PERSPECTIVES IN PRIMARY NURSING

Professional Practice Environments

Barbara J. Brown

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Editor

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Foreword

Perspectives in Primary Nursing is a much needed collection of major contributions to the evolution and refinement of primary nursing. Nurses in all practice settings are raising questions and concerns about the significance of primary nursing. It is intended that this selection of key articles from previous issues of *Nursing Administration Quarterly* will provide readers with the perspectives of primary nursing that will assist in the development of the professional practice environment.

In 1976, when NAQ presented its first issue on primary nursing, I raised the question as to how long would primary nursing be here. Would it be a fad, here today and gone tomorrow, such as team nursing? It is apparent that the increasing number of hospitals applying primary nursing organization to their practice setting is indicative that it is *the* modality of hospital nursing practice and that it is here to stay. What then can we share with the nursing world, hospital administration, and others concerned about nursing practice that reflects the essence of primary nursing? Indeed it is a philosophy and a modality of professional health care delivery in which the patient and his or her family become active participants in the total health care process.

Each professional nurse is assigned a specific patient and family-client relationship and assists them with determining the client's health care needs, effecting a care plan based on integration with a medical care plan and other health care disciplines. As it relates to the science of nursing, the individual nurse must adopt a commitment to professional practice that embodies accountability, responsibility, and authority implying that the nurse is giving direction to his or her own practice. The increased personal satisfaction resulting from the performance of the professional role in nursing as a personal nurse providing total comprehensive care in partnership with associate nurses is a fulfilling role for each professional.

In other organizational modalities of nursing practice, the Registered Nurse generally abdicates the responsibility in fragmentation of patient care. Primary nursing requires a sound philosophy of nursing practice which enables the nurse to apply a family centered, humanistic approach to patient and family care needs in all phases of the health-illness continuum. The patient-family teaching role is embodied in the primary nurse role, and the primary nurse provides both preventive and curing aspects of patient care. In creating an environment conducive to professional practice that is supportive of primary nursing, many steps must be taken administratively. Placing these steps in the proper mosaic at the right time is the mastery of the art of change.

In most care settings, the implementation of primary nursing requires significant change in philosophy of the nursing department, organizational structure change with a decentralized model of nursing practice decision making, and a direction toward self-governance in nursing practice. Job

descriptions must be changed and clear expectations of individuals must be delineated. Such job descriptions include the role of the licensed practical nurse as an associate nurse with the capability of providing total patient care including responsibilities for patient medication. It also includes developing support systems for nursing so that nursing assistants are assigned to nurses rather than patients. Registered nurses then need the tools to practice primary nursing histories with comprehensive nursing assessments and delineation of the nursing care plan interfaced with the medical care plan. The primary nurse involves the patient and family together to formulate that plan of care, and shares that plan of care will all other members of the health care team.

The continuous implementation and regular update of that plan of care is a major responsibility of the primary nurse. It is through this process that the accountability for each primary nurse's patient care is achieved. While many changes are needed within nursing, primary nursing also impacts the entire hospital setting. It is most appropriate that collaborative joint practice committees be developed on primary nursing units as well as the centralized hospital medical nursing joint practice committee. These committees must give direction to mutually agreed upon standards of medical nursing practice, change for specific clinical provisions of practice, and mutually agreeable protocols for working through the quality care components needed by patients.

Other departmental support systems must be addressed. A key colleague of nursing is the clinical pharmacist. Examples of primary nurse implementation include changes in direction in practice of pharmacy, such as clinical based pharmacies with an integration of the clinical pharmacist role as primary care giving role along with the primary nurse. The same concept can be applied to a primary clinical dietician working in partnership with the primary nurse and other health care disciplines as appropriate.

Changes within ancillary support systems such as housekeeping, materials management, transportation, secretarial support to a nursing staff, as well as physical environmental changes may be necessary. In other words, the introduction of primary nursing to any hospital environment is not simple unit based activity. It impacts the total organizational structure; therefore, hospital administrators, financial directors, medical staffs, and boards of trustees must become fully involved in the change process and be supportive of nursing giving direction to its own practice.

It would be possible to achieve such level of professional practice without primary nursing per se, and primary nursing per se will not necessarily ensure that the professional practice environment will be effected. It is a combination of both that affords nursing the opportunity to become accountable for its own practice on a daily basis in any hospital setting.

