Primary Nursing

An introductory guide

EDITED BY

FRANCES BLACK

KING'S FUND CENTRE

THE FOUNDATION OF NURSING STUDIES

PRIMARY NURSING NETWORK

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EDITED BY

FRANCES BLACK MN RGN RM
PROJECT WORKER
PRIMARY NURSING NETWORK
KING'S FUND CENTRE

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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The Foundation of Nursing Studies

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The Foundation of Nursing Studies (FoNS) was set up to put nursing research into action. It is a charity designed to give nurses the help they need to maintain and improve the quality of their practice through the promotion of proven research findings.

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FoNS — another step forward in nursing care

Foreword

Since the Primary Nursing Network was established more than three years ago there has been a steady increase in membership which has reflected the growing interest among clinical nurses in adopting this approach to organising their work. Many enquiries are received each week seeking information about such things as relevant literature, changes in roles and responsibilities and contacts with colleagues in similar work settings.

Experience of the type of enquiries which are made led us to recognise that numerous people were facing similar difficulties. Furthermore, many lessons had been learned by those who had already made the move to primary nursing. It is with these thoughts in mind that this text has been prepared. It brings together some of the information and ideas, from both the literature and experience, which are commonly sought.

The purpose of this book is to offer an introduction to primary nursing for nurses who are interested. It is not intended to be a 'stand alone' text, but a starting point and a means of sharing some of the work which has already been undertaken.

The book offers an overview of the background to primary nursing. It raises some of the implications for practitioners in terms of responsibility and accountability, as well as some practical ideas about work roles and job profiles. Reading lists and bibliographies have been prepared to guide people to the literature which they feel is relevant to their particular needs. Since so much has now been written about primary nursing it is not always easy for people to track material down, especially if they are working in places where access to libraries is difficult. By bringing together information in this way we hope that considerable time and energy can be saved in the future.

This work could not have been undertaken without the generosity of the Foundation of Nursing Studies which has provided funding for the work necessary to prepare the material and the production costs of the package. We are grateful to the Foundation for recognising the need for such a publication and for giving us financial support.

We hope this text proves useful to you and we should be grateful for your comments. We are also aware that, as more and more people gain experience of primary nursing, new lessons will be learned and that this work will need updating. We hope that you will take advantage of the Primary Nursing Network as a means of sharing your experience and knowledge with others and of providing new ideas which could supplement this guide in the future.

Barbara Vaughan
Director, Nursing Developments Programme
King's Fund Centre
London 1992

Introduction

This guide has been published to satisfy the need of nurses for a comprehensive and brief outline of primary nursing. What is primary nursing? How can it be implemented? Does it provide a better way of giving nursing care? The guide seeks to answer these questions and provide a resource for the clinical practitioner and others interested in primary nursing.

Section 1 looks at the structure in which care is given. It contains a brief history of primary nursing and examines its philosophical basis. The specific role of a primary nurse is discussed, as well as that of other members of the health care team.

Section 2 looks at the environment in which care is given. It contains a discussion concerning the skill mix in a primary nursing structure and the dependency of patients. The place of carers, relatives, clinical nurse specialists, learner nurses and the mulitdisciplinary team are addressed. In addition the actual process of implementing primary nursing is outlined.

Section 3 is concerned with the outcomes of primary nursing for the patient, the nurse and the manager of the health care system. Do patients receive better care? Do nurses have greater job satisfaction? Does primary nursing cost more? In reviewing the research concerning primary nursng these questions are raised, if not answered. The future prospect for primary nursing in the UK is discussed.

Section 4 contains quick reference guides for the reader. Who has written about the quality of nursing care in a primary nursing structure? Has anybody written about staff relationships in a primary nursing ward? Readers should be able to see quickly who has written about the subject they are interested in and then obtain the original source material for themselves. Full references for all articles mentioned in the guide are found at the end of this section.

This guide is colour coded for ease of reference.

Contributors

Frances Black MN RGN RM	Project Worker, Nursing Developments Programme, King's Fund Centre, 126 Albert Street, London
Mary Finch BN(Hons) RGN RHV	Staff Nurse, Ward 7B, John Radcliffe Hospital, Oxford
Mary Griffiths BA SRN	Formerly Research Fellow, Centre for Health Economics, University of York
Rebecca Malby MA RGN DipN	Senior Nurse Manager, Strategic Development, Yorkshire Regional Health Authority, Harrogate
Sally Quilligan BEd(Hons) RGN DipN(London) RNT	Lecturer in Nursing Studies, Queen Alexandra and Newham College of Nursing and Midwifery, The London Hospital (Whitechapel), London
Margaret Rogers BSc RGN RSCN	Nursing Developments Facilitator, The Hospital for Sick Children, Great Ormond Street, London

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The authors' contributions to the text were woven together and then placed in the various sections. No one author is responsible for a specific section alone. Contributions have also been gathered from members on the King's Fund Centre Primary Nursing Network Steering Group who are currently Liz Adair, Steve Ersser, Liz Tutton and Barbara Vaughan.

Thanks to not only to the authors of the text, and to the Primary Nursing Network Steering Group, but also to Hazel O'Donnell, the Primary Nursing Network project assistant, for her invaluable contribution in helping to get the text ready for publication.

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1

The history, philosophy and structural organisation of a primary nursing system

section

1

The history of primary nursing in the UK

Primary nursing as a system of organising nursing care was adopted by nurses in the United States of America earlier than it was in the United Kingdom. Within British nursing literature, primary nursing was mentioned in the late 1970s by Kratz (1979) and Lee (1979), both of whom discussed its merits having seen it on trial in Perth, Australia. These authors encouraged British nurses to consider introducing primary nursing to their wards and units. Lee (1979) traced a concise history of the different methods of organising nursing care which have been employed during the nineteenth and twentieth centuries and looked at possible sociological factors influencing this.

During the 1970s, many British writers contributed to discussions about the value of the different methods of organising nursing care in use at that time — namely, task allocation, team nursing and patient allocation. Most of these writers claimed positive outcomes for patient allocation in comparison with the other methods of care organisation. For discussion on nurse/patient relationships see Matthews (1975), Jones W (1977), Marks-Maran (1978), Plumpton (1978); and on the development of qualified nursing staff and students see Matthews (1975), Pembrey (1975), Jones E (1977), Jones W (1977), Marks-Maran (1978), Plumpton (1978). Some reservations about patient-allocation were also noted however. For example, both Jones E (1977) and Jones W (1977) claim that patient allocation is more easily broken down by problems of staff shortage than team nursing and task allocation; as well as this, Matthews (1975) and Plumpton (1978) voice concern that the potential for personality clashes exists between nurses and 'their' patients in patient allocation. (For a more detailed discussion of these issues see Ersser and Tutton 1991, Chapter 1.)

Such debates continued in the literature during the 1980s. Overall, there existed an atmosphere of increasing general approval by British nursing writers towards the move from task allocation and team nursing to patient allocation during the 1970s and 1980s. Accompanying this, concepts such as holism and individualism and their significance in nursing care began to be discussed more in the literature. Turnbull (1978) relates her experiences of carrying out 'total nursing care' in America, appealing to British nurses to consider these concepts carefully, pointing out the World Health Organization's definition of health as 'a state of complete physical, mental and emotional well-being'. However, as Johnson (1981) suggests, primary nursing and its underlying concepts have not been accepted quickly by British nurses on the whole. Instead these ideas have taken time to sink their roots into the world of British nursing.

section

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Primary nursing literature

Figure 1 illustrates that there has been a marked upward trend in writing about primary nursing in the British nursing press during the past few years, which reflects the growing interest which British nurses have in primary nursing as a method of work organisation.

Within the literature, reasons for the development of primary nursing are explored. Informative texts on this subject are by Bowers (1989), Melia (1990) and Ersser and Tutton (1991), all of whom identify factors which have led to the increased prominence of primary nursing in British nursing research, education and practice. Such factors include changes in many aspects of the British nursing profession, changes in the management of the National Health Service, and many other political and social factors.

Until the late 1980s most British research into primary nursing was on a very small scale, too limited for application to other nursing situations, and many writers admitted their inability to provide meaningful and reliable reports of results because of problems in methodology. In the past three years, however, a definite attempt by researchers to acknowledge and tackle these problems has been revealed in the literature (e.g. Thomas and Bond 1990, Johns 1991, Mead 1991). An increasing variety of tools for research is being put to use within individual research projects (Eaton and Thomas, 1991), and primary nursing is being analysed more closely by established researchers. One other noticeable point is that research into primary nursing is taking place in an increasing variety of nursing specialties, including acute nursing care for adults on general medical and surgical wards. Section 3 deals with this research in more detail.

A considerable amount of the literature concerning primary nursing is of an anecdotal nature. The implications of introducing such a change into the clinical environment are reflected in the growing number of reports of study days on primary nursing (Johns 1990a, Tutton 1989), conferences (Chudley 1983, Hunt 1988, Binnie 1989) and activities of the Primary Nursing Network.

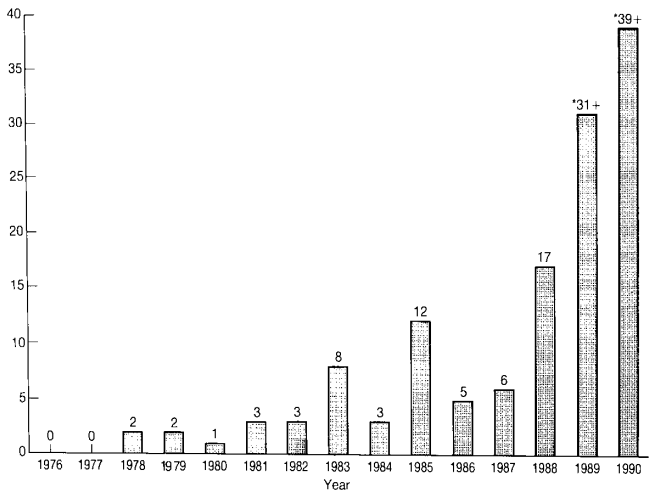

Figure 1 *Number of articles/books mentioning primary nursing in the British nursing press (Finch 1991) By 1989, the number of books and articles in British literature mentioning primary nursing was large as many books and articles about nurse management mention it; only books and articles specifically about primary nursing in the years 1989 and 1990 have been counted.*

Resistance to primary nursing

Within primary nursing literature there have been several indicators of resistance to its development in Britain.

Sparrow (1986) points out that many British nurses associate primary nursing with 'Americanistic jargon' and are quick to discount its value. Some authors note that a general atmosphere of resistance to change prevents the development of primary nursing at many levels (Chudley 1983, Green 1983, Rogers 1987, Crowder 1989, Gilbert 1989). Swaffield (1983a) suggests that many nurses are resistant to the idea of being more open, either to fellow professionals or to their patients, and feel threatened by this aspect of practising primary nursing.

Other problems mentioned in the literature include the lack of preparation of nursing teams for a change to primary nursing (Malby 1989), unrealistic expectations of primary nursing leading to disappointments (Bowers 1987), lack of motivation for change (Castledine 1985b), the low morale of nurses (Castledine 1985a), nursing staff shortages (Cavill and Johnson 1981, Chudley 1983, Castledine 1985a), and problems concerning the ward sister's role (Chudley 1983).

Barriers to primary nursing from outside the nursing team include problems related to hospital and nurse management (Chudley 1983, Castledine 1985a), inadequacies in nurse education programmes (Chudley 1983), and the dominance of the medical profession at ward level (Chudley 1983). Ways of preventing such resistance are discussed by Sears and Williams (in Ersser and Tutton 1991).

Summary of the factors affecting resistance to primary nursing

These group into two areas:

Management
Underlying resistance to change
Lack of motivation in staff
Low morale in staff
Inappropriate nurse education programmes

Internal ward structure
Changes required to ward sister role
Unrealistic expectations of staff
Medical dominance on ward
Lack of appropriate preparation of ward staff

section 1

The King's Fund Centre Primary Nursing Network

The Primary Nursing Network was established in 1988 by Jane Salvage, then director of the Nursing Developments Programme at the King's Fund Centre, and Liz Tutton and Steve Ersser of Oxford Regional Health Authority.

The funding for the network came from a grant from the Sainsbury's Family Charitable Trust, administered by the King's Fund Centre, and a project worker was appointed early in 1990. For logistical reasons the network office was based at the University of Wales College of Medicine, Cardiff. The Primary Nursing Network staff consists of a project worker and project assistant. In addition there are currently 35 regional volunteer link members throughout the UK.

