

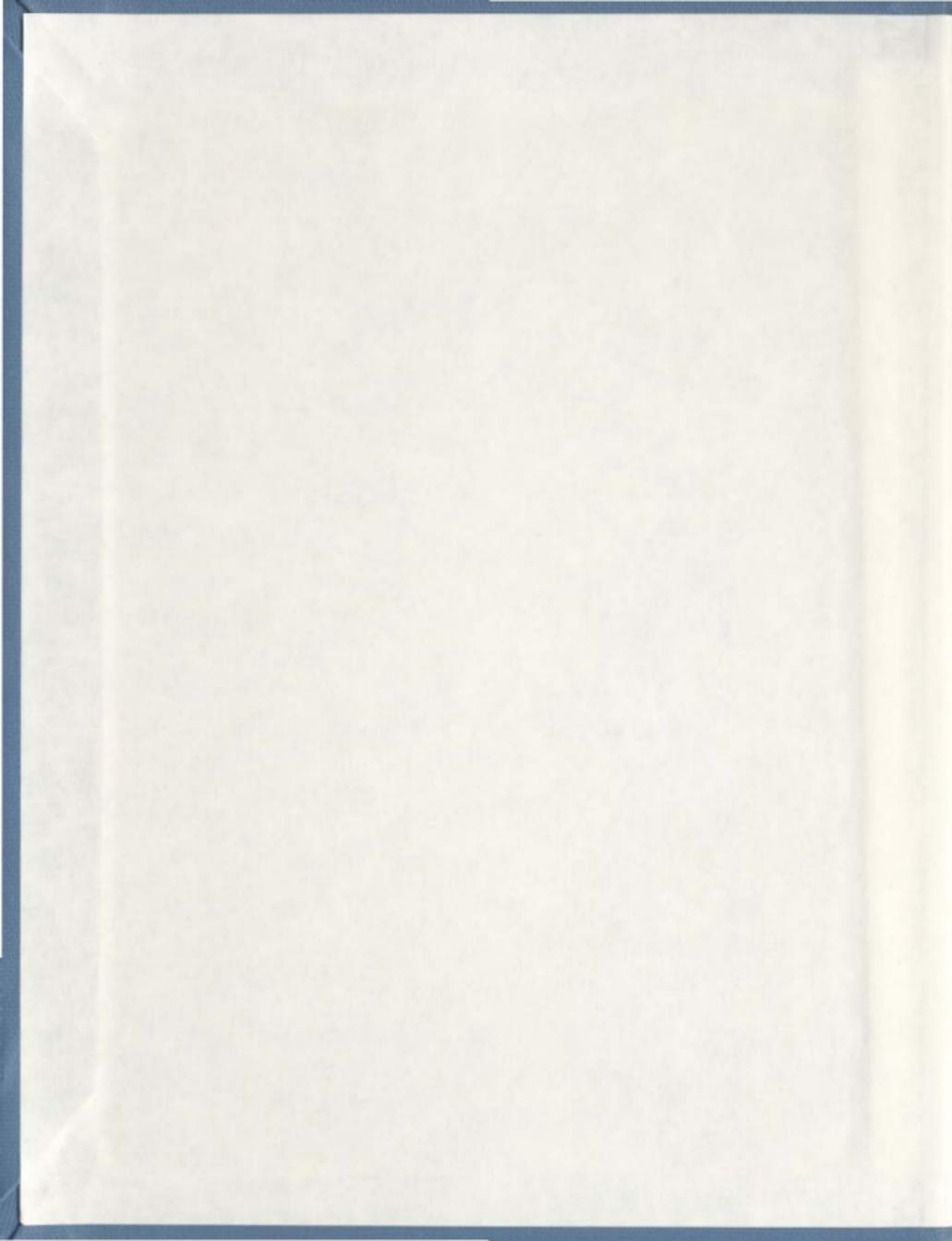
ETHNOGRAPHY: PRIMARY NURSING, AN
INVESTIGATION INTO THE NATURE OF
ONE TYPE OF PATIENT CARE MODALITY

CENTRE FOR NEWFOUNDLAND STUDIES

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MINEKO YAMASHITA



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**ETHNOGRAPHY: PRIMARY NURSING
AN INVESTIGATION INTO THE
NATURE OF ONE TYPE OF
PATIENT CARE MODALITY**

BY

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**A Thesis submitted to the School of Graduate
Studies in partial fulfillment of the
requirements to the degree of
Master of Nursing**

School of Nursing

Memorial University of Newfoundland

October 1986

St. John's

Newfoundland

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ISBN 0-315-33638-2

ABSTRACT

The purpose of this study was to describe the nature of primary nursing by using five core elements under which nurses' activities were described by observing nurses on a unit and interviewing them over a period of three months.

The study was based on the ethnographical approach. Through the method of participant observation, the interactions taking place between the nurses and their patients, the family members, peers and other health care personnel were examined. The main focus was placed on the nurse-patient interaction as occurred on the unit. Documents, such as Progress Notes (Nurses' Notes), kardex and communication books, which were related to patient-care delivery, were also examined. From the literature review, the following five core elements were identified. These core elements were: *Responsibility, accountability, autonomy, caring and decentralized communication*. The data were analyzed on an ongoing basis to identify, sort and categorize the nurses' activities under appropriate core elements.

Each participant practised her primary nursing care delivery mode with definite, identified constructs which formed a conceptual framework to guide her practice. While the constructs identified and the outcome of care delivered by the participants were similar, the mode of patient care delivery was found to be unique to each individual nurse.

Despite each participant's diverse approach to patient care, a similar pattern of activities and behavior occurred consistently among all participants under the identified constructs and the pattern was examined as a group behavior to derive a definition of primary nursing. Based on the data obtained from this study using these constructs to describe the nature of primary nursing, the following definition of primary nursing emerged.

Primary nursing is a nursing care delivery system whereby each primary nurse is assigned to a group of four to six patients. The primary nurse is *responsible* and *accountable* for her patients' individualized total care. She carries out a comprehensive patient care in an *autonomous* and *caring* manner by coordinating and collaborating with the family and other health care members through direct and *open communication*. As a multidisciplinary member of the health care system, the primary nurse acts as the patient advocate. She is empowered to delegate responsibility, in her absence, to her peers by the nursing care plan. In this way, continuity of care on a 24-hour basis is ensured throughout the patient's hospitalization.

ACKNOWLEDGEMENT

With thanks to Dr Samuel Danquah, the thesis-supervisor; and Dr Suzan Banoub.

Thanks to Ms Shirley Solberg and Ms Sheila Stenzel whose help in editing and proofreading was most invaluable!

Thanks also to my friends both at home and abroad and colleagues who continue to lead the health care arena as autonomous practitioners.

DEDICATION

To the five nurses who participated in this study and to their patients; to my parents in Japan and Jean T. Hugill, M.D. in Vancouver who remained interested in my work and extended continuous support and encouragement over a decade of study since my arrival in Canada.

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Chapter 1

INTRODUCTION

The Problem

Since the Nightingale era, when modern nursing emerged, there have been a number of major changes in the modalities of delivery of nursing care. Four distinct nursing modalities, each with different values and characteristics, have been identified in the nursing literature (Marram, Schlegel, & Bevis, 1974). They are: Case modality, functional modality, team modality and primary nursing modality. Each of the four models seemed to emerge as a response to certain problems perceived in the delivery of nursing care, or as a response to other factors in the health care field or society in general.

The first model of delivery of nursing care, which was prevalent until about 50 years ago, was known as the "case method", or private duty nursing. In this method a nurse was employed to look after the sick in the patient's own home where nursing care was delivered based on the individualized needs and the patient's family members became involved in the delivery of care. When more and more patients went into the hospital, the private duty nurse moved into the hospital and employed the case method to look after one or more patients.

After World War II there were a large number of auxiliary health care workers who had been produced to meet the demand created by the war and were available for minimal pay. These auxiliary health care workers such as practical nurses, nurses' aide and orderlies, moved into the hospital. Functional nursing arose in response to this situation. Patient care was divided functionally, so that the task requiring the least skill would be done by the least skilled worker. As the practical nurses, nurses' aide and orderlies became the main source of inexpensive hospital labor, registered nurses were removed from the bedside of all but the most acutely ill patients. Thus, no one person integrated care to meet the patient's total needs as a unique individual.

During the fifties, the concept of team nursing developed and was overwhelmingly accepted by hospital administrators who believed it to be the panacea to solve the chronic shortage of nurses. Team nursing allowed the care of the patient to be distributed among the members of a team. Team nursing was unsuccessful leading to staff dissatisfaction because of fragmented care, and no one person assuming responsibility for a patient care. Despite the intended purpose which was efficiency in patient care delivery, team nursing resulted in the opposite outcome.

The term primary nursing was given to a new pattern of nursing care first introduced to a medical unit at the University of Minnesota Hospital in 1969. The word primary reflected the principle that a nurse's relationship with specific patients would transcend shifts and remain primary in priorities and interactions (Zander, 1980, p. 23). Since that time, primary nursing has been instituted in a

variety of settings. Researchers have studied various aspects of this patient care modality, including patient satisfaction (Sellick, Russell, & Beckmann, 1983), nurse satisfaction (Carlsen & Malley, 1981), quality of care (Donahue, Weiner, & Shirk, 1977; Eichhorn & Frevert, 1979; Hamera & O'Connell, 1981), and cost-effectiveness (Felton, 1975; Marram, 1976). Various studies of primary nursing describe how it developed from a previous nursing care delivery system such as functional or team nursing. The majority of these descriptive studies reported predominantly the theoretical framework and characteristic concepts with which primary nursing was identified (Marram, 1973; Ciske, 1977; Hegyvary, 1977; Manthey, 1980; Zander, 1980). No reports were found describing primary nurses' activities as practised within its philosophical context. A problem seems to stem from continuous attempts to measure this process which is difficult to quantify; moreover, instruments employed in the previous studies lacked validity and reliability. Definitions of primary nursing have been inconsistent, and most importantly, none of the studies examined the nature of primary nursing based on an operational definition. Zander (1980) and Giovannetti (1984) identified the methodological difficulties in measuring and quantifying patient care delivery, together with the lack of a consistent definition and practice. Therefore, it becomes necessary at this point to investigate more fully the nature of this patient care modality so that a better understanding of primary nursing may be attained.

Purpose and Objective of the Study

Previous studies on primary nursing have not taken a detailed look at the nature of this patient care modality. The present study examines the nature of primary nursing as practised in one particular setting by focusing on selected

4

aspects of the nurses' activities, using five core elements which were identified from the literature review. The overall objective is to describe nurses' activities by employing ethnography where participant observation in conjunction with interviewing was the central data gathering technique.

Conceptual Framework

The following core elements of primary nursing were identified in the literature: Responsibility, accountability, autonomy, continuity of care, direct communication with peers, doctors, supervisors, family members and other allied health care team members, assertiveness, patient advocacy, collaboration, coordination, contracting, decentralized decision-making, and professional and self-growth (Marram, Schlegel & Bevis, 1974; Brown, 1976; Ciske, 1976; Hegyvary, 1977; Manthey, 1980).

Out of the above, five core elements were selected along four dimensions. The five core elements were: *Responsibility, accountability, autonomy, caring, and decentralized communication*. The four dimensions were: *Patient care, the patient's family members and significant others, physician, and other health care members*. These five major core elements together with four dimensions form the conceptual framework for this study. The remaining elements, namely: *Continuity of care, assertiveness, patient advocacy, collaboration, contracting, decentralized decision-making, and professional and self-growth* were implicitly incorporated into the conceptual framework throughout the narratives under the five major constructs, since they are closely interwoven with these five major constructs along the four dimensions. The first three constructs, namely:

Responsibility, accountability, and autonomy together with a comprehensive, coordinated, continuous and individualized total patient care on a 24-hour basis were identified as the major elements representing primary nursing philosophy as practised on unit 5 (see Appendix G). A model of primary nursing is suggested by the researcher and depicted in Figure 1.

Assumptions of the Study

1. Primary nursing has certain core elements in terms of nurses' role behavior.
2. A veterans' unit which employs primary nursing has a formal and an informal structure, with a set of norms and expectations, values and beliefs that regulate the behavior of its members.
3. The nurses' behavioral pattern can be studied in depth by focusing intensively upon the culture of the nurses over a period of time.

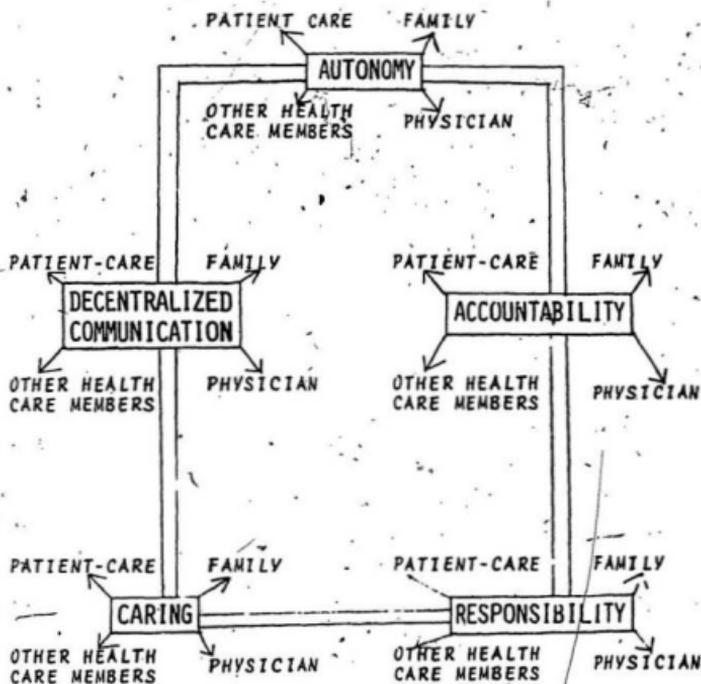
Definition of Terms

In this study the following terms are used as defined:

1. Primary nurse: A registered nurse who is employed full-time. She delivers direct patient care by coordinating and collaborating with other health care members. She is responsible to deliver total patient care from admission to discharge.
2. Associate nurse: A registered nurse who is employed on a casual basis and takes the primary nurse's place when the primary nurse is off duty. She delivers total patient care on behalf of the primary nurse in her absence, and she is accountable to the primary nurse for the care she delivers until the primary nurse returns to take over the primary patients from the associate nurse.
3. Nursing assistant: A certified nursing assistant employed full-time and is co-assigned to the primary nurse's patients. She delivers nursing care under the supervision and guidance of the primary nurse and works with in the same district.

4. **Responsibility:** The primary nurse is responsible for making clinical judgements and decisions on behalf of a group of assigned patients to plan and deliver nursing care from admission to discharge.
5. **Accountability:** The primary nurse is accountable for her decisions and actions, through which she delivers total patient care to her patients and their family members on a 24-hour basis.
6. **Autonomy:** The primary nurse knows when nursing is needed and administers a variety of nursing measures which fall within the jurisdiction of nursing.
7. **Caring:** The primary nurse displays, both verbally and non-verbally, a humanistic attitude to the patients, family members and other health care members including peers.
8. **Decentralized Communication:** The primary nurse communicates directly with the patient, family members, physician and other health care members. She also communicates among peers verbally and in writing to ensure continuity of care.
9. **Total Nursing Care:** The nurse delivers individualized care using physical, emotional and social data of the patient, and intellectual and hands-on skills to identify and resolve the patient's unhealthful health-maintenance behavior, regardless of any nursing care modality.

Figure 1-1: PRIMARY NURSING MODEL OF INDIVIDUALIZED PATIENT CARE



Chapter 2

SURVEY OF THE LITERATURE

The survey of the literature summarizes primarily the historical development of the studies on primary nursing. One of the leaders in the sixties, Lydia Hall (1969), criticized team nursing as follows:

... we perpetrate the greatest disservice to the American public ... team nursing ... is concerned mainly with getting the nursing work done ... Any career that is defined around the work that has to be done, and how it is divided to get it done, is a trade. Thus, the assumption behind team nursing is that it is a trade, at a time when patients not only could profit from professional nursing, but that professing nursing is vital in their achieving rehabilitation through learning. (p. 83)

This dynamic leader, Lydia Hall, established the Loeb Center for Rehabilitation Nursing in New York City in 1963 to demonstrate professional nursing in institutional care where the nurse was and still is the chief therapeutic agent and the final effector in providing interrelated patient care while medicine and other health care professions served as ancillary. However, the Loeb Center, the prototype of primary nursing, never spread to other institutions. As possible reasons, Hegyvary (1982) postulates as follows:

1. The concept of professional nursing was already so abused that it had little appeal or challenge for most nurses.
2. The model was simply misunderstood, feared, or resented. (pp. 9-10)

Additional reasons are suggested by the researcher. There was a resistance to implementation of this model on administrative levels because to the hospital administrator, a team or functional nursing modality met the demand to satisfy the "manpower shortage". Furthermore there was a continuous enrollment of students at vocational institutions whose graduates sought employment to work as ancillary staff under these patient care delivery systems. Once employed as full-time with progressive seniority, these ancillary staff secured their position to maintain their status in the institution. Baccalaureate programs in nursing were just beginning to be accepted to prepare nurses as professional health care workers about this time. To aggravate this problem there were very few nurses who had graduate degrees and were qualified to teach at baccalaureate level. Still a problem existed where resistance was met by auxiliary as well as professional health care workers in the process of attempting to bring about change. Any change was a menace to their job security, particularly for the veteran auxiliary staff who were resistant to change including implementation of primary nursing.

A need to establish such an institution to deliver professional nursing care was recognized by other nurse leaders at this time. Malone (1964) pointed out the dilemma of a professional in a bureaucracy due to different values between professional and bureaucratic value systems. She identified professional value to be more important and suggested a change within a bureaucratic organization where professional values could be recognized and practised.

Kramer (1974) examined the phenomenon of a gap existing between professional and bureaucratic value systems in the course of her research in the

later sixties which was compiled in the book Reality Shock. She described the phenomenon as the dilemma experienced by a new graduate who entered into an institution where she became disillusioned about the way nursing was practised, which was far from the ideal which she believed to be practised in reality.

Primary nursing was first implemented at the University of Minnesota Hospital under the direction of Mantley (1970) in 1969. Since that time primary nursing has been implemented around the globe and reports of its implementation have been reported from such countries as Australia, Belgium, Japan, and the Netherlands (Hegyvary, 1982). Does primary nursing which is practised in one country differ from another? The answer is emphatically positive, particularly at this stage when there is no consistent definition of primary nursing. Regional variations occur even within a country. A national survey was conducted to examine similarities and differences in the practice of primary nursing in 118 hospitals in the United States. It revealed a wide variation of practice from one hospital to another. Most hospitals practised a combination of primary nursing and team nursing rather than primary nursing exclusively. The differences arose when a lack of uniformity in the definition of its concept occurred among nursing leaders. In fact, the literature reveals multiple translations of the original concept of primary nursing (van Servellen, 1981).

To date, studies on primary nursing can be summarized into five major categories, depending on the particular focus of study.

1. satisfaction (patient, nurse, and physician) (Knecht, 1973; Cicatiello, 1977; Corpuz, 1977; Ciske, 1974; Daeffler, 1975; Isler, 1976; Donahue, Weiner, & Shirk, 1977; Nenner, Curtis & Eckhoff, 1977; Hegedus, 1980; Carlsen & Malley, 1981).

2. cost-effectiveness (administration) (Felton, 1975; Jones, 1975; Brown, 1976; Marram, 1976)
3. professionalization (Knecht, 1973; Bakke, 1974; Bolder, 1977; Cicatiello, 1977; Smith, 1977; Anderson & Choi, 1980)
4. quality of care focusing on the process (Ciske, 1974; Hamera & O'Connell, 1981)
5. quality of care focusing on the outcome (Ciske, 1974; Christman, 1977)

A number of studies described the impact of the role of the head nurse; several of these evaluated primary nursing from the head nurse's perspective. Once the concept of primary nursing is successfully implemented, its ultimate success or failure is the responsibility of the head nurse. The head nurse must believe totally in the concept's ability to provide optimum patient care, to develop the staff's potential as professionals and to serve as the avenue which will put nursing in its proper position within the health care delivery system (Ferrin, 1981).

Page (1974) examined the role of the head nurse and identified it to be that of a role model to demonstrate clinical knowledge and skills, add leadership ability. Zander (1977) also suggested that the head nurse should accept a change in her own role, in her leadership style, and in her functions as unit manager on a unit where primary nursing was implemented, and stated that the credibility and influence as a head nurse were crucial factors to implement primary nursing successfully. Ciske (1974) proposed that the role of the head nurse, unit management system and support systems (pharmacy, central supply) could be important factors for primary nursing to be successful. She (1974) further reported that float nurses observed better care plans on primary nursing units

than units which practised other modalities, although a survey of patients' opinions on primary nursing unit did not live up to surveyors' expectations.

Primary nursing has been evaluated in terms of cost-effectiveness. Felton (1975) reported that the cost of nursing care per patient per day under primary nursing was \$30.14, whereas in team nursing \$34.49. In another study on the comparative costs, Marram (1976) concluded that it was less on the primary unit than on the team unit.

Primary nursing has also been considered as a return to patient-centered care. It was found to increase patient, family, physician and administrator's satisfaction with the quality of nursing care; increase staff nurse satisfaction, responsibility and accountability for the individual professional primary nurses as well as decrease absence and turnover rates (Donahue et al., 1977). Other studies indicate that the quality of care was markedly increased following the implementation of primary nursing (Williams, 1975; Eichhorn & Frevert, 1979).

A summary of primary nursing evaluation studies is listed in Appendix P. Comparative studies were done on primary nursing and team nursing (Young, Giovannetti, & Lewison, 1980; Giovannetti, 1981; Young, Giovannetti, Lewison, & Thoms, 1981; Hamera & O'Connell, 1981; Chavingny & Lewis, 1984). Hamera and O'Connell (1981) found that the primary patient group received more nurturance and participated more actively in care than the team patient group, which supported the hypothesis that primary nursing increased quality of nursing care. However, Giovannetti et al (1980, 1981) reported conflicting findings as qualitative

differences in nursing personnel, managerial, organizational and environmental factors were not taken into account. The interplay between primary nursing activities and the organizational structure were identified as significant and it was contended that for primary nursing to succeed, a high level of initiative from the nurses and from the organization that provided structural autonomy to the nurses was required (Spitzer, 1979; Anderson & Choi, 1980).

Organizational and environmental factors were examined in other studies. The interplay between support systems and nursing care structures were identified as an important factor (Shukla, 1982, 1983; Shukla & Turner, 1984). These studies reported contradictory findings; the primary structure provided the least amount of direct care by each nurse, and also primary nursing cost was more expensive than modular and team units. The problem appears that primary nursing was treated as a system instead of a philosophy in these studies, emphasizing their focus on the organizational and technical support systems instead of function and structure of nursing staff. Therefore, as Manthey (1980) pointed out, primary nursing, treated as a system, does not define or guarantee the quality of nursing care.

Concurrent evaluation of primary nursing focuses on review of nursing care while it is in process and while the patient is still in hospital. There are three major approaches in concurrent evaluation; from the nursing staff's perspective (job satisfaction), from the patients' perspective (satisfaction of care received), and the administrative perspective (cost-effectiveness).

Of studies examining patients' perception of care, it appears to be the investigators' consensus that due to a lack of valid and reliable instruments to measure patient care outcomes, inconsistent sometimes contradictory findings were produced. In order to measure patients' perception of care, methodological considerations should be the primary concern. Conflicting findings and the high variances in the satisfaction within each structure suggest that it is imperative that the instrument used must have construct validity and reliability.

French (1981) surveyed response rates for studies conducted in Britain and the United States. She concluded that interviews with patients were preferable to self-completion questionnaires. High response rates obtained through interviews lessened worry about non-response bias. Although researchers originally attempted to measure the degree of patient satisfaction both in primary and team nursing modalities; they had difficulties regarding validity and reliability of instruments (Risser, 1975; Ventura, 1980; Ventura et al., 1982).

Besides methodological difficulties, a major problem in evaluating primary nursing in terms of patient satisfaction may be summarized as measuring the multidimensional aspects of patient satisfaction described by Donabedian (1983) as follows:

Client satisfaction has many connotations that are relevant to the quality of care. In one sense, it is an "outcome" of care, much like a change in physical or physiological function. In another role, satisfaction is an "input" into care, since care is merely something that is passively received, but a process to which both the client and the practitioner contribute. A dissatisfied patient is hardly the right partner in this often arduous enterprise. (p. 219)

Due to conflicting research findings and the high variances in the satisfaction within each structure, the investigators of these studies suggested that there could be other factors that should affect patient satisfaction more than the nursing modalities of team or primary nursing. It was postulated that the clinical and interpersonal skills of the nursing staff were important intervening variables (Felton, 1975; Shukla, 1981). None of the studies utilized ethnography to evaluate patient satisfaction.

In order to clarify these two issues of the efficiency of the support systems and the competency of the nursing staff, Shukla and Turner (1984) replicated a study to examine the impact of structures on patients satisfaction with nursing care after controlling the quality and quantity of the nursing staff. The results indicated no statistical differences between the team and primary nursing care units. This result was contrary to the findings of Daeffler. Matching was done on staff levels, competency of the staff, and sample size for the two nursing modalities in a study by Shukla and Turner (1984). In contrast, a study done by Daeffler (1975) did not control staff competency and his samples were of different sizes between the two nursing units. Both of the studies, however, used the same instruments.