Probably the most significant aspect of primary nursing is the professional registered nurse's willingness to assume this responsibility and accountability; therefore, it is imperative that the nursing staff itself give direction to change. More active participation by staff nurses in the change process is essential. Ultimately nursing staffs could be organized similar to the self-governance model of medical staffs. However, with the conflict of professional practice and collective bargaining, it is a tenuous change process to allow more active managerial decision making to take place by all nurses.

A key member in the clinical decision making for nursing is the integration of the advanced prepared clinical nurse specialist. Without clinical excellence through the leadership of clinical nurse specialists the professional practice environment is next to impossible to accomplish. The clinical nurse specialist has the ability and the knowledge to give the leadership to the appropriate documentation systems for each clinical division of practice, to be able to share in standard setting with colleague physicians, and demonstrate role model behavior as practicitioners, consultants, researchers, educators, and active decision makers in the administration process. Therefore, it is significant that in any setting wherein professional practice environment is desired, the appropriate integration of the role of the clinical nurse specialist is imperative.

Change in practice requires multiple negotiation and change strategies. There is no one best way to accomplish change, but we all know that nothing is done so well that someone will not find fault with it. As Machiavelli has said, "Nothing is more difficult than to initiate a new order of things." Nursing practice is on the pathway to a higher level of professionalism through the creation of primary nursing and professional practice envrionments. It is hoped that this book on primary nursing will assist the reader with moving forward in the change process.

Barbara Brown
Editor
January 1982

Preface

The impact of primary nursing programs on the internal structure and functioning of nursing departments is the focus of this collection of essays from *Nursing Administration Quarterly*. Many of the authors represented here are, or have been, primary nurses, and offer valuable firsthand insights into the conflicts, challenges, and rewards of the role. A broad perspective on the implementation of primary nursing programs in different kinds of hospitals, large and small, will be found in these pages.

A comprehensive view of the concept of primary nursing is essential to successful implementation of the program. Too often programs have failed because of an emphasis on externals—increased staffing, decentralized environments, the primary nurse's name on a kardex—rather than on internal changes in attitudes, feelings, and relationships. It is a dangerous oversimplification to view primary nursing as merely an administrative change in the method of assigning patients to nurses.

Primary nursing makes waves! It upsets the traditional balance of the social system within the nursing department itself and also between the department and other hospital staff. It reorders priorities, and may reveal deficiencies in professional competence that formerly were covered up by shared accountability. It is not surprising that some hospitals have abandoned primary nursing programs because of the inevitable problems of resistance, confusion, and fears. It seemed to them that primary nursing did not solve any problems; it only generated new ones and magnified old ones. And yet, if leaders are prepared to deal with these problems, the outcome can be successful despite all these difficulties.

In showing how nurses cope successfully with the challenges of primary nursing, this anthology offers practical assistance to leaders who are seeking the best way to initiate, support, and maintain programs in their own institutions. Successful implementation brings a gradual, pervasive change throughout the nursing department, with positive effects on all the areas that nursing touches. Most important of all, the philosophy of primary nursing will be incorporated by nursing administrators into all their plans for the department, because primary nursing actualizes their concept of professional nursing. There will be a feeling of expansive, creative energy. Primary nursing can be a catalyst that enables the ideal of professional practice to become a reality.

Karen L. Ciske
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Primary Nursing
January 1982

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Part I
Philosophical considerations in choosing primary nursing

The autonomous nurse and primary nursing

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ARE YOU an autonomous nurse? Some nurses may choose to enter a joint practice relationship with a physician, such as a nurse-midwife or family nurse practitioner. This autonomous nurse is associated with physician and hospital, and must apply for privileges for practice to the nursing staff organization in the same way a physician applies for privileges to the medical staff. Some privileges can be denied for lack of evidence of adequate preparation and experience. When competence can be demonstrated, privileges will be extended.

FAMILY-CENTERED HEALTH CARE IN PRIMARY NURSING

Most nurses choose to practice through employment in an institutional setting, such as a hospital. The

Adapted from a presentation at the program "Prerequisite for Nurse-Physician Collaboration: Nursing Autonomy," sponsored by the National Joint Practice Commission at the American Nurses' Association Convention '76, in Atlantic City.