The main aims of the network are:
1. to establish and maintain a database of information on primary nursing;
2. to provide information for network members;
3. to encourage network members to exchange information between themselves;
4. to support nurses who are introducing primary nursing;
5. to encourage the efficient use of expertise on primary nursing issues on a nationwide scale;
6. to develop and encourage a critical evaluation of primary nursing.

The Primary Nursing Network database provides a record of the development, growth and spread of primary nursing in the UK. It holds information on the size and medical specialty of wards and the stage of implementation of primary nursing on those wards. It is also seeking to obtain a record of evaluation processes that wards using primary nursing are undertaking. There are currently over 1,000 wards and units on the database. The database thus has a complex and unique record of nursing structures throughout the UK.

The network publishes a quarterly newsletter containing articles of interest to its members. It also collaborates with the UK nursing press on articles concerning primary nursing. In addition, the network runs national study days and conferences on primary nursing and seeks to assist its members in organising similar events in their regions.

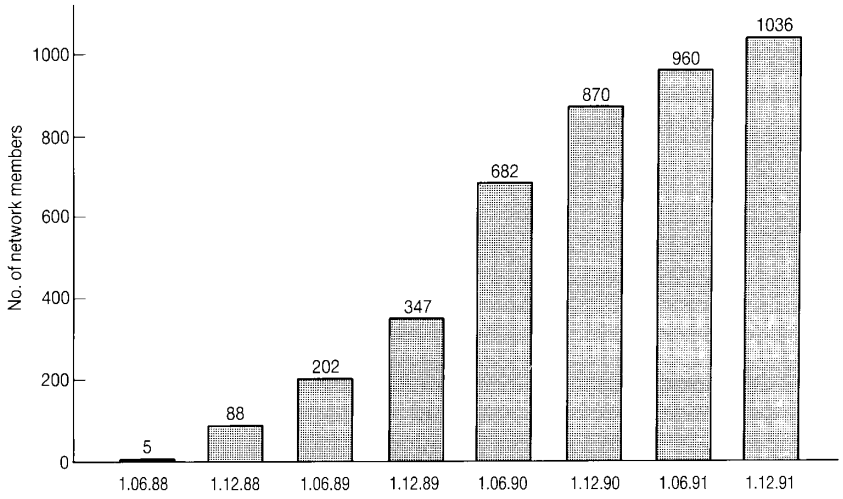

Figure 2 *Growth rate of primary nursing*

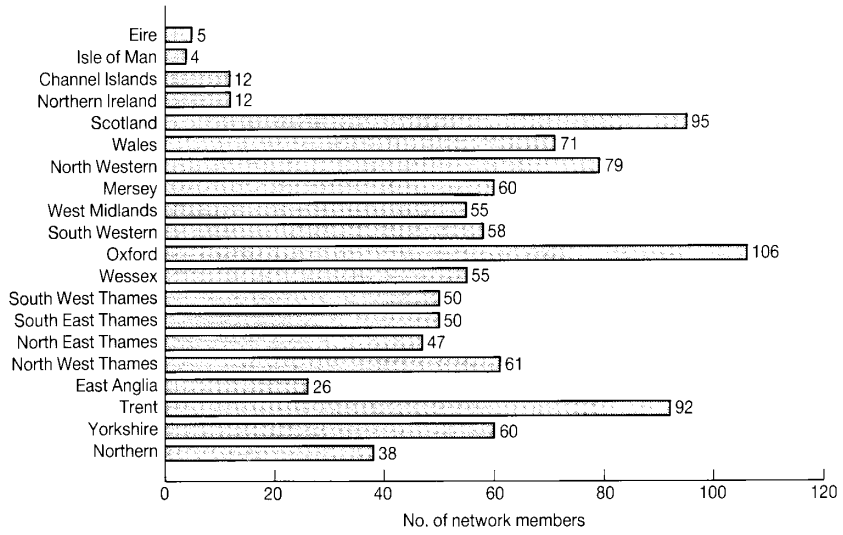

Figure 3 *Regional spread of primary nursing, December 1991*

section 1

Key concepts in primary nursing

A Strategy for Nursing issued by the Department of Health (1989a) recommended that:

'. . . the development of primary nursing should be encouraged.'

It did not however identify what primary nursing was and perhaps assumed that the term had a universal meaning. There is controversy over whether primary nursing is only an organisational method or whether it is also a philosophy of care giving. By highlighting the definitions below which have been offered by several notable authors on primary nursing some facets of this debate are illustrated.

Just a method of organising nursing care or also a philosophy?

Manthey (1988a) suggests that primary nursing was developed in a unit at the University of Minnesota in the late 1960s. Therefore it appears appropriate to begin with her definition which sees primary nursing in organisational terms:

'. . . a system for delivering nursing care in an organisational facility'. (Manthey 1980a)

In 1988 she re-emphasised that she viewed it as nothing more than an organisational design:

'At its best primary nursing is simply a way of organising the people on the staff and the work to be done in a common sense system based on professional organisational principles.' (Manthey 1988a)

These principles are:
1. *Allocation and acceptance of responsibility for decision making to one individual.*
2. *Individual assignment of daily care by case method.*
3. *Direct person-to-person communication.*
4. *One person operationally responsible for the quality of care administered to patients on a unit 24-hours a day, seven days a week .*

(Manthey 1980a: 31).

Or in summary: responsibility; continuity of care; direct communication; care giver as care planner.

Hegyvary (1982) identifies similar attributes.

Accountability: the primary nurse is answerable for the nursing care of a patient 24-hours a day throughout the hospital stay.

Autonomy: The primary nurse has, and acts on, the authority to make decisions about the nursing care of her patients in the mode of professional governance.

Co-ordination: nursing care is continuous around the clock with a smooth, uninterrupted flow from shift to shift and with direct communication from care giver to care giver.

Comprehensive: each care giver gives all required nursing care to a patient during a specific time period, e.g. a shift.

Wright (1990) and Hegyvary (1982) suggest that these criteria constitute the basic ingredients for professional practice, but argue that primary nursing is more than an organisational system:

'Primary nursing is not merely another way of organising care. It is a wholesale re-appraisal and re-valuing of the nurse and the nurse's role.' (Wright 1990a: 8)

Manley (1990a) believes that primary nursing is both an organisational approach and a philosophy:

'It is a philosophy where the central feature is a belief that the nurse/patient relationship is therapeutic ... the relationship between nurse and patient is beneficial in its own right.' (Manley 1990a: 67)

Ersser and Tutton (1991) suggest that whether or not primary nursing is a philosophy remains unclear. Those who argue that primary nursing is underpinned by a central belief cite humanism as that philosophy. Humanistic nursing is an approach to nursing which views the individual as a whole, recognises the individual's uniqueness and is sympathetic to the notion that human behaviour is unpredictable (McKee 1991). Humanism draws on the philosophies of existentialism and methods of phenomenology (Paterson and Zderad 1976). It emphasises people's own perspectives of their lived experiences and is based on certain assumptions:

1. That a person is intrinsically worthwhile.
2. That human beings have the ability to develop their potential which, once realised, allows them to exercise freedom and make choices to control their lives.

What appears to be crucial to the debate about whether primary nursing is a philosophy of care, is how individual primary nurses interpret their role within the nurse/patient relationship. If primary nursing incorporates the notion of giving patients greater control over their lives and increased independence, then this appears to be consistent with a theme from existential philosophy — that of holding a belief in a person's freedom and ability to choose and according them respect. There can be no doubt that these beliefs are evident in many aspects of modern nursing. In particular the notion of the nurse as therapist and nurse/patient partnership, but whether they are beliefs intrinsic to organising care in the primary nursing mode is less clear. Wright (1990) has suggested that:

'. . . primary nursing will only work where nurses are ready and willing to take on board their accountability and autonomy, to work with colleagues in a relationship of equals and to share care with patients and their carers as partners.' (104)

The philosophical debate

How far nurses can adopt such a humanistic philosophy is debatable. Paterson and Zderad (1976) emphasise that in order to be receptive to the information arising from experience, the nurse must strive to eliminate all previous assumptions, judgements and labels. This demands highly developed interpersonal skills as well as skills of assessment. McKee (1991), describing a case history of a patient nursed using a humanist philosophy, noted that humanists would see the underlying nursing philosophy as deterministic. She also suggested that the emphasis on understanding what is happening between the nurse and patient may be to the detriment of the family who, to some extent, are ignored because the relationship between nurse and patient becomes all encompassing.

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Ersser and Tutton (1991) state that in practice the key concepts embodied in primary nursing may be on a continuum from low to high occurrence and that what is significant is whether movement towards these can be identified. The notion of a continuum may apply equally to those who try to adopt a philosophy of humanism as the foundation for their practice.

Thus how nurses define primary nursing may depend on whether they view it as:
1. an organisational system;
2. a move towards patient-centred care in which nurses are individually accountable for their actions;
3. a philosophical change in which the nurse/patient partnership becomes central.

How individual nurses interpret primary nursing may vary and may consist of only one of these three principles, or all three.

The seven care studies outlined in Ersser and Tutton's (1991) book give clear evidence that primary nursing appears in many different guises. Each area that practises primary nursing may need to modify it according to the skill mix, client group and environment. The addition of new members to a team may also result in an adaptation of the way primary nursing is practised, principally because the new members may not fully understand the concepts involved.

If nurses want to adopt the concepts of responsibility, autonomy, accountability, continuity of care and care planner as care giver, there is a need for clarification. Nurses must be clear about what is meant by these concepts, how they relate to primary nursing and what the implications of adopting them could be, both for their practice and for the development of nursing.

Sharing control — nurses and patients

'Partnership between nurse and patient' is a term frequently used by practitioners describing primary nursing (Wright 1990, Tutton 1987, McMahon 1989b, Casey 1988). A critical contribution to the understanding of partnership was offered by Muetzel (1988) who sought to clarify what 'partnership with the patient' means. In order to do this, it is helpful to look to other disciplines — business, for instance. A review of business literature appears to suggest that partnership embodies concepts of shared control, trust and equality, although equality of what is unclear (Quilligan 1991). By relating each of the three components — sharing control, trust and equality — to nurse/patient relationships further insight into partnership between nurse and patient can be gained.

Within primary nursing the nurse often adopts the role of enabler, working with patients in order to assist them to participate in their care and share in decision making. Primary nurses wishing to share control within the nurse/patient relationship may try to negotiate care with patients. Negotiation is a delicate process which requires highly developed skills. It requires nurses to recognise that both partners (themselves and the patient) are powerful forces who share control and responsibility, and have equal opportunity to influence the outcome (Marks-Maran, 1991). It also requires both partners to be aware of the boundaries of what is and is not negotiable, and for them to be able to assert themselves and articulate their needs.

If negotiation is to take place the primary nurse must value the patient's contribution. Roberts (1990) outlines the process of negotiation as follows. The patient has his view of the problem acknowledged and is able to make his goals and expectations explicit. The nurse states what her thoughts about the problem are and then both nurse and patient

are free to discuss and negotiate, based on a shared view of the problem and possible courses of action.

It is questionable how realistic the process of negotiation can be. Swenson (1978) argues that because of the greater technical and clinical expertise of the professional, any collaboration is unequal. Indeed, the whole process of negotiation appears to rest on certain assumptions:

1. that nurses are not necessarily the experts;
2. that nurses can accept that patients may not always comply with their advice;
3. that nurses are willing and able to share control;
4. that patients wish to take control.

The need to give patients more control is emphasised by writers promoting primary nursing (Wright 1986, Pearson 1988). They assume that patients want control but it is suggested that this assumption may need to be challenged. In an account about the use of care plans Biley (1989a) perceptively comments:

'It is not questioned whether or not the patient or his family actually want to know more about their condition, whether they want to take a more active role or even whether they want to have a partnership relationship.' (23)

There may be times during illness when people may be happy to let others assume control of the situation. Preoccupation with their illness or feelings of vulnerability and helplessness may make some people wish to be free of the responsibility of decision making. Some patients may choose to participate by giving the primary nurse permission to make decisions on their behalf.

Waterworth and Luker (1990) explored with 12 patients how they perceived being involved in decisions concerning their own nursing care. They concluded that:

'. . . promoting individualised care is not necessarily synonymous with active patient involvement.' (971)

Patients made it clear through interviews that rather than wanting to participate as active partners in their care they were more concerned with staying out of trouble and 'toeing the line'. Waterworth and Luker argue in their conclusion that some patients may not wish to be actively involved in their care. This study raises interesting questions about whether some patients feel coerced into accepting a share of the control.