Zander (1980, p.7) states that "the current debate is whether primary nursing is a return to an old pattern of nursing with a new name or whether it is a truly new idea". She describes primary nursing as an integration of attitudes, knowledge and skills some of which have been part of the nursing profession since its inception and others are relatively modern and even futuristic. She further

states that "primary nursing is as old as the laying-on of hands and as new as consumer rights. Because of this paradox, primary nursing is potentially the most powerful force in the health care delivery system" (p. 7).

Hegyvary (1982) states that implementing primary nursing is a giant step toward the professionalization of nursing practice, which requires a drastic change in behavior and organization. She (1982, p. 15) regards primary nursing as a "model of professional practice coming closest to meeting the criteria of 'profession' in the practice of nursing in institution". She continues as follows:

Although primary nursing was based on the principles of professional practice as applied at the Loeb Center,¹ it was regarded by many nurses as a new concept. It added the dimension of 24-hour accountability of one nurse and offered a solution for fragmented, task-oriented care, for dissatisfaction with nursing, and for the depersonalization of the hospital. It was an ideal that attracted many nurses. (p.10)

Primary nursing is not new. What is new is an attempt to organize the way we deliver care in hospitals into a methodology that provides the maximum exposure of nurses to the patients and allows for the same satisfaction and professional relationship with the patient and family that happened when we did private duty nursing years ago (Brown, 1977).

Various definitions of primary nursing have been documented by many researchers. The central features of primary nursing appear to focus on one patient-one nurse and delivery of care on a 24-hour basis from admission to discharge. The followings are definitions of primary nursing.

¹At Loeb the term primary is not used. "We prefer not to use the term 'primary care' ... We have been practicing Mrs Lydia Hall's philosophy of professional nursing practice." (D. Kolditz, Acting Director of Loeb, Personal Communication; May 17th, 1985)

Marram (1978) defines primary nursing as follows:

A primary nurse is one (usually a registered nurse) who functions to give total care to a small group of patients and who plans the care for these patients on a twenty-four hour basis throughout the patient's hospitalization. While primary care agents are usually located in prevention centres, clinics, and doctors' offices, primary nurses are exclusively in the hospital setting. (p. 2)

Manthey (1980) identifies four elements of primary nursing. They are:

1. the clear individualized allocation of responsibility for decision-making about patient-care,
2. daily assignment or the case method assignment which is patient-centered rather than task-centered,
3. direct channels of communication among the nursing staff as well as from the nurse and the patient, to the physician, dietician, physiotherapist, pharmacist, chaplain, etc., and
4. caregiver as care-planner. (p. 31)

Zander (1980) defines primary nursing as follows:

Primary nursing is a series of nursing activities performed on behalf of a patient and/or the patient's family by the same, specifically assigned registered nurse who is answerable both to the patient and to the administration of the institution for the outcomes of those activities ... The primary nurse is the consistent representative of the whole nursing staff to the patient and the patient's family throughout the length of their contact within the health care unit or agency. To be most effective, the primary nurse must deliver hands-on care to the primary patient when on duty. This includes assessing, planning, intervening, and evaluating nursing care. Even when off duty, the primary nurse is responsible for the nursing care that others have been directed to give. By talking to peers, physicians, and other members of the health care team on behalf of a primary patient, the primary nurse becomes the patient's spokesman within the system. (pp. 5-6)

Joiner, Johnson and Corkrean (1981) state as follows:

Primary nursing is an attempt to re-establish the traditional nurse-patient relationship. Its objective is to make a single nurse responsible for the total care of patients during their stay in the hospital. Primary nursing recognizes the patient as a whole person with psychosocial as well as physical needs. It establishes a therapeutic relationship between the patient and the primary nurse. The primary nurse reduces the isolation, apprehension and misunderstanding felt by many patients during their stay in the hospital. (p. 71)

Over the last decade, the definition of primary nursing has shifted its focus from structure to the nature of care being delivered. The central features of primary nursing have been consistent. These features are the three core elements as identified by Marram, Schlegel and Bevis (1974): Autonomy, authority and accountability. Marram, Schlegel and Bevis (1974) compare nursing's history of delivering patient care to Erikson's developmental tasks and claim that primary nursing is a step toward professional maturity.

While acknowledging that the structure and function of primary nursing differ from patient to patient and from institution to institution, Zander (1980) lists twelve key elements which are necessary to formulate an operational definition for primary nursing. They are: Accountability, advocacy, assertiveness, authority, autonomy, continuity, commitment, collaboration, contracting, coordination, communication and decentralization.

Lack of a consistent definition and practice of primary nursing has been resulted in difficulties in conducting nursing research on primary nursing (Zander, 1980; Giovannetti, 1982). Nonetheless, the previous researchers persisted to continue to use quantitative methodology. Objective measurement using reliable

and valid instruments and appropriate research designs, sample techniques and quantitative analysis is lacking in all but a few of these studies. Giovannetti (1984, p. 236) suggests that "Continued study of primary nursing using experimental or quasi-experimental study designs similar to virtually all of research to date is inappropriate". The reason for not continuing to do experimental studies on primary nursing are that we do not have an operationalized definition of primary nursing, therefore we do not know what primary nursing is (P. Giovannetti, personal communication, December 21, 1984). Given the assumption that primary nursing is a process with a conceptual definition which cannot be measured, continuation of using quantified method becomes totally inappropriate.

Although Smith (1977, p. 2) states that "primary nursing care is a way to organize nursing services for the acute care hospital", primary nursing has been recognized as a valuable care delivery system in various care settings including long-term care facilities. Successful implementations have been reported from psychiatric nursing units (Carsen, 1981; Dundas, 1983; Green, 1983; Martin & Forchuk, 1984; Ritter, 1985), medical units (Ciske, 1974; Fairbanks, 1977; Hamera & O'Connell, 1981; Dawson & Wilson, 1983; Sellick, Russell, & Beckmann, 1983; Shukla & Turner, 1984), surgical units (Daeffler, 1975; Marram, 1976) and paediatric settings (Felton, 1975).

Ventura et al. (1982) reported that within the Veterans' Administration, primary nursing has gained recognition as an alternative to team nursing. Keiser and Bickle (1980) reported that primary nursing was well known among nurses in

the Veterans' Administration units where most nurses had had exposure to the general concept of primary nursing but did not possess information on how to assess, plan, implement or evaluate primary nursing. Daeffler (1975), examining patients' perception of care under team or primary nursing at a Veterans' Administration Hospital, found that primary nursing care was perceived to be superior to team nursing. Following implementation of primary nursing on a long-term geriatric unit, the majority of nurses preferred primary nursing to team nursing (Dawson & Wilson, 1983). A successful implementation was reported at the San Francisco Veterans Administration Medical Center (McGreevy & Coates, 1980). Of all the reports on primary nursing implementation in Canada, two were from a long-term care unit (Dawson & Wilson, 1983; Wiancko, 1985), another two came from psychiatric nursing units (Dundas, 1983; Martin & Forchuk, 1984) and one from a surgical unit (LaForme, 1982).

Due to the very ambiguous nature of primary nursing, it becomes imperative to investigate the actual nature of primary nursing so that an attempt may be made to derive a conceptual definition by examining this new philosophy of nursing care.

In summary, numerous studies on primary nursing have been conducted since the late sixties. Some authors compared and contrasted primary nursing system with another modality or modalities of nursing care, using experimental or quasi-experimental design. Efficacy of primary nursing system in terms of cost, patient satisfaction and staff satisfaction were the main focus of the studies. Since none of the studies described primary nurses activities, it is necessary to look at

primary nurses' activities closely so that the nature of this nursing system may be understood.

Chapter 3

METHODOLOGY

Since the introduction of primary nursing, there have been a number of studies done which examine staff satisfaction, cost-effectiveness and improved patient care. The majority of these were experimental or quasi-experimental, comparing primary nursing with another modality of patient care delivery. In several cases, conflicting results were reported. A major problem which had ultimately affected the results was that the researchers considered primary nursing as a system instead of a philosophy and did not take a closer look at the nature of primary nursing (Shukla, 1982, 1983; Shukla & Turner, 1984). It is, therefore, necessary to examine the nature of patient care delivery under primary nursing in terms of intra- and inter-nursing activities with other support systems in the health care arena. Rooted in ethnography, the researcher in this study employed participant observation and informant inquiry through which data were gathered to describe a group of nurses' activities in the process of patient-care interaction. An ethnographic approach to the study of primary nursing will provide new insights into this care modality, and will lead to role clarification of the primary nurse, and a detailed account of patient-nurse interaction under this system of care.

A) Design

Participant Observation

The selected methodology for this study was ethnography which allowed the researcher to enter into a nurses' culture and describe nurses' activities on a long-term care unit. Toward this end, the role of participant observation was taken by the researcher. Ethnography of participant observation in conjunction with interviewing was the central data gathering technique. This data gathering technique of participant observation together with interviewing were combined to strengthen and to compliment each other.

As Spradley (1980) states, the ethnographers do not merely make observations, they also participate. Participation allows them to experience activities directly, to get the feel of what events are like, and to record their own perceptions. In order to discover the cultural rules for behavior, they need to observe a large sample of similar activities repeated over and over. An important criterion for selecting a social situation is the frequency of recurrent activities which serve for analysis.

The researcher observed the nurses' activities on the unit for a period of three months and also participated as a complete observer in social activities which were related to patient-care delivery. While the main focus of observations was placed on the nurses' activities, a peripheral contact was maintained in the form of informal conversation with the rest of the nursing staff in terms of discussing their major activities on a daily basis. Once a nurse's pattern of activities was identified, the main focus was shifted to another nurse's activities

and further to another until a group pattern of behavior was observed and identified as a common recurrent behavioral pattern of the informants.

Each nurse's activities were observed continuously for a minimum of one week during the total study period of three months. The nurses' activities were confined to the unit where nursing care was delivered. The nurses were observed as they interacted with their patients, family members, doctors, peers, nursing supervisors and other health care members. All the participants remained in the study and no major incidents occurred so as to affect their participation or to their nursing care delivery. Four to five nurses' activities were observed on a daily basis over a five to seven day period. Occasional observations were made on the evening and night shifts in order to observe continuity of care between the day and evening and/or night shifts.

Data were gathered through extensive field notes describing events in detail in form of anecdotes, stories, incidents, and happenings. The researcher separated the usual from the unusual, the commonplace from the idiosyncratic, and concentrated on recurring significant phenomena. Such phenomena, upon being categorized and analyzed, served as a description of the nature of the patient care modality under study.

Due to the participants' objection to being tape-recorded during interviews, the researcher took notes while formal interviews were held with the informants. Numerous opportunities for informal interviews with the participants were also utilized. Unstructured interviews took the form of impromptu discussions in the

hallway, at the nursing station and in the primary nurses' room. Such discussions were brief and held mainly for the purposes of clarification of the patient-care just delivered. If a further need for capturing a nurse's feelings was perceived, an appointment was made for another occasion, usually in the afternoon the following day or following weekend. Both verbal and non-verbal behaviors were recorded.

Data collection can be made based on two perspectives; the researcher's and the informant's points of view. Data analysis to test hypotheses which emerged from the researcher's point of view is called the "etic" approach (Leininger, 1985). With the main purpose of this study to describe the primary nurses' activities, the etic approach was the basic strategy employed in observing such activities in a variety of settings. The "emic" approach was taken for the daily observations where one nurse's activities and her perception of primary nursing were examined closely. The emic approach seeks the native viewpoint and relies on the culture-bearers, or actor to judge whether something they do, say, or think is significant or not (Leininger, 1985, p. 320).

Based on the linguistic distinction between phonemic and phonetic, terms emic and etic were suggested by Pike (1954). Phonemics examines the sounds used in a particular language, while phonetics attempts to generalize from studies of individual languages to universals covering all languages. In ethnography, emic data are culturally specific while etic data are culturally universal. Tripp-Reimer (1984) explains the distinction as follows:

An emic analysis seeks to discover the significant distinctions made by

the members of a particular culture. An emic analysis is made from within each cultural system and therefore, culturally specific, describing the phenomenon from the subjective perspective of the client ... An etic analysis consists of observing behavior without learning the viewpoint of those studied. Using externally derived criteria, the etic investigator examines and compares several cultures. (p. 103)

Both emic and etic approaches were necessary and sufficient to help observe overt and covert manifestations of such behavior. These approaches substantiated the information acquired in order to present a well-rounded account of the nurses' activities and perceptions of primary nursing. The major focus was placed on several numbers of key propositions which resulted from testing a set of hypotheses in a descriptive ethnographic context. Under the framework of participant observation, the researcher had earlier outlined a general design of the study beforehand as a form of hypotheses. However, as she became involved in the activities of the nurses delivering care she was studying, the researcher was aware that she should report the activities as they existed, rather than following preconceptions, or hypotheses.

Thus, the emic approach was applied in the form of structured interviews in order to identify the informants' cognitive, ideational categories in terms of identifying the main constructs. These constructs signified the informants' perception of primary nursing and they served as "working hypotheses" as identified by McCall and Simmons (1969). Such emic data derived from interviews were used to supplement the etic data which were obtained via intensive observations and were the main research strategy.

Moreover, informal interviews helped to provide information related to activities and situations which the informant would ordinarily perform under primary nursing, thus ascertaining a wide range of typical pattern of activities taking place on this unit. Their insights were recorded; however, they were not analyzed or grouped according to classification of constructs presented in this study.

Formal interviews to evaluate nurses' job satisfaction were conducted utilizing a questionnaire which was previously used by Sellick, Russell, & Beckmann (1983). Permission to use this tool was granted by K. Sellick, who stated that the questionnaire was "more valid than other measures reported in the literature" but offered no elaboration on validity or reliability (K. Sellick, Personal communication, March 14th, 1985). The questionnaire they utilized to evaluate nurses' job satisfaction was employed in this study (see Appendix A). The questionnaire is divided into two sections. The first section is designed to measure nurses' job satisfaction and their perception of the importance of various nursing activities by means of a linear graphic, seven-point scale. Informants indicate the satisfaction with their jobs from "very satisfied" to "very dissatisfied" and their perception of importance of nursing activities from "extremely important" to "moderately important". The second section of the questionnaire is designed to evaluate nurses' perception of the importance and the frequency of occurrence of the characteristic elements at work. Similarly, the informants indicate their perception of importance of nursing activities on a seven-point scale from "extremely important" to "moderately important", and

the frequency of occurrence of the characteristic elements at work on four-point scale, from "a lot" to "not at all".

The questionnaire was completed after each informant was formally interviewed on two separate occasions. Both specific and general questions encountered in patient care situations were asked in the questionnaire under these two sections; one was centered on nursing activities and plan of care, the other section on core elements as the informant saw them in her practice.

B) Procedure

Initial Contact

The researcher was introduced to the administrator of the hospital by a faculty member who was involved in a project to implement primary nursing on this nursing unit two years prior to the commencement of this study. This made entree strategies easier for the researcher. After the initial contact, the researcher held one meeting with the administrator and a second meeting with the unit supervisor. Following the second meeting, the researcher was taken by the unit supervisor for a tour of the unit where the researcher was introduced to the staff members present. Arrangements were made for the researcher to meet with the primary nurses the following week.

Sample Population

Six full-time primary nurses working on this unit were met by the researcher, and invited to participate in this study. They were the only full-time primary nurses working on this unit. The researcher stated the purpose and the

nature of the study to them. The primary nurses were also informed that the researcher would be back the following week with consent forms to be signed by those who had decided to participate in the study (see Consent Form in Appendix B).³ In the meantime, a copy of the consent form explaining the nature and purpose of the study was posted on the unit (see Appendix C). Five primary nurses agreed and they signed the form. However, deletion of a clause to use a tape-recording machine at interviews was made at the request of the participants.

C) Data Analysis Procedure⁴

To reduce the threat of being observed, the participants were informed of the nature and the purpose of methodology. The researcher explained to the participants the ethnographic approach in participant-observation and referred to Leininger's Stranger-Friend Model (1985). A copy of this specific chapter was posted on the bulletin board in the primary nurses' room during the period of observations. The researcher further emphasized that the observations were concerned with what the participant was doing and were not of an evaluative nature of her performance. In addition, the researcher stressed confidentiality of the data collected, particularly to the hospital administrator.

There were no major difficulties in observing nurse-patient interactions, asking questions and taking notes. Field notes were reviewed daily and whenever unclear points arose, the researcher clarified with the informant at the earliest opportunity usually within the following day or so. Categorization was made on a weekly basis in an attempt to determine a consistent pattern of activities within the minimum duration of a week. Until a third informant exhibited a similar

pattern of activities, as her other two colleagues, the attention was focused on the nurse's activities which signified a construct.

At the beginning of the study, the researcher indicated to the informants that formal interviews were to be conducted at their convenience. The second formal interviews were conducted after an interval of four weeks, primarily due to the following reasons:

1. to verify consistency between the two sections of the questionnaire in the nurses' beliefs, attitudes or practice in answering the second set of questions;
2. to ensure that all interviews were to be completed prior to the summer holiday season. It may have altered the nurse's perception of primary nursing if interviews were conducted immediately upon their return from a few weeks' holiday.

The Role of the Observer

Observation of the primary nurses on the unit was the major research tool, with extensive field notes providing a record of most of the data collected. The primary nurses were observed as they were involved in all aspects of primary nursing activities, including active patient care, staff conferences, ward meetings, change-of-shift reports and in-service education lectures. On such occasions the researcher exercised every precaution that patient care delivery was not disrupted as a result of the observations. During the observation period, the researcher did not evaluate the primary nurses' performance, but she merely took notes on the primary nurses' activities.

The researcher spent a period of three months on a veterans' unit as a participant observer in order to collect data from the five primary nurses who

worked on a 32-bed floor. As the majority of nursing activities took place during the morning hours, intensive observations were focused on their activities between 07:45 and 12:00 hours including most weekends. All the primary nurses on this unit worked straight day shifts and alternate weekends. The researcher went into the unit, being highly aware of the informants and their surroundings.

During observations, the researcher was treated as a member on this unit. She went on rounds, attended conferences, sat in staff meetings, and attended in-service education lectures which took place in the hospital. The majority of the researcher's time was spent on observation of the primary nurses' activities interacting with the patients, the doctors, the dietician, the social worker, the clergyman, the family members, the colleagues, the supervisors and other health care personnel.

Occasional observations were made in the evening, including shift changes although only one registered nurse with a few nursing assistants were on duty during the evening and night shifts. On several occasions, the researcher arrived at the unit very early in the morning. These were the occasions when some significant event had taken place and the researcher wanted to follow the sequence of care.

The method of recording was adjusted, depending on the nature of activities the nurse was engaged in. For example, if the nurse was observed exchanging significant information over the phone, which would be categorized later under a specific construct, such conversation was recorded simultaneously. Similarly, at

staff meeting when the nurse's interaction with the physician was observed to be meaningful, constant note-taking while conversation was exchanged, took place. While observing the nurse's interaction with her patient in the room, the researcher tried to focus on the main content of the activities. On such occasions, only key points were jotted down at the time of observation to be elaborated in detail as soon as that set of activities were observed to end at that point. In this manner, the researcher tried to limit note-taking so as not to interfere with quality and quantity of observation, and possibly not to lose significant detail in the sequence of events, thus not distorting interpretation of the primary nurses' activities.

The researcher withdrew from the situation for a week after an observation period of nine weeks. This week two primary nurses were concurrently away on their annual leaves, and the unit was staffed by two or three regular primary nurses and two other registered nurses who worked on a casual basis. During this week, two of the regular primary nurses worked evening and night shifts, thus resulting in disruption of the usual pattern of staffing. This break helped to prevent the possibility of occurrence of ethnocentrism, expressed as in "going native" where a field worker passes the point of field rapport by literally accepting the informant's views as his own as a result of total immersion into the culture (Gold, 1969; McCall & Simmons, 1969). Moreover, the field worker may feel either that she/he no longer understands what is going on or that nothing significant is happening. One may become so immersed in the data that one has lost his sense of direction and must get away for a time to recover the perspective

on the problem (Janes, 1969). One-week absence from the scene aided the researcher in resuming the role of the complete observer. Sometimes immersion broken up by brief periods of withdrawal generates insights into the themes of a culture (Spradley, 1980).

Ethical Considerations

Nurses' participation in this study was sought on a voluntary basis and consents were attained following a thorough explanation of the nature and the purpose of the study. A period of one week was allowed to them prior to their decision-making. Confidentiality and anonymity were stressed to each participant during formal and informal interviews. It was also explained to the participants that the researcher would remain as an observer, would not participate in the care being given by them, nor make any comments or give advice regarding care they gave. Furthermore, the researcher was not to obtain any information pertinent to the patients and/or their families from the patient records.

It was also assured to the participants that all data and consents would be kept strictly confidential and their identity would not be disclosed in the report of the study, or to the administrator of the hospital. Furthermore, it was conveyed to them that raw data would be destroyed as soon as the study was completed. The participants were asked if they would like to be informed of the study results, in which case they were asked to so indicate on the consent form.

D) Data Analysis

Data analysis is an ongoing process in qualitative research (Bogdan & Taylor, 1985, p. 128). The analytic process is dialectic, not linear, as the process

occurs in several different stages of analyses in this type of study, each building on the other.

In participant observation, the experimental model is approximated through the use of analytic induction which is a strategy of analysis that directs the investigator to formulate generalizations that apply to all instances of the program. Analytic induction was designed to identify universal propositions and causal laws and is a rigorous qualitative method for arriving at a perfect fit between the data and explanation of social phenomena (Bogdan & Taylor, 1985, p. 127). This differentiates analytic induction from multivariate analysis where concern is directed in generalizations that apply not to all instances of the phenomenon at hand, but rather to most or some of them (Denzin, 1978).

Preliminary analysis was made weekly and following several weeks of observation. Throughout participant observation, informant interviews and examination of Progress Notes (Nurses' Notes) the researcher maintained her focus on emerging themes, read the entire description of her field notes, and developed concepts or propositions based on the data to formulate hypotheses as the researcher searched through data analysis for themes and patterns of the group behavior. Usually the researcher began her analysis soon after she left the unit while data were still fresh in her mind, and continued to refine some hypotheses and discarded others as she progressed through the study. Inferences were made from analyses and these inferences were compared to a set of hypotheses generated throughout the study by the researcher. Further data were collected to test that set of hypotheses on a continuous basis until a clear pattern of characteristic behavior occurred among the informants.

Through triangulation the researcher was able to cross-validate data between and/or among observations, interviews and Progress Notes (Nurses' Notes) as the study progressed. Triangulation is one of convergent methodology or convergent validation, and it is the combination of methodologies in the study of the 'same phenomenon' (Webb et al., 1966; Denzin, 1978). Such data, validated against one another, were placed under a construct which best signified those data. Triangulation is used "in the validation process to ensure that the variance reflected that of the trait and not of the method" (Jick, 1979, p. 602). Thus, the convergence or agreement between two methods "enhances our belief that the results are valid and not a methodological artifact" (Bourchard, 1976, p.268).

Triangulation can be categorized into two types: Between and within types (Denzin, 1978). Between (or across) type is largely used to cross validate when two or more distinct approaches are found to be congruent and yield comparable data, and employs multiple techniques within a given method to collect and interpret data, such as observations, interviews and examination of Progress Notes (Nurses' Notes) in this study. Between type tests the degree of external validity. The data obtained from the formal interviews using the questionnaire was tested for internal consistency in terms of within type triangulation. Participant observation as an approach of within type triangulation is presented next.

Internal Validity: Informants as Reliable Source of Information

Denzin (1978) identifies seven intrinsic factors which sensitize the observer

to biasing and distorting effects. They are: 1) Historical factors, 2) subject maturation, 3) subject bias, 4) subject mortality, 5) reactive effects of the observer, 6) changes in the observer, and 7) peculiar aspects of the situations in which the observations were conducted.

History refers either to events that occurred before observations were made or to events that intervene between the first and last observation. To reduce the effect of historical factors, the triangulation method was used. Structured and unstructured interviews and Progress Notes (Nurses' Notes) were employed to "uncover the operation of historical factors that might jeopardize the internal validity of the study" (Denzin, 1978, p. 198).

Two traditional checks have been suggested as a continuous intrinsic procedure in participant observation (Becker & Geer, 1960; Dean & Whyte, 1969; McCall, 1969; Naroll & Cohen, 1970). One is to inquire whether the account seems plausible. Implausible statements in the area of descriptive data can be checked through internal triangulation by the use of observations, Progress Notes (Nurses' Notes) and interviews. Another check is to assess the stability of the account to determine whether it is consistent with other accounts from the same source. This is achieved by continuous observation of the same informant's behavior and accounts in different settings over a period of time. Every item of information, whether derived from direct observation or from interviewing, should be continuously evaluated for its internal and external consistency (McCall & Simmons, 1969).

With the application of the above observational conditions, the researcher was able to detect and correct for it. Distortion may have been introduced into the report as a result of anxiety the informant presented as a form of defense mechanism, selective perception of the situation at the conscious or unconscious level, and also idiosyncratic factors of the informant.