The Autonomous Nurse Is Not:

- a trained nurse.
- a team member or team leader.
- an efficiency machine. "Nursing care was being provided in a Totally Efficient World. There were no sick people anymore, there were only sick lungs, sick hearts, sick bones, and on and on. There was no longer any need for nurses, so they were dismissed. For as any Machine will tell you immediately, nurses care for whole people—and that's Inefficient." (Thomas, Lauraine, R.N., M.S., "And Then There Were None," *RN*, August, 1972).
- a watcher of watchers or a care giver by proxy.
- a desk or charge nurse.
- a checker upper of cheaper doers.
- does not do everything when no one else is there to do it.
- does not get caught on a limb without any alternatives.
- does not take orders from doctors.

practice of nursing requires that the organizational relationships allow the nurse's relationship with individual patients to be as direct and undiluted by delegation as possible. This is only possible through primary nursing. Primary nursing has been utilized in implementing family-centered care at Family Hospital.

The concept of family-centered health care emerged from an active regard for the dignity and individuality of all persons, whatever their age, sex or lifestyle. In family-centered care we are committed to dealing with patients' needs on three levels:

- the needs of the patient as an individual;
- the needs of the patient as a family member; and
- the needs of the total family that can be touched by the hospital.

Our primary goal is to provide an atmosphere in which the patient and his or her family feel at home in the hospital environment. We seek an informed patient in control of his or her health care needs. We seek family participation in our health care delivery approach, so that we achieve effective management of the patient's health problems. As we evolved family-centered care for every patient, we turned to *primary* nursing as the only methodology each family care nurse should employ to organize and deliver direct patient care.

The Autonomous Nurse:

- is responsible to the patient and family for individualized, total nursing care.
- is capable of independent clinical decision-making and does not need to get this decision ratified ahead of time either by physician or nurse.
- has a thorough command of nursing practice. He/she is capable of thoroughly assessing his/her patient's needs (history and physical taking; developing a plan of care in collaboration with physicians, the patient and family, and other health disciplines.
- provides direct care to patients and their families, and provides an opportunity for patients and families to participate in their own care whenever desired and possible.
- serves as a consultant to patients and families and assists them in informed decision-making regarding their health status through comprehensive teaching processes.
- has professional parity with physicians and deals with individual physicians as a fully accountable member of the hospital organization in providing quality patient care.
- practices the complete professional model of service, education, consultation and research.

FAMILY CARE NURSE

Traditional nursing care would not work. In traditional nursing care systems, the registered professional nurse took care of patients on a daily assignment basis and often delegated most of this care to practical nurses and nursing assistants. A patient with general medical-surgical care needs was often lucky to see an RN during hospitalization. Care, therefore, was rendered according to doctors' orders, a medically oriented approach. The head nurse and team leader were usually "desk" nurses, who only check up on care given by nursing assistants and practical nurses. With few RNs functioning in direct patient care staff positions, there was little time or responsibility for patient teaching, discharge planning or coordination of patient care with other disciplines. Registered nurses could provide very little direct patient care and primarily worked through assigning non-professional people to give care. Our patients, physicians and nurses found this traditional care system to be very unsatisfactory. And nurses left, due to their frustration with this system. So we changed.

Each patient is assigned to his or her family care nurse upon admission to a hospital unit. Some patients may select their nurse prior to admission and request to be placed in a specific unit where that nurse is practicing.

The nurse has a direct patient and family responsibility and a 24 hour accountability to provide consultation, coordination, evaluation, and direction of that care throughout the hospitalization. The family care nurse is responsible for a complete patient history and physical assessment; determining the plan of care and evaluating care; and recording care on a patient progress record in a chronological sequence just as the physician does.

- **Detailed documentation** is done through clinical data sheets, daily activity sheets, and patient self-charting. Nurses' notes are no longer necessary. A "medical" record is a "patient" record. All parts must contain relevant, integrated data regarding the total state of health of the patient. Peer collaboration can be facilitated more readily when nurses and physicians chart together on behalf of the patient.
- Each nurse is responsible for **teaching and discharge planning** for his or her patient. A referral to another nurse is (and should be) a nursing prerogative. If a patient needs a nursing care component that I cannot render, it is my responsibility to seek out a colleague who has the capability to do so.
- Physicians seek consultants when they cannot handle an aspect of care. Nurses must exercise this **consultant role** more fully. The teaching component of care is provided directly by the individual nurse as well as in group processes such as pre-natal, parenting classes and pre-operative, post-operative hysterectomy group counseling sessions.
- **Research** is a vital component for the autonomous nurse. The research process must be used by all nurses to find solutions to some of the problems and questions which arise continuously in clinical nursing.
- **Problem solving** process is a more frequently used and comfortable approach for most practicing nurses. These processes can best be implemented in an environment which can be supportive both in provision of time and resource personnel with research knowledge. Family Hospital is committed to provide support and assistance necessary for the implementation of research in nursing.