Sharing control has many ramifications. It demands highly complex skills from the primary nurse and the patient. It may influence efficiency because professionals will not have complete control over their interactions with patients and therefore, as Roberts (1990) argues, may no longer control the process and outcome. Other practical issues are raised relating to the client's ability and desire to participate as well as the legal and moral dimensions of joint decision making.

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Trust between nurses and patients

Trust appears to be implicitly linked to issues of control and autonomy for, as Melia (1988) identifies, maintaining trust is one way of respecting the patient's autonomy.

Travelbee (1971) sees trust as *'the assured belief that other individuals are capable of assisting in times of distress and probably will do so.'* Whether trust can ever be total is speculative. *'Neither the nurse nor patient is ever completely trusting or mistrusting.'* (Thomas 1979: 164)

The patient has confidence and trust in the specialised knowledge and skills of the nurse. The initial trust may, however, be eroded if the nurse fails to present the patient with sufficient comprehensible information to make an informed choice. In effect, by withholding or giving false information, the primary nurse takes control from the patient (Schrock 1980). Subsequently, it may be that if the nurse has lost the patient's trust she also loses the ability to act effectively for that patient. As Williamson (1981) argues, if trust is absent, patient care will suffer as there may well be diminished accuracy in observation and diagnosis.

The capacity to develop a trusting relationship will be influenced in part by the nurse's and patient's past experiences. Thomas (1979) suggests that if relationships are to be interdependent and built on trust, certain behaviours must exist. The nurse and patient must be comfortable with an increasing self awareness and be able to share that awareness with each other. Learning to trust is therefore difficult and time consuming and nurses may not always gain the trust of their patients. This suggests that if trust is central to the development of partnership, primary nurses may not always be able to build partnerships with their patients.

Equality

The final component identified within partnerships in business literature is equality. But equality in what is unclear. Raatikainen (1989) suggests that the principle behind equality is that *'No matter how different from each other people may be, they each have equal right to life, freedom and security'*. The underlying question that seems to be asked is 'does being different necessarily mean being unequal?'.

Webb (1986), in presenting a feminist perspective, argues that you cannot be equal unless you have equal rights. She identifies partnership as a concept which demystifies health by sharing knowledge and skills with people so that they can make decisions for themselves. True sharing, she argues, is only achievable in an equal relationship in which neither partner has more privileges than the other. Orr (1985) supports this notion of equal rights by stating that equal relationships can only exist in non-hierarchical situations.

Curtin and Flaherty (1982) suggest that illness makes the patient a petitioner. Patients go to the health care professional and must ask for help. It is suggested that because the patient goes to the nurse, and not vice versa, this places the patient on an unequal footing. In addition it could be argued that, because the primary nurse has a greater knowledge base than the patient, this itself makes them unequal. Davis (1985) suggests that patients' equality within the relationship will depend on the value placed on their expert knowledge of themselves, their aims and their situation outside hospital. For equality within the relationship the patient's contribution must be valued and must complement what the professional has to offer. Vaughan (personal communication) suggests that nurses have the responsibility of being experts in their field as a means of legitimising the service which they offer the patient.

Also identified within business literature on equality is the idea that although equal status is not necessary, the partners have both to need each other and have something to lose. It is related to equal risk taking. Equal need for each other may be evident in primary nursing. Benner (1984) suggests that the creation of a healing relationship yields mutual benefit. There is some evidence that nurses who work as primary nurses in 'partnership' with their patients feel that their level of job satisfaction is increased (Bond 1990a). Increased job satisfaction may relate to the patient and the nurse being of equal importance. It could be argued that some nurses experience increased stress levels owing to much closer nurse/patient relationships (Pearson 1988) but this seems to be counterbalanced by more positive outcomes.

Summary

Partnership between the primary nurse and patient should be based on trust and that will not exist unless control within the relationship is shared. Debate exists over whether primary nurses and patients can share control and trust each other. Every patient may not be able to be cared for using a philosophy which emphasises partnership.

Partnership is a complex phenomenon. Primary nurses who wish to attempt to adopt the role of partner need to be confident, reflective, assertive practitioners. They must be able to demonstrate an awareness of the enormity of the change they are trying to make. Educational preparation and support is vital before nurses can explore the complex and difficult issues that partnership encompasses.

section

1

Roles in the primary nursing system: Introduction

The following part of section I looks at the roles of the primary and associate nurse, the senior ward nurse/ward sister, the ward co-ordinator and the health care assistant or nursing auxiliary.

When considering role profiles in relation to primary nursing it is important to differentiate between the responsibilities of being a primary nurse and those of fulfilling an organisational role. Primary nursing is concerned with the responsibilities of providing care for a named group of patients. However, most nurses will also have an organisational role (such as that of a ward sister, a team leader or a staff nurse) which gives rise to a different set of responsibilities, separate from those which are specific to the named role. Thus, while both the ward sister and the team leader will have the same responsibilities to the patients they care for as a primary nurse, their work will be different in relation to their organisational roles.

The role profiles outlined here are only meant to serve as a guide and should not be taken as a blueprint which can be used in any setting. It is very important that consideration is given to the local situation when preparing any job profile and that attention is paid to both the nursing and the organisational responsibilities which will be required of the post holder.

Since primary nursing may take place in a wide range of clinical settings the word 'unit' has been used wherever possible to describe a defined clinical area such as a ward, a health centre or an outpatient department.

Roles in the primary nursing system: Primary nurse

The four elements of primary nursing as defined by Manthey (1980a) are:

1. Allocation and acceptance of responsibility for decision making to one individual.
2. Individual assignment of daily care by case method.
3. Direct person-to-person communication.
4. One person operationally responsible for the quality of care administered to patients on a unit 24-hours a day, seven days a week.

The role of the primary nurse is described here using Manthey's concepts.

24-hour responsibility and accountability

The primary nurse:

- Is responsible for the assessment, planning, delivery and evaluation of nursing care for her patients for the time that the patient remains in her caseload, and for making the necessary plans for discharge from that caseload (MacGuire 1989a). Although the primary nurse has 24-hour responsibility for her patients, this responsibility is accepted by an associate nurse when the primary nurse is not on duty (Donovan 1971).
- Is the care giver wherever possible, and for the majority of the time. She must give enough care to carry out her role as care planner and evaluator.
- Is responsible for communicating the information necessary to enable the patient to receive the planned nursing care.
- Has the authority to act on her decisions concerning the nursing care of her caseload of patients.

Assignments of care

The primary nurse:

- Manages a defined caseload of patients.
- Develops a therapeutic relationship with her patients (Manley 1990a).
- Ensures that care is assigned to the nurse best able to meet the individual needs of each patient in her caseload in her absence.
- Ensures that the nursing care for her caseload focuses on the patient, not on the organisation's routines (Wright 1990a).
- Acts as a mentor to other nurses caring for her caseload. (Clarke and Gorton 1990).

Person-to-person communication

The primary nurse:

- Is responsible for giving and getting all information relevant to his/her patient's individual plan of care, from all other members of the health care team including expert nursing staff.
- Is the primary source of communication with the patient and his/her family and determines the nursing contribution to the patient's care in partnership with the patient.
- Is responsible for explaining the role and responsibility of a primary nurse to the patient and carers and what they can expect from him/her (Zander 1980).
- Acts as the patient's advocate if the patient and/or relatives are unwilling/unable to speak for themselves.

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Zander (1980), describes 12 key elements of the primary nurse's role. These are accountability, advocacy, assertiveness, authority, autonomy, continuity, commitment, collaboration, contracting, co-ordination, communication, and decentralisation. The role has been summarised by Wright (1990) as:

'. . . *sitting at the centre of the web of care with the patient, working as a partner and companion in care, and pulling together all the many strands involved in his health and well being.*' (33)

Who can be a primary nurse?

There is much debate on this question within British nursing literature. This is a summary of the different arguments presented:

- Qualified nurses only (Green 1983, Ashley 1984a, Pearson 1988, Gilbert 1989, Wheeler 1989).
- Registered general nurses only (Bowers 1987, Wheeler 1989).
- Qualified nurses with minimum length of experience (Burns 1988, Gilbert 1989, Wheeler 1989, Wright and Khadim 1989).
- Some writers have suggested that student nurses under supervision may also be primary nurses (Faulkner 1981, Ritter 1985, MacGuire 1988, Salvage 1989b).

For debate about whether enrolled nurses may be primary nurses, the key texts are Ersser and Tutton (1991) chapter 17 and Cole (1989). Walsh (1989) calls for further study of this question.

Some writers argue that nurses' qualities, experiences, attitudes and capabilities need to be assessed on an individual basis rather than making hard and fast rules about which categories of nurse may or may not be primary nurses (Wright 1987b, Salvage 1989b).

What qualities are required of a primary nurse?

Few writers specifically outline the qualities which a primary nurse should have. Perhaps it is assumed that the qualties are those which any nurse should possess. In addition the following specific attributes are mentioned.

- Knowledge, skill, empathy (Johns 1989).
- Questioning minds and a desire to keep up-to-date with practice and research (Binnie 1989, Sturt 1989).

What needs do primary nurses have?

Some writers identify specific needs which nurses practising as primary nurses have, over and above nurses working in other organisational systems. These are

- Preparation for their role (Bowers 1987, Lathlean 1988, Binnie 1989, Johns 1990b, Vaughan 1990).
- Good quality, continuing in-service training (Bowers 1987, Wright 1987b, Lathlean 1988, Preston 1989, Wright and Khadim 1989).
- Support while in the role (Johns 1990b).

Key texts concerning accountability are Biley (1989b), Johns (1990b), Ersser and Tutton (1991 Chapter 1) and Goulding and Hunt (Chapter 4 of Ersser and Tutton 1991).

Responsibility and accountability

According to Batey and Lewis (1982) there is considerable confusion about the terms 'responsibility' and 'accountability', many people using the words interchangeably. As

Bergman (1991) suggests, responsibility is a key part of accountability, but only a part. Batey and Lewis (1982) clearly differentiate between the two. They define responsibility as a 'charge' for which you are answerable. Once responsibility has been accepted by an individual he or she can be held accountable for its fulfilment. In this situation it is the person from whom you have accepted the responsibility to whom you must account. Thus, as a senior nurse, if you ask someone to ensure that the stores are ordered and that person accepts the responsibility, he or she must account to you for the work done. However, since you as the senior nurse made the decision that the person was capable of ordering the stores, you must account for this decision to the person who offered you managerial authority for organising the work.

At a more complex level, the same principle applies to the delivery of patient care. Once responsibility has been accepted by a primary nurse for the nursing of a named patient, she can be held accountable for the care given. In this instance, accountability would be to the senior nurse from whom the primary nurse accepted the responsibility, and also to the patient who has the right to expect the primary nurse to act with the knowledge of a registered nurse. However, the senior nurse can still be held accountable for deciding that an individual is able to act as a primary nurse and for the overall quality of nursing in the unit. Similarly, if a primary nurse offers some aspects of work to an associate nurse, and it is accepted, it is the associate nurse, rather than the primary nurse, who becomes accountable for completing that work. However, it is the primary nurse who must account for having made the decision to offer the work to another person.

MacGuire (1988) sought to clarify the concept of 24-hour responsibility in relation to primary nursing by expressing it in operational terms. A primary nurse plans care beyond her span of duty — that is, the care planning is proactive. A primary nurse hands over personally to the associate nurse, retaining responsibility for the care she has planned. However, it is the associate nurse who is responsible for the continued delivery of that care while on duty, calling on the primary nurse outside her span of duty should an exceptional problem arise.

Accountability

Bergman (1981) suggests that there are three preconditions needed to be able to account. They are:

'the ability to decide and act on a specific issue, (indicating a need for knowledge)

'acceptance of responsibility to carry out the action required (ie, a decision has been made to accept the responsibility)

'authority to carry out the action.'

If all these pre-conditions are fulfilled then a person may be held to account. As the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1984) Code of Professional Conduct states:

'. . . each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to serve the interests of society and above all to safeguard the interests of individual patients and clients.'

In the examples given above, the issue which would be judged in a court of law is whether it was 'reasonable' to expect the person concerned to accept the responsibility for the work he/she was asked to undertake. Inherent in the Code of Professional

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Conduct is the fact that every registered nurse is accountable for his/her actions as a professional at all times, both on and off duty, even if not engaged in current practice (UKCC 1989). Thus, nurses should not accept work beyond the boundaries of their competence or ask another person to undertake work for which they have not been prepared, except in an emergency. However, the code also protects the nurse from being held accountable for other people's carelessness or mistakes if, under normal circumstances, it was reasonable to expect those people to be able to undertake the work asked of them.