Data given by one informant were compared with the accounts given by another informant. The accounts could then be cross-checked in order to detect any discrepancies which, if present, were verified for clarification.

Limitations of the Study

There were some limitations in this particular study during the data collection phase. Due to the nature of certain nurse-patient interactions and the need for privacy, the informants closed the door. The researcher missed some planned observations, as she was unable to see or hear interactions when this occurred. The above only happened on two occasions.

Another problem encountered in an ethnographic study occurs determining when sufficient data have been collected. It was difficult to determine where to stop one observation and move onto another involving another informant. It was also difficult to set boundaries on the categories of activities observed. In this sense, the criteria for determining a pattern helped the researcher decide whether to go on to further observation of an informant or not.

The informants were volunteers, therefore they may be atypical of the

population as a whole. Hence, it is not appropriate to assume that this is a typical primary nursing unit. Moreover, the small sample size needs to be mentioned here. This study is limited to nurses working on a veterans' unit.

Differentiation between indicators of some of the constructs puts a limitation on data analysis. In particular, it was difficult to differentiate between indicators of the two closely related constructs; namely, *responsibility* and *accountability*. For example, identification of activities representing the construct of *responsibility* was difficult because there was no overt evidence to illustrate the informant's cognitive process unless it was documented in the Progress Notes (Nurses' Notes) and indicated the informant's intent and behavior which lead to the conclusion of that construct.

The questionnaire used at formal interviews does not indicate reliability and validity.

Chapter 4

FINDINGS

In this chapter, information on primary nursing obtained through observations and interviews of the nurses in this study will be presented. From the data the informants' philosophy, beliefs and values on primary nursing will be included.

The Setting

Nursing unit 5² is one of nursing units in a long-term care facility, situated in a city with a population of 84,000³ people. The hospital complex includes among other services, rehabilitation, convalescent, geriatric and laboratory services.

The nursing unit 5 is financed by the Federal Government and managed by the hospital, thus under the operation and management of a two-tier government system. The federal offices located in the metropolitan area exert financial control of the hospital's policies and programs and assess the eligibility of those who seek admission to the unit.

²The names of places and persons have been changed to ensure anonymity in the narrative.

³Statistics Canada 1981, Census of Canada. Ottawa: Queen's Printer, 1983

The floor plan of the unit is shown in the Appendix F. The primary nurses' room is in the mid-way between a TV room and a patients' room, and diagonally across from the nursing station. The dining room is situated next to the kitchen into which meal trays are delivered through the elevator. The unit is divided into two areas according to the condition of the patients. The area on the north side, including the nursing station, accommodates 14 bed-ridden patients; the area on the south side, including the dining room, is occupied by 18 ambulatory patients, with a total bed capacity of 32. In front of the nursing station is a large board which gives information to the patients indicating the month, date of the week, the weather, next meal due, and next statutory holiday. There is also a large daily assignment planner adjacent to the board, indicating primary nurses' names for groups of patients. The patients' list including a mode of evacuation for the patients in case of emergency is also placed on the board.

The Patients on Unit 5

The unit accommodates thirty-two patients, and all of whom are war veterans. The age range is from 60 to 98 years old, with 38% between 60 and 70, 18% between 70 and 80, 18% between 80 and 90, and 26% over 90. All of them present a multiplicity of medical problems including mental health and behavioral problems. Their educational preparation is limited and all of them served during the last world war; several of them in both world wars. Their major lifetime occupations were fishery, mining, trades, longshore man and wharf watch. The majority are widowers. The patients are medically supervised by two physicians on this unit.

The unit is categorized as long-term care and the patients are classified under three different levels of care⁴. Level I is for those who are ambulant and/or have mental faculties, and who require primarily supervision for meeting psychosocial needs through social and recreational services. During the study period, one patient in this category was discharged to a boarding house close to the hospital following a 14-month stay on the unit. Another died suddenly of a myocardial infarction during his sleep.

Level II care is that required by a person with a relatively stabilized (physical and/or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future. Such a patient has relatively little need for the diagnostic and therapeutic services of the hospital but requires availability of personal care in a hospital on a continual 24-hour basis, with medical and professional nursing supervision and provision for meeting psychosocial needs. There was no discharge or transfer of patients under this level of care during the period of this study.

Level III care is that required by a person who is chronically ill and/or has a functional disability (physical and/or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, and whose potential for rehabilitation may be limited. Such a patient requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psychosocial needs. Two deaths occurred among the patients in this category.

⁴Definitions and descriptions of types of care were established by the hospital and were taken from the manual on the unit.

During the three months' observation period, a number of social activities were arranged on a regular basis. The primary nurses made arrangements and coordinated activities on behalf of the patients with other services. They contacted the recreation and dietary services frequently and the interaction between the primary nurses and these personnel was positive. The outdoor activities took place frequently during the summer months, and the informants took part in activities with the patients such as garden parties, picnics, barbecues, camping, cards and games.

The recreational therapist visited the unit regularly to seek volunteers and participants for the up-coming activities. A tentative list of participants was made by the recreational therapist. The primary nurse ensured the final count of the participants on the day of the activity.

The primary nurse contacted other departments so that no omission or commission of services resulted. Interaction between the primary nurse and the recreational therapist took place frequently and positive, which was probably due to their sharing of activities with the patients on and off the unit. The primary nurse communicated with the recreational therapist closely, particularly in terms of giving instructions regarding the consumption of alcoholic beverages, as the patients were often entertained by the Royal Canadian Legion at the Club.

The Primary Nurses on Unit 5

The unit is divided into six "districts", each of which is assigned to a primary nurse and a nursing assistant on a rotating basis of every four weeks. In

each district, the primary nurse was assigned to a group of four bed-ridden patients and to the maximum of eight ambulatory patients. The primary nurse was responsible for total care of her assigned patients from admission to discharge. While serving as primary nurse for each patient in her caseload, the primary nurse admitted the patient and assessed his needs for care utilizing the nursing admission history forms. She set prioritized and realistic goals based on the needs of the patient and family, initiated a nursing care plan, and administered care according to that plan. She coordinated care with other disciplines such as physiotherapy and dietary, and made discharge preparations or alternatively provided instructions to the associate nurse if she expected to be off duty on the patient's discharge day. A unit clerk on the unit freed the primary nurse from administrative and housekeeping duties in order to maximize time available for patient care. In fact, after the change of shift report, no primary nurses were seen at the area of the nursing station throughout the shift, except for such times as to check the kardex, up-date the kardex, chart progress notes or answer the telephone.

The primary nurse's activities usually started with feeding breakfast to her bed-ridden patients. All nursing staff carried breakfast trays and fed patients who required total care. This was followed by bathing. The primary nurse in coordination with her nursing assistant, gave a tub or bed-bath to all her patients twice a week; these days were fixed for each patient as "tub-day".

The primary nurse who was assigned to ambulatory patients instructed them in self-care measures and guided them in their self-care towards their

independence and continuous rehabilitation. Physical aspects of care for ambulatory patients were obviously minimum. With sensitivity to the patient's needs and concerns in the psychosocial domain of care, the primary nurse approached her patients in a caring manner, implying that she was their advocate in the frequent encounters with hospital bureaucracy.

When the primary nurse was assigned to a group of selected secondary patients to act as associate nurse, she worked with her primary patients first, and then went to her secondary patients to check what care was further required. The nursing assistant had meanwhile given the basic care to the secondary or associate patients.

Identification of the primary nurse with each patient was clearly posted at the patient's bedside. At the time of rotation to another district, the primary nurse took off the posting of her name and placed it at the bedside of the new patient to whom she was assigned. Other health care workers used the daily assignment planner to identify the patient's primary nurse and communicated directly with her regarding patient care.

Two groups of primary nurses worked their rotations complementary to one another, each group sharing the same rotation. For example, primary nurse A took primary nurse B's place to work as associate nurse for B's primary patients whenever B was off duty, and vice versa. The same applied to the rest of the primary nurses. The primary nurses were accountable to each other's primary patients while they were assuming the role of associate nurse. The primary nurses

worked seven consecutive days with two days off, then another three days on with two days off. Scheduling was done so that the primary nurses could be off every other weekend. The primary nurses worked straight eight-hour day shifts. At the end of the day shift, the nursing assistants working a twelve-hour shift covered the whole floor between 15:45 and 19:45 hours.

The primary nurses were assigned to two districts of patients acting as primary nurse to one district, and as associate nurse to the other. As an associate nurse, the major responsibility to the district's patients was to administer medication, since physical aspects of care were designated to the nursing assistant assigned to that same district as the primary nurse.

Issues and Concerns related to the Informants

One topic of concern discussed by the primary nurses regarded the additional role of general guidance and supervision of the students they had to assume when students came on to the unit. On one occasion three groups of students were on the unit at the same time from three different institutions; baccalaureate students, a nurse-intern in a diploma program from this hospital and nursing assistant students, from a vocational school. Although baccalaureate students and nursing assistant students were guided and supervised by their clinical instructors, the primary nurse was responsible for a written evaluation of the student intern who had been assigned to work with her as a buddy.

The scope of responsibility of associate nurse was also discussed. The primary nurses felt that since associate nurses worked only on a casual basis and

were not as familiar as the primary nurses with patient care, they should not assume the same level of responsibility as the primary nurses. This issue was specifically raised in terms of the associate nurses attending the multidisciplinary teams conference in addition to all primary nurses' attending these conferences. The primary nurses felt that it was not necessary for associate nurses to attend these conferences. Other aspects of responsibility such as in updating the kardex, particularly in relation to nursing orders and coordination of patient care in the absence of the primary nurse, were raised for clarification. These discussions were held briefly in the medication room, usually during the first medication time in the morning, since this was the time for all primary nurses to assemble altogether to discuss such issues as above.

Apart from the issues surrounding the role and function of the primary nurse and boundaries of responsibilities between her and the associate nurse, no other concerns or issues were raised. Patient care management, particularly concerns pertaining to specific behavioral problems of a certain group of patients were discussed formally and informally among the primary nurses and also between the primary nurses and nursing assistants. The nursing assistants actively sought advice and suggestions from the primary nurses while giving care and supplied information from their observations when they considered important for the primary nurses to know. The nursing assistant reported directly to the primary nurse who shared the district with her.

The inter- and intra-group dynamics among the groups of the patients and nursing staff were observed to be cordial. The common element which was

identified within and between the sub-groups of patients and nursing staff was a gesture of caring. Caring was displayed on a daily basis throughout the study period of three months. The five core elements signifying the nurses' activities as observed on the unit will be presented in the next section.

Development of Primary Nursing on Unit 5

Prior to introduction of primary nursing into the unit, the nursing staff on unit 5 were displaying signs of dissatisfaction. Frequent sick leaves, high turnover and low morale were evident among the staff on the unit. The modality of nursing care delivery at that time was team nursing. Under team nursing, the staff were assigned according to task. The organizational structure was hierarchical and included a head nurse, two team-leaders and registered nurses who delivered care at the bedside. Under this care delivery system it was evident that communication was centralized, the quality of nursing service was incomplete, sporadic, standardized and routine and nursing care was delivered in a disintegrated fashion, thus affecting the quality of care provided.

Manthey (1980, xvi-xvii) identifies three problems with team nursing: 1) fragmentation of care, 2) complex channels of communication, and 3) shared responsibility. The antithesis of these three elements in turn provide the basis of primary nursing. Team nursing was reported to promote transiency of nurses due to unrealistic expectations of team leaders and feelings of frustration among nurses (Garber, 1977). One main difference between primary and team nursing is that the aide is assigned to the nurse for task assignments in primary nursing; whereas in team nursing the aide is assigned to the patient (Mundinger, 1977).

Under team nursing⁵, development of the nursing care plan, a vital tool in the nursing process, was the responsibility of the team leaders which was implemented by the registered nurses. Similarly, charting in the Nurses' Notes was done by team leaders, even though the actual care was delivered by the registered nurses. Moreover, tape-recorded change-of-shift reports were listened to by the team leaders who subsequently gave the shift report on all the patients to the on-coming staff. The team leaders gave direction and supervision to the registered nurses and to the nursing assistants. There was essentially no communication between the nurses and the doctors, the patient's family members, the supervisors and other health care team personnel. Continuity of care and consistency and stability of the delivery of nursing care was disrupted and often dealt with in a piecemeal fashion. Consequently, it did not provide an opportunity for the nurses to evaluate care they delivered. Care which was initiated during the day shift was not followed through by subsequent shifts, resulting in either duplication or omission of nursing care activities. With the involvement of multiple personnel in the patient's care, responsibility became diffuse, and the collective responsibility resulted in nobody's responsibility. Nursing care responsibility was presumably placed upon the team leaders; however, this occurred only in documentation since the team leaders dealt exclusively with clerical tasks at the nursing station.

During the summer of 1982 the nursing administrators in the hospital began

⁵Information on team nursing on Unit 5 was obtained from the informants at formal and informal interviews.

to explore the possibility of implementing the primary nursing system as a pilot project. The anticipated outcome of primary nursing was an increased staff satisfaction, which in turn would lead to an improvement of patient care.

A preparatory period of approximately ten months was allowed prior to implementation. A committee set up for this project consisted of three nursing supervisors, five staff nurses, the project coordinator and staff development officer, and the director of nursing as ex-officio. The committee acted as a liaison between the administrator and the staff to bring about changes. The committee facilitated implementation of primary nursing by providing the administrator with interim reports throughout the stages of planning, implementation and evaluation of a pilot project progressing on the unit. The committee also acted as advocate for the staff to facilitate the change-over process by providing support and assistance. The committee included a faculty member from the School of Nursing as the project coordinator and staff development officer and the peer group members. This composition was less imposing to the staff, and they were comfortably able to approach committee members with their concerns. During the first three months, the nursing assistants felt that they were doing most of the basic nursing care. During the second three months, the registered nurses felt that they were doing the majority of work. After a frustrating trial-and-error period of approximately ninth months, the foundation for the primary nursing system began to solidify. About this time, a survey was conducted to ask the staff if they would return to the team nursing system. Of the 64 staff questioned, 98%

⁶ replied in a negative and supported the primary nursing system. At the time this research was conducted, the unit had been practising primary nursing for two years. No further evaluation of this unit had been done for two years since the survey.

Unit Philosophy on Primary Nursing

A manual outlining the definition of primary nurse, associate nurse and nursing assistant was placed on a shelf in the primary nurses' room together with other manuals on hospital policies and regulations. (see Appendices G, H, and I).

Informants' Profile

The five nurses who participated in this study had similar qualities in terms of the age range, educational preparation and number of years on the unit (see Appendix E). None of the participants had previously worked under a primary nursing system, nor had they done a literature survey of primary nursing. All five nurses had graduated from a hospital affiliated diploma school; two graduated from the same school, two others graduated from another school in the same city and one from a school in a neighboring province. One nurse also held a Bachelor of Arts degree.

The informants stated that the overall goal of nursing care was to keep the patients safe, comfortable and to make their each day worthwhile living and enjoyable. They mentioned a lack of time to respond to psychosocial aspects of

⁶The result of the survey was quoted from the primary nursing manual on the unit

care, considering physical aspects of care to be top priority. They stated that they were aware of the need for psychosocial aspects of care; however, that the majority of their nursing time was spent on physical care, charting and "kardexing" so that little time was left to provide psychosocial care. They regarded these two domains of care, physical and psychosocial, to be administered separately in a prioritized sequence in which physical aspects of care took precedence. This was probably due to their educational preparation in which physical aspects of care were stressed, as well as its prioritization in a bureaucratic setting.

In general, the nurses expressed satisfaction at being able to make independent decisions, to be able to carry out nursing interventions in all phases according to their nursing care plan, and knowing that they were the direct care giver. The feeling of satisfaction reflected the performance of their services which were acknowledged in notes of appreciation and on a plaque placed at the nursing station. One nurse stated that she had worked in an acute area most of her career and had taken this position because it was the only one available when she was searching for a job. Despite her uncertain feelings as to how she would adjust to a different type of care and the elderly patient population she confirmed that she actually enjoyed very much working with the elderly.

The informants' satisfaction with the job was generally a consequence of positive feedback and responses from the patients and good interpersonal relationships with peers, doctors and supervisors. The informants stated that what they liked most was the fact that they could use their independent

judgement and make independent decisions. Moreover, an in-depth knowledge of the patient promoted better rapport with patients and their family members, which in turn enabled the nurses to become more involved in planning and provision of nursing care.

Yet, feelings of being under pressure and stress were expressed. They were related to the amount of charting they had to do in order to meet the deadline for the impending nursing audit. The primary nurses were to complete problem-oriented charting and the entire process of nursing care plan according to the guideline set by the nursing audit committee. The preliminary audit was to be conducted in several weeks by one of the nursing audit committee members. Its purpose was to provide nurses with an opportunity to practise problem-oriented charting procedure and formulation of nursing care plan to meet the formal audit criteria, and to familiarize nurses with the format for the charting criteria. The official audit was to take place unannounced sometime in September.

The six primary nurses were divided into two groups of three to work on the same rotation. A special friendship appeared to have developed among members of each group. The informants stated that since they worked together all the time, they were bound to socialize more on the unit and in their off-duty time as well. The atmosphere of camaraderie was evident and esprit de corps was observed in their interaction with one another on the unit.

In-Service Education

In-service education lectures were offered by a nurse educator on a regular

basis. The lectures given during the study period were on cardiac drugs, nursing care plans, and other topics related to nursing skills and knowledge. The other lecture topics included oxygen therapy and home care program in the city and were delivered by respective experts in these areas. The in-service lectures were usually held at two o'clock in the afternoon in one of the lecture rooms in the hospital. Two to three primary nurses went to a given lecture each time. Attendance was decided on a voluntary basis and dependent upon recommendation by the supervisor or the primary nurse in charge when the supervisor was off duty.

Continuing Education

A gerontology course was offered to the interested staff nurses. The course was offered twice a year, lasted for five months and required a full-time commitment on the part of the student. The nurse who attended this course received fifty percent of her salary every month. One of the informants had just completed the course at the commencement of this study. Another informant was considering taking the course in the fall.

Discussions on continuing education in nursing were held on several occasions at coffee breaks when the nursing assistants were also present. Two informants expressed their desire to pursue a baccalaureate in nursing. One of them has started preparation to take an evening course when this study was well in progress. Among nursing assistants as well, an issue was raised concerning the domain of their responsibilities vis-a-vis their educational preparation. One of the nursing assistants stated her intent to start taking courses at the university in the near future.

The informants' commitment to nursing was evident on several occasions. For example, one of the informants volunteered to give a lecture on Alzheimer's disease. She prepared notes and delivered a lecture for public speaking. She was frequently observed volunteering to go to in-service lectures. On one occasion, she volunteered to go to a nursing home which was considering implementation of primary nursing and expressed a desire to have someone from this unit to present the concept and operationalization of primary nursing to their staff. When the primary nurse and the unit supervisor visited the nursing home, the researcher accompanied them. Presentation of their views on primary nursing to the nursing home staff enabled the researcher to get to know the views of primary nursing held by the primary nurse and the unit supervisor. Interestingly enough, the supervisor's view and the informant's view of primary nursing were different. While the supervisor's view was based on staffing and rotation, focusing on the structure rather than the philosophy, the informant presented some of the core elements of primary nursing and emphasized the concept of "my patient-my nurse". The informant also pointed out the nursing care plan as a vital tool for communication with peers to ensure continuous and consistent nursing care on a 24-hour basis. The difference in their views is probably largely due to the fact that the unit supervisor did not deliver nursing care but spent most of her time off the unit, attending meetings.

Guilianelli (1977, p. 43) states, "For me to enjoy job satisfaction as a head nurse, I must have the opportunity to be a primary nurse". Therefore, it is recommended for the unit supervisor to carry even a one-patient load to deliver

care, so that she can demonstrate her knowledge and skills as a role model to the staff on the unit.

Primary Nursing as Practised on Unit 5

Selected examples will be presented in terms of nurses' activities signifying each construct. Due to the nature of the unit, the patient population, and the nature of nursing care delivered, examples collected during the observation period are limited in number and these examples under a given construct do not necessarily exclude reflection of the remaining constructs. In fact, all examples given in this chapter more or less symbolize five major constructs. The first construct, *responsibility* will be presented first followed by *accountability*, *autonomy*, *caring*, and *decentralized communication*.

RESPONSIBILITY

The sense of responsibility among the informants through interviews has been summarized as follows:

"I feel good about the total responsibility I have."

"I get the total picture of the patient, as I'm doing medication and all the rest, so when I talk to the doctors I know exactly what's happening to my patients."

"Before we changed to primary nursing, I didn't feel comfortable about talking to the doctors because I did not know them enough."

"Since we are responsible to the total patient care, we know that we've done it, nobody else has done it."

"Such a feeling of satisfaction is enhanced by the patient's thank you'. They [the patients] are so appreciative of little things and that makes me feel good and gives me an incentive to carry on and try to do even a better job."

Manthey (1980, p. 32) calls responsibility for decision-making about patient-care "the heart of primary nursing which is the essential difference between this

and other systems for delivering nursing care". In primary nursing it is always the nurse who gives direct care and makes decisions concerning patient care. Those decisions which have been made for delivery of care are to be carried out continuously throughout the following shifts, days or weeks even when the primary nurse is off duty. The primary nurse is in essence responsible for appropriate use of the nursing process in administering total care to her patients. The nursing process as defined by Zander (1980, p. 13) involves "assessing, planning, intervening, and evaluating patient or family needs and their responses to nursing care". In fact, it has been considered as the "best and last chance for the nursing profession to respond to the patient as a consumer in the competitive health care fields" (Mauksh & David, 1972, pp. 2189-2193).

In this study, the primary nurse was directly responsible for all aspects of nursing care i.e. total care of patients in her district. She administered medications, transcribed doctor's orders, and delivered comprehensive care. She was also responsible for patient care delegated to the nursing assistant. To ensure provision of proper care to each of her patients, she gave directions to and supervised the nursing assistants on the unit.

Responsibility for Patient Care on the Unit

While delivering physical care, the primary nurse paid detailed attention to her patient's ears, eyes, mouth, finger nails and toenails. Meanwhile, she continued conversation with the patient regarding the time of the day, the date of the month, the weather, and local events taking place in the community in an attempt to focus the patient's attention on reality. The primary nurse ended the

AM care by shaving the patient. Seeing the patient being shaved in the wheelchair in the room or hallway by their primary nurse, the researcher could tell the approximate time for the completion of AM care. It was usually eleven o'clock. After this, the primary nurses went into the medication room to prepare and administer medications and then started charting until the lunch trays were delivered to the unit at 11:30 hours. The primary nurses assisted the patients with their lunch, ensuring that the patients received correct diets, setting up lunch trays so they could have easy access to their food and feeding patients if they were unable to do so by themselves. In the mid-morning and mid-afternoon when snacks were delivered to the unit, the primary nurse also assisted her patients and ensured that they consumed and retained the additional nourishment.

Patients' nutritional needs were one of the basic concerns of the informants. None of the patients, particularly those bed-ridden, exhibited signs and symptoms of dehydration and decubitus ulcers. Shortly after commencement of this study, the researcher noted no water jugs placed at the bedside. However, upon further observation it was clear that the patients were provided an adequate amount of fluids. It was the primary nurse's responsibility to assist her patients with meals and snacks and to offer extra fluids at the time of each administration of medication.

One morning, following breakfast, the primary nurse asked one of the patients if he had had his breakfast. He replied, "I got sick, and I threw everything up". The primary nurse asked the nursing assistant in the room

whether she noticed anything unusual about him or not, to which she replied in the negative. The primary nurse asked the cleaning person who had been working in that room if he had noticed that one of the patients had been sick. Again, his answer did not substantiate the patient's statement. The researcher continued to observe the interactions between this patient and the staff. Despite the fact that the patient was suffering from organic brain syndrome and may have fabricated the sickness episode, the primary nurse continued to collect data from other personnel in order to validate the patient's statement rather than dismissing his statement as totally invalid, because he was mentally incapacitated. The primary nurse thus made her nursing assessment promptly, including a plan of action to call the physician in the event that the incident was confirmed, and to follow with appropriate nursing measures. She also instructed the nursing assistant to observe him closely and maintained constant observation herself, especially during the next meal.

The kardex and nursing care plan were thus utilized continuously every day. The daily review of nursing care plans was done by the primary nurse with her assigned nursing assistant. The primary nurses were observed frequently discussing with their assigned nursing assistants for the purposes of reviewing and revision of both the kardex and nursing care plans of their patients. Consultation and collaboration of patient care among primary nurses were observed, thus demonstrating their responsibility for maintaining continuity of patient care. The primary nurse worked closely with nursing assistants assigned with her, supervising their nursing activities which were directed toward maintaining the patient's welfare.

The primary nurse was also responsible for maintenance of the patient's clothes. On one occasion, while assisting one of her patients to get dressed, the primary nurse noticed one of the shirt buttons was missing. She brought a needle and a thread from the laundry room and sewed the button back on the shirt. Caring for the patient meant total care of that patient. To the primary nurse, attending to a need such as sewing on a button was equally as important as delivering AM care. The primary nurse attempted to deliver all aspects of care on behalf of the family while he was in hospital. Ciske (1980) clarifies the concept of total care. Total care is a necessary condition for primary nursing; however, total care is not an absolute condition. With total care as a pre-requisite, primary nursing further requires an establishment of a one-to-one relationship where the nurse continually assesses the patient and evaluates care.