PHILOSOPHY

Our philosophy of nursing services states that the primary responsibility of the professional nurse is to "provide and *evaluate* comprehensive family centered care to patients assigned."

In addition, our philosophy calls for nursing to "initiate, utilize and/or participate in studies or projects designed for the improvement of patient care."

In accordance with our stated philosophy, all professional nurses have a responsibility to identify researchable problems and participate in studies related to the quality of nursing care.

ORGANIZATION

The fullest professional role of the autonomous nurse has been explored in terms of service, education, consultation, and research. This clearly calls for the organizational structure of primary nursing to allow for complete implementation.

If a nurse is to be autonomous, hierarchical organizational structures must be leveled to provide fullest autonomy, responsibility, and authority. Authority refers to legitimacy and must be linked to autonomy. This is evidenced in organizational realization that the nurse has the primary responsibility for coordinating all aspects of patient care.

The domain of action for the nurse gives evidence to decision-making initiated and acted upon by each nurse in exercising authority, responsibility, and accountability to the patient for quality nursing care.

Every medical staff committee meeting at Family Hospital is attended by appropriate nursing staff according to area of competency. For example, OB-GYN Section Meeting is open to all OB-GYN nurses. Nurses participate in and give direction to change in behalf of improved patient care. Nurses cannot blame administration, doctors, or other nurses for lack of progress.

Budget and fiscal priorities are set by nurses on each unit. Each nurse has a responsibility for appropriate allocation and utilization of human resources. How do nurses accept this accountability? It's not easy—the malpractice insurance crisis created sudden drops in census; decisions had to be made as to who would provide care to patients; when nurses are confronted with "is it an RN or a nursing assistant or an LPN?", what decision can be rendered?

DIRECT PATIENT RESPONSIBILITY

Every patient has a right to expect that a registered nurse will provide him with care while in the hospital. Any person less than an RN is unacceptable to the public when nursing intervention is needed.

The patient who needs a nurse most is frequently abandoned to others. How many times do we see a postoperative patient ambulated with an IV running by a nursing assistant. Who assesses pre-ambulation state, i.e., blood pressure, vital signs, surgical site, general condition, and reassesses same following ambulation? Is nursing capable of rendering a professional care system of parity, symmetry, and balance? What stake will nurses take in the health care endeavor?

Our goal should be the mutual integration of medicine and nursing to provide the best consultation to the patient and family in medical and health care. Nursing is promotion of wellness, health maintenance; medicine is illness oriented, therapeutic intervention based on medical diagnosis of state of illness.

TRANSITION TO AUTONOMY

How does a nurse reach this autonomous state of being? Few nurses

graduate exhibiting the full professional characteristics of autonomy in providing service, education, consultation, and research to the health care consumer. Whether a particular educational model produces such a graduate is not the forum for this article and has certainly created much debate in nursing service and education.

It has been my experience that each nurse, whether an AD, Diploma, or Baccalaureate, requires a transition program clearly defined and specified to provide an orderly environment and milieu in which to develop an autonomous nurse state. We have evolved an internship program of three months in length to evolutionize our new graduate family care nurses so that each nurse is enabled to function as clinically competent autonomous professionals.

A new colleague and collaborator for the independent practice of health care is ready to join forces with medicine to preserve autonomy in health care delivery.

Nurses and physicians must be honest enough to collaborate with one another in the interest of health and safety of the public. Nurses and physicians need to respect each other for the territorial right that is professionally theirs. Each independent health professional must accept individual responsibility and accountability for his/her acts. The autonomous nurse and primary nursing mandate that every professional nurse is responsible and accountable for all of his/her acts.

Machiavelli said, "There is nothing more difficult to carry out nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things."

Are you ready to assume your state of autonomous being?