Professional autonomy

Autonomy is used in the literature to mean self-determination. Batey and Lewis (1982) suggest the following definition of autonomy:

'. . . freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions.'

Within primary nursing, professional autonomy can mean freedom to design the plan of care without intrusion, independent from, but with consideration for, other professionals. Advice from others may be sought but whether it is adopted is the autonomous decision of the primary nurse. Associate nurses who make changes to care plans will be expected to justify their actions to the primary nurse, who keeps the right to make further adaptations on return to work as the overall responsibility for management of the patient's nursing needs is retained. This does not mean that the primary nurse has total freedom, since her responsibilities are bounded by the limits of her professional knowledge and authority and should be open to scrutiny and challenged by others. Only if she can justify her actions can she exercise the right to retain her responsibility for managing care. With this in mind, it should be remembered that the role of primary nurse is optional; those who are offered and accept the responsibility must also accept the accompanying need to account.

Applying accountability to primary nursing

When trying to ascertain how levels of accountability alter within primary nursing, it is useful to consider the following question:

'Who holds responsibility for the quality of an individual's care during his/her need for nursing?'

Within more traditional ways of organising nursing care, the team leader or ward sister holds this responsibility, but may delegate some aspects of it on a day-to-day basis. Individual nurses are then responsible and accountable, provided they are appropriately skilled, for the care they provide for a shift of duty. With primary nursing, one named nurse accepts continuous responsibility for meeting a patient's nursing needs, throughout his or her need for nursing. Thus, even though the ward sister retains responsibility for the overall standards on the unit, it is the primary nurse who can be identified as the one who offers nursing care to any one patient. In this way the location of accountability for the delivery of care becomes much clearer.

The enormity of this change is highlighted in Matek's (1977) operational definition:

'Accountability is the fulfilment of a formal obligation to periodically disclose in adequate detail and consistent form to all directly and indirectly responsible or properly interested parties the: purposes, principles, procedures, relationships, results and expenditures involved in any . . . enterprise . . . so that evaluations and decisions can be made.'

Bergman (1981) emphasises that accountability is also time related. Nurses practising primary nursing need to be accountable for the past, present and future.

Past: be prepared to analyse, evaluate and take responsibility for past activities and use the experience constructively in the future.
Present: account for current practice.
Future: be accountable for planning and developing future innovations and a climate for change.

In order to ensure that there is consistency of standards within a clinical unit there is a need for open discussion and debate between colleagues through the use of such things as care conferences and peer review. In this way primary nurses can monitor each other's standards and share experiences and knowledge. In no way does this jeopardise the individual autonomy of each practitioner, but it does give some assurance that patients can benefit from the wider range of knowledge which the whole team possesses.

The implementation of the government reforms in health care (DoH 1989(b), DoH 1990), and the introduction of health care assistants, together with severely limited resources, means that the importance of primary nurses demonstrating their effectiveness through evaluative studies should not be underestimated. Increased emphasis on consumer rights in the health care setting (DoH 1991) highlights the issue of accountable care. The opportunity which a primary nursing structure gives to identify the care prescriber and care giver in a precise way, may carry with it the risk of litigation for incompetence or inappropriate care. However, it also serves to protect patients from poor practice which can be viewed positively by nurses and patients alike.

Continuity and care planner as care giver

These two attributes are discussed together because they are inter-linked. The essence of primary nursing is that one nurse cares for the patient from admission to discharge and is continuously accountable for the nursing care the patient receives. Some practitioners who view primary nursing as more than an organisational change may argue that this continuity is one of the things that makes the development of a therapeutic relationship between nurse and patient possible.

In reality, whether continuity of care involves giving hands-on care or planning care is debatable. Manthey (1988b) argues that the registered nurse needs to provide enough hands-on care to be able to *'assess the patient's status and the effectiveness of decisions currently in place'*. She has recently described a nurse extender system in which the registered nurse remains accountable for all care given to a patient, but technicians and aides may in fact provide some quite complex hands-on care. What amount of care the registered nurse needs to provide in order to remain accountable for overall care is an issue that we in the UK need to address rapidly in light of the growing numbers of health care assistants. However, it is worth adding here that in providing continuity of decision making for a named patient, the primary nurse can, to a large extent, also provide continuity of practice even when care is at times delivered by others.

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Example role profile: Primary nurse

Role: primary nurse

Monitored by and accountable to: senior ward nurse/ward sister

Purpose

- To be responsible and accountable for the assessment, planning, delivery and evaluation of nursing care for a named caseload of patients.
- To contribute to the continuing development of nursing care, in agreement with the unit philosophy.
- To provide prescribed nursing care in an associate role for a patient caseload in the absence of the named nurse.
- To contribute to the smooth running of the unit through the acceptance of agreed additional responsibilities.
- To act in accordance with the professional code of conduct (UKCC).

Key areas

Clinical

- To take responsibility for the assessment, planning, delivery and evaluation of nursing care for a named caseload of patients.
- To provide nursing care for that caseload of patients, and for other primary nurses' patients as an associate nurse when necessary.
- To assist in developing an environment which supports the value of nursing care.
- To liaise and communicate with other members of the nursing and multidisciplinary team in the planning and delivery of patient care.
- To participate in the monitoring of standards of care.
- To contribute to the continuing development of the unit's philosophy.
- To act as an advocate when necessary for the patient and/or carer.
- To be aware of and demonstrate practice based on current advances in nursing practice and research.

Managerial

- To provide leadership and supervision for associate nurses and support workers or care assistants.
- To act as co-ordinator of the shift in rotation with other nurses in the team.
- To liaise with the multidisciplinary team in relation to the care for named patients.
- To ensure the promotion of the safety of patients, staff and visitors to the unit.
- To ensure that the health authority policies and guidelines relevant to the unit are given due consideration.
- To be aware of budgetary implications when prescribing care.
- To contribute to the review of junior nursing staff's performance.

Educational

- To act as mentor to junior nursing staff and students.
- To contribute to meeting the learning needs of all other team members.
- To demonstrate a continuing process of attaining educational, research, clinical and leadership skills.
- To share expertise with nurses from other wards.

These are critical characteristics which are shared by people working as primary nurses. However, there is a variety of other functions which the primary nurse may take on in addition which are dependent upon the individual's position in the ward team. These may include such things as responsibility for individual performance review, ward management, ward co-ordination, research, and teaching.

section

1

Roles in the primary nursing system: Associate nurse

The associate nurse's role

Many different interpretations of this role are reflected in British literature on primary nursing. Key texts on this topic are Burns (1988) and Wilson (1990). Wilson (1990) notes a lack of literature on the associate nurse's role and writers' tendency to focus on the role of the primary nurse.

The associate nurse is the nurse assigned to undertake the nursing care of the patient in the primary nurse's absence. The associate nurse is responsible for carrying out the plan of care and communicating any observations of the patient's response to that care, to the primary nurse. The importance of the role of the associate nurse is stressed by many authors (Geen 1986, Sparrow 1986, Gibbs 1988, MacGuire 1988, McMahon 1990a b, Wood 1990). All feel that associate nurses must be given respect for their work and that any potential for elitism on the part of primary nurses must be broken down.

Relationship with the primary nurse

The associate must consult with the primary nurse before any major alterations in the care plan are made (MacGuire 1989c). However Vaughan and Pillmoor (1989) point out that although it may be necessary to make alterations in the plan of care for the well-being of the patient, this should be tempered by the primary nurse's ability to make contingency plans. Hegyvary (1982) describes the relationship between the primary and associate nurses as collegial, with associate nurses retaining accountability for the care they provide.

The associate nurse's role may be a post in its own right when the post holder supports one or more primary nurses. Alternatively the role may be fulfilled by primary nurses for their co-primary nurses, acting on their behalf and respecting their care planning. Pearson (1988) advocates that a primary nurse should have specified associates, thus creating a primary nursing team. In this instance, as associate nurses gain experience, they may be asked to act on primary nurses' behalf when they are away for a significant length of time (e.g. annual leave), and make changes to the care plans, if necessary, in their absence (Sparrow 1986). However, this would still be under the guidance of another primary nurse or the senior ward nurse. Thus the role can be used as a training post for potential primary nurses allowing associate nurses the opportunity to learn to accept a wider range of responsibility over a period of time (MacGuire 1988, Lidbetter 1990). It must be added that this is only acceptable when someone working as an associate wishes to move towards becoming a primary nurse and would be unacceptable if this were not the case.

There is some debate about the position of students but it may be that, for expediency, there are times when they act as associates. However, it would not be reasonable to ask them to take the responsibility for decision making which is normally vested in the primary nurse.

Continuity of care, according to Manthey (1980a), is dependent upon the primary nurse's instructions and the primary nurse as care giver. She does not see the associate role as another step in the hierarchy, rather a role alongside the primary nurse which any experienced nurse can be expected to perform. Zander (1980) has suggested that the associate nurse should be someone who could pick up any of the primary nurse's responsibilities in her absence, although in practical terms there are times when an

associate would not have the range of experience and knowledge to do this. In some cases the senior ward nurse may choose to work as an associate if she is unable to offer sufficient continuity to work as a primary nurse. This also offers the opportunity to monitor the care given by her team, although it would be unacceptable to alter patients' care plans without being able to give valid reasons.

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Example role profile: Associate nurse

Role: associate nurse

Monitored by: primary nurse

Accountable to: senior ward nurse

Purpose

- To assist the primary nurse in the assessment, planning, delivery and evaluation of nursing care for the primary nurse's caseload.
- To provide the prescribed nursing care for a patient caseload without supervision.
- To contribute to the development and evaluation of nursing practice in the unit.
- To act in accordance with the professional code of conduct (UKCC).

Key areas

Clinical

- To assist the primary nurse in her management of a patient caseload, discussing all aspects of that caseload's nursing care with the primary nurse.
- To provide nursing care to the patient caseload as prescribed by the primary nurse.
- To maintain accurate records of the care given.
- To take responsibility for the patient caseload in the absence of the primary nurse, consulting colleagues when necessary.
- To assist other nurses in the ward team as necessary.
- To assist in developing an environment that supports the value of nursing care.
- To liaise and communicate with other members of the nursing and multidisciplinary team.
- To participate in the monitoring of standards of care.
- To contribute to the continuing development of the unit philosophy.
- To be aware of and demonstrate practice based on current advances in nursing and research.

Managerial

- To contribute to the smooth running of the unit by providing leadership and supervision as necessary.
- To act as co-ordinator of the shift in rotation with other nurses in the team.
- To liaise with the multidisciplinary team in relation to the care for a patient caseload in conjunction with the primary nurse.
- To ensure the promotion of the safety of patients, staff and visitors to the unit.
- To ensure that the health authority policies and guidelines relevant to the unit are given due consideration.
- To have regard for the budgetary implications of decisions.
- To contribute to the review of junior nursing staff's performance.

Educational

- To act as a mentor to student nurses.
- To contribute to meeting the learning needs of all other team members.
- To demonstrate a continuing process of attaining educational, research, clinical and leadership skills.

Roles in the primary nursing system: Senior ward nurse/ward sister

The nurse in charge of the ward

Many articles have been written by those in charge of wards or units about their experiences in implementing and practising primary nursing and these form a large proportion of articles on primary nursing.

Important aspects of the senior ward nurse's role which are identified by writers are:

- Leadership.
- Staff development and teaching (Swaffield 1983b, Binnie 1987, Campen 1988, Gibbs 1988, Milne 1988).
- Staff and student support (Green 1983, Ashley 1984a, Fradd 1988).
- Provision of information and resources (Lathlean 1988).
- Oversight and administration (Fox 1988).

Many writers feel that primary nursing necessitates a change in role from that held in more traditional systems of organising care. In primary nursing, the nurse in charge:

- has a more clinically oriented role (Wheeler 1989);
- has a change in authority due to primary nurses' accountability (Green 1983, Pearson 1983b, Binnie 1987, Lathlean 1988, Malby 1989);
- needs to be open and approachable (Campen 1988, Binnie 1989, Malby 1989).

Such changes in the role could be resented by nurses in charge, and several authors suggest that they may see such changes as threatening to their traditional status (Campen 1988, Fradd 1988, Lathlean 1988, Malby 1989, Binnie 1989). Faulkner (1981) suggests that such fears are unnecessary. Castledine (1980) points out that senior ward nurses must seek out support from their managers, their peers and their own staff when setting up and establishing primary nursing.