Responsibility for Patient Care off the Unit

The primary nurse not only demonstrated her responsibility for the care of the patients on the unit, but off the unit as well. One of the patients was scheduled to have minor surgery and was to be transferred to another hospital. His primary nurse informed the nurse on the surgical unit in the other hospital of the patient's imminent admission. While the patient was in this hospital, the primary nurse contacted the surgical unit daily to obtain information regarding the patient's condition and recorded it in the General Communication Book. This book was utilized to chart information pertaining to the patients and staff on the unit. At the end of the day shift the primary nurse also reported the patient's condition on the tape to inform the rest of the staff of the patient's progress.

The same phenomena occurred with other informants' patients who had surgery done at another hospital. The primary nurses followed the patient's progress closely by telephone every day, and reported it verbally on the end-of-shift tape and in writing in the General Communication Book. Therefore, when the patients returned to Unit 5, the staff were aware of what surgery had been done and their status of recovery. This method was particularly helpful for the nursing assistants, whose assignments between the ambulatory and bed-ridden patient areas changed daily.

The following is an example of the primary nurse's responsibility for patient care while admitted in another institution. The clerk received a message from the emergency room from another institution, notifying the unit of an emergency re-admission of one of the patients. The message was relayed to the patient's primary nurse on the unit. The primary nurse called the emergency room in an attempt to obtain a detailed account of the incident prior to the patient's re-admission to the unit. After obtaining a full verbal report, she contacted the patient's doctor to inform him of the patient's imminent re-admission and his condition.

Along the same line, whenever the patient was leaving the unit whether for a week or for an outing with family members or friends, or just to go to the canteen or cafeteria downstairs, he always sought out his primary nurse and reported to her the nature and duration of the activity off the unit. Thus, the primary nurse was always aware of the patient's absence from the unit and the reason for the absence.

Family Members and Significant Others and Responsibility

The primary nurse was responsible for establishing and maintaining open communication with the patient's family members. Whenever the status of the patient changed, the primary nurse promptly contacted the family to inform them of the change. The primary nurse interpreted and explained the treatment for the patient to the family so that they could have a better understanding of his condition. Whenever a patient was scheduled to go to another hospital for either tests or surgery, the primary nurse notified the family of the patient's condition. The primary nurses were familiar with the most of the patients' family members and addressed each other by their first names.

The family members and friends usually visited the patients in the afternoon and in the evening. The primary nurses were aware that communication between the family members and evening staff was as equally important as with the staff from other shifts. The General Communication Book was used as the major vehicle to relay messages from the evening and/or night shift to the day shift. Messages obtained through both telephone and personal contacts on the unit were entered into the General Communication Book on a 24-hour basis. The book thus enabled the nurses to carry out nursing care in a continuous and consistent manner involving both the family in plan of care and with the nursing care plan. The primary nurse's signature appeared at the end of the message.

The primary nurse took responsibility for facilitating family members to become involved in patient care. For example, a family visited one of the patients every afternoon indicated her wish, to take the patient's laundry home and bring

fresh clothes for the patient as necessary. The primary nurse put a sign at the patient's bedside to read: Please put laundry and leave it here together, the family will do the laundry for the patient.

The following illustrates very well the primary nurse's responsibility for patient care involving the family. Shortly after admission, a patient started to present problems to the nursing staff. He suffered with insomnia and would be up all night in the TV lounge, smoking incessantly. He was always a heavy smoker and frequently asked the other patients for cigarettes. He became nuisance to the other patients. Eventually he began to steal cigarettes from other patients' rooms. On one occasion the patient fell asleep with a lit cigarette in his hand while sitting in a leather chair in the TV room and burned a hole on the arm of the chair. When the problems first appeared, the patient's associate nurse contacted the downtown office of Veterans' Affairs and informed them of the problem the staff were encountering with this patient. There was no primary nurse assigned to the patient in his district at this time, and the unit supervisor was on annual leave so the decision to contact the Veterans' Affairs was made by the nurses in consultation with her peers.

When one of the informants was assigned to the district as primary nurse the following week, she approached the area supervisor regarding this patient. The area supervisor suggested that the patient's doctor speak to the patient about the matter. The primary nurse thought it the best to involve the family members in the matter. The primary nurse called the patient's wife and explained to her the series of incidents and accidents instigated by the patient and also asked her

to bring some cigarettes for her husband. The primary nurse reminded her of other supplies and toiletry articles which were not provided by the hospital. The following day cigarettes and other articles were delivered to the patient by his wife and there were no further incidents related to cigarette-smoking or cigarettes.

The primary nurse was thus able to solve the problem by involving family members in the care of the patient in an appropriate manner. With adequate information provided, the family were encouraged and assisted by the primary nurse in the delivery of care in collaboration with the primary nurse and other health care members.

The Physician and Responsibility

The primary nurses' responsibility as collaborators with the physician can be outlined along two dimensions: Dependent nursing functions and interdependent nursing functions.

In terms of dependent nursing functions, the primary nurse transcribed the doctor's orders and executed them, and ensured that all medical orders were in order and up to date. The primary nurse checked her patients' medications closely against the doctors' orders, and administered treatments and therapies according to the doctors' orders. These included medical nursing procedures such as initiating and maintaining inhalation therapy as well as other procedures and treatments delegated to the nurse to carry out in place of the physician. Philpott (1985, p. 9) defines that, "Dependent functions refer to those which flow directly from the presence of the medical order, and without which order, the nurse has no

jurisdiction to perform the activity concerned*. Dependent nursing functions are distinct from the independent nursing functions which are totally within the jurisdiction of nursing and are carried out through nursing orders. Independent nursing functions will be delineated under the construct *autonomy*.

Interdependent nursing activities included those activities carried out in collaboration with the physician and in consultation with other health care members. Philpott (1985, p. 9) defines interdependent nursing functions as "transfer of functions process" and they are founded in consensus through the active participation of nurses with other health care members to bring about total effect of all services involved. Such "transfer of functions process" were functions normally considered medical practice which could be carried out by registered nurses. These procedures were performed by a specially prepared nurse only within written agency policy and the written order of the physician. The informants commonly monitored the patients' vital signs and administered injections. On one occasion, in response to the doctor's order, the informants inserted a nasogastric tube into a patient who had become critically ill and required prompt medical intervention.

Other Health Care Members and Responsibility

Responsibility with other health care members is best illustrated by the primary nurse's coordinating and collaborating activities with the appropriate services. Health care members other than the physician with whom the informants had frequent contacts included other nursing personnel, the social worker, dietician, physiotherapist, and clergyman.

The primary nurse demonstrated her responsibility to a nursing assistant when an incident in which one of the patients scratched the nursing assistant in an effort to avoid her help to get him dressed. There was a minute amount of fresh bleeding noted on her arm. She reported it to the primary nurse, who in turn, notified the patient's doctor of the incident. The primary nurse asked him if there was any need to have the nursing assistant's blood checked for HBAG (Hepatitis B. Antigen) level. Next, the primary nurse approached the patient and started to trim his fingernails. The patient protested the care and struggled to show his protest. The primary nurse had intervened immediately to prevent another similar incident because she felt responsible for protection of the staff.

An illustration of the primary nurse's responsibility with the social worker emerges from the following incident. The primary nurse was approached by one of her patients and told that he wanted to donate a large sum of money to a charity organization. She consulted with the physician regarding this 94-year-old's mental capacity to execute such a large transaction of money. Upon the physician's affirmation that indeed the patient was fit to do so, the primary nurse contacted the patient's social worker who was in charge of the patient's financial affairs and asked her to consult with the patient's lawyer in the event that the patient executed the transaction. She further suggested that the patient's lawyer be the witness for this matter.

The primary nurse's responsibility with the dietician was carried out through consultation regarding the patients' special diets. For example, one morning a new admission arrived on the unit. The primary nurse began the

interview with him to take his history and do a general assessment of his condition. The patient was obese, diabetic, and had been on medications which were contraindicated with certain kinds of foods. After obtaining the exact information on his diet, the primary nurse notified the kitchen personnel and asked them to add a tray of this special diet to the forthcoming meal wagon. She contacted the dietitian and arranged an interview between the dietitian and the patient so that he could continue to receive a proper diet.

Responsibility with the physiotherapist was demonstrated by administering range-of-motion exercises, for example, to her patients, thereby supplementing and reinforcing the therapy received from the physiotherapist and by communicating with the therapist regarding the patient's general condition and progress.

In terms of responsibility with the clergyman, the primary nurse used her own judgement to decide when to notify the clergyman if a patient became critically ill. The priest came and gave the patient the last rites.

Responsibility for co-ordinating patient care with the other health care members was displayed through regular contacts with the disciplines that were appropriate for a given patient. The primary nurse acted as the information disseminator of the patient's needs to the other health care workers involved so that the patient could receive the services to meet his total needs.

Hence, the primary nurses assumed responsibility for the nursing care

delivered to the patient on a 24-hour basis, from admission through discharge (Manthey, 1973, 1980; Marram, Schlegel & Bevis, 1974; Ciske, 1979, 1983; Zander, 1980; Brown, 1982). Responsibility for patient care throughout the patient's hospitalization period was demonstrated by application of the nursing process which includes assessment of the condition of the patient and the family on admission, statements of the patient's problems on admission, formulation of nursing care plan on a 24-hour basis, continuous review of the care plan, implementation of care according to the care plan, collaboration of care with nursing staff, physicians and other health care members and continuous evaluation of the care delivered. For the primary nurse to assume full responsibility successfully, it is important to have an atmosphere in which there is an opportunity to use clinical judgement and decision-making and where there is support from the peers.

The informants identified responsibility, i.e. being able for making their own judgements and decisions as one of the most important aspects of primary nursing. They stated that primary nursing provided the structure for greater individual responsibility and accountability of nurses for their patients; this fundamental aspect of primary nursing has been repeatedly cited in the literature (Hegyvary, 1977; Ciske, 1979; Carser, 1981).

The primary nurse demonstrated her responsibility to make independent clinical decisions by involving the family, as in the case of the patient with smoking problems, and on other occasions which are described in Other Health Care Members and Responsibility. The primary nurse assumed responsibility for

assessing the patient's needs, and responsibility to change the direction of care. Regarding the concept of responsibility, Brown (1980, p. 38) states: "Primary nursing is a method to maintain excellence in that the nurse has the responsibility for individual clinical decision making and must be supported with these decisions".

Responsibility is a means to achieve *accountability*. These two constructs are built on each other to attain a third construct *autonomy*. *Accountability* will be presented next.

Accountability

To whom should the primary nurse be accountable for her acts? She should be accountable for her professional actions to her patient or an aggregate of patients, that is, society, also other health care members and herself, and for legal accountability to the hospital as well as the professional organization to which she belongs.

Patient Care and Accountability

The definition of *accountability* as related to patient care is best summarized by a statement made by one of the informants:

You have to do it [patient care], as nobody else will do it for you. You are responsible for the total patient care given.

Breakfast time and other mealtimes were the only time when collective accountability was demonstrated. All the nursing staff shared the responsibility of assisting the patients at each mealtime. Each patient received a meal which was placed in front of them; the food was warm and ready to eat. Supervision and assistance were provided to all the patients by the primary nurse or her nursing assistant at each mealtime. When significant observations were made by the nursing assistant during mealtime, it was reported to the patient's primary nurse.

Hahn's (1970) article "It's Tough to be Old" described the elderly patients' feelings of frustration and resentment towards the nursing staff. One example described in this article depicts the situation where patients' meal trays were delivered at the edge of the bed so that they could not reach the tray. The

untouched trays were taken away by the aide and the nurses would wonder why the patients would not eat, or some assumed that the patients were not hungry because they were old and sick. Meals are important for the hospitalized patients not only because they provide nourishment but also meals provide patients with opportunities to socialize with others. Robinson (1984) points out that the hospitalized patients spend a great amount of time choosing menus, anticipating meals and evaluating their food.

On rare occasions a breakfast tray was missing or a wrong tray was delivered to a patient who was on a special low fat and sodium diet. On such occasions the patient reported the error to his primary nurse, or the primary nurse would note the error and promptly contact the dietary department to request the correct tray for the patient.

Upon a new admission the primary nurse interviewed the patient and his family, for an initial assessment which included history-taking. This was completed within 24 hours following admission. Although the primary nurse introduced herself to the patient as his nurse, the concept of primary nursing was not explained to him. This indicates the lack of demonstrating formal teaching to the patient and his family. Raab (1985, p. 13) states that "clients should be briefed about the concept of primary nursing during their admission interview, as it may be a new term to many of them". When a new patient arrived in the evening shift, the evening nurse admitted the patient and made a general assessment of the patient. On the following morning, the patient's primary nurse further interviewed and examined the patient for an in-depth nursing assessment

and to design his plan of care. When the primary nurse was off duty, this task was delegated to her associate nurse. When the primary nurse returned to the unit, she received a report from her associate nurse regarding the patient and his condition, since it was the primary nurse who was ultimately accountable for the care delivered to the patient on a 24-hour basis.

The informants stated that they paid a great deal of attention to physical aspects of care. Referring to a patient who was recovering quickly from bad decubitus ulcers he had developed while at another hospital, they agreed that their patients on Unit 5 would not develop decubitus ulcers because they delivered good nursing care. There were not, in fact, any patients on the unit with decubitus ulcers. This phenomenon was significant since half of the patients on the unit were bed-ridden and incontinent of urine. The informants were aware of the importance of preventing decubitus ulcers from occurring and felt accountable for complications the patients might develop as a result of poor nursing care.

Due to the age range of the patient population and the nature of nursing care required, the primary nurse attempted to restore and maintain the patient's optimal functional level. She demonstrated her accountability for her patient care by administering speech therapy to those patients with aphasia and by administering passive range-of-motion exercises to those patients with hemiparalysis, in addition to carrying out basic nursing care. The primary nurse talked to the aphasic patient slowly and clearly asking questions and requiring simple "yes" or "no" answers so that the patient's wishes could be conveyed nonverbally. She administered passive range-of-motion exercises while giving a

tub or bed bath to the patient and encouraged his independence in daily activities. Accountability for the care delivered by herself and other nursing staff on her behalf was executed through formulation and implementation of nursing care plan.

With regards to the safety of patients for which the primary nurse is accountable, the primary nurse manipulated some environmental variables for those who had Alzheimer's disease or senile dementia. For example, she transferred patients who wandered about from a four-bed room to a two-bed room where there would be less exposure to environmental stimuli. Such measures and their rationale, together with the expected outcome dates, were documented in the kardex and the patient's progress was recorded in his chart. The primary nurse demonstrated her accountability not only through direct patient care delivery but also through providing a safe environment for the patient in an attempt to prevent undue falls and similar accidents. Her accountability for safe patient care was hence maintained.

The following is one example of the nursing activities symbolizing accountability. A patient who had been on the unit for seven years was a most challenging case of nursing management, as he had not been particularly compliant with care related to his smoking habits since his admission. He had been a heavy smoker all his life in spite of having a chronic obstructive lung disease and a past history of respiratory arrests. Despite the restricted amount of cigarettes ordered by his doctor, he frequently came to the nursing station demanding still more cigarettes. After observing this behavior repeatedly, his

primary nurse decided to set up a contract between the patient and herself whereby he would be given half a package of cigarettes at the beginning of the shift which was to last him until the end of the shift. She explained the rationale of this strategy to the researcher, commenting that if he were regarded and treated as a responsible adult, he would develop a sense of autonomy and responsibility enough to participate in his own care, and learn how to ration the given cigarettes over the eight-hour period successfully. She further mentioned that the patient used to be given a ration of one cigarette per hour as had been suggested by the unit supervisor. However, this approach did not work as the patient smoked the cigarette in a matter of minutes and would come back to the station demanding another one within the same hour. The primary nurse explained the contract to the patient's family member who visited him regularly and tried to incorporate this strategy with the involvement of the family, staff and his room-mates. The patient appeared to be less demanding for the cigarettes and the frequency of his appearance at the nursing station seemed to decrease for the rest of the study period. Ciske (1980) speaks of fixed accountability whereby accountability is clearly visible in terms of a one-to-one relationship between the primary nurse and her patient.

Family Members and Significant Others and Accountability

The following exemplifies the nurse's accountability to the patient's family members. A patient's death occurred during the night. The following morning when his primary nurse arrived on the unit, the news was relayed personally to her by the night nurse, although it was already taped as a part of the night report. The news of this patient's death was unexpected to everyone, particularly

since the patient had established a good rapport with the staff. That afternoon, in a telephone call received from a family member of the deceased patient, the primary nurse was able to report on his condition up until 12 hours prior to the incident, and although she was not present at the time of death, she was able to answer questions raised regarding the deceased.

Another example of the primary nurse's accountability to family members is illustrated by the following incident. When one of the patients became critically ill, the primary nurse called the patient's family and notified them of his critical condition. She called the patient's doctor, the supervisor, and the clergyman in that order. Next, she discussed the plan of care for this patient with the nursing assistant. The primary nurse indicated the gravity of the patient's illness and emphasized the importance of focusing their attention on this patient at that time. They started to deliver care in a coordinated, systematic fashion. Meanwhile, the family members arrived at the unit to visit this critically ill patient. While supervising the nursing assistant as well as assisting her with delivery of care to the patient, the primary nurse remained at the bedside with the family members to explain the care delivered and reasons for it. In so doing, the primary nurse provided the family with emotional support and comfort, informing them of the patient's condition and his response to care. She listened to the family's questions and, in an attempt to supply the most accurate information, directed them to the most appropriate source of information or resource person such as the physician, clergy or supervisor.

Thus, accountability to the patient's family and significant others was

exercised by the informants. Their relationship was friendly and a sense of trust was evident between them. The relationship was further strengthened by such traumatic incidents as patients' deaths and dying when the primary nurse's accountability was demonstrated to the patient's family members in a warm, humanistic way. Furthermore, the primary nurse's accountability was clearly delineated in the patient's progress notes describing physical, psychosocial aspects of the patient's condition.

Accountability with patient's family and significant others can be summarized as follows: The primary nurse is responsible for keeping the patient's family members informed of the patient's condition, particularly in emergency situations which require the family members to visit the patient in hospital promptly. She is accountable for her decisions and actions through which she delivers patient care to her patients and their families. She acts as patient advocate as well as encourages the family members and significant others to participate in patient care activities.

The Physician and Accountability

The primary nurse carried out the physician's orders, both verbal and written, for her patient. She reported her patient's condition in detail at the weekly staff meeting when both the physicians and primary nurses were present. The primary nurse was not only accountable for carrying out the doctor's orders but also for monitoring the effects of the treatments administered. She monitored the patient's condition closely and if the patient started to exhibit adverse signs contacted the physician to report her findings and sought further advice on medical care management.

The following exemplifies the primary nurse's accountability for patient care. The primary nurse noted a rash on the patient's limbs and abdomen one morning while she was assisting him to get dressed. She asked the patient if he was experiencing any discomfort in these areas, to which the patient replied that he was. At the next staff meeting, which was the follow in a day, the primary nurse reported this patient's newly discovered problem to the physician. The physician ordered a medication to help subside the rash. Shortly after he had been placed on this medication, he started to exhibit gastrointestinal problems; his appetite decreased, he became lethargic and complained of nausea. Noting such a change in the patient's condition, the primary nurse observed him closely. Monitoring his intake and output, she also informed the nursing assistant and administered a variety of nursing interventions in an attempt to alleviate the discomfort the patient was experiencing. Despite these nursing measures, the patient continued to exhibit adverse reactions. At the following staff meeting, the primary nurse reported the patient's prolonged rash and those signs and symptoms he exhibited following administration of the medication. The primary nurse pointed out the medication as the probable cause and asked the physician if it could be replaced with another or be totally discontinued. The physician decided to discontinue the drug, following which the patient ceased to exhibit the adverse symptomatology.

Another example of the primary nurse's demonstration of accountability to the physician is by assisting him in up-dating her patients' drug profiles every month. She checked all her patients' drug profiles regularly and drew the

physician's attention to those who required re-ordering medications and/or treatments, or she suggested which medications or treatments should be discontinued for the patients who no longer required them. Whenever the patients' condition deteriorated, the primary nurse directly notified the patient's physician and kept him closely informed of the patient's condition. She monitored the patient's condition and his response to drug therapy and other treatments, and shared her observations and findings with the patient's physician at the weekly staff meeting.

Other Health Care Members and Accountability

The primary nurse's accountability with other health care members was best demonstrated while conducting the multidisciplinary team conference and staff meeting. When a new patient was admitted, the patient's primary nurse contacted the other health care members to arrange a suitable time to meet with them on the unit for the purpose of introducing the new patient to them and coordinating his plan of care. By virtue of the fact that the primary nurse was the expert capable of describing her patient's most recent health status as a whole, she chaired the multidisciplinary conference and coordinated the care offered by other health care members or family members.

To illustrate the primary nurse's accountability with other health care members, the following example is presented. The primary nurse discussed one of her ambulatory patients and indicated his possible readiness for discharge in the near future. The physician responded to this suggestion and initiated the referral procedure to a nursing home. After transcribing the order for referral, the

primary nurse exercised her authority to communicate directly with the social worker. She also indicated the patient's discharge planning in the kardex and the progress notes as well as in the Primary Nurses' Book. The plan was relayed to the patient by the primary nurse.

Thus, the primary nurse was accountable for the results of care to the patient, since she alone knew the patient well enough to determine realistic outcomes. In order for the patient to benefit from the maximum care, the primary nurse coordinated activities with other health care members.

Hence, accountability means being answerable for one's acts. Such acts include establishing therapeutic relationships with patients, their families and peers. By virtue of the authority she exercised via the nursing process, delineated in the form of the care plan, through which she devised the nursing care plan, the primary nurse was responsible for the outcome of care delivered by other nursing staff as well. Both the associate nurse and nursing assistant carried out the orders of the primary nurse and the physician, but only the primary nurse was directly accountable for the physician's orders. The primary nurse demonstrated her sense of accountability by actually carrying out nursing care.

The informants were responsible for the outcome of care on a 24-hour basis. Although the informants worked straight day shifts, they were responsible and accountable for the outcome of care delivered by other nursing staff on a continuous basis, 24 hours a day. By utilizing the nursing care plan, the nursing personnel in another shifts knew exactly what care was required by a given

patient, and they reported the outcome of care they delivered to the primary nurse who devised and revised the care plan according to the changing needs of the patient. Spoth (1977, p. 224) states of accountability as an "extremely important concept in that it distinguishes primary nursing from other care-giving systems, especially the case method where nurses were responsible for total care but only for the eight hours that the nurse is present".

Thus, the informants demonstrated their accountability for patient care to the patient and his family, the physician, other health care members, the hospital and the professional association. However, the evaluation of the degree of each informant's accountability was not evident due to the fact that peer review programs were not practised on this unit. Such an informal peer review is essential on a continuous basis as a part of a patient care conference. The only mechanism where evaluation of care was done was by nursing audit. Such a chart audit gives an elementary picture of the nurses' acceptance of accountability for care (Hegyvary, 1982, p. 148).

The informants displayed accountability to the patient for the results of the nursing care delivered by themselves and other nursing personnel. They accounted for the results of any nursing care given from admission to discharge or death. They consulted each other regarding the kinds of nursing strategies to be employed; however, the evaluation of such strategies was not done. Therefore, they were not evaluated on the "degree to which clinical practice achieves patient care outcomes", as suggested by Zahler (1980, p. 126):

There exists a close link between *accountability* and *responsibility*. Clear differentiation between the two is made in terms of process and outcome. Passos (1973, p. 18) defines *accountability* as "answering for the results or outcomes of responsible actions". She defines *responsibility* as "expressing the 'oughts' or expectations of performance, while *accountability* implying our 'dids' or actual performance judged against expected performance".

Distinction between *responsibility* and *accountability* may be expressed in the term, "cognitive" behavior for *responsibility*, and "executive" behavior for *accountability*. *Responsibility* is a means to achieve an end of *accountability*, and these two constructs are built upon each other to attain a third construct, *autonomy*. *Autonomy* will be presented next.

Autonomy,

Autonomy in nursing refers to the ability of the nurse to make independent decisions based on professional judgement and to perform nursing functions without obtaining a doctor's order or consulting with other health care professionals. Nursing functions are strictly nursing activities which are carried out on the basis of systematic data collection and assessment of the patient. The nurse makes inferences concerning the data, defines the patient's needs and strategies to meet them, and validates these with the patient to set realistic goals. Throughout the nursing process, the nurse's ability to make clinical judgement and independent decisions becomes a crucial factor.

Autonomy in patient care reflects the true nature of nursing. Nurses are the only health care professionals who assess the patient's needs in a total perspective and who attempt to meet those needs by actions which are unique and belong to nursing alone. The nurse implements a variety of nursing measures based on principles and theories borrowed from the natural and social sciences. Furthermore, she applies theoretical knowledge derived from other disciplines. The nurse is therefore able to diagnose, analyze and evaluate a given nursing situation and intervene with the patient in the most effective way.

