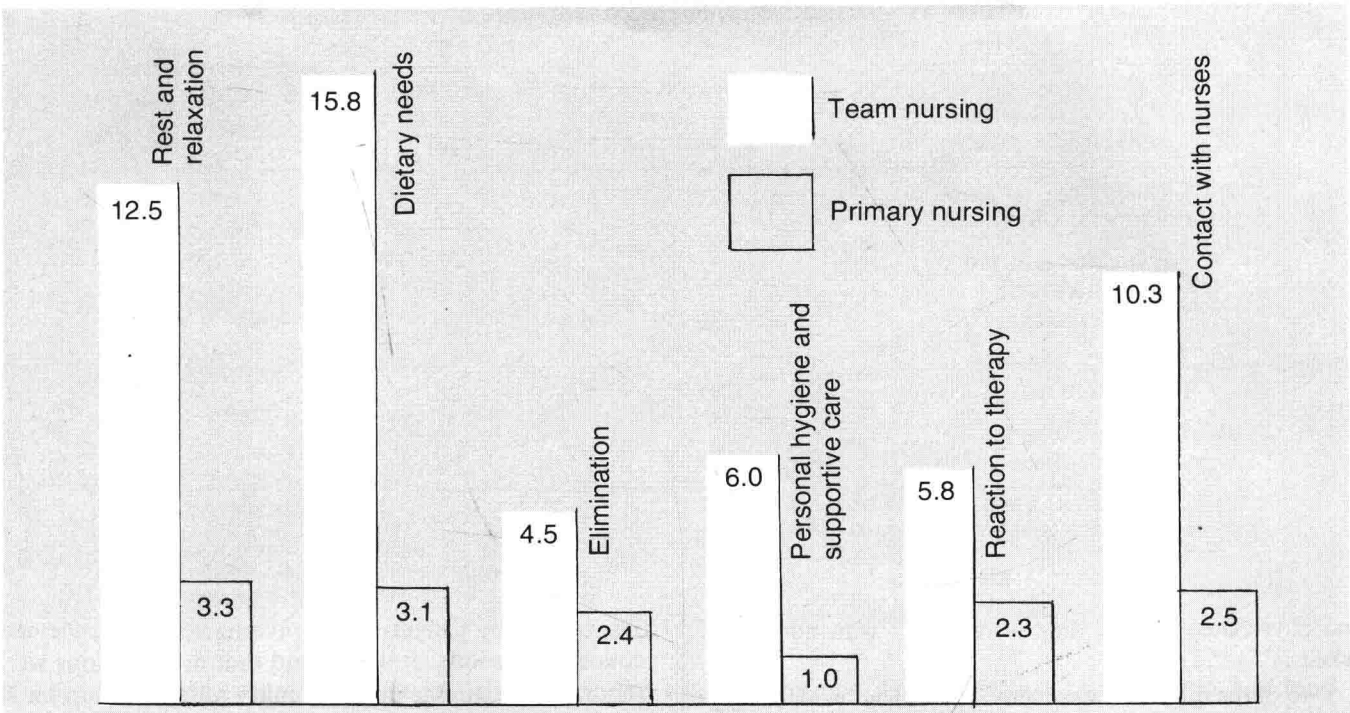

Figure 1. Omissions in care as measured by weighted category scores for the team nursing and primary nursing groups of patients.

RESULTS

Omissions in Care

According to the hypothesis that there are fewer omissions in care reported by the primary nursing group of patients, group I (team nursing) would show higher scores on the checklist than group II (primary nursing). Figure 1 shows that in all 6 categories, the weighted category scores indicating omissions in care were higher in the team nursing group. However, the difference was statistically significant in the dietary needs category only. The team nursing group reported significantly more omissions than the primary nursing group on 4 of the 8 items in the category Rest and relaxation. These items were "Other patients made disturbing noises," "Room was too warm or too chilly to sleep," "There was too much noise in the hall," and "Air in room was poor." Significant differences in the same direction were found in half of the items in the category Dietary needs; more patients in the team nursing group reported that their food was served in a hurry and was cold when served, and that they were not propped up for the meal, so it was difficult for them to enjoy it. In the category Contact with nurses, the team nursing group reported significantly more omissions on three of the items: "Nurse left before I could ask her questions," "My nurse would not tell me what was wrong with me," and "Nurse was unfriendly." None of the items on the checklist produced significantly higher percentages of omissions in the primary nursing group than in the team nursing group.

Satisfaction with Care

Table 1 shows responses on the three items on the checklist that indicated satisfaction with care. Occurrence of these items were reported by higher percentages of the primary nursing group, indicating higher satisfaction in these patients than in the team nursing group of patients. The difference was greatest on the item "My nurse explained my care to me," with 59% of group I and 87% of group II reporting this event.

Greater satisfaction with care in the primary nursing group than in the team nursing group was further indicated by responses to the open-ended questions.

Responses to open-ended questions

A significantly higher number (%) of the primary nursing (II) group felt that they had received adequate information about the hospital environment, routine, and procedures, as compared to the team nursing (I) group. Patients in both groups felt they had been treated as individuals in the hospital. The percentage of confirming answers dropped considerably when patients were asked if they had taken part in decisions about their own care: 67% of group I and 80% of group II answered positively, while 13 patients in group I and 3 in group II gave negative answers. Many of the patients commented that they left such decisions to the nurses