Because the ward sister role changes so substantially in primary nursing it is often renamed. The new titles that may be used include senior nurse, consultant nurse, clinical specialist and senior nurse practitioner. The role, referred to here as senior ward nurse, encompasses responsibility for managing the clinical area, providing leadership and supporting those nurses delivering care. Rather than directing all patients' nursing care, the senior ward nurse empowers primary nurses to manage their own caseloads, giving them freedom to practise (Malby 1988). Sparrow (1986) identifies three key functions of the role:

1. Co-ordination of nursing staff: this includes ensuring that each patient is assigned a primary nurse.
2. Resource/information giver: providing expert research based information to assist the primary nurse in decision making.
3. Support giver: managing staff development and interpersonal relationships within the nursing team.

Ersser and Tutton(1991) add to this the responsibility for ensuring that high standards of care are maintained; ensuring appropriate allocation of patients to primary nurses; budgetary control for the area and continuing personal development.

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Manthey (1980) gives examples of powers that must rest with senior ward nurses, including being able to select their own nursing staff, allocate resources, set the standards for practice and evaluate the nursing staff's individual performances. MacGuire(1989a) describes the place of the senior ward nurse as giving professional advice and guidance to primary nurses and Hunt (1988) sees the senior nurse as being the validator of the primary nurse's decisions. The senior ward nurse can still be (and it is argued should still be) a care giver acting as a primary or associate nurse (Campen 1988, MacGuire 1988, Singleton and Gamlin 1989). Finally the senior ward nurse should ensure that the clinical unit is a suitable learning environment for learner nurses (if allocated there), and should co-ordinate the education programmes for learners and qualified staff as well as any research projects being undertaken on the ward (Pearson 1988).

It is becoming more common for the responsibilities outlined above to be divided between two posts: one concentrating on practice development and research; the other on staff development and management. However, even when there is a division of work in this way it is vitally important that all members of the team are clear about who holds ultimate responsibility and hence authority in the unit. Confusion can arise if it appears that more than one person has this responsibility and boundaries of responsibility need to be carefully planned.

Example role profile: Senior ward nurse/ward sister

Role: senior ward nurse/ward sister (ward manager)

Monitored by: unit nurse manager/senior nurse

Accountable to: director of nursing services

Purpose

- To lead the nursing team in the provision of a nursing service.
- To facilitate the development of staff within the team.
- To manage the ward efficiently and effectively within allocated resources.
- To manage the unit in the absence of the senior nurse manager.
- To contribute to the formation of nursing policy within the hospital.
- To act in accordance with the professional code of conduct (UKCC).

Key areas

Clinical

- To provide expert advice to primary nurses and associate nurses.
- To allocate patients to primary nurses in collaboration with the primary and associate nurses, ensuring appropriate assignments are made.
- To act as a primary or associate nurse for a patient caseload.
- To develop an environment that supports nursing care.
- To monitor the work of the nursing team in the delivery of patient care.
- To ensure the maintenance of high standards of nursing care.
- To provide an environment that enables the nursing team to challenge all aspects of nursing practice.
- To evaluate the effectiveness of nursing practice on the unit.
- To be aware of and demonstrate practice based on current advances in nursing practice and research.

Managerial

- To take 24-hour responsibility for the management of the nursing service on the unit.
- To manage the allocated budget to ensure that the best service is provided within the resources available.
- To take responsibility for the selection and retention of the nursing team.
- To facilitate staff development and undertake regular individual performance reviews with staff.
- To ensure safe and effective deployment of nursing staff on the unit at all times within unit requirements.
- To foster positive collegial activities among unit staff and between them and the multidisciplinary team.
- To audit unit processes and procedures.
- To ensure the promotion of the safety of the patients, staff and visitors to the unit.
- To ensure that the health authority policies and guidelines relevant to the unit are given due consideration.
- To take responsibility for the unit in the absence of the senior nurse manager.
- To contribute to the formation of nursing policy within the unit.

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Educational

- To share knowledge and expertise with peers.
- To demonstrate a continuous process of attaining educational, research, clinical and leadership skills.
- To provide appropriate learning opportunities for ward staff.
- To foster enquiry and, where appropriate, research within the clinical environment.
- To ensure that the learning needs of students are met.

Roles in the primary nursing system: Ward co-ordinator

The term ward co-ordinator is used in the literature to describe two distinct support roles in primary nursing organisation. One of these roles may be fulfilled by nurses in co-ordinating nursing activity. The other role is that which a ward clerk may undertake and is of an administrative nature (Ersser and Tutton 1991).

The nursing function of the ward co-ordinator is concerned with gaining an overview of nursing activity within a unit area including:

- allocating nurses to patients based upon the relative dependency of each caseload;
- relaying information between nurses;
- answering general nursing enquiries on the telephone;
- attending a ward round when the primary or associate nurse cannot be present. Ersser and Tutton (1991) comment that this was a more common adaptation of the ward co-ordinator role in primary nursing within the acute wards they examined, and represented a modification of the principle of person-to-person communication. This role did not feature in Manthey's original work.

The administrative duties of ward co-ordinators have been outlined by Pearson (1988) who points out that their work in dealing with visitors and enquiries, whenever possible, reduces the number of interruptions to nurses. Those events occurring on a ward which are not related to individual patients may be dealt with by a ward co-ordinator (Campen 1988). However, clarity is needed to establish a division of labour which clearly identifies where nursing expertise is required, rather than simple administrative support.

section

1

Roles in the primary nursing system: Health care assistant

Demographic studies (Beardshaw 1991) clearly show the need for an increasing labour force to provide health care in an environment of diminishing traditional resources. The role of health care assistants needs to be more clearly defined by nurses before it is defined for them.

The role of the care assistant is discussed to some extent by Sparrow (1986), Fox (1988), Pearson (1988), Easton (1989) and MacGuire (1989a), and their comments reflect considerable variation in policy and practice, due to factors such as specific health authority policies, ward philosophies, and different nursing specialties. For example, Fox (1988) allows auxiliaries on her ward to act as associate nurses in the long-term care of elderly people. Easton (1989) defends such action by commenting that relying on qualified nurses to carry out all direct patient care is an impossible ideal in the light of recruitment problems in nursing in Britain. She suggests that care assistants can be given some degree of training in order to enhance their quality of patient care, illustrating this from her own experiences as a ward sister.

Care assistants can assist primary and associate nurses in the delivery of nursing care. Pearson (1988) does not see this role as actually *giving* nursing care, rather facilitating nurses by undertaking non-nursing duties. However, Wright (1990) sees care assistants as part of the nursing team giving nursing care under supervision, and contributing their observations on patients' progress to the evaluation process. Certainly health care assistants are expected to be competent in the delivery of nursing care (Care Sector Consortium 1990).

There are, therefore, two roles identified which are not mutually exclusive. One that supports nurses in direct care and one that enables nurses to nurse. The aim of both roles is to provide support to nurses to allow them the maximum time with their patients.

Care assistant (support)
A care assistant can act as an associate to the primary nurse but will not be able to undertake the primary nursing function in the primary nurse's absence. The care assistant will always be supervised either by a qualified nurse acting as an associate nurse, or by a primary nurse.

Care assistant (facilitation)
In this case the care assistant assists the nurse with some aspects of care requiring two people — lifting for example — and carries out other tasks such as running baths and laying up dressing trolleys. She also carries out domestic duties and serves the meals. Each primary nurse may have a care assistant in her primary nursing team (Pearson 1988). Another title for a similar role is 'ward housekeeper'. This person carries out much the same role but is not allocated to a primary nursing team (Armitage et al 1991).

Example role profile: Health care assistant

Role: health care assistant

Monitored by: primary/associate nurse/senior ward nurse

Accountable to: senior ward nurse

Purpose

To support the primary and associate nurse in the delivery of nursing care.

Key areas

- To assist the primary and associate nurse in giving direct patient care.
- To provide the primary and associate nurse with relevant information concerning patients.
- To carry out other work delegated by the primary and associate nurses.
- To act in accordance with the unit philosophy of care giving.
- To contribute to the safety of patients, staff and visitors to the unit.
- To work with the nursing team to promote a supportive working environment.
- To be aware of and comply with the health and safety policies of the hospital.

section

1

Roles in the primary nursing system: Night staff

Many authors do not mention night nurses in their writing about primary nursing. Key references on this topic are by Remington (1989) and Kemp (1991), both of whom discuss issues affecting night staff involved in primary nursing. Khadim (1991) looks at practical ways in which night staff can be more involved in primary nursing teams.

Kemp (1991) writes that *'sensitively handled, the introduction of primary nursing could be a force for the integration of night staff into the ward nursing team.'* Remington (1989) stresses the importance of night staff understanding the concepts which underlie primary nursing. In relation to this, Kemp (1991) points out that night staff need access to learning materials both about primary nursing and about other topics for the development of their knowledge.

Some aspects which need to be considered when implementing primary nursing are:

- arranging meetings with day and night staff at appropriate times;
- encouraging people to share their expectations and fears of the new system;
- including night staff in negotiations over new procedures, e.g. reporting and drug administration.

It could be argued that any qualified nurse who is not functioning as a primary nurse, is marginalised in occupational and social terms (Robinson 1991). Addressing the potential issue of increased marginalisation of night staff under a primary nursing system is important. The following points may be considered:

- the risk of creation or perpetuation of hierarchial nursing systems;
- the provision of appropriate staff development opportunities for night staff;
- the use of night staff in research and evaluation;
- the inclusion of night staff in ward celebrations;
- developing trust between day and night staff.

It is noticeable that night staff themselves have made very little comment about their views on primary nursing within British nursing literature.

The general overall conclusion in articles which mention night nursing in relation to primary nursing is that night staff must find their own place in the primary nursing structure within their own particular ward or unit, and that there should be no rules laid down in relation to this. Interestingly, there is little discussion about whether night staff may be primary nurses — most writers assume that they may only be associate nurses. Manthey (1980) writes that in some circumstances it may be appropriate for a night nurse to be a primary nurse and does not feel that there is anything wrong in this.

Night sister

As with the ward manager, this role undergoes significant changes in a primary nursing setting. The night sister is no longer seen to direct the care at night, rather she extends the role of the ward manager into the night, by providing expert advice, ensuring the identified standards of care are met, teaching staff, acting as a resource, and co-ordinating the management of the clinical area at night.

Permanent night staff in the clinical area

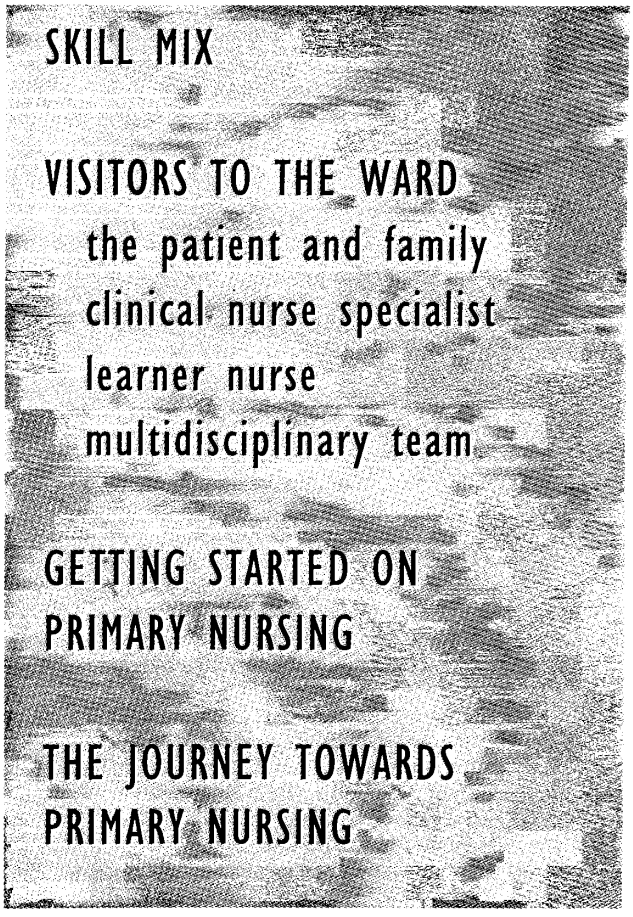
Manthey (1980) states that night staff can be primary nurses if the patient's primary requirements for care are at night. The caseload in this instance will be significantly smaller than that of a primary nurse on day duty. Remington (1989) says that permanent night staff cannot become primary nurses except when they are required to admit a patient on to the unit at night who will be discharged prior to the completion of handover to the day staff. Remington also suggests that permanent night staff may undertake the role of associate nurse and co-ordinator. This means that the night staff can only alter the plan of care in exceptional circumstances and must liaise closely with the primary nurse to ensure that patients' requirements for nursing at night are incorporated into the plan of care.