Patient Care and Autonomy

Independent nursing activities were performed in a systematic fashion by the use of nursing care plan. As an example, the informants performed various comfort measures related to bodily care. One area of concern to the nurses was elimination. Although the majority of the patients were placed on a bowel regime

with prescribed medications, the informants administered various nursing measures to facilitate a patient to establish a regular pattern. The majority of bed-ridden patients and some of the ambulatory ones wore adult disposable diapers. Also, a vertical strip on the outer layer of the diaper changes color upon being wet by urine thereby enabling the nurse to readily tell if the patient had urinated. Noting the color change, the staff changed the soiled diaper and gave skin care. If the patient did not void into the diaper, the patient was assisted and encouraged to do so.

The following illustrates the autonomous nature of nursing activities. One patient had acquired a bladder infection, and was subsequently having difficulty voiding following catheter removal. Despite the doctor's suggestion to catheterize the patient again, the primary nurse started to implement various nursing measures such as offering fluids on an hourly basis. The patient's selection of cranberry juice and other acid-fast fluids was also encouraged by the primary nurse when the dietary aide visited the unit to offer nourishments between the meals. The patient was also assisted to stand at the bedside each time he indicated an urge to void. A praise was offered immediately whenever the patient voided on his own; however, reassurance and support were given to the patient on each unsuccessful attempt, and the patient was reassured that he would be assisted in further attempts to void.

The following patient's case illustrates a good example of professional nursing care. A 90-year old man was admitted to Unit 5 after having been hospitalized in another city after suffering a stroke. Up until the stroke he had

been healthy and kept activities while looking after his 84-year old wife by doing such things as cooking breakfast every morning for themselves. His only previous health problem was cataracts. After admission to the unit he became confused and developed aphasia and weakness in his right arm and leg, but had no definite paralysis. He was confused about time, place and person; his speech became slurred. On admission he was found to be very drowsy and did not respond to his name. He only responded by opening his eyes. By the time he was admitted to Unit 5, he had already developed large decubitus ulcers on both ankles. Vigorous nursing measures began immediately by establishing scheduled times during which he was encouraged to sit up in a stroke chair and by initiating passive range-of-motion exercise and speech therapy. Reports from the physiotherapist following each session were conveyed to the patient's daughter who visited him every day. Signs of remarkable improvement started to appear by the third week. The patient started to utter some words and responded in monosyllables. He also took a few steps while being assisted by the staff and most of his decubitus ulcers had begun to heal. On one occasion, the patient was observed laughing. Continuous and consistent use of a nursing care plan facilitated the provision of quality nursing care. The measures utilized by the staff were strictly within the domain of nursing and did not require consultation from other health care members. They were innovative and non-invasive, individually designed and monitored by the nursing personnel under the guidance and supervision of the primary nurse.

During the study period there was only one patient (described above) who required treatment for decubitus ulcers; in his case they had originated outside of

this hospital. Nearly half of the patients on this unit were bed-ridden and required total assistance in both getting dressed and transferred from the bed to the wheelchair. One patient who had multiple sclerosis was totally incapacitated and required total physical care. Despite his constant bed-ridden state, his skin was intact, and he exhibited no signs of developing decubitus ulcers. The primary nurse initiated and administered an overall plan of care. Each problem in the care plan was identified by the original date where the review date was entered in brackets next to the original date in the kardex. The review date was determined depending on the nature of the problem and reflected a realistic outcome in the light of the multifaceted problems and needs of the patient. The patient care plan was reviewed each day and an appropriate revision was made with consideration given to the individual patient's needs, and his ability to assimilate information and participate in his care, to bring about a desired outcome. Alternate ways of providing nursing care were shared and discussed among the primary and associate nurses.

The nursing care plan was formulated and written in the kardex. Once a patient's problems were identified, expected outcomes and nursing actions were elaborated upon and the dates to review those problems were specified. For example, for the patient with Alzheimer's disease, nursing interventions were focused on the psychological and social dimensions and interpersonal transactions whose variables could be manipulated to alter and minimize adverse stimuli from the environment. The doctor's orders were not required in order to carry out these measures. The psychologist, Robert L. Kahn (1975, pp. 1560-1573)

described dementia, as a "bio-psycho-social phenomenon" while the biological aspects are not currently treatable, the psychological and social are often amenable to intervention.

Autonomy for patient care was displayed in terms of administrative and organizational aspects as well. Based on a master rotation, the nurse-in-charge on the weekend scheduled the daily assignments for the upcoming week; it was the night nurse's responsibility to write this schedule with a water-soluble marker on the daily assignment planner prior to the shift change in the morning. In addition to this; the nurse-in-charge was responsible for other administrative tasks otherwise assigned to the unit supervisor and the unit clerk who were off duty on the weekend. Being in charge on the weekend was an additional responsibility and the primary nurses rotated in this assignment as well. On the weekend the primary nurse, although in charge, had a similar caseload of patients as the other primary nurses and administered care to her primary patients as well as acted as chairperson at the weekly ward conference. The informants had their say in terms of their preference regarding the rotation, thus displaying their sense of independence, authority and power. If a primary nurse needed to have a day-off on a scheduled duty day, she telephoned and asked the part-time nurses to find a replacement, thus saving the administrator from having to telephone various casual staff who were on call. Once such arrangements were made, the primary nurse took the responsibility to adjust her time schedule on the unit accordingly and notified the nursing office of the change.

While the medical domain of responsibility was carried out by executing the

doctor's orders, nursing care was administered over and beyond the basic medical care management. The informants dealt with each patient care situation designing the most appropriate plan of care. Although it was designed and utilized exclusively by the nursing personnel, it was recognized by other health care members as the vital tool for the nurses and served as the core of the system which assimilated other services into nursing care delivery.

Thus, the nurse has responsibility and is accountable for the delivery and outcome of care. These two elements are pre-requisites for an autonomous profession. When these are achieved, the nurse may be called an autonomous practitioner.

Family Members and Significant Others and Autonomy

The patient's family members' recognition of nursing contributions was apparent by the notes, flowers and cookies they brought to the primary nurses. The primary nurse was the first-line person for the family to contact and consult and her suggestions and ideas were willingly listened to and accepted by the family members. The primary nurse acted as the patient advocate and the facilitator for the other health care members, particularly for the physician.

The primary nurse's autonomy may be illustrated by a demonstration of patient advocacy directed to the patient's significant other. A patient who was newly admitted to the unit expressed his wish to go home for a few days. Although he had an appointment with his optician the following day, the primary nurse cancelled the appointment for him and proceeded to make arrangements so that he could go home as requested. The primary nurse contacted the patient's

friend who used to look after him, at home, and asked him to come and pick him up. She also made arrangements so that during his absence his other needs were met, thus ensuring a safe return to the unit.

By virtue of the fact that the informants were the direct care givers, they demonstrated in-depth and up-to-date knowledge of the patient and his condition. This allowed the informants to provide further guidance or advice to the family and others as long as it fell within the jurisdiction of nursing. They exercised their authority to make independent judgements and accounted for the decisions they made. Due to the involvement of the family and significant others in the plan and the delivery of care, as well as frequent contact with the informants, the family members and significant others felt a sense of belonging as members of a group who were striving toward a common goal with the patient.

The Physician and Autonomy

The relationship with the doctor in terms of autonomous nursing function is best exemplified by the following remarks made by the informants:

"Before primary nursing, we had nothing to do with the doctors, because the team leader dealt with the doctors and her major responsibility with them was to receive and transcribe orders. The doctors did not get any input from the staff nurses. But now all of us communicate closely with them, we take an active part in their plans of care. We make a lot of suggestions and they listen to us. They think we can do a lot and they recognize us as equal partners in the health care system."

Initiating and conducting a multidisciplinary team conference signifies autonomous nursing function on this unit. At the multidisciplinary team meeting, the primary nurse acts as the chairperson and takes the minutes for the meeting.

The primary nurse is the effector of total patient care delivery at multidisciplinary level.

Autonomy in terms of to the physicians can be best described in the following example. The weekly sit-down rounds involving the primary nurses and the two doctors which were followed by walk rounds took place every Wednesday morning. However, the informants found that dealing with two doctors at the same time was time consuming and at times confusing. At one of the regular staff meetings, the informants suggested to the doctors to schedule separate sit-down and walk rounds on two separate days each week. Both doctors agreed to this suggestion, and the primary nurses met with one doctor on Wednesday morning, and with the other on Thursday morning. The following week, the one scheduled for Wednesday came on Thursday and the other who did rounds on Thursday came on Wednesday, nevertheless adhering to the informants' suggestions to take turns. Assertiveness to initiate changes for the better is a fundamental requirement for autonomous nursing. This is particularly significant as the nurse's role has historically been influenced by the medical model to assist the doctor as a subservient right-handed maiden.

Other Health Care Members and Autonomy

In discussing nurses' autonomy in relation to other health care members, one needs to look at nurses' roles and functions which are internalized by nurses and reinforced by other health care members. It must be evaluated within the context of the health care system since all systems are interrelated and directed toward meeting the the patient's bio-psycho-social needs.

A profession may be able to exercise autonomy in one particular aspect of practice while it may not be able to do so in other aspects. Possession of autonomy and execution of it depend on the degree of interaction with other disciplines. The process is dynamic and therefore it is useful to examine autonomy in systems' perspective.

Nurses, like other professionals, must be cognizant of the nature of reciprocity in the process of negotiating their boundaries with others in each practice situation. Autonomy means freedom to take responsibility; authority is a pre-requisite to attain autonomy. The following example illustrates informants' exercising their power through negotiating their boundary of practice with a health care arena for the purpose of consolidating the nursing territory. This example illustrates the informants' achieving equilibrium in systems' perspective so that they may continue to identify and exercise their own domain of practice through an on-going negotiating process among other health care members.

As one of the clerical tasks, the primary nurse was responsible for charting Patients Workload Measurement for each of her patients on a daily basis. This assessment was developed by the Management Engineering Unit⁷.

Using the manual for references, the primary nurses checked off the appropriate number which represented the degree of care patients required under specific category of activities, and indicated the level of care required by their

⁷Nursing Workload Management System Implementation Manual for Extended Care Hospitals. Prepared by: Joe H. Jhala, B. C. Hospitals Shared Systems Society, Management Engineering Division, Royal Columbian Hospital, New Westminster, British Columbia

patients for the day by totaling those numbers on the workload measurement sheet. The primary nurses found this exercise tedious and time consuming. Furthermore, they felt that it was unnecessary to fill it out every day, because the patient's condition commonly did not change from day to day. One of the primary nurses took the initiative to approach the management engineer who visited the unit periodically. She suggested that the checklist be done every two weeks and explained the reasons for the suggestion. She stated that it did not make much sense to record the same thing every day just for the sake of recording it. The primary nurse continued to explain that it would be more meaningful to do it on bi-monthly basis with occasional recordings between regular ones as deemed necessary. The informants stated that the primary nurse was responsible and accountable for patient care. Since the primary nurse continuously observed, assessed, intervened and evaluated nursing care and was the decision-maker for the overall assessment of patient care delivery, she alone had the information on which the Patient Workload Measurement was based and the most reasonable idea on how frequently it should be done.

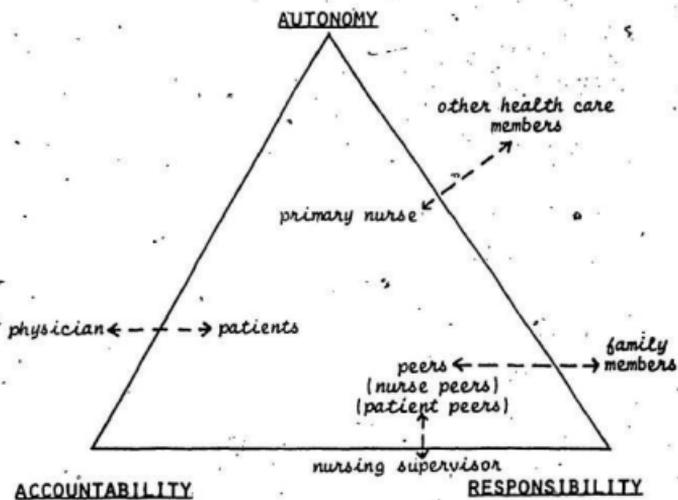
Autonomy takes accountability and responsibility as necessary and absolute conditions. In a triangle model (see Figure 2), shows the bases supported by responsibility and accountability on both sides and the third point is analogous to autonomy which signifies the accomplishment of a profession. Nurses are depicted inside the triangle interacting with their patients and peers and also dealing with the patient's family members and other health care personnel who are interacting at the boundaries. The regulatory functions of permeability occurring between

the inside of the triangle and the outer environment is controlled by the nurses, and the maintenance of the configuration of the triangle is dependent upon the ability of the nurses to regulate the flow of traffic at the boundary. In this environment the degree of autonomy is proportional to the maintenance of the configuration of the triangle. The dynamic interaction between the inner and outer environments of the triangle is analogous to the activities of atoms.

The following statement reflects a concept of autonomy in nursing. The then director of nursing at Loeb, Lydia Hall (1969, p. 81) stated that "nursing is in charge; medicine is an ancillary service. I, as the Director of Loeb, hire and fire the doctors who are employed here". A staff nurse at Loeb describes that what makes Loeb Center so unique is because, 1) it is genuinely patient-centered, and 2) the nurse serves as the chief therapist (Englert, 1971, p. 281).

Autonomy is a concept concerning the right to independent self-government. In primary nursing, autonomy is a concept of independence, authority, power and professional identity. In this study, the informants knew when nursing was needed, and based on their independent judgement and decision making, they administered a variety of nursing measures which fell within the jurisdiction of nursing. These interventions did not require consultation or permission from the physician and/or other health care members. Such nursing activities decided and acted upon by nurses alone signified nursing as an autonomous discipline. The informants displayed their autonomous nursing practice through independent nursing actions in order to resolve the patients' health problems. Such nursing

Figure 2 The Relationship of the Three Major Constructs



measures were implemented, whenever appropriate, in collaboration with other health care members. Autonomy is operationally defined as power (Mundinger, 1980).

Mundinger (1980, p. 20) gives definitions of *autonomous* and *independent* as follows:

Autonomous: Self-governing, independent, subject to its own laws only.

Independent: Not influenced or controlled by others in matters of opinion, conduct, etc.; thinking or acting for oneself. Not subject to another's authority or jurisdiction; autonomous; free, possessing a competency.

In nursing, autonomy is one of the most frequently discussed issues unlike other professions. Most acknowledged professions do not make an issue of their autonomy or independence.

The informants in this study demonstrated autonomy through their power and authority to make and act on decisions about nursing care of their patients. The underlying principle of autonomy is self-governance, governing their own clinical judgements (Hegyvary, 1982). Power is authority, and the authority of primary nurses is derived from the demonstration of unquestionable competence in providing nursing care, which is based on application of a systematic and scientific integration of both nursing and other disciplines in order to deliver total patient care. The authority of primary nurses also comes from the outcomes of care delivered for which they were personally accountable.

Caring

Caring displayed between the patient and the nurse can be stated as the most significant phenomenon observed repeatedly throughout the study period. Caring attitude acted as a vehicle to promote a sense of trust and a therapeutic relationship between the patient and the nurse. Without such rapport, nursing care would end as a technical service dealing with the physical aspect of care alone. Dynamic exchanges in response to psychological needs between the care recipient and care giver occurred throughout the course of the observation period. Caring was displayed on all levels of interactions within and between the subgroups of the patients and primary nurses, including: 1) Caring displayed to the patient by the primary nurse; 2) caring displayed to the nurse by the patient; 3) caring displayed to the nurse by another nurse; and 4) caring displayed to the patient by another patient. Each category of caring will be presented as related to patient care.

Patient Care and Caring

Every morning when the nursing staff saw the patients in the room or in the hallway, every patient was greeted by name and asked how he was feeling. Thus, exchanges of greetings were observed frequently in the earlier part of the morning. Some patients were called by a nickname to indicate the primary nurses' acceptance and caring towards the patients.

One of the patients, an 85 year-old man with organic brain syndrome, used to walk constantly along the corridor holding onto the railing and moving with a slightly unsteady gait but constant tempo. He was short, plump and had an

amicable disposition. Although he did not speak, he was able to communicate by vocalization. The informants used to call him, "Pumpkin", "My little dumpling", or "Little ducky", or "Georgy" instead of his proper name George, to draw his attention whenever they approached him to deliver care, or used such nicknames in greeting to indicate their caring form him. The informants were observed smiling, and commonly using a gentle touch, when addressing him. These diminutives were used not to demean the patients, but rather to display the informants' attention and caring for the patients, reflecting this particular enclave of cultural population.

From the mid-morning onwards, all the patients were dressed in their own clothes, clean-shaven with an evident smell of after-shave lotion. The patients the researcher observed were both mentally and physically incapacitated, therefore they lacked skills necessary to perform self-care activities. However, they appeared clean and well-groomed and no patient was seen drooling at the mouth, or with mucous discharge around the eyes. Although one half of the patient population on this unit was incontinent, there was no odor of urine detected anywhere on the unit.

There were two blind patients who shared a room. One was 88 years old and the other 98 years old. The older patient's routine was the same as the rest of the patients. Following breakfast in bed, these two patients were washed, clothed and groomed. They were assisted to a geriatric chair and usually placed near the nursing station for a closer observation. The younger of the two stayed sitting up in his wheelchair most of the day. When the primary nurse saw this

patient sitting in his wheelchair, facing towards the wall in a dark room, she went in and said, "You are facing the wall and it is awfully dark here. Let me take you to the dining room where you can talk and listen to your friends."

On one occasion the staff celebrated a patient's birthday by presenting a birthday cake to him, accompanied by the birthday song. A picture of the patient surrounded by the nursing staff was taken and it was added as an additional "family picture" to the collection of photos of other patients and the staff on the unit.

As one of the overt ways to express caring, the staff displayed hugging to the patients. Hugging was observed on the unit on a daily basis. Hugging was exchanged between the patient and the nurse as a form of greeting, indicating the nurse's understanding and compassion, and with a friendly "How are you?". Various types of hugging as therapeutic human interaction were illustrated in the literature (Keating, 1983).

Bevis (1984) writes of caring as a life force, and describes as follows:

People experiencing grief are usually open to caring acts from others. They allow more hugging, holding, kissing, acts of thoughtfulness and kindness, protection, and support than usual and from a wider variety of people, including people with whom they are in stages of caring that do not have such acts as central and usual behaviors. (p. 54)

The following illustrates an example of caring as a form of hugging between the patient and the primary nurse. One morning the primary nurse went into her district and started to prepare her patients for breakfast. She approached

Georgy who was still asleep and started to call him in a soft voice with a longer stretch on the vowels of his name. She called him a few times; however, it did not wake him. The primary nurse started to crawl her fingers across his shoulder, calling him again. *Georgy* responded to her gentle touch and he was awake. He smiled and gave her a hug.

Apart from hugging, behaviors of caring were displayed by the informants in their own unique ways, which reflected their personality. One of the younger informants dealt with the patients in a casual and cheerful manner. She joked with the ambulatory patients while assisting them in their self-care and readily engaged herself in conversation with them. While she encouraged the ambulatory patients' independence, she gave a helping hand willingly to those who required assistance. The oldest of the informants had a quiet disposition. She was often observed sitting with the patients in their rooms, or in the TV room, conversing patiently, showing interest in them. She displayed her caring through careful and thorough nursing care delivery and showed understanding and compassion to those who required more time to participate in self-care activities as well as to those who required total care.

One of the patients was frequently depressed, would not initiate his own care and became dependent, staying in bed most of the day. Although he was 94 years old, he was alert, capable of wheeling his own wheelchair, and could be ambulated with assistance. One morning upon seeing the patient who indicated his wish not to be disturbed for AM care and grooming, the primary nurse said to him:

"I want you to be up, Mr. G. All my efforts in the last two weeks are out of the window. Your legs won't stand you up and move any more. While I was away for five days, you weren't up, were you? Might as well enjoy as much as you can while you can, Mr. G. You're ready, but He is not; He is the boss. If I'm not here I cannot get after you. Last week you were doing pretty well with your walker. Now this week we're back to square one."

The primary nurse brought a walker to the bathroom where the patient was, and asked him to walk into the hallway. The patient followed her instructions and started to take a few steps when he suggested that he would like to be assisted back to bed. The primary nurse encouraged him to take a few more steps into the hallway and reassured him that she would assist him back in his wheelchair following the walk. The primary nurse said to the patient:

"Now you should feel like a new man! Don't you feel good after a little walk? You need to do some exercise. Keep using your legs, otherwise they'll get no good ... I don't want you to go to bed. Stay up, please."

While the nurses displayed their caring towards the patients through carrying out nursing measures, caring was observed on the part of the patients towards the nurses. Ambulatory patients hugged the nurses in the hallway, as the nursing staff were carrying out activities across the two areas of the patient population. Some patients would indicate that they wanted to be hugged by putting their arms up. The informants documented the patient's response to hugs in the chart, "The patient seems to be responding well to 'hug therapy'". There was a copy of an article on "Hug Therapy" at the nursing station (Keating, 1983). The article described different kinds of hugs and implicated the therapeutic effect of close bodily contact to the patient.

The following illustrates this reciprocal relationship of caring between the patients and the nurses. One of the ambulatory patients assumed the role of leader on the unit. For example, every day he collected meal trays and tray covers from the dining room and patient rooms after the patients finished their meals. He also announced the mealtime. Standing at the entrance of the kitchen and looking towards the nursing station, he would shout, "Breakfast is up!". If the staff were still discussing patient care plans, and did not respond to his call, he would shout again, thus urging the staff to start distributing the trays for the patients who were awaiting in the dining room and in the patient rooms. He used to give candies to the staff and leave candies on the counter at the nursing station. Occasionally he would open the door of the "quiet room" where the nursing staff were having a break and would give candies to them. He was frequently seen assisting the disabled patients to ambulate in the hallway or dining room.

Another patient in the ambulatory section was confined to his wheelchair due to his amputated legs. He would go downstairs to the canteen, buy several cans of Coke, bring them back to his room and stock them underneath the night table. Later he would give away a can of Coke to the staff. Some staff kept cans of Coke given by him in the refrigerator at the nursing station, and by the time the day shift was over, some took home a bagful of the "gift". The patients' feelings of gratitude and appreciation for the care they received were displayed by the giving of material gifts by the ambulatory patients, who were able to go and purchase candies and the like at the canteen and/or gift shop downstairs, and

through hugs and kisses initiated by the bed-ridden patients. Such a caring behavior instills the foundation of mutual trust and rapport between the patient and the nurse.

There were two ambulatory patients who were particularly friendly to the informants. Every morning they used to come to the nursing station and took snack "orders" from the informants for their upcoming break. The youngest informant regularly gave her "order" to the patients who volunteered to go downstairs to the cafeteria to fetch the snack for her. On one occasion, the primary nurse asked the patients to bring her usual snack, an apple and a cup of coffee. The two patients had to decide which would get an apple and which, a cup of coffee. Seeing the two discussing this, the primary nurse said, "You two figure it out. Make sure you bring them back in time for my coffee break." The primary nurse stated to the researcher that delegating such a chore to the ambulatory patients would promote their sense of self-worth and a feeling of accomplishment.

After a week's break when the researcher returned to the unit, a few ambulatory patients approached the nurse researcher, hugged her and said to her, "Where have you been? We missed you." During the study period the researcher was hugged regularly by these patients.

The nurses displayed caring not only to their patients but also to one another throughout the day's interaction. There was a collegial friendship present among the informants. Upon arrival to the unit every morning, friendly greetings

were exchanged. They consulted one another regarding interventions for nursing care plans, particularly a primary nurse would consult her colleague who acted as associate nurse to her patients while she was off duty. They displayed caring toward and were considerate of one another. For example, when one of the informants was busy delivering AM care and was supposed to go for her break, the nursing assistant came to her and volunteered to finish the task the informant was doing. The same phenomenon was observed in the other pairs of primary nurse and nursing assistant. Thus, nursing activities were carried out smoothly in spite of interruptions due to break times. Although half of the nursing staff were not present on the unit at each break time, the patients' immediate needs were communicated among the nurses and were met promptly by the other staff left on the unit. The nursing staff were aware of certain patient needs. Patient needs were not interrupted during the break time. Such needs would be met by the associate nurse or nursing assistant delegated to complete the task on behalf of the primary nurse who was on her break. This was reciprocated when the associate or the nursing assistant was off the unit for her/his break.

At break times conversations were pleasant. The main topics were their families, home activities, holiday plans and cars. There were no remarks made concerning their physical fatigue or work conditions. When the unit was considered acute due to a patient's sudden change of condition or behavioral problems, remarks were made to describe briefly the behavior, but there was no criticism of the patients as people. Details were not elaborated upon and soon the conversation moved on to different topics. There were smiles, jokes and laughter

which contributed to the staff's esprit de corp to work toward common goals by delivering quality care; their interpersonal relationships at work appeared to be fostered through informal interactions at break times. The nursing staff generally used the "quiet room" for their breaks, preferring to stay on the unit rather than going to the cafeteria which was on the other end of the complex. This appeared to have contributed to the enhancement of group cohesiveness.