Internally rotating staff

Manthey (1980) suggests that a primary nurse rotating on to night duty should be reducing the assignments to her caseload prior to commencing her allocation to night duty. Any patients remaining on her caseload could be reassigned to another nurse. This nurse could be the primary nurse's associate nurse in a primary nursing team situation. It is possible for a primary nurse to continue in that role with her remaining patients while on night duty if it does not impair decision making and communication and, thus, the quality of the patient's care. To do so, she would need to inform the members of the health care team and the patient's family or friends who are involved in the care process.

Summary

Discussion of the issues raised by introducing primary nursing as a method of organising nursing care needs to include the role of night staff. It is important to address such subjects as the possibility of marginalisation of staff on night duty and how this should be dealt with. The introduction of a new way of organising care should include the opportunity of developing more innovative and appropriate ways of utilising night nurses in order for them to give maximum benefit to their patients.



section

2

Managing the ward environment

Skill mix

Some consideration has to be given, from an administrative point of view, to the use of primary nursing at a clinical level. The means by which its effectiveness can be monitored and optimised need to be reviewed by nursing and hospital managers.

Several British writers make the point that it is difficult to assess the financial costs and potential benefits of primary nursing (Binnie 1987, Hunt 1988, MacDonald 1988, Malby 1988). Binnie (1987) looked at the impact of changing the skill mix on her ward to a higher proportion of qualified staff within her current budget, and found a consistent improvement in the quality of nursing care. Clarke and Gorton (1990) discuss the administrative aspects of a change to primary nursing at ward level. Sears and Williams (1991) discuss the managerial implications of primary nursing in some detail.

In management terms, primary nursing can, according to some writers, cause problems at ward level. For example, Bowers (1987) claims from his own experiences that primary nursing is sensitive to fluctuations in staffing levels. He is supported by Chudley (1983) who feels that lack of staff on wards may be a barrier to the development of primary nursing in Britain. Cavill and Johnson (1981), however, argue that short staffing should not be used as an excuse to delay the introduction of primary nursing, and Green (1983) suggests that once primary nursing is established on a ward it results in nurses being better prepared for crises such as short staffing.

There are misconceptions that primary nursing cannot be implemented without changes to skill mix and staffing numbers. When Marie Manthey started the project that led to primary nursing, she did not change the skill mix; however, she did redefine the expectations and roles of the staff. There are reports that other systems for delivering care under-utilise qualified nurses' skills (Waterworth and Luker 1990).

Caseload allocation

There is little literature on the number of patients primary nurses should have in their caseloads. Hegyvary (1982), while stating that there is no standard formula for assessing the adequacy of staffing for primary nursing, notes Watson's (1977) recommendations that the number of patients per primary nurse should be two in a critical care unit, five in acute care wards and seven in long-term care, and that there should be 2.5 associate nurses for each primary nurse. Pearson (1988) reports the ratio of eight patients to each primary nurse in the nursing development unit, although at times there could be as many as 11 (Tutton 1986). However, there may be times when a primary nurse could take on a much larger caseload, as would be the case for community nurses or midwives.

Ultimately this is a decision which must be made at a local level and will be dependent upon the degree of need of the patients concerned and the type of support services available. It is not always helpful to rely on a 'head count', but rather to give consideration to the amount of nursing time needed in order to be able to provide the desired service. There is no single rule on which to base the number of patients the primary nurse should have in a caseload. The individual care needs of the client group will lead to variations in the sizes of caseloads from one ward to another, and even within a single area.

When considering caseload allocation, factors additional to patient needs should be considered. These variables include the individual nurse's abilities, knowledge base and skill, off-duty patterns, and annual leave, plus other commitments such as teaching,

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study leave or project work. Effective caseload management is dependent upon an appreciation of all these things. Concentrating purely on the numbers of patients can be a 'red herring' in the allocation of named nurses to named patients. Using indicators of patient care needs or dependency may provide useful information from which to make decisions concerning allocations.

For example, it is possible that on one shift:

Nurse A may have seven low dependency patients in her caseload.

Nurse B may have three high dependency patients in her caseload.

Nurse C may have one high dependency patient, two medium dependency patients and one low dependency patient.

Nurse D (who has less experience and expertise than the others) may have two low dependency patients in her primary caseload but works in association with Nurse C in the care of those patients.

An indicator of patient care needs or dependency, however, will only facilitate effective caseload allocation if it truly reflects all the nursing care a patient requires — for example, it must take into account all aspects of care required and not be based on physical needs alone.

Qualified and unqualified staff

It may be that in order to obtain the number of primary nurses required, the number of pairs of hands has to decrease to remain within budget (Wright 1990). In order to determine the staffing of the unit, the skills of the nurses must be seen as more important than the numbers (Binnie 1987). Ersser and Tutton (1991) state that a *'shift in skill mix towards a higher proportion of qualified staff is compatible with primary nursing'*. However Manthey, in her address at the *Nursing Times* ward sisters' conference in May 1991, warned of the danger of taking this too far by equating primary nursing with an all-qualified staffing pattern. She reports that the belief that pure primary nursing requires an all registered staff is a myth, since the essential component in primary nursing is the'*establishment of a responsibility relationship between a nurse and a patient*' (Manthey 1988a).

In order to determine the requisite skills, the roles that will support primary nursing must be identified (see separate information on roles). This will depend on staff availability, recruitment and retention patterns and local preferences. Thus the skill mix will depend on such issues as:

1. whether the associate nurse role is undertaken by a specific associate nurse, or by primary nurses alongside their own caseloads;
2. whether the associate nurse undertakes all of the primary nurse's responsibilities when she is away (for example on annual leave);
3. whether the senior ward nurse acts as co-ordinator, takes on a caseload of primary patients, or acts as an associate;
4. how much time the senior ward nurse spends on patient care;
5. whether the care assistant supports or facilitates primary nurses;
6. whether primary nurses rotate on to night duty;
7. whether the night sister is ward based;
8. the range of patient specialties requiring expert clinical care;
9. the allocation of learners to the unit and their experience and knowledge;
10. the presence of voluntary workers and the involvement of carers in the delivery of care in the unit;
11. the changing pattern of health care delivery and the move towards early discharge from acute settings to the community.

Manthey (1991) has found the solution to the use of unqualified staff to be what she calls *'partnership in practice'*. This scheme pairs auxiliary workers with registered nurses, so that they work the same shifts with the same patients. In this scheme the primary nurses take care of larger caseloads.

Summary

It is difficult to assess the financial costs and potential benefits of primary nursing. A common perception is that the skill mix needs to change in order to implement primary nursing. However, Manthey (1990) suggests that a redefinition of the expectations of staff and their roles is required.

The size of a primary nurse's caseload is dependent upon a range of factors in addition to the patient's need for nursing care. Such things as the nurse's knowledge base and other responsibities need to be taken into account when determining caseload allocation.

What emerges from the skill mix debate is that there are no hard and fast rules. The danger is that people will use an over simplistic approach of seeing the work as a series of so called 'basic tasks' when reviewing the skill mix rather than looking beyond the task to the degree of decision making inherent in the activity. At one level, helping someone to eat may be seen as a simple task which could be carried out by an unqualified person. However, if the patient's condition is changing or he is at a critical stage of rehabilitation, this can be seen as a highly skilled task where assessment and teaching are incorporated into the whole process. The crucial issue is to review the rate of change in the patient's clinical condition and the degree of professional decision making which needs to be incorporated into the work, as the basis for deciding on the caseload of a primary nurse and hence the skill mix.

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Visitors to the ward

The patient and family

Manthey (1980) sees the impact of primary nursing on patients as the most important aspect on which nurses should focus when considering primary nursing. However, this is not reflected within British literature on primary nursing. MacDonald (1988) rightly points out the difficulties involved in trying to measure and analyse levels of patient satisfaction, but calls for more research into this area. A few British practitioners have carried out small scale studies investigating patients' views of primary nursing via questionnaires (Carlisle 1988, Malby 1988, Milne 1988). Thornett (1991) looked at relatives' perceptions of primary nursing care. Additionally there are anecdotal accounts of the positive and negative effects of primary nursing found in British nursing literature.

Positive effects of primary nursing

- Closer nurse/patient relationship (McMahon 1989a).
- Greater patient security (Wright 1987b, Robinson 1989).
- Increased patient contact with qualified nurses (MacGuire 1988).
- Primary nurse as focus for information and advice for patient and family (Castledine 1985b, Carlisle 1988, Robinson 1989).
- Facilitation of patient and family participation in care and discharge plans (Ellis et al 1982a, Castledine 1985b, McMahon 1989a).
- Increased family satisfaction with care (Ellis et al 1982a, Geen 1986, Campen 1988, Carlisle 1988, Robinson 1989).
- Greater continuity of care (Sparrow 1986, Tutton 1986, Robinson 1989, Wheeler 1989).

Negative effects of primary nursing

- Potential for nurse/patient clashes and 'forced' relationships between patients and nurses (Bowers 1987, Carlisle 1988, Robinson 1989).

Clinical nurse specialist

The role of the clinical nurse specialist is still undergoing development in clinical settings in Britain. A summary of the functions that the role encompasses is that of practitioner, teacher, consultant, researcher, change agent and manager (Meyrick 1991). Others have included the role of preceptor (Armitage et al, 1991). Manthey (1980) sees the clinical nurse specialist as someone who offers clinical expertise in an area of specialist practice, in which instance this expertise is offered at the request of the primary nurse.

Learner nurse

There is very little written by students themselves about their views on primary nursing. The three brief articles written by students are all positive in their opinions of primary nursing (Burke and Elliot 1989, King 1989, Dooks 1991).

Many writers claim that a change to primary nursing brings about an improved learning environment for student nurses (Chudley 1983, Ashley 1984a, Ritter 1985, Binnie 1987, Fradd 1988, Drummond 1990). Singleton and Gamlin (1989) suggest that the chance for student nurses to take on the role of associate nurses means that they can have greater involvement in true holistic, individualised and comprehensive patient care. Carlisle (1988) argues that primary nursing results in greater fulfilment for student nurses and brings them closer to the theories of nursing taught in the classroom than other systems of organising nursing care. Several writers feel that primary nursing optimises the effects

of the student and qualified nurse mentorship system (Ashley 1984a, Carlisle 1988, Fox 1988, Fradd 1988, MacGuire 1988, Gilbert 1989, Lidbetter 1990).

Two researchers have published reports of their studies on the effects of primary nursing on students' learning experiences. Lidbetter (1990) carried out a small-scale study from which she drew some serious conclusions, not all of which presented primary nursing in a good light. She suggested, for example, that primary nursing may give students less experience in evaluating nursing care, as primary nurses have to take on this aspect of work more diligently than qualified nurses would in other systems of organising care. Drummond's research (1990) presents primary nursing in a more positive light, concluding that it enables students to develop a research based, professional approach to their practice. The resultant breakdown in the hierarchy of the ward nursing team gives students greater freedom to learn, in keeping with the ideals of the recent changes to the nurse education system.

Primary and associate nurses may act as mentors to learner nurses, liaising with the college of nursing and the senior ward nurse. Learners are assigned to primary nurses, and work with them or their associate nurses, caring for the primary nurse's caseload. This system provides learners with role models (Bowman 1990), and provides them with the opportunity to learn and experience the effects of their nursing care on patients. It also gives them an opportunity to observe the totality of patient care. Senior learners may act as associate nurses for the primary nurse (Lidbetter 1990, Wright 1987a). The involvement of learners in care will vary according to the individual learner's ability and experience (Wright 1990), and also the patient's needs when matched to the learner's ability. Learner nurses need explanation and support in a primary nursing unit, as the organisation is fundamentally different from traditional approaches. Provision of written explanations may be useful. Good liaison with the college of nursing is also important.

Multidisciplinary team

No British articles or books were reviewed which looked specifically into this area in any detail, and no comments about primary nursing by members of the multidisciplinary team other than nurses have been detected. In general, the literature suggests that primary nursing simplifies communication between members of the multidisciplinary team because the primary nurse takes on responsibility for co-ordinating the work of all members of that team (Chapman 1985, Tutton 1986, Courtenay-Thompson 1989, Preston 1989, MacGuire 1989a and c).

The positive results of this are observed by some writers; for example, Preston (1989) claims that discharge planning, which requires co-ordination of input from several professionals other than nurses, improved on her ward after the introduction of primary nursing. Also, Castledine (1980) and Fradd (1988) write that the quality of reports to other professionals were better when given by patients' primary nurses than when given by the nurse in charge prior to the introduction of primary nursing. Increased respect for the nursing team as a whole by other professionals was claimed to occur with the establishment of primary nursing on the wards of Chapman (1985) and Castledine (1980).

However, actual and potential problems are pointed out by some writers who emphasise the need to prepare all members of the multidisciplinary team carefully for a change to primary nursing from another system of organising nursing care, in order to prevent unnecessary misunderstandings and resistance (Sparrow 1986, Fradd 1988, MacGuire 1988).

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Specific instances of resistance to primary nursing from other members of the multidisciplinary team are described in the literature — for example, consultants wishing to keep to 'traditional' ward rounds, walking from bed to bed around the ward beside the ward sister (Crowder 1989, MacGuire 1989c). McMahon (1989b) asks whether doctors may feel threatened by the primary nurse's more assertive role and suggests that open discussion about issues of the nurse's expanded role within primary nursing should be held with doctors (and other professionals) to prevent such feelings developing.

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Getting started on primary nursing

The impetus for primary nursing must come from the ward team. However, encouragement and facilitation from management is essential; prompting discussion about exploring primary nursing will encourage innovation in all areas of nursing practice.

The starting point must be to look very closely at what is happening now in your ward or unit. Experience has shown that frequent meetings have been crucial in the development of primary nursing on most units. On a unit where there is a very large team of nurses, a sub-group can be identified, either on a voluntary basis or by nomination. Secret nomination is a good idea as this helps to identify the natural leaders in the team, who will have a lot of influence, and therefore need to be included. The way the sub-group works will need to be decided locally, but it is suggested that the members could act as the key people to read and research primary nursing, disseminating their new knowledge to other specified nurses in the unit team. Feedback by the members to the sub-group meetings contributes to debate and discussion. This method ensures that everyone feels involved and that their opinions will be heard. Every nurse and health care assistant needs to be involved with the preparation.

When is the right time to inform multidisciplinary team members? It is essential to gain their support, but it may be prudent to inform them after the nursing team has developed a good level of knowledge and is fully committed and motivated towards the change. It can be very destructive if outsiders to the nursing team start to criticise the value of such a change before nurses are articulate and confident in the change themselves.

Do not set unrealistic timetables; see how the early preparation goes. If things are going well there is no harm in identifying an implementation date. This is valuable as it creates a feeling among the team that it really is going to happen; built into this can be the proviso that the date can be postponed if necessary. There will probably never be an ideal time but, if preparation has been thorough, things like 'being very busy' will not deter the implementation. If primary nursing does not seem to be a possibility for you at the moment, do not feel that your unit is less innovative. You may be concentrating on other problems that you have identified, or introducing other changes at the present time.

section

2

Implementing primary nursing — where to start

Answering the following questions may aid clarification:

- Do we need change in our unit?
- What is happening in our unit now?
- Are there any problem areas in our practice?
- What do the patients/relatives expect from us as nurses?

Prerequisites for implementing primary nursing:

- The ward sister/charge nurse is an experienced clinical expert, a leader and values self/others.
- The nursing team is cohesive, open and collaborative.
- There is freedom, colleagueship and support.
- Everyday problems are already managed very well.
- There is commitment to primary nursing from the *majority* of the nursing team.

IF NO

- Address identified problems and present limitations.
- Develop the team, interpersonally, by open communication, freedom and support; and professionally by deciding standards of care, philosophy and objectives.
- Address the problems of the everyday management of nursing care.

IF YES

- Plan meetings to discuss development and implementation of primary nursing.
- Gain support of the nurse manager, nurse teacher and the nursing development unit.
- Encourage all nurses to read about and enquire into primary nursing.
- Network and contact other wards and units.
- Begin to decentralise the management of nursing care.

section

2

The journey towards primary nursing

This section aims to identify some ideas about implementing primary nursing. It is not a recipe for success but rather offers some thoughts which may guide your own ideas. The journey towards a primary nursing approach to giving patient care can be divided into the following stages.

- Getting the vision.
- Sharing the vision.
- Getting prepared for the journey.
- Setting off.
- On the way.

Getting the vision

1. Read as much as you can about primary nursing.
2. Reflect on your current method of work organisation. Identify what you like about it and what you dislike. Question your beliefs about nursing.
3. Go to conferences and meetings about primary nursing.
4. Meet or make contact with others who are also interested or already practising primary nursing.
5. Identify what you think are the essential key features of primary nursing.
6. Visit areas already practising primary nursing.
7. Find someone with whom you can discuss and debate issues about primary nursing.

Sharing the vision

1. Encourage staff to read about primary nursing.
2. Make articles and books easily available to all staff.
3. Target staff who seem the most interested and enlist their support.
4. Encourage interested colleagues to pursue some project work on the subject.
5. Hold regular meetings to provide a forum for discussion of the issues.
6. Be open about your personal beliefs about nursing.
7. Encourage a questioning approach among staff and be prepared to answer questions.
8. Try to arrange study days or visits for staff.
9. Invite speakers on primary nursing to your meetings.

Getting prepared for the journey

Once there is a shared vision among the team about primary nursing, the next stage is to prepare for its introduction into your area.

1. Continue with discussion focusing on specific concerns. For example:
   allocating work
   providing continuity of care
   decision making — will changes occur?
   responsibility and accountability
   communication patterns.
2. Develop role profiles for staff.
3. Identify additional resources that may be necessary in a primary nursing structure.
4. Discuss how you can evaluate the effect of primary nursing; seek expert help if necessary.
5. Identify potential primary and associate nurse roles.

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6. Identify learning needs of staff and cater for those needs.
7. Communicate your aspirations to the multidisciplinary team.

Setting off on the journey

1. Set the date — it can be changed if necessary.
2. Make sure you are visible when you 'go live'.
3. Expect staff to experience a grieving time for the old system.
4. Trust and encourage each other.
5. Encourage staff to achieve real relationships with their patients and other staff.
6. Celebrate your achievements.

On the way

Now you are on your way. Although the organisational changes necessary for primary nursing may have happened, the attitudes and behavioural changes required often take longer to develop and for staff to feel comfortable with them. Some things which may help are:

1. Continue to hold regular meetings. Only decrease these when everyone feels comfortable with the changes.
2. Maintain links with other units interested in or practising primary nursing.
3. Remember that many people find change uncomfortable and need support in the change process.
4. Provide learning packages for new staff and learners on the unit.
5. Implement some methods of evaluating primary nursing. This will help to demonstrate to yourselves and others what you have achieved.
6. Enjoy the personal and professional development of the members of the team.
7. Congratulate yourself and celebrate.

OVERVIEW OF RESEARCH REVIEWED

BRITISH RESEARCH STUDIES

NON-BRITISH RESEARCH STUDIES

SUMMARIES OF THE TOPICS COVERED BY RESEARCH

THE FUTURE OF PRIMARY NURSING IN THE UK

section

3

The outcomes of primary nursing

section

3

How to use section 3

Full references can be found in section 4 of this book. They are arranged by author surname and year of publication.

The same research study sometimes has several different published papers concerning the study. The main papers are listed, together with critiques in some cases.

No attempts have been made to evaluate either the methodology or the results of the studies.

In order to help you to place the research studies into some logical order they are divided into sections.

1. British studies

2. Non-British studies
   The non-British studies are subdivided into those dealing with:
   - quality of care — mainly Qualpacs
   - patient and nurse satisfaction
   - evaluation of the implementation of primary nursing
   - crossover trials
   - support services.

Primary nursing research

Primary nursing was introduced as an alternative method of organising the delivery of nursing care. Since its inception it has attracted much attention from researchers attempting to show whether its implementation has improved the quality of patient care, despite Manthey's statement that:

'The quality of nursing service in primary nursing can be good or bad, comprehensive or incomplete, co-ordinated or spasmodic, individualised or standardised, creative or routine.' (Manthey 1980)

Giovannetti (1986) criticised many of the studies for failing to define primary nursing, failing to check the competency of nursing groups before the comparison of wards took place, not allowing enough time between the introduction of primary nursing and evaluation, failing to employ experimental designs with random selection and assignment, and failing to provide an in-depth description of the statistical tests employed and the level of significance.

The majority of the studies reviewed here have been conducted since 1980 and, therefore, only the more recent take account of Giovannetti's reservations.

section 3

Overview of research reviewed in pages 51 to 68

section

3

British research studies

Primary nursing was developed in America and was introduced into this country in the 1980s. Its recent arrival accounts for the relatively small number of studies undertaken on this side of the Atlantic.

Wainwright and Burnip's paper (1983) has been included as it is the first reference to monitoring the quality of patient care under primary nursing in this country. Reed (1988) and Manley (1989) used Qualpacs and a job satisfaction questionnaire to evaluate the impact of primary nursing in very different settings — the former in care of the elderly wards and the latter in an intensive care unit. Pearson et al (1989) and Pearson (1989) measured quality of care, patient satisfaction and dependency on discharge of a group of patients admitted to a primary nursing unit, comparing the data with a control group of patients who continued with a conventional hospital stay. MacGuire (1988, 1989a, 1989b, 1989c, 1990 and 1991) compared an elderly care ward into which primary nursing had been introduced with two compatible wards using 'Senior Monitor', activity analysis and interviews with staff. Bond et al (1990) compared a newly opened care of the elderly ward in a community hospital practising primary nursing with a similar, established ward practising team nursing. Five of these studies report positive findings for primary nursing; only MacGuire is ambivalent.

Studies by McMahon (1990) and Thomas and Bond (1990) are intrinsically different from the other studies in this section. McMahon compared the relationships and communication between nurses on a primary nursing ward with a ward where a more traditional form of nursing was being practised. Thomas and Bond (1990) attempted to define the properties of a primary nursing system and to classify wards according to the types of nursing organisation practised so that research studies could be replicated. This work has similarities with the studies by Bailey and Mayer (1980) and Kent and Larson (1983) who attempted to assess how well primary nursing had been implemented within a particular hospital setting, although the reasons for performing the studies were different.

These studies are arranged in year order:

Wainwright and Burnip (1983). Qualpacs at Burford. Nursing Times, Vol.79(5): 36-38.

Wainwright and Burnip (1983). Qualpacs — the second visit. Nursing Times, Vol.79(33): 26-27.

These two papers have been included because they represent the first British references to comparing the quality of nursing care before and after the introduction of primary nursing.

The first assessment, using Qualpacs, was performed in November 1981 before the introduction of primary nursing; the second assessment in November 1982 after the introduction of primary nursing. The authors note that at the time of the second visit there were acute staff shortages because of sickness but, despite this, care in every section had improved.

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Reed (1988). A comparison of nurse-related behaviour, philosophy of care and job satisfaction in team and primary nursing. Journal of Advanced Nursing, Vol.13(3): 383-395.

This study used Qualpacs, Phaneuf's retrospective nursing audit, a questionnaire adapted by Anderson (1973), and a job description index developed at Cornell University to test the following hypotheses:

1. Patients on the experimental (primary nursing) unit would score higher on quality patient care than those on the control (team nursing) unit.
2. Nurses working on the experimental (primary nursing) unit would hold a different philosophy of care from those nurses working on the control (team nursing) unit.

The primary nursing unit was situated in Oxford, and was compared with a general medical ward in Wolverhampton. Both wards were of similar size; the patients involved in the study were comparable in terms of diagnosis and were at a similar stage in their rehabilitation, were mentally alert and could speak and understand. All nurses employed on both units at the time of the study completed a questionnaire to assess job satisfaction and philosophy of care. One patient and 14 nurses from the control unit, and one patient and seven nurses from the experimental unit were included in the study.

Results

Qualpacs: the overall score and the score on all sections, with the exception of a psychosocial individual, was significantly higher on the primary nursing unit.
Phaneuf's retrospective nursing audit: the overall score and the score on every section was higher in the primary nursing unit.
Analysis of data on philosophy of patient care showed significant differences between the two groups of nurses. The nurses on the primary nursing ward held a similar philosophy towards individualised patient care, while the nurses on the team nursing ward held more diverse views towards priorities and individualised patient care.
Job satisfaction: nurses on the primary nursing ward exhibited a higher level of job satisfaction. Team nurses found the work 'more endless' and found it did not allow for creativity. Both groups were dissatisfied with frequency of promotion and rates of pay.

The author acknowledged as weaknesses of the study the small sample size of nurses and patients, the use of wards from different health authorities, the lack of control for the competence of the nurses and the variety of educational programmes undertaken by the nurses.