Caring was evident through each nursing action and such a caring attitude displayed by the nursing staff permeated the entire unit to foster the group dynamics among the patients. The patients responded willingly to nurses' caring and displayed caring towards their fellow patients as well. Among the patients, comradeship was apparent. Some patients formed small groups among themselves for socializing both on and off the unit. Although the unit was divided into two areas separated by double doors, visiting among patients between the two areas occurred. In particular, ambulatory patients made visits to the bed-ridden patients. Some of the ambulatory patients visited one of the bed-ridden patients nearly every day to help him smoke cigarettes, or to merely sit at his bedside and talk, since he was totally incapacitated due to a deteriorating disease.

At one point, major room changes occurred. A roommate of one of the patients approached his primary nurse with a concern about his roommate. He stated that now that the patient was transferred to a room further away from the nursing station, the patient would have no means to call the nurse whenever he wanted to, particularly at night. The patient was paralyzed from the neck down, and could not use his limbs to use a call bell. An electric apparatus which sent a

signal to the nursing station upon a gentle touch of it was immediately installed at the patient's bedside.

In the hallway of the ambulatory area the patients were seen stopping and conversing with each other but the dining room was the main area for the patients to gather around the table for a cigarette and/or a cup of coffee.

The patients on the unit helped one another. The ambulatory patients contributed a great deal in assisting those physically disabled fellow patients. The patient nicknamed "Pumpkin" was frequently observed, being lead by the hand to the dining room by another patient. Commonly patients who were in a wheelchair were wheeled by their fellow patients to the dining room at mealtimes.

Parker (1958) examined leadership patterns in a psychiatric ward. He identified that in the culture of the ward, there was a tacit understanding of the difference between those activities that were part of "treatment" and those that served to make the ward a "nice place to live in". He further distinguished between types of behavior that fell into the task and social-emotional areas respectively. It was concluded that the types of leadership pattern that emerged were functionally related to felt needs of the group members. As a recommendation, the therapist's task is to evolve positive affect and warmth and at the same time inspire respect because of perceptiveness and skills. This is especially true of therapists on the staff and in the patient's peer groups. Equally, the staff must allow the patients to have a sanctioned and active role in the therapeutic process, thus the concept of "milieu" which was developed by Maxwell Jones in Britain around that time was affirmed in Parker's study.

Family Members and Significant Others and Caring

Interactions with family members and significant others occurred on the unit and more frequently during telephone conversations. The informants dealt with the family members in a friendly manner. They were familiar enough with one another to be called by the first name. Whenever the family called in to inquire about the patient's condition, it was ensured that the primary nurse spoke with them directly. In doing so, the primary nurse not only provided them with necessary information regarding the patients' condition but interacted with them in an equally concerned manner. This was evident when the primary nurse usually ended the conversation by inquiring about the rest of the family members, or particularly the one who visited the patient regularly.

The primary nurses were seen talking with the family members, as the family members sat on the edge of the patient's bed, near the patient who was in a wheelchair in the TV room or standing and talking in the hallway in an unobtrusive way. The family members were encouraged to participate in care or the plan of care of the patient, which was to be carried out the next shifts.

Hospitalization can be a traumatic experience, particularly for an older individual whose adaptability to a strange environment is not as flexible as the younger individual due to his decreased capacity in cognitive and psychomotor skills. Such an individual would have to spend a greater amount of energy and concentration in order to adjust to the new environment in the hospital in addition to having to cope with his illness and eventual death. The informants helped the patients to cope with their illness and hospitalization by demonstrating

that they cared, understood and accepted them as they were. They further encouraged the family members to become a part of the care providers and support system. By having family members become involved in plan of care, the informants became aware of the therapeutic effect that the family had on the patient, which reinforced the informants' nursing care.

The common phenomenon observed in examining three primary nurses' feelings with death and dying on this unit was found essentially similar; they displayed caring to the surviving family members. Following such events, the primary nurse usually received a package of sweets from the patient's family who expressed their deep sense of appreciation for nursing care given to the deceased.

Caring to the family members was demonstrated by accepting them as a member of the health care teams already working within the hospital, and encouraging them to be a part of it. Only the primary nursing system allows such a delivery of care whereby the nurse directly deals with the family members and significant others to bring about the maximal effect of care on multifaceted levels.

The Physician and Caring

A good rapport was observed between informants and the two physicians. At the regularly scheduled meetings in the primary nurses' room, all the recent laboratory results were placed together with the patients' charts so that the physicians could initial a variety of laboratory results. Following this, the primary nurses initiated the discussion of the patients who required their immediate attention and reported to the physicians the current status of each patient. Thus, the physician could see the patient's profile in a total perspective, which was provided by the primary nurse who was acting as the information-disseminator.

The primary nurse assisted the physician as a form of caring in reviewing the patient's status, particularly in terms of the patient's medication. Every four weeks, the physician reviewed each patient's drug profile. Reviewing drug profiles and re-ordering drugs and treatments became an enormous amount of work, since some patients were on many different drugs. The physician was seen flipping pages of old order sheets back and forth and at the same time trying to write new orders whenever such a review time came for each patient. The primary nurse volunteered to read out a number of the existing orders. One time while the physician was reviewing one of the patients' drug profile, he spent over an hour trying to update the patient's drug profile in the primary nurses' room after the sit-down rounds were finished. The primary nurse remained in the room and assisted the physician until he finished reviewing the patient's drug profile.

Other Health Care Members and Caring

Frequent interactions between the informants and a recreational therapist were observed throughout the study period. The recreational therapist visited the unit frequently, whenever an activity program was in session. She visited the patients in their rooms, mainly to solicit their participation in the forthcoming activities which she had organized for them. She made a monthly schedule of both indoor and outdoor activities and posted it on the bulletin board near the nursing station. A weekly schedule was also posted to highlight the major events. She conducted inactive games such as playing cards with a group of patients, and playing horseshoe.

When a "sleep out" was originally organized by the recreational therapist, a

primary nurse volunteered to help the recreational therapist take the patients to a cabin for a "camp out". Interactions between the primary nurse and the recreational therapist were frequent and friendly. This is probably because the recreational therapist organized the patient-centered recreational activities which necessitated frequent exchange of comments and reports.

The following is an example of caring between the primary nurse and the physiotherapist. Ordinarily the physiotherapist assisted a patient back to his room following his session, and would report to the primary nurse as to how the patient tolerated the therapy and his condition. On one occasion one patient's physiotherapy session finished as the primary nurses were going off duty. As they were leaving the unit, the primary nurses noticed that the patient who was being assisted back to his room by the physiotherapist looked tired. A primary nurse took her jacket off, approached the physiotherapist, and volunteered to assist the patient back to bed. She then wheeled the patient to his room and, with a help of another primary nurse, assisted the patient back to bed.

Lipkin (1973) described various kinds of occupational therapy activities and points out the important effect such activities brings about as follows:

"Encourage the patient to go on outside walks when this is possible, and to participate in dancing, exercise classes, bingo, card playing, games, baking, or other available activities. Your joining these activities will encourage the patient to accept them as valuable. Activities keep the patient focused on reality, reduce his level of tension, provide satisfaction and gratification, and expose him to interactions with others." (p. 82)

The primary nurse was aware of the therapeutic effect of recreational

therapy and kept a close working relationship with the recreational therapist. While the patient was engaged in recreational activities on the unit, the primary nurse was able to assess the patient's participation and degree of physical capability from a distance, and to incorporate some of the principles of recreational therapy in nursing care. For example, one of the ambulatory patients used to wear his shirt unbuttoned. When asked to button the shirt, he used to reply, "O, I can't. My fingers don't work. I had a stroke, and my hands are weak." To this habitual reply, the primary nurse confronted him one day in a firm but in a gentle manner and in a soft voice, "I saw you playing cards with Holly (recreational therapist) the other day. And you go to Bingo games, too. You seemed to be able to handle cards very well. Why don't you try to button your shirt up; you'd look much more handsome..." The patient's shirt was buttoned the following morning.

Leininger (1984) clarifies care and caring as an important distinction as follows:

Caring refers to the direct (or indirect) nurturant and skillful activities, process, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or group being assisted. Caring is the dominant intellectual, theoretical, heuristic, and central practice focus of nursing, and no other profession is so totally concerned with caring behaviors, caring processes, and caring relationships than nursing. (p. 46)

Care is described by Leininger (1984) as follows:

Care, on the other hand, remains the essence of nursing. Care is a central, unifying, unique and dominant feature and discipline-based knowledge of nursing as a profession. Care, in a generic sense, refers to those assistive, supportive, or facilitative acts toward or for another

individual or group with evident or anticipated needs to ameliorate or improve human condition or lifeway. (p. 3)

Mayeroff (1971) has identified the following ingredients of caring: Knowing, alternative rhythms, patience, honesty, trust, humility, hope and courage. Caring is a "feeling of commitment to self and others to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual-actualization" (MacDonald, 1984, p. 234).

Thus, care encompasses all nursing actions to assist, support and facilitate patients to perform his own care and care is the central philosophy in nursing. Caring, on the other hand, is a purposeful activity often with therapeutic outcome in mind a set of acts or behavior as a process. Caring takes a systematic, logical approach which is a synthesis from theorizing, analyzing and predicting outcomes of nursing functions to bring about definite, therapeutic effect as a result of caring.

In the context of nursing functions, caution must be exercised to differentiate among such constructs as care, caring, nursing care and caring in nursing. The term nursing care refers to the performance of specific procedures performed by nurses; whereas the phrase caring in nursing connotes the totality of service rendered through the interpersonal relationship between the patient and the nurse.

Caring has been presented by examining the purposes and intents of the behaviors demonstrated by the informants. Since all behavior is purposeful, it is

necessary to examine purpose and motive behind behavior displayed by the informants. The two major assumptions concerning care and caring are that "nursing heritage and traditions are firmly rooted in the value of care, and that caring is envisioned as a crucial and vital component of nursing" (Bevis, 1984, p. 27).

Caring is a communication of human mind to produce healing and curing as a result of caring. *Decentralized Communication* will be presented next as the last construct in delineating core elements of primary nursing.

Decentralized Communication

Decentralized communication in the context of this study refers to the primary nurse's direct communication with the patient, family members and other health care members including the physician. It is best considered in two different forms, written and verbal. Verbal communication may be described within each of the four dimensions: *Patient care, the family members and significant others, the physician, and other health care members.* Written communication is solely disseminated by the patient charts, the Primary Nurses' Book, the General Communication Book and the Doctors' Book. Verbal communication between and among the primary nurses and others was clearly decentralized. The decentralized communication system facilitated the primary nurse to act as the sole authority to communicate with other health care personnel and the family members, regarding patient care. Questions posed to the primary nurse were immediately answered, or were responded to at a later date when the proper information had been obtained. The purpose of communication is the transmission of information. The mode of communication becomes a crucial issue to bring for therapeutic effect to the patient to alleviate his feelings of stress, anxiety, and fear during his hospitalization.

Patient Care and Communication

Over half of the patient population, those with clear mental faculty, knew who their primary nurse was. The ambulatory patients would seek out their primary nurse whenever they wanted to communicate with her. Communications with the patients were conducted in an unhurried manner on a one-to-one basis.

Each morning after the report and brief pre-conference at the nursing station, the informants went to their own districts and spoke to their patients individually while checking and supervising self-care of ambulatory patients and while giving direct care to those who required total nursing care. The informants started the conversation with greetings, "Good morning, how are you? Now are you ready to start the day?". They continued to inform the patients of the time, date and local activities taking place, if any, in the community.

On one occasion, a patient in a wheelchair was shouting in the hallway. The patient's primary nurse approached the patient and spoke to him in a calm and soothing tone of voice, "We'll get you lunch and then put you back to bed." The patient stopped yelling, and said to the nurse, "I just wanted to say 'Hello'". He simply needed the social interaction and reassurance of the nurse that he was doing fine.

The primary nurse's clear communication with the patient is demonstrated in the following example. Two of the nursing assistants were having difficulty with a patient, who did not appear to be cooperative and did not seem to be understanding the nurses' interactions. The two nursing assistants were frantic, trying to make the patient understand and follow their instructions. The nursing assistants were getting the patient dressed, and were asking him to lift his buttocks. Hearing the problem they were having, the primary nurse who was in the same room stopped her work with her patient and went to the other side of the room where the nursing assistants were struggling with this patient. The primary nurse calmly asked the patient to put his hands on the monkey (triangle)

bar above the bed and on the count of three to lift his buttocks. The patient followed the instructions. The primary nurse remarked, "I've never had problems with him to get dressed."

The following is an example of communication with a therapeutic purpose between the primary nurse and the patient. One morning the primary nurse approached one of her patients and said, "Get up now. It's breakfast time. I want you to have your breakfast." This 87-year old patient replied, "I'm tired." to which the primary nurse said, "Why don't you have your breakfast first, and then I'll let you rest after breakfast?" The primary nurse put his glasses on and asked, "Do you see me now?" She continued, "Do you know my name?" The patient replied, "Nurse, Nurse S." "That's right. I hope I'll be good to you. [I] try to be [good]." and then she brought the breakfast tray for the patient.

The following illustrates the therapeutic effect of a primary nurse's communication on the patient which helped him focus on reality. One of the patients was shouting, "Hello!" in his bed. The primary nurse sat at the bedside and started to talk to him. The primary nurse later commented to the researcher that some patients in the bed-ridden area habitually called out, often calling their deceased wife's name. The primary nurse mentioned that they were lonely and needed a lot of emotional support.

One of the patients who was alcoholic and had chronic-brain syndrome was seen dressed with a tie for a special event to take place off the unit later that afternoon. It was an unusually warm day and upon seeing him in a tight shirt

and vest, standing at the nursing station, the primary nurse remarked, "Renea, my darling, you look gorgeous! But aren't you a bit warm?" Making these comments she was not only paying attention to him and complimenting his appearance, but also subtly reminding him that it was summer and suggesting he was improperly dressed that another shirt would be comfortable. He did not, however, respond to her suggestions.

When one of the patients was transferred to another hospital to undergo minor surgery, the primary nurse used to call the unit on a daily basis where the patient was admitted. The primary nurse first inquired about the patient's condition and said to the nurse on the other end of the line as follows:

"This is his primary nurse, Mrs. B. Would you please tell him that we're all thinking of him?"

One time a patient fell on the floor twice during the night within a period of a few weeks and sustained cuts around the eye orbit which required extensive suturing. Consequently his face was covered with dressings only to reveal his eyes. The patient made progress toward recovery and eventually dressings were taken from his face on which remained some scars. Since that time, this 87-year old patient was observed covering his face and putting his head down whenever he was up in his wheelchair and placed with other patients in the TV room. Psychologically the patient was more concerned with his changed appearance, but this was not brought up as a concern, informally or formally, by any member of the staff. The patient did not express his feelings or concerns about his blemished face, nor did his primary nurse identify his behavior as a potential problem. In

this case, communication between the patient and the primary nurse did not occur.

On one occasion, "depression" was discussed as a common problem among the patients on the unit. Many patients were widowers and they were still mourning for their beloved's death. As an example, one of the patients became so depressed upon hearing his wife's death that he attempted suicide. The loss of a spouse is rated as the number one stressor in life. This patient appeared catatonic, had a blank expression on his face and was mute, none of which was due to a pathological origin. The most of the patients who displayed signs and symptoms of depression were predisposed by factors such as poor general health, poor education and poor socioeconomic status. However, the immediate precipitant, the spouse's death, aggravated the patient's depressive state. The staff were aware that these patients had a special need for love and to be loved, and "hug therapy" in concert with communicating with them in a caring manner appeared to be effective responses to their needs.

Communication among the nursing staff was best facilitated through the weekly staff meeting where all the nursing personnel participated in discussions of patient care. Patient care conferences took place every weekend; the primary nurses took turns chairing these conferences. The meeting took place in the afternoon when the unit was less busy with fewer activities and visitors. The conference provided the opportunity for verbal information and plans about nursing care to be conveyed to the rest of the nursing staff. It was often an occasion when ideas or suggestions were made on the primary patient's care by the rest of the staff.

—As an example of one occasion a new patient's profile was presented by the primary nurse. This 86-year old man had been already presenting problems due to his particular disease such as voiding indiscriminately anywhere on the unit and wandering off the unit. The following is the discussion regarding the patient care management among the nursing staff.

"I don't think restraints will be a good idea."

"He'll trip over the geriatric chair."

"He might be better off to eat dinner in his room and see if he'll sit still and eat."

"We'll have to take him to the bathroom every now and then."

"He used to sleep in a twin-bed room at home. I wonder he'll do better if we'd put him in a two-man room?"

"When his daughter comes next, we can ask her how much he could do at home."

"Don't lose the red flash-light, for God's sake, it's his security blanket!"

Thus, the patient-centered conference involving all nursing staff served to promote a unified approach for each individual patient.

In spite of the primary nurse's role as an autonomous, independent care giver, the primary nurses frequently consulted each other concerning patient care. For example, at each change of shift and rotation, communication with the colleagues to ensure continuity of care was made. Similarly, when the primary nurse returned to work from a several-days off period, she would ask her "buddy" primary nurse about her patients whom the later had cared for during her

absence. Such a "take-over" conversation took place following a taped report at the beginning of the day shift. The two nurses remained in the primary nurses' room and had a brief conference on the patients before they started their regular activities. Such a take-over conference was observed between the other pairs of primary nurses who took each other's place as an associate nurse while the other was off duty.

There was a close, direct pattern of communication between the primary nurse and the nursing assistant working in the same district. Conversation regarding patient care occurred whenever an exchange of information about patient care was perceived as necessary. This was initiated by either party for purposes of clarification, confirmation, seeking advice and reporting or evaluating care. The mode of communication for the entire nursing staff on the unit was a ward conference which was conducted every weekend. The primary nurses took the chair on a rotative base and presented their patients' profiles to be discussed as cases of patient management. Each primary nurse selected an appropriate patient for discussion. The nursing assistants contributed their opinions and suggestions to issues and problems revolving around the patients. Recognizing the nursing assistants as equal contributors to patient care delivery in collaboration with the primary nurses, their presence at such meetings contributed greatly to the effort made to maintain and promote care delivery as a unified mode on the unit.

Once a person enters the health care system as a patient, the nurse becomes a major source of information. The longer hospitalization is prolonged, the

greater the number of opportunities for the primary nurse to communicate with other members of the health care arena. Major decision-making occurs in multidisciplinary meetings, where the primary nurse affects the process of decision-making by either providing information or withholding it. When she disseminates information, how much information and how it is delivered influences the perception of the patient by others. This is particularly significant when the primary nurse conducts a multidisciplinary meeting where the primary nurse's contribution of patient assessment and report are regarded as important enough to influence the other health care members' decision-making process. Thus, the primary nurse's role as an effective communicator with other health care professionals becomes a very crucial one.

Family Members and Significant Others and Communication

Each primary nurse communicated with her patient's family members directly. Whatever questions or concerns the family members might have, they would approach the appropriate primary nurse, and receive the first-hand information from her. A close relationship was observed between the primary nurse and the family members. The primary nurse involved the family in the plan of care, and gave instructions and suggestions to them accordingly. The primary nurses also acted as interpreter for the physician and the family and a liaison and resource person between the family and other health care services. At the end of a telephone conversation with the patient's family member, the primary nurse usually ended the conversation with "take care".

The Physician and Communication

The informants stated that direct and open communication with the doctor was the most significant change since the implementation of primary nursing. They further stated that each primary nurse was recognized as the responsible care-giver for a group of patients, and that she was approached by the doctor concerning all aspects of the patient care management. Direct communication with the doctor produced the following outcomes.

1. The doctors stated to show more of a personal interest in management of patient care. Prior to primary nursing, the doctors had less contact with the patients. When contact occurred, it was usually sporadic, and since no one assumed the responsibility for the follow-up of the care.
2. The nurses began to take more initiatives in patient care. They provided an in-depth observation and report on the patient and based on the data they gathered, they suggested care from a nursing perspective which often involved other health care services. Subsequently, referrals and consultations were made on a regular basis following the initial discussion and assessment with the doctor.

Other Health care Members and Communication

Whenever a need arose as to contact other services, the primary nurse on behalf of the patient, took the initiative. When the other health team members called the unit, they asked for a specific primary nurse for the patient. The most frequently contacted person was the recreational therapist from the Recreation Department. Due to her regular visits to the unit, she knew exactly as to whom she should speak concerning the patients she was dealing with. On one occasion, the recreational therapist was planning for a "pub-out" at a hotel nearby. After finding out who was participating in this outing, she approached the patient's primary nurses and checked to see if there was any problem for the patients going to a pub.

Communication between the primary nurse and the physiotherapist was initiated by both parties, either the physiotherapist approached the primary nurse to report or the primary nurse checked with the physiotherapist following a patient session to find out how the patient reacted to the therapy and what kind of progress he was making. She then reported this to the patient's family member and suggested that the family take an active part in it when appropriate.

During consultation with the patients' physician, the primary nurse initiated the referral process to other professionals with the total patient's needs in mind. The primary nurse could observe, assess and refer her patients to appropriate services so that nursing care would support and enhance such integrated care administered by others. It was the primary nurse who facilitated a climate where a multidisciplinary team approach brought a synergetic effect to patient care. In this light, the primary nurse stood at the core of the services, ensuring that all the peripheral services were brought together so that she could act as the effector for the other disciplines. In this manner, the danger of omission and duplication of services was avoided. The primary nurse also made the needs assessment of her patient based on a total perspective, and she delivered nursing care which reinforced other services delivered to the patient so that all needs were met in a holistic fashion.

Charting

Written communication was done, apart from Progress Notes (Nurses Notes) through the Primary Nurse Books and also through the General Communication Book to give a general picture on the unit in terms of staffing, the patients' and

the staff's activities for the day. Following a day's nursing care, the primary nurse charted all aspects of the patient's condition and response to care in the patient's chart. Patients' charts and kardexes were treated as legal documents. As a form of documenting the present state of the patient, the primary nurse recorded her observations and findings under Progress Notes in the patient's chart. The integrated charting system was utilized in which all health care professionals recorded their work in the section called "Progress Notes". The recordings included clinical observations and symptomatology in relation to the patients' activities, feelings and behavior, the patients' condition and their response to medications or treatments. Summaries of patients' conditions were important means of communicating about the patients. A summary of each patient's condition was made in the Progress Notes at the end of each shift. In addition, a four-week summary was entered in the chart under the heading, "General Condition and Care Plan" prior to changing districts of the primary nurses.

There was no category such as "Nurses Notes". Notes were made in chronological order by the primary nurse, the physician, the physiotherapist, the dietician, the psychologist and other health care personnel. Each recorder can see which other health care providers reviewed the patient; this system enabled the primary nurse to readily review total patient care to be administered by a multidisciplinary team. Nursing was accepted as an autonomous profession by other disciplines by virtue of the fact that nurses' notes were entered together with other health care team members' notes. The use of a separate section for

nurses to chart was not practised in this unit. Such a separate charting system means a "remnant of discrimination against nurses" (Zander, 1980, p. 135). No matter how nursing care would be professional, if charting were not accepted as an integral status, equal to other disciplines, nursing could not be called a professional discipline.

The main vehicle of communication used to convey information and plans for nursing care was done through kardex. Review and revision of patient care was done by the group of nurses assigned to each district of patients, the primary nurses kept the kardex up-to-date with a series of review dates for each problem statement. The kardex was used to elaborate the future plan of action of the nursing care plan. This was the major communication tool with other nursing staff and to establish a collegiality for implementing 24-hour nursing care. In addition, as an informal way of charting, the primary nurse utilized three communication books: The General Communication Book, the Primary Nurses' Book, and the Doctor's Book.

The General Communication Book was helpful for all the personnel concerned in obtaining a quick overview of the unit on a given day. It aided the unit supervisor to assess and predict the staff situation over a period of time and also served as a quick reference with regarding patient condition and care. The General Communication Book proved to be a valuable asset for the nursing assistants. Unlike the primary nurses, nursing assistants were not assigned to patients, but were nonetheless observed answering a physician's questions regarding the patients' conditions by referring to this Book.

The Primary Nurses' Communication Book was a vital tool for ensuring continuity of care. Through the Communication Book, the primary nurse was able to obtain up-to-date information on the condition of her patients when she returned to the unit from her days-off. Moreover, she could assess the overall condition of the unit. "Take-over" communications were done verbally between the in-coming and out-going primary nurses and through the taped report, in addition to the General Communication Book and the Primary Nurses' Book. Apart from conveying messages regarding patient care and the patients' condition, reminders were written in the Primary Nurses' Book, such as asking the colleagues to sign for the medication given during the previous shift or shifts if they had forgotten to do so on the medication sheet. Thus, collegial efforts to maintain legal documents were evident.

While the formal charting of progress notes and nursing care plan in kardex served the medico-legal and professional purposes, the informal charting via three modes of communication ensured continuity of quality care and further facilitated a direct and smooth pattern of communication among the primary nurses, the physicians and the nursing assistants. A search of the literature did not indicate use of such communication books. All the recordings were kept in a precise manner to convey the necessary information on a given patient. The charting was done in an integrated manner with other health care professionals who shared the patient care information verbally and in writing.

One issue that needs to be addressed is how much information the primary nurse may obtain and dispose to whom. Such ethico-legal aspects should be dealt

with in consultation with the hospital policies and regulations, philosophy and value of the primary nurse versus those of the hospital. The informants are required to examine their philosophy of primary nursing in order to have a clear idea of the concept, exercise it in their daily practice and refine and revise it as necessary. The primary nurses are the very vehicle to demonstrate what primary nursing is according to the operationalized concept within a given environment of an institution.

Caring and communication were displayed as closely related constructs by the informants in this study. Whenever interpersonal communication was in process between the patient and the nurse, the element of caring was present. Communication, accompanied by the non-verbal gesture of hugging, proved to be one of the effective measures which kept the patients on this unit oriented to reality. The informants dealt with reality orientation as a form of psychotherapy by displaying their caring to the patients, showing their concern and interest in the patient and his family.

Glasser (1965, p. 9) referred in his book Reality Therapy to the "need to love and to be loved and the need to feel that we are worthwhile to ourselves and to others". As a form of reality orientation, validation therapy was designed and implemented for the elderly to validate and support their feelings in whatever time or location is real to them, even though this may not correspond to the concept of "here and now" (van Amelsvoort Jones, 1985). Another form of reality orientation is the Reflection Technique, which is a form of psychotherapy for patients on a rehabilitation unit which practised primary nursing. It was based on non-directive approach developed by Carl Rogers (Englert, 1971).

The five major constructs identified in a primary nursing system have been described in terms of nursing activities under five core elements. In the next section, the results of questionnaire together with the findings of the informants' philosophy of primary nursing will be presented.

Questionnaire Results

Appointments were made with the informants one or two days ahead of time. Formal interviews utilizing the questionnaire (see Appendix A) were conducted in private in the primary nurses' room. All interviews took place in the afternoon when the primary nurses were not as busy as in the morning.

Five primary nurses were interviewed individually. All of them were women, who were similar in terms of age-group, number of years of post-basic experience, and ethnocultural and educational backgrounds. The length of work experience on this unit ranged from two years to six years, with a mean of five years. Two were married, another two single and one separated. The longest duration of the post-basic experience was a minimum of two years to a maximum of 16 years (see Appendix E). None of the informants had previously been exposed to a primary nursing system.

Although privacy was secured for each respondent, the interview was interrupted once by a nursing assistant accompanied by the unit supervisor, who opened the door to ask the respondent questions regarding patient care. This interruption could have altered the respondent's thought process and may have influenced her choice of answer at that particular moment.

During formal interviews, the researcher took notes to describe incidents in detail. The combination of the questionnaire format and interview allowed the informants to share information, perceptions and their philosophy of primary nursing. It provided an opportunity for the informants to explore areas of

concern, express feelings or report behaviors, as examples to illustrate their conceptualization of primary nursing. Conversations were written down as soon as possible after they occurred to limit distortion. Whenever perceived as necessary and appropriate, the researcher clarified the meaning and dimension of the questions so that it became clearer to the respondents. Therefore, the respondents were able to choose their answers instead of leaving it to the suggested response or not responding at all. Although the questionnaire-interview contained closed questions, the answer was rated on scale from one to seven. A closed questionnaire generally provides no information about the rationale or justification for the chosen answer; the context or frame of reference in which the answer is given is not captured. Yet, in the present study, the rated scale questionnaire-interview enabled the respondent to explain reasons for her choice of answer.

While each question was read to the respondent twice, a list describing the scale and explanation for each number on the scale was placed in front of the respondents to facilitate the answer. The respondents were requested to reply by giving the number as well as the corresponding description of the selected answer. The informants responded to all questions confidently, except to one occasion. One of the respondents could not decide between the answers "satisfied" and "very satisfied" in relation to the "opportunities where she had to do something that made her feel good as a person". A score 6 ("satisfied") was assigned as her answer to this question.

Throughout the interpretative phase of this study, common themes began to

emerge from the qualitative and quantitative data. Similarities between the findings collected through participant observation and those obtained from the formal interviews helped the researcher to categorize the primary nurses' choice of response according to those common themes; namely, the major constructs as identified in this study.

The questionnaire items were therefore classified under the five major constructs of core elements in primary nursing. From the first set of the questionnaire dealing with nursing activities and the work environment, two items were categorized under the construct of *accountability*. These are "chances you have to do something that makes you feel good as a person" and "chances you have to accomplish something worthwhile" (see Appendix D-1). Eight items were categorized under the construct of *autonomy*. They were "opportunity to develop your skills and abilities", "chances you have to take part in making decisions", "independence in making professional decisions", "opportunities to voice opinions", "work-assignments according to preference", "opportunity to change assignments periodically", "to do the things you do best", and "degree of challenge in your job". It takes a certain degree of independence and power to act on opportunities which enable the nurse to develop her skills and abilities, take part in making decisions, voice opinions, obtain work assignments according to their preference, change assignments periodically, do the things she does best as well as finding it challenging at work.

Caring and communication were put together as a combined construct under which five items were categorized, including way you are treated by

people you work with", "respect you receive from the people you work with", "friendliness of the people you work with", "personal recognition" and "amount of information you get about how well you are doing your job". The remaining two items; "amount of pay" and "job security" were not categorized.

From the second set of questions, which dealt with the informants' perception of performance of the characteristic elements at work and the frequency of occurrence of those characteristic elements, six were categorized under three major constructs (see Appendix D-2). "Need for speedy work" was categorized under *accountability* as completion of a task requires a certain amount of both organizational skills and speed. The "need to do a variety of different tasks" was categorized under *responsibility* to imply the scope of responsibility and decision-making. The four remaining questions classified under the construct *autonomy* included "setting pace of work", "need for creativity" and "need for high level skill". The nurse must have a certain degree of autonomy, independence, and power to set the pace of work, to use all skills and training, to be creative and to use high level skills.

Regarding the questions concerning the first section of the questionnaire, two of the respondents were "very satisfied", three were "satisfied", and one, "slightly satisfied". The reason for being "slightly satisfied" was reported as due to the relationship with the physician who did not always write orders legibly. In terms of receiving respect from co-workers, only one was "very satisfied". However, four were "very satisfied" with the co-workers' friendliness. With respect to feedback on job performance, two of the informants were "slightly

satisfied". In response to the question on receiving feedback, each of the informants selected different answers from the scale. The formula used to measure the estimate of internal consistency was that of Spearman-Brown prophecy. The estimate of internal consistency for "satisfaction" of this questionnaire is .86.

In response to the questions concerning "importance" under the construct of *autonomy*, four informants identified these elements from "extremely important" to "less than extremely important". Four informants stated that interpersonal relationship was "extremely important". In terms of receiving respect from co-workers, three stated that it was "extremely important" to maintain a good rapport with peers. Three considered the "amount of pay", "quite important". Four informants indicated that the "amount of job security" was important. The estimate of internal consistency for "importance" score in the first set of questionnaire is .33.

The second half of the questionnaire concerned the frequency of occurrence of nursing activities. The "need to work fast" was indicated as "somewhat" by three informants; one informant indicated "a lot" occurring and another "a little". Under the construct *responsibility*, the "need for a variety of different tasks" was reported by all informants as "a lot". The estimate of internal consistency for the "frequency of occurrence" of these six specific questions is .86.

Similarly, in terms of "importance" in the second half of the questionnaire, the "need for speedy work", two informants found it to be "less than quite

important", but remaining two responses were skewed in opposite directions. The "need for a variety of different tasks" was perceived by three informants as "extremely important". The estimate of internal consistency for "importance" in this section is .88.

Thus, the estimate of the internal consistency for all but one section of the questionnaire was greater than .85. The estimate of the internal consistency for the section regarding the informant's perception of importance of nursing activities was only .33. The informants regarded some nursing activities and core elements less important than others. This may reflect the nature of the unit i.e. a long-term care unit or marital status, or differences in age, and the years of the post basic experience among the informants and the individual life philosophy, experience and value system.

In general, the informants indicated overall job satisfaction. Their perceptions of core elements of primary nursing were reflected in their nursing activities throughout the observation period. Moreover, quantitative results obtained from the questionnaire regarding the frequency of occurrence of core elements were cross-validated by the qualitative data collected through participant observations.

The data obtained during formal interviews indicate that the philosophy of the unit and the overview of primary nursing were identified and cross-validated within the observations and patients charts (see Appendices G and I). However, the objectives set by the unit regarding provision of psychosocial care and

education of patients and their families on a continuous and/or periodic basis, of the primary nursing concept were not carried out by the primary nurses in this study (see Appendix H, objectives 2, 7 and 8). This finding was consistent by data obtained through observations of nurses' activities, patient charts, informal interviews and formal interviews utilizing the questionnaire. Reasons for this may be:

1. A heavy patient load, particularly in the bed-ridden area where most of the patients require total patient care.
2. Previous educational programs may not have encouraged the nurses to implement patient and family education nor to assume the role of counsellor.
3. There was no formal method used for evaluation of patient care besides the nursing audit, which evaluated the unit as a unit.

The core elements of primary nursing in this study were compared to those corresponding ones at the University of Minnesota Hospitals. There was one significant difference between the objectives identified in primary nursing on unit 5 and those at the University of Minnesota Hospitals. Whereas home visits were one of the primary nurses' responsibilities at the University of Minnesota Hospitals, they were not done by nurses on Unit 5 (see Appendix K). The above was the only significant difference in the objectives identified in primary nursing between Unit 5 the units at the University of Minnesota Hospitals.

Robinson (1974) reported her impression of the practice of primary nursing following her visits in different units at the University of Minnesota Hospitals and at the University of Rochester, New York. She reported, "At Minnesota, I was much impressed with the general atmosphere of the primary-care unit I visited. It

was quieter and less hurried than the usual medical floor, and the personnel seemed to enjoy work" (p. 33). She also observed that at Minnesota, 70% of the primary nurse's time was spent giving direct patient care whereby comprehensive care and continuity of care were achieved through the combination of primary nurses, associate nurses, and other staff. On unit 5, the primary nurses in general spent nearly 80% of their time at the bedside, based on the actual number of hours spent for delivery of patient care. The remaining time was spent charting, taping shift-change report and communicating with family and other health care members.

Robinson (1974) reported that since the implementation of primary nursing at Rochester, New York, staff nurses knew more about patients and more patients knew the staff. That unit used float (part-time staff), who acted only in the capacity of associate nurses. At Minnesota, the role of associate nurse as described in the manual¹ is as follows:

Associate nurses are responsible for delivering total patient care to assigned patients during a given work shift in the absence of primary nurses. Associate nurses work closely with primary nurses in assessing, planning, intervening and evaluating patient care. This role provides associate nurses with knowledge and experience that may enable them to assume primary nursing responsibilities at a later date.

Thus the role of associate nurse on unit 5 and the unit at Rochester is thus identical.

¹Primary Nursing: A Handbook for Implementation. Prepared by: Department of Nursing Services, University of Minnesota Hospitals and Clinics, 1978

Informants' Philosophy of Primary Nursing

The informants were asked to identify core elements which would differentiate primary nursing from other modalities of care delivery.

One informant stated that she felt good about having total responsibility of patient care under primary nursing. She added that previously, under team nursing, she had felt as though she had been working in the capacity of a nursing assistant due to a lack of responsibility. She also identified establishment of open communication between the unit supervisor and primary nurses as well as other staff as another characteristic of primary nursing which was not present while practising team nursing.

Another informant stated that the primary nursing modality allowed her to have time to sit down and talk with the patient. Furthermore, primary nursing allowed her to use judgement, act independently and be accountable for the decisions she made. She also remarked that under team nursing there had been no contact with the doctors, nor was there use of the kardex. Unit conferences among the nursing staff and staff meetings with the doctors started following implementation of primary nursing. Another informant found primary nursing fulfilling and satisfying due to the one-to-one contact with the patient. She stated that knowing that she was totally responsible and accountable for her patient care gave her motivation to do an even better job. She also found the working relationships with her peers satisfying.

The informants identified family involvement in plan of care as essential for meeting the patients' total needs. They stated that under team nursing they found no time to deal with family members or to get to know the patient. They described the importance of family involvement as follows:

"You are caring for the patient and his family as a unit, not only him as a separate individual."

Another informant commented that geriatric nursing would be particularly suited to primary nursing. She found it less stressful at work and felt less burnt out than when working under team nursing. She stated that she had a chance to go through the nursing process from problem identification, intervention and evaluation for the first time since she had graduated from nursing school. She explained that when she worked under team nursing, she would implement one intervention, but would not have an opportunity to evaluate it, because she would not have the same patient the following day. Thus, there was neither consistency nor continuity of care under team nursing. She questioned whether or not nursing care plans would be successfully implemented.

An informant stated that the patients were so appreciative of little things done for them by the primary nurse. She affirmed that those patients who were mentally intact, however old they might be, could remember their primary nurse and identify her at a given time during a four-week rotation period. She also identified a 24-hour accountability as one of the basic elements of primary nursing and that accountability could best be demonstrated through nursing care plan. She described it as follows:

"A good assessment makes you get to know your patient better. This will help you to identify his problems. Then you can set up a good nursing care plan and stick to it. Once you've got to know your patient, you get to communicate with the doctor. And it makes you feel good, knowing that everything is under control. You get motivated and try to do even a better job."

When asked to give core elements which would differentiate primary nursing from other modalities of care, the informants identified five core elements. They were *responsibility, accountability, autonomy, caring and decentralized communication*. An in-depth examination of these five constructs was made by observing the participants' activities on the unit, as described previously. When asked again about core elements which made primary nursing unique in addition to these five major constructs, the following elements were mentioned by the informants: *Continuity of care, assertiveness, patient advocacy, collaboration, coordination, contracting, professional and self-growth and decentralized decision-making*. *Responsibility and accountability* were used interchangeably by informants at interviews. Two informants used the term *responsibility* exclusively; one stated that she was responsible for decision-making; and another explained responsibility in terms of total patient care. She replied that she was responsible to a group of patients' care management. One informant made a clear distinction between these two constructs and explained the difference in that she was accountable for decision-making, which used to be made by the team-leader under team nursing. Another used the term *accountability* for independent judgement and decision-making.

The term *autonomy* was not mentioned by any informants. However, the

concept was conveyed by the statements expressed in the form of: *Continuity of care, 24-hour accountability by using nursing care plan, one patient per one nurse, coordinating and conducting multidisciplinary team conference, involvement of family members and other services in plan of care, and assertiveness.* The activities involving these elements of care were observed and they were incorporated into the construct of *autonomy*.

Caring as a core element in primary nursing was mentioned by most of the informants. Some expressed this construct in relation to a good rapport or a trusting relationship with the patient. *Caring* was identified as the most significant construct in this study. The informants' verbal and non-verbal behavior exhibited the essence of caring, which was present in all informants throughout the study period. The informants expressed caring in their own unique ways, reflecting their own personalities, values and belief systems and philosophy of life.

Communication with the patient was maintained exclusively by the primary nurse. Hence, the patient was provided with opportunities to ask questions. Direct and open communication channels were also established and maintained between the primary nurse and the physician, and between the primary nurse and the supervisor, which were identified by the informants as significant characteristics of the primary nursing system.

In summary, at formal interviews, the informants were able to identify the core elements of primary nursing. Furthermore, they demonstrated core elements

through their nursing activities on a daily basis. These core elements were identified through observations of nurses' activities as well as examination of both the Progress Notes (Nurses' Notes) and Communication Books.

Although each informant's operationalization of delivery of nursing care was unique to each individual, her conceptualization of it which formed the basis to achieve the outcome of nursing care was similar. Once such conceptualization of nursing care delivery was demonstrated as a group behavior by the primary nurses on the unit, a definition of primary nursing emerged, and included the five core elements as identified in this study.

Chapter 5

Summary, Conclusions, Implications and Recommendations

Summary

This study was conducted in order to derive a definition of primary nursing. The researcher employed the ethnographic approach where participant-observation in conjunction with interviewing was the central data gathering technique. The researcher spent three months on a veterans' unit which professed to practise primary nursing. The researcher assumed the role of participant-observer, focusing observations on each individual nurse's activities in an attempt to identify an emerging pattern of group behavior demonstrated by five primary nurses. Data obtained from observations were cross-validated by formal and informal interviews of the nurses and documents such as the Progress Notes (Nurses' Notes), kardex and communication books, thus increasing the validity of observations. Such a group behavior, once cross-checked against Progress Notes (Nurses Notes) and interviews, was categorized under the five core elements which symbolized the process of patient-nurse interaction.

In spite of the variety of approaches and measures taken by each informant,

the pattern of behavior that emerged was remarkably similar. Each nurse demonstrated acts which signified *responsibility, accountability, autonomy, decentralized communication, and caring*. *Caring* was displayed to every patient. The nursing staff displayed caring through nursing activities; they demonstrated it in an overt, affectionate manner such as by hugging and calling the patient by nickname; and they showed their caring both verbally and non-verbally.

There was a collegial atmosphere among the primary nurses and the nursing assistants. The spirit of teamwork and commitment to caring for the patients were evident. The interaction between the primary nurse and the patient revealed a sense of trust. There were many occasions which demonstrated that the primary nurses showed their advocacy for the patients and acted accordingly.

Through an in-depth, prolonged observation, the researcher was able to describe the primary nurses' activities. Core elements of this patient care modality were identified as primary nursing was practised on this veterans' unit. As a result of the group behavior, the following definition emerged:

Primary nursing is a nursing care delivery system whereby each primary nurse is assigned to a group of four to six patients. The primary nurse is *responsible* and *accountable* for her patients' individualized total care. She carries out a comprehensive patient care in an *autonomous* and *caring* manner by coordinating and collaborating with the family and other health care members through direct and *open communication*. As a multidisciplinary member of the health care system, the primary nurse acts as the patient advocate. She is empowered to delegate responsibility, in her absence, to her peers by the nursing care plan. In this way, continuity of care on a 24-hour basis is ensured throughout the patient's hospitalization.

Every patient was recognized as a unique individual with his own human needs. Attempts to meet these needs were made through an individualized care plan which was carried out in a caring manner. Feelings of commitment, trust and belonging were present between the patient and the primary nurse and were directed working toward restoration, maintenance and promotion of health.

Primary Nurses' Activities

Primary nursing on this unit exhibited five core elements: *Responsibility, accountability, autonomy, caring, and decentralized communication.* The primary nurses were responsible for a district of four to six patients for a period of four weeks during which each nurse was accountable to total patient care on a 24-hour basis. They carried out a comprehensive plan of care and were responsible for the outcome of care delivered. Accountability was demonstrated through outcome of care delivered and recorded in the Progress Notes, the Communication Books, and responsibility was clearly indicated on the daily assignment planner at the nursing station and at every patient's bedside.

Each nurse was the main care giver and the physician took an ancillary role which assumed the domain of medical responsibility for the patients. The primary nurse performed a variety of interdependent tasks and kept the physician well-informed of the patient's condition, including the need for psychosocial aspects as well as physical aspects.

Each primary nurse had her own kardex which contained descriptions of her patients' profiles and nursing care plans. Her responsibility and accountability were demonstrated through her continuous and consistent use of a nursing care plan, a vital tool for her delivery of care.

The primary nurses demonstrated their responsibility, accountability and autonomy during multidisciplinary team conferences. When a new admission was received on the unit, the primary nurse conducted a multidisciplinary conference which she chaired and contributed to the team's decision-making process in establishing the plan of care for the new patient. At the conference, each primary nurse exercised authority as the sole health care professional with an in-depth knowledge of the patient and his condition from a total perspective, and acted as the patient's advocate. Autonomy was best demonstrated by a variety of individualized approaches of care, all of which had a sound scientific basis. Such nursing actions were delivered on the nurses' own initiatives so long as they fell under the jurisdiction of nursing responsibility.

The nurses generally had a clear idea of the scope and domain of responsibility for patient care. However, they did not appear to be comfortable themselves as autonomous workers at multifaceted levels which required integration of psychological, social and educational nursing interventions, particularly in situations requiring coordination and collaboration with other professionals. The primary nurses were observed to be willing to contact and coordinate activities for the patient within the limited extent; however, they did not take initiatives involving other health care workers and community resources with which they could incorporate care and plan of care. Their role appeared to be limited only to restoration and maintenance of physical health care. On psychosocial aspects of care, formal counselling or teaching involving the patient or family as active participants in his care was observed to be minimal, in spite of

their objective (see Appendix H, objective 7). For ambulatory patient, this area is considered significant, particularly in terms of preparing patients to go back to the community. Physical aspects of care were delivered in an almost impeccable, well-organized manner in order to keep the patients clean, comfortable and safe. The nurses appeared consciously to put more emphasis on physical care than the psychosocial domain of care.

Upon inquiry of reasons for their emphasis on physical care, the informants stated that they did not have enough time to deliver psychosocial care, nor the appropriate professional training, they further stated that psychosocial aspects of care were too abstract to deal with. They indicated their preference for delivering care in the bed-ridden area to the ambulatory area, because they could see the immediate outcome, which produced a feeling of gratification. It appeared that the informants were compelled to prioritize physical aspects of care over psychosocial care in order to satisfy the bureaucratic requirements which have traditionally been practised in an institution. None of the informants suggested that psychosocial care can be effectively given by the primary nurse while physical care was being delivered.

The primary nurses displayed, both verbally and non-verbally, a humanistic, caring attitude throughout the study period. The patients were approached and cared for in a positive way based on the individuals' uniqueness. Humanistic caring was observed as the dominant feature on this unit. This phenomenon was not identified as one of core elements of primary nursing in previous studies.

One of the significant changes brought about by primary nursing was the establishment of open and direct communication with the physician. This phenomenon reinforced the jurisdiction of responsibilities which has emerged between nursing and medicine. Furthermore, it reinforced the liaison between the members of the two professions to work as inter-dependent health care givers.

The general atmosphere on the unit was good. All patients were dressed in their own clothes, well-groomed, and well-hydrated. A lot of tender, loving care was given to the patients by hugging, kissing, touching, talking and greeting on a daily basis. However, regarding providing emotional support in a systematic manner, the informants expressed feelings of inadequacy in meeting their patients' psychological needs. One reason to this may be that effectiveness of psychological care is difficult to evaluate and measure. The informants agreed that psychological care should be prioritized with the ambulatory patients who were capable of self-care, but also have multiple levels of emotional or behavioral problems.

The nursing care plan which was recorded in the kardex also mentioned specific patients' problems identified by the nurse; however, the problems, both physical and psychosocial, were not always prioritized. Nursing activities initiated and delivered by each nurse was mainly self-evaluated, although the nurses regularly consulted one another on patient care and intervention issues. Yet, the informants dealt with only the actual problems, and potential problems, particularly those of psychosocial aspects were not dealt with in terms of prevention. The informants' approach to problem-solving was limited to dealing

with overt manifestations of complaints which were actually voiced by the patients or exhibited in their behavior. The only formal evaluation took place in the form of nursing audit, which resulted in a collective evaluation of the unit. Due to a lack of feedback on the part of the unit supervisor and absence of a peer review system, evaluation of patient care from different perspectives was not done.

Informants' Beliefs on Primary Nursing

The informants saw primary nursing as a nursing care delivery system in which one nurse was responsible for delivery of total patient care on a 24-hour basis to a group of patients for a period of four weeks. They believed that such a system allowed the nurse to make independent judgements and decisions regarding nursing care by virtue of the fact that they were responsible and accountable for their patients' care.

The findings from this study and the insights derived from the interviews were analyzed and synthesized, thus allowing identification of the core elements of primary nursing. The following is the pattern of a primary nurse's activities:

The primary nurse is responsible and accountable for the plan, execution and outcome of nursing care in a one-to-one patient-nurse relationship on a 24-hour basis during hospitalization. She performs nursing actions based on her independent judgement and decision-making. She directly communicates with the physician, other health care professionals and family members to incorporate their views on plans of patients' care.

Value of Prolonged and In-Depth Contact

The researcher assumed a role of complete observer and examined and described in detail the activities of the primary nurse on the unit. Due to the

homogeneous nature of the patient population and the informants as a captive audience on a long-term unit, it was relatively easy to focus on the informants' activities, and to support the hypothetical propositions identified in their activities.

Given the assumptions of the ethnographic approach, the observations were centered around their activities, perspectives and documentation. It was, however, necessary at times to clarify their activities and meanings with the informants while activities were taking place or after completion of such activities. Together with participant observation, the "triangulation" method was used to cross-validate the data obtained through interviews, Progress Notes (Nurses Notes) and activities.

The effect of the observer on the nurses' activities did not appear to be sufficient enough to distort the data. No obvious changes in the informants' activities or behavior were observed or perceived by the researcher, nor were such evidenced in the Progress Notes. Conversations held with casual nurses and nursing assistants working within the system of primary nursing frequently gave the researcher insights into the perceptions and activities of the informants which had not been previously obtained. Thus, additional information often validated the researcher's perception and interpretation of the primary nurse's activities. Since the nursing assistants worked twelve-hour shifts, they provided an in-depth and rich information on the patients' family members and their interaction with the patients on the unit.

An ethnographic approach of the study of primary nursing was valuable and viable. It allowed the researcher to observe the process of patient-nurse interaction as it occurred. Continuous observations over a prolonged period reinforced and verified nursing activities which were significant enough to be categorized under specific constructs. The primary nursing model was useful to codify nurses' activities under appropriate constructs and dimensions.

Participant observation in conjunction with interviewing was proved to be a most appropriate method to describe the primary nurses' activities. The combined method of questionnaire and interviews facilitated validation of the informants' activities and their perception of primary nursing.

Implications for Nursing

The study was conducted to describe five nurses' activities on a unit which professed to be practising primary nursing. The participants were volunteers in a fixed setting, therefore it is not appropriate to draw the conclusion that nursing care on this unit typifies the primary nursing system. The informants identified core elements in primary nursing. Based on these elements, they performed their daily activities in their delivery of care.

One of the reasons for implementation of primary nursing in this hospital was to add another dimension of psychosocial aspects of care involving the family members (see Appendix H, objective 2). During the implementation phase, a thorough in-service education was given to the informants to understand primary nursing. Hence, they were able to demonstrate an internalization of these constructs in each nursing situation. However, their demonstration of nursing

care delivery with psychosocial aspects of care was not evident. The informants displayed caring to their patients; however, their dealings with meeting the patients' psychosocial care were not demonstrated in a systematic, integrated fashion on multifaceted levels. Therefore, noticeable outcomes were not observed. It is important to take a closer look at psychosocial care so that changes and/or improvements taking place in a patient may be identified and evaluated for further reinforcement of psychosocial care which is reciprocal to physical aspects of care. Some suggestions will be made under recommendations.

In this primary nursing unit, there was a lack of positive feedback from the unit supervisor, from the peer group members and from the doctors. The only feedback came from the patients. Therefore, there were no suggestions from other health care professionals or the administrator concerning improvement of care, nor mutual sharing of feedback among nurses themselves. Although considerable efforts toward restoration and maintenance of health were made, aspects of prevention were not considered. It is suggested that both short- and long-term goals be delineated in measurable terms and that accountability by the care-giver be clearly specified.

In general, there are three major implications derived from this study. The first is that the educational preparation prior to actually practising primary nursing clearly influences the nurses' perception and the expected outcome of care delivery. Therefore, the educational preparation for primary nursing affects the success or failure of implementation of primary nursing. In this respect, it is the educator who is responsible for specifying the objectives and goals of patient care, particularly those concerning the psychosocial needs of the patient.

Primary nursing is akin to professional nursing. Therefore, the primary nurse should have at least a baccalaureate level education. This education enables the nurse to apply her scientific knowledge supplemented with a background on both social sciences and liberal arts and allow her/him to become more skillful and effective at meeting the patient's psychosocial needs. To this end it is imperative that the educators as well as administrators define their goals clearly so that they may strive toward the ultimate goal in health care, which is, quality patient care.

The second is the need for encouragement coming from the administrator to give feedback on their performance to the nurses, and also mutual sharing of feedback among nurses.

Thirdly, it is important to increase nurses' awareness of the need for an ongoing evaluation of the primary nursing care system on the unit it is necessary to assess not only the patients' needs but also the staff's needs, and to clarify their role and identity. Such an insight is called for on multifaceted levels; from the staff members themselves, administrators, other health care members and the family.

Recommendations

1. Psychological Aspect of Care

Given the assumptions that the primary nurse ensures total patient care on a 24-hour basis, the very definition of care needs to be clarified. Care may be divided into two major categories, physical care and psychological care. By the virtue of the behavioral objectives employed in the nursing care plan, problem-

identification appears to originate from the patient's overt behavior. Supposing that the psychological nature of problems were identified, the nurse did not appear to be cognizant as to how to deliver such covert dimension of care effectively. A nursing care plan utilizing quantifiable, measurable behavioral objectives is suggested. Such a quantifiable nursing care plan can be used as a patient contract as well as a tool to communicate with peers and other health care personnel. It would visually indicate to the patient the progress and/or regress he was making at a given point of time and would serve as an incentive to the patient to become actively involved in his plan of care. It is also suggested that in-service education on delivery of psychosocial aspects of care be provided by a nurse educator on a regular basis.

2. Peer Review

The peer group review requires a strong sense of trust among the group members who would feel comfortable giving constructive criticism and receiving the same with an understanding that they are striving toward the common goal of quality patient care. A regular session to evaluate nursing care plans involving the group efforts may be incorporated into weekly unit conferences and/or regular staff meetings. It is not meant to negate the nursing care plan originally formulated by the primary nurse, nor to jeopardize her autonomy and independence regarding care of her patients. Instead, contributions by peers would enhance patient care as well as promote each other's accountability, and facilitate the development of more professional and peer group relationships in primary nursing system (Michaelson, 1980; Ciske et al, 1983; Warren, 1983;



Zander, 1984). The primary nurses should be given an opportunity to write ideas and suggestions in the other nurses' patients charts and the kardex and encouraged to discuss them informally.

3. On-going Evaluation of Primary Nursing System

Evaluation of primary nursing should be recommended and encouraged with other health care teams. Nursing audit alone is not sufficient to evaluate patient care under this system. As a means to establish an open channel of communication between the staff and the administrator, written suggestions for improvement of patient care may be helpful. Such comments or suggestions made on the staff level will facilitate the administrator to plan, and make necessary adjustments or changes, if appropriate, in staff development and other organizational needs, thus contributing the ultimate goal of quality nursing care.

Suggestions for Further Research

1. Replication in a similar setting using a larger population of informants is recommended. In such a case, more than two researchers acting as participant-observer would be suggested to increase validity and reliability.
2. Replication in different practice areas in nursing is suggested to observe an emerging pattern across different practice areas.
3. A similar study on a unit where 12-hour shifts practised is suggested, particularly in terms of examining a pattern of staff communication and continuity of care.
4. The role of the evening nurse and night nurse may be studied as a possible associate nurse who assumes the responsibility for all aspects of patient care and the absolute accountability for the outcomes of nursing care for each patient for that period of eight hours.
5. The role of the unit supervisor may be examined vis-a-vis that of the primary nurse in terms of the direct care giver, specifically with a

focus on communication patterns within and between the sub-groups of primary nurses, the supervisors, and the administrators of an institution.

- C 6. A successfully operating primary nursing unit should be investigated focusing on the psychosocial aspects of care in terms of patient satisfaction, utilizing the primary nursing model and ethnography.

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APPENDIX A

QUESTIONNAIRE

Instructions: Please indicate your response to the questions by selecting the appropriate number together with corresponding descriptions. Part One

Satisfaction

- 1 ... very dissatisfied
- 2 ... dissatisfied
- 3 ... slightly dissatisfied
- 4 ... neither/nor
- 5 ... slightly satisfied
- 6 ... satisfied
- 7 ... very satisfied

Importance

- 1 ... moderately important
- 2 ... more than moderately important
- 3 ... less than quite important
- 4 ... quite important
- 5 ... more than quite important
- 6 ... less than extremely important
- 7 ... extremely important

1. The opportunity to develop your skills and abilities.
2. The chances you have to accomplish something worthwhile.
3. The chances you have to do the things you do best.
4. The chances you have to do something that makes you feel good as a person.
5. The amount of pay you get.
6. The amount of information you get about how well you are doing your job.
7. The opportunity to change assignments periodically.
8. The amount of job security you have.
9. The degree of challenge in your job.
10. The opportunity to voice opinions.
11. Work assignments according to preference.
12. The way you are treated by the people you work with.
13. The respect you receive from the people you work with.
14. The friendliness of the people you work with.

15. Personal recognition within your work situation.

16. The chances you have to take part in making decisions.

17. Independence in making professional decisions.

Part Two

Frequency of Occurrence

- 1 ... not at all
- 2 ... a little
- 3 ... somewhat
- 4 ... a lot

Importance

- 1 ... moderately important
- 2 ... more than moderately important
- 3 ... less than quite important
- 4 ... quite important
- 5 ... more than quite important
- 6 ... less than extremely important
- 7 ... extremely important

1. I have to work very fast.

2. I have to have a high level of skill.

3. I have to be creative.

4. I have to do a variety of different tasks.

5. I have to use all my skills and training.

6. I set the pace of my work.

APPENDIX B
INFORMED CONSENT FORM

Project title: **Ethnography: Primary Nursing, an Investigation into the Nature of One Type of Patient Care Modality**

This is to certify that I, _ hereby agree to participate as a volunteer in the research project investigating the nature of primary nursing in terms of nurses' behavior.

I consent to participate in a taped interview. I understand that I am free to deny answers to questions I prefer not to answer and that I may withdraw from the interview and/or study at any time, without consequence.

I understand that my name will not be disclosed at any time, and that the tape will be erased at the conclusion of the study.

I further understand that the results of the study will be made available to me if I wish (check below).

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

I HEREBY CONSENT TO PARTICIPATE IN THIS STUDY.

Signed:

Date:

Witnessed:

I would like to be informed of study results.

Subject Code No:

APPENDIX C

INFORMED CONSENT

Means of Obtaining Informed Consent

The investigator will explain verbally, the nature of this study to the staff. Efforts will be made whenever a need is perceived to clarify any point which is unclear to the staff so that she/he will have a full understanding of the nature of the investigation and the purpose of her/his participation in the project. If appropriate, time would be allowed for the staff to seek further advice from a third party.

Explanation of the Procedure to the Staff

You are invited to participate in a study "Ethnography: Primary Nursing, an Investigation into the Nature of One Type of Patient Care Modality" to be carried out at Leonard A. Miller Centre, on a long-term care unit.

The purpose of this study is to describe core elements of primary nursing in terms of nurses' activities.

As a means of collecting descriptive data, I will be on the unit, observing the interaction taking place between you and your patient(s), or other staff, and also interaction among the staff. I will not be evaluating your performance, nor will I be performing any task required to carry out nursing care. I will remain as an observer, and I will not participate in the care being given by you, nor will I be making any comments or giving advice to you regarding care you give.

Also, I will be asking questions regarding care you give and while such an interview takes place between us, privacy will be provided. I will be taking notes during the interview, and also the interview will be tape-recorded and later transcribed. Raw data (direct quotes from you) will be destroyed as soon as the analysis is made for the purpose of completing the study.

You are assured that all data and consents will be kept strictly confidential and your identity will not be disclosed in the report of the study, or to the administrator of the hospital.

The potential benefit of the study is a clarification of the nature of primary nursing.

You are free to withdraw from the study at any time before it begins or during the study in session so long as your intent is notified to the investigator. Such a decision on your part will not influence present and future medical and nursing care of your patients.

APPENDIX D
QUESTIONNAIRE RESULTS

Table 1. Primary Nurses' Job Satisfaction and Their Perception of Importance of Nursing Activities
 (N=5)

Nursing Activities	score						
	7	6	5	4	3	2	1
Accountability	4	1					
chances to make you feel good as a person	(2)	(2)		(1)			
chances you accomplish something worthwhile	2	2	1				
	(3)	(1)		(1)			
Autonomy							
opportunity to develop your skills and abilities	3	2					
	(3)	(2)					
chances to do things you do best	1	1					
	(2)	(2)	(1)				
Independence in making professional decisions	4	1					
	(3)	(1)		(1)			
opportunities to voice opinions	4	1					
	(2)	(2)			(1)		
work assignments according to preference	1	2	1	1			
	(1)	(1)	(1)	(1)		(2)	
opportunities to change assignments occasionally	2	2	1				
	(2)	(2)				(1)	
degree of challenge in your job	1	3	1				
	(1)	(2)	(1)	(1)			
chances you have to take part in making decisions	5						
	(3)	(1)	(1)				

Table 1. Primary Nurses' Job Satisfaction and Their Perception of Importance of Nursing Activities
(continued) (N=5)

	7	6	5	4	3	2	1
Nursing Activities							
Caring and Communication							
the way you are treated		3					
by the people you work with	(4)				(1)		
respect you receive from people you work with	1 (4)						
friendliness of people you work with	(3)		(1)	(1)			
personal recognition within your work situation	2 (2)			(1)	(1)		
amount of information you get about how well you are doing your job	1 (1)	1 (1)	2 (1)			1 (1)	
amount of pay you get	(1)	3 (1)	1 (3)				(1)
amount of job security you have	1 (2)	3 (2)					(1)

- * score 7=very satisfactory (extremely important)
 6=satisfactory (less than extremely important)
 5=slightly satisfactory (more than quite important)
 4=neither/nor (quite important)
 3=slightly satisfactory (less than quite important)
 2=dissatisfactory (more than moderately important)
 1=very dissatisfactory (moderately important)

Numbers in brackets refer to the degree of (importance)

Table 2. Primary Nurses' Perception of Importance and Frequency of Occurrence of Characteristic Elements at Work score (N=3)

	7	6	5	4	3	2	1
Primary Nurses' Perception of Importance:							
<u>Accountability</u> need for speedy work	1		1		2		1
<u>Responsibility</u> need for doing a variety of different tasks						1	1
<u>Autonomy</u> setting pace of work	4			1			
need for using all skills and training			2	1	1		
need for creativity		1		2		1	1
need for high level skill		1				3	1

* score 7-extremely important
6-less than extremely important
5-more than quite important
4-quite important
3-less than quite important
2-more than moderately important
1-moderately important

Table 2. Primary Nurses' Perception of Importance and Frequency of Occurrence of Characteristic Elements at Work (N=5) (continued)

	score			
	4	3	2	1
Frequency of Occurrence of Characteristic Elements	a lot	somewhat a little	not at all	
Accountability need for speedy work	1	3	1	
Responsibility need for doing a variety of different tasks	3	1		1
Autonomy setting pace of work	4		1	
need for using all skills and training	2	2	1	
need for creativity	1	3		1
need for high level skill		4		1

APPENDIX E

PROFILE OF THE INFORMANTS

Age-Range Distribution of the Informants

Primary Nurse A	36-45 years old
Primary Nurse B	36-45 years old
Primary Nurse C	26-35 years old
Primary Nurse D	46 years or over
Primary Nurse E	36-45 years old

Range of Post-Basic Nursing Experience

	(on this unit)	(post-basic experience)
Primary Nurse A	4 years	16 years
Primary Nurse B	2 years	5 years or less
Primary Nurse C	6 years	6-15 years
Primary Nurse D	5 years	6-15 years
Primary Nurse E	4 years	6-15 years

APPENDIX F
THE FLOOR PLAN OF THE UNIT

APPENDIX G

PHILOSOPHY OF PRIMARY NURSING ON UNIT 5

We believe that primary nursing is a delivery of comprehensive, coordinated, continuous and individualized total patient care through the nurse who has autonomy, accountability and authority on a 24-hour basis.

We believe that through decentralized decision making, the nurse has the freedom to develop and utilize her clinical capabilities, qualities of leadership, sophistication of judgement and organization abilities, thereby having greater job satisfaction and enhancing quality of care.

We believe that achievement or failure to achieve established standards are immediately recognizable and measurable, and that remedial actions and improvement of standards result.

APPENDIX H

OBJECTIVES FOR PRIMARY NURSING ON UNIT 5

1. To provide the highest level of care and services to patients by focusing nursing care on the individual patient's needs.
2. To provide an emotional, psychosocial, spiritual and physical environment for patient care.
3. To provide an environment where the primary nurse is responsible for the coordination of continuity of individualized patient care.
4. To provide an environment where communication between patients, staff and family is effective.
5. To provide and promote a unified approach by all staff for each individual patient.
6. To provide an environment that will be conducive to learning by staff.
7. To provide services which educate patients and their families in the expectation of the primary nursing concept.
8. To evaluate and assess the primary nursing concept on a continuous and/or periodic basis.

APPENDIX I**OVERVIEW OF PRIMARY NURSING ON UNIT 5**

Primary nursing is a method of nursing care that provides individualized patient care. The nurse working within a primary nursing concept is responsible for the patient twenty-four hours a day for the duration of the length of hospitalization or for a specified period of time.

The primary nurse:

1. Assesses the patient care needs.
2. Collaborates with the patient and other health professionals.
3. Formulates a plan of care that she/he is responsible for carrying out around the clock every day.
4. Delegates to a secondary nurse/nursing assistant the responsibility for executing the care plan.

The primary nursing concept provides the nurse with autonomy, authority and responsibility for patient care. The nursing care plan is developed in a collaborative and colleague manner, rather than the present subordinate way.

The nurse is responsible for the totality of patient care by developing and implementing the comprehensive nursing care plan for a continuous 24 hour period and for as long as the care is needed.

In addition, the primary nurse is accountable for all decisions regarding patients in her care.

APPENDICES J - M

PRIMARY NURSING PRACTISED AT THE UNIVERSITY OF MINNESOTA
HOSPITALS

APPENDIX J**ELEMENTS OF PRIMARY NURSING**

1. A one-to-one nurse-patient relationship is maintained.
2. Patient care decision making is decentralized to the individual nurse.
3. Clear allocation of responsibility and authority for nursing decisions is defined.
4. Total nursing care planning for assigned patients is the responsibility of one nurse.
5. Direct communication with nurses and those in other disciplines who care for the patient is ongoing.
6. Involvement of the patient and/or significant others in planning care is essential.

APPENDIX K

DIFFERENTIATING PRIMARY NURSING
FROM OTHER CARE DELIVERY SYSTEMS

Functional Nursing: Emphasis is on the *task* to be performed for each patient. Individual nursing staff members are assigned specific *tasks* and many staff members interact with one patient.

Team Nursing: Emphasis is on the *entire team* knowing each patient's needs and working together to give patient-centered care. A team leader is responsible for coordinating efforts of the team members.

Total Care Nursing: Emphasis is on *one nurse* interacting with assigned patients *during a given work shift*. Patient assignments may change from day to day.

Primary Nursing: Emphasis is on *one nurse*, assuming responsibility for planning and whenever possible administering care to assigned patients throughout their hospitalization. When appropriate, this responsibility is expanded to include re-admissions, home visits, clinic visits, etc.

APPENDIX L

PRIMARY NURSE ROLE

A primary nurse is the designated nursing staff member to whom the head nurse delegates responsibility and accountability for assessing an assigned patient's needs in addition to planning and evaluating the patient's nursing care from time of admission through discharge. Since the primary nurse is accountable for delivering quality patient care, he or she has the additional responsibility for recognizing when assistance (i.e. more staff, more knowledge, etc.) is needed.

The primary nurse obviously cannot give all care during a patient's hospital stay and therefore plans patient care and delegates responsibilities to other nursing staff members. The head nurse gives authority to the primary nurse for assuming that the care plan is followed in the primary nurse's absence.

This role is fulfilled by accomplishing the following role responsibilities and expectations.

APPENDIX M

RESPONSIBILITIES AND EXPECTATIONS OF THE PRIMARY NURSE

1. Completes the nursing history (admission interview).
 - a. A kardex card or interview form may be used as the interview tool.
 - b. A nurse who is not assigned as the primary nurse may have to take the nursing history if the primary nurse is not available.
2. Writes admission information on kardex and patient care plan. This should include:
 - a. Information needed by other health professionals in caring for patients.
 - b. Nursing intervention required for patient care.
 - c. Patient education initially planned.
3. Informs the patient and family that he or she is the primary nurse and explains what this means. Some things the primary nurse may want to tell the patient and family are:
 - a. The primary nurse will be responsible for planning nursing care.
 - b. Other nurses will assist the primary nurse in caring for the patient when the primary nurse cannot be there.
 - c. The primary nurse will need to know how the patient feels about hospitalization and what questions he or she has so they can plan together for the patient's care.
 - d. The primary nurse will talk with the doctor and other health personnel to coordinate patient care.
 - e. The primary nurse and associate nurses will talk with the doctor and other health personnel to coordinate patient care.
4. Gives nursing care to the patient when on duty.
 - a. Because the primary nurse is responsible for planning patient care, he or she should care for assigned primary patients whenever possible.

- b. If the primary nurse cannot care for her or his patients because of assignment adjustments or patient acuity level, the primary nurse is still responsible for maintaining contact with the patient and the family in some way.
5. Communicates with the family when the patient is admitted and throughout the hospitalization.
 - a. The primary nurse exchanges information with the family, gives emotional support, helps make plans for the patient's discharge, etc.
 - b. The primary nurse is responsible for recording pertinent information on the patient's kardex/care plan and in the patient's chart.
6. Maintains a current kardex/patient care plan.
 - a. Pertinent nursing directives and problem solving make a useful kardex/patient care plan.
 - b. The kardex/patient care plan should be systematically reviewed to keep it up to date.
7. Communicates with others who care for his or her patients (associate nurses, physical therapist, dietician, etc.) to make suggestions, compare observations of patient reactions, their perception of the patient; and correct practices that interfere with accomplishing desired patient outcomes.
 - a. Identify oneself as a particular patient's primary nurse (verbally and also by writing one's name on the patient's care plan and on the patient's chart).
 - b. Record the results of communications on the kardex and patient's chart as appropriate.
 - c. Communicate questions and concerns that remain after these conferences.
 - d. Follow up on communications and evaluate results.
8. Attends or arranges for another nurse to attend daily doctors' rounds. Communicates with the physician, and is present if possible when the physician sees his or her primary patients.

9. Attends health team, rounds and contributes specific information to discussion about his or her patients.
 - a. Health team rounds may be attended by social workers, dietician, doctor, and other personnel.
 - b. Health team rounds may be used for clarifying the patient's treatment plan, discussing problems, and identifying possible causes and solutions.
 10. Initiates, follows through, and evaluates appropriate referrals (e.g., public health nurse, nursing home).
 11. Arranges for conferences with nursing staff, family, or health professionals in other disciplines.
 12. Writes summaries on kardex and progress notes at time of transfer or discharge. Some patient care areas save the kardex/patient care plan to use if the patient returns; others send them to the appropriate outpatient clinic to be used when the patient returns for clinic visits.
-

APPENDIX N

LETTER OF SUPPORT OF THE STUDY



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MEMORIAL UNIVERSITY OF NEWFOUNDLAND

St. John's, Newfoundland, Canada A1C 5S7

School of Nursing

Telex: 016-4101
Telephone: (709) 737-6695

April 25, 1985

Mr. John Breen
Assistant Executive Director
Leonard A. Miller Centre
104 Forest Road
St. John's, Newfoundland
A1A 1E5

Dear Mr. Breen:

RE: Letter of Support and Approval of a Study by Mineko Yamashita

Miss Mineko Yamashita's proposal for a study of "Primary Nursing: An investigation into the nature of one type of patient care modality" was submitted to her Thesis Supervisory Committee and Human Ethics Review Committee of the School of Nursing has been reviewed and approved for study.

She has met the standards and the necessary precautions as set down by the Research and Ethics Committee to safeguard the confidentiality of the individuals who will be involved in the study.

I am therefore writing in support of her application of the hospital for permission to carry out the study.

Sincerely,

MARY JO BULBROOK, R.N., Ed.D.
Coordinator, Graduate Programme
in Nursing

/rc

APPENDIX O

LETTER OF APPROVAL TO CONDUCT THE STUDY

THE GENERAL HOSPITAL

ST. JOHN'S NEWFOUNDLAND A1A 1E8



OPERATED BY
THE GENERAL HOSPITAL
CORPORATION

Telephone: (709) 737-8300
Office: (709) 737-7354

1985 05 01

Miss Mineko Yamashita,
c/o Memorial University of
Newfoundland,
St. John's, Nfld.
A1C 5S7

Dear Miss Yamashita:

This will confirm our approval for you to visit the Miller Centre and study our Nursing System of Primary Care. I understand from Ms. Johnston, Patient Care Manager, that this is primarily a system review and will not require access to patient records or contact with patients.

Sincerely yours,

J.D. BREEN,
Assistant Executive Director,
(Miller Centre)

JDB/jmy

APPENDIX P**SUMMARY OF PRIMARY NURSING EVALUATION STUDY**

Summary of Primary Nursing Evaluation Studies.

Author(s)	Control Group(s)	Control for Variables	Random selection/Allocation	Dependent Variable(s)	Instrument(s)	Statistical Test(s)
Deeffler (1975)				Patient satisfaction	Checklist	Incomplete X ratios
*Felton (1975)				Quality of care	QualPacs Sister Pharmut	t-test
McCarty & Schifalacqua (1976)				Patient satisfaction	Questionnaire	Chi-square
Watson (1976)				Patient satisfaction	Questionnaire	Chi-square?
Eichhorn & Everett (1979)				Quality of care	QualPacs	t-test
Marras et al (1979)			matched samples	Staff satisfaction Patient satisfaction	Questionnaire Questionnaire	--
Giovanetti (1980)			audits only	Quality of care Patient satisfaction Staff satisfaction	Observation Audits Questionnaire Questionnaire Records	Babiers-Fisher Chi-square
Hogedus (1980)			for QualPacs only	Quality of care Staff satisfaction	QualPacs Nurse Audits Harrberg tool	ANOVA t-test ANOVA

Summary of Primary Nursing Evaluation Studies (continued)

Author (s)	Control Group (s)	Control for variables	Random selection/Allocation	Dependent Variable(s)	Instrument (s)	Statistical Test (s)
Steckel et al (1980)				Quality of care	QualPaCs Health Status Dimensions Tool deemed Inadequate Tool deemed Inadequate	ANOVA ANOVA
Roberts (1980)				Quality of patient satisfaction Staff satisfaction Cost	Audit Questionnaire Questionnaire Questionnaire Records	-- -- -- --
Shulka (1981)			Matched staff	Quality of care	QualPaCs Stacer	t-test t-test
Ventura et al (1982)				Patient satisfaction	Risser Scale	t-test

* Included in research design
 * Not included in research design
 * also reported by Williams (1975)
 * reported previously (Hogedus, 1979)
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