The Kingsmead study

MacGuire (1988). I'm your nurse — here's my card. Nursing Times, Vol.84(30): 32-36.

MacGuire (1989). Prime movers. Nursing the elderly, Vol.1(3): 19-24.

MacGuire (1989). An approach to evaluating the introduction of primary nursing in an acute medical unit for the elderly. I. Principles and practice. International Journal of Nursing Studies, Vol.26(3): 243-251.

MacGuire (1989). An approach to evaluating the introduction of primary nursing in an acute medical unit for the elderly. II. Operationalising the principles. International Journal of Nursing Studies, Vol. 26(3): 253-260.

MacGuire (1989). Primary nursing: a better way to care. Nursing Times, Vol.85(46): 50-53.

MacGuire and Botting (1990). The use of the ethnograph programme to identify the perceptions of nursing staff following the introduction of primary nursing in an acute medical ward for the elderly. Journal of Advanced Nursing, Vol.15(10): 1120-1127.

MacGuire (1991). Quality of care assessed: using the Senior Monitor index in three wards for the elderly before and after a change to primary nursing. Journal of Advanced Nursing, Vol.16(5): 511-520.

The purpose of this study was to evaluate the impact of introducing primary nursing on an acute care of the elderly ward. A quasi-experimental research design was employed involving three matched acute care of the elderly wards from one unit. Primary nursing was adopted by one ward team (the experimental ward); the other two wards continued to organise patient care without any change (the control wards).

All three wards were similar in terms of geographical layout, staff levels, skill mix, patient throughput and client group (for example, age, acuity and diagnosis). This allowed comparisons between the three wards and with the experimental ward's past performance following the implementation of primary nursing.

The effects of introducing primary nursing were considered in relation to:

1. nurses' activity
2. quality of care (measured by Senior Monitor)
3. nurses' views
4. patients' views (unpublished)
5. patient outcomes using specified indicators (unpublished), for example, length of in-patient stay, recovery rates, death rates, destination on discharge, use of services on discharge, readmission patterns.

Activity sampling was carried out simultaneously on all three wards over a period of seven days. Analysis suggested that the pattern of work on the three wards was similar — dominated by direct patient care. On the primary nursing ward a smaller proportion of overall staff time was spent on direct care, perhaps resulting from less 'doing' for patients and more time being spent supporting and assisting patient rehabilitation. More time appeared to be spent on communicating with patients, relatives and others about patient care on the primary nursing wards. Qualified staff appeared to spend more time on clerical duties. The ward sister's activities, although still dominated by direct patient care on the primary nursing ward, indicated more time spent supporting, co-ordinating and monitoring patient care. These findings perhaps indicate role changes in relation to primary nursing.

Quality of care measurements using Senior Monitor were carried out prior to the introduction of primary nursing, and again six months and a year following its implementation. Comparisons of the overall results indicated that although the primary nursing ward achieved marked improvement in the quality of care measurements, both the control wards also improved their scores. By the end of the study the difference between the overall quality of care scores across the three wards was not found to be statistically significant. It appeared that the process of implementing quality assurance measures alone may have resulted in the improvement in quality of care.

Interviews with nurses on the experimental ward were carried out following the first six months of primary nursing. Findings indicated improved knowledge of patients, better communication and relations with patients and relatives. Increased knowledge of and

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responsibility for specific patients coupled with improved continuity of care resulted in greater job satisfaction than prior to the adoption of primary nursing.

Findings in relation to patients' views and patient outcomes as a result of primary nursing have yet to be published.

Primary nursing in intensive care units

Manley (1989). Primary nursing in intensive care. Scutari Press.

Manley (1990). Applications in I.C.U. Nursing Times, Vol.87(7): 32.

A 12-bedded ICU was split into two six-bedded units, one implementing primary nursing, the other acting as a control. Patients were admitted alternately to each unit, and the staff was assigned randomly to either unit, ensuring that qualifications and grades were equivalent in both units.

Quality of care was assessed using Qualpacs (excluding section two — psychosocial group) and staff satisfaction information was collected.

Results

There was no statistical difference between the experimental group and the control group before randomisation, but post implementation the experimental group demonstrated a higher quality of care. The sub-sections concerned with physical care, professional implications and communications showed the largest differences, the smallest differences being in the sub-section psychosocial individual.

There were no statistical differences between the two groups when job satisfaction levels were compared.

The Oxford study

Pearson, Durant and Punton (1989). Determining quality in a unit where nursing is the primary intervention. Journal of Advanced Nursing, Vol.14(4): 269-273.

Pearson (1989). Therapeutic nursing — transforming models and theories in action. Recent Advances in Nursing, 24: 123-151.

Critique by:
Mead (1990a). Research report: primary nursing and quality assurance. Nursing Times, Vol. 86(19): 71-72.

The Oxford study was an evaluation of a nursing unit where nursing was the primary therapy. Although a strict comparison cannot be made between primary nursing and non-primary nursing, as the unit introduced other innovations, it merits inclusion because primary nursing was one of the major differences between the unit and the control.

Patient outcomes were compared for patients who had been admitted to the nursing unit (the treatment group) with a matched group which pursued its normal hospital career (the control group). All the patients included in the study were over 60, and had been admitted to a general hospital with a fractured neck of femur, a cerebral vascular accident, or (in a minority of cases) had undergone an amputation of a lower limb. Patients were randomly assigned to the treatment or control groups after a medical

assessment ensured that their conditions were stable enough for transfer and they would not require acute medical care. A sample of 164 patients was included in the study; seven were subsequently withdrawn leaving 73 in the control group and 84 in the treatment group.

The study compared the following:

- quality of nursing care, determined by a retrospective audit of nursing notes;
- life satisfaction of patients using Neugarten's life satisfaction survey, administered on discharge and at six weeks and six months post discharge;
- patient satisfaction with nursing care, using a patient satisfaction check list;
- patient dependency at discharge, and at six weeks and six months post discharge;
- length of stay;
- cost per bed;
- mortality for the two groups of patients.

Results
Scores from the retrospective nursing audit were significantly higher for the patients admitted to the treatment group; moreover, the scores from the control group were more variable. It was concluded, therefore, that the nursing care experienced by the treatment group of patients was consistently higher than that experienced by the control group.

Scores from Neugarten's life satisfaction survey were not significantly different in the two groups of patients. In both groups scores fell between the first interview at discharge and the second interview six weeks after discharge. However, the score improved somewhat at six months post discharge, but did not recover to the level recorded at discharge.

Patients in the treatment group were more independent on discharge than those in the control group. There was no difference in dependency between the two groups at six weeks or six months post discharge. The patients in the control group spent three times longer in acute hospital care than those in the treatment group. However, the treatment group spent slightly longer under NHS care and this may account for the difference in dependency scores on discharge.

The cost per bed was 11.6 per cent less in the treatment group than it was for the control beds. However, the patients in the treatment group spent longer in hospital; therefore the cost per patient was almost identical in the two groups.

The patients in the control group were three times more likely to die in hospital than those in the treatment group. This was an unexpected result.

The Derbyshire study

Bond S, Fall and Thomas with Fowler and Bond J (1990). Primary nursing and primary medical care. A comparative study in community hospitals. University of Newcastle upon Tyne, School of Health Care Sciences, Health Care Research Unit, Report 39.

Bond S, Bond J, Fowler and Fall (1991). Evaluating primary nursing, parts 1, 2, 3. Nursing Standard, Vol. 5(36) 35-39, Vol.5 (37) 37-39, Vol.5 (38) 36-39.

The purpose of this study was to inform North Derbyshire Health Authority of the implications of primary nursing following its introduction in a newly opened ward in a community hospital. A comparative design was employed — the primary nursing ward was compared with similar wards in two other community hospitals. Qualitative and quantitative data were collected from and about patients, staff and work.

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Staffing establishments for the two wards were similar in terms of medical care, remedial therapy, social workers and nursing, although the experimental ward provided more nursing hours per patient. This was because the ward operated a shift system to minimise the afternoon overlap, thus allowing for a qualified nurse from each primary nursing group to be on duty, and also because it operated a policy of buying replacement staff when nursing staff numbers fell. The population of patients in both wards was similar in terms of age, sex and diagnosis, although more patients in the primary nursing ward were admitted for respite care.

Data were collected by direct observation of nursing staff, interdisciplinary team meetings and shift handover reports. Activity analysis was performed and patient records were examined; in addition, formal and informal interviews were carried out with staff and patients.

Results
The results of this largely descriptive report can be summarised as follows:

1. Patients re-admitted to the primary nursing ward were more often assigned to the same primary nurse than patients who were re-admitted to non-primary nursing wards were assigned to the same team.
2. There was greater attention to social circumstances on the primary nursing ward.
3. More choice was given to patients concerning activities of daily living on the primary nursing ward and patients were more likely to contribute to their own notes and care plans. Greater emphasis was placed on attempting to accommodate patients' home routines.
4. A higher level of team work was demonstrated on the primary nursing ward: nursing auxiliaries contributed to shift handover reports and attention was paid to equalising the workload of the groups.
5. Primary nurses showed a higher level of responsibility for and control over patient care than did team nursing leaders.

The length of stay in hospital was shorter in the primary nursing ward, and patients were more positive about their stays in hospital. There was no difference in the Neugarten life satisfaction index.

Nurses on the primary nursing ward reported:
- greater job satisfaction;
- more knowledge about patients and their circumstances;
- better teamwork;
- greater delegation of authority and responsibility;
- clearer and more consistent definitions of roles;
- more harmonious working relationships;
- greater ability to identify, work towards and perceive successful patient care;
- greater appreciation of the unique nursing contribution to care as well as other disciplines;
- greater ability to take risks and make suggestions;
- more specific identification of learning needs;
- a higher level of continuous in-service education, therefore more knowledge;
- more opportunities to put new knowledge into practice,
- more confidence in management;
- more contact with health authority services;
- easier to recruit new staff.

However, primary nursing staff reported a greater feeling of stress when they were unable to give the standard of care that they wished. There was no internal rotation on to

nights and night nurses found it difficult to adjust to and receive reports from three different primary nurses. The authors recommended adopting a system of nursing care which may be called primary nursing into other wards.

Power and collegial relations

McMahon (1990a). Power and collegial relations among nurses on wards adopting primary and hierarchical ward management structures. Journal of Advanced Nursing, Vol.15(2): 232-239.

Critique by:
Mead (1990). Research report: Collegial relationships among primary and associate nurses. Nursing Times, Vol.86(42): 68.

The purpose of this study was to investigate the effects that different styles of ward management have on the power and collegial relationships between ward based nurses. Four wards, two each from two hospitals in the same city were selected. In each hospital one of the two wards had adopted primary nursing. The remaining two wards had a hierarchical nursing structure in place. One hospital admitted non-acute, mainly elderly patients; the other hospital had acute medical and surgical admissions.

The study had two components. First, a non-participant observer shadowed particular nurses during the morning shift and recorded verbatim all nurse to nurse interactions. In addition, two nurse report sessions ('hand overs') were observed each day, for a five-day period per ward. Qualitative analysis of this data revealed genuine differences in the power relations between the two sorts of wards. In the non-primary nursing wards, power tended to reside with the person 'in charge'; in the primary nursing wards, power seemed to be vested with individuals who became the centre of communication for a particular patient.

The second component of the study was a self-completion questionnaire which was distributed to nurses on the participating wards. It used a 'Likert scale' (1932) to measure participants' ratings of collegial communication. Analysis of the responses suggested that nurses on the primary nursing wards found their communication to be more collaborative.

Organising nursing care

Thomas and Bond (1990). Towards defining the organisation of nursing care in hospital wards: an empirical study. Journal of Advanced Nursing, Vol.15(9): 1106-1112.

Critique by:
Mead. (1991). Research report: Defining primary nursing as a basis for comparison. Nursing Times, Vol.87(17): 71.

The purpose of this study was to attempt to identify the discriminating features of different methods of delivering nursing care. This is an important prerequisite before research into the organisation of nursing care can be performed.

Three different organisational types of nursing were identified: task allocation (functional); team nursing; primary nursing.

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A self-completion questionnaire was devised, based on six main features that had been identified as being important distinguishing features of the different organisational approaches to nursing. These features were:

1. grouping of nurses and length of allocation to specific patients;
2. allocation of nursing work;
3. organisation of the duty rota;
4. nursing accountability for patient care;
5. responsibility for writing patients' nursing notes; and
6. liaison with medical/paramedical staff.

It was distributed to 36 ward sisters on 27 acute and rehabilitation care of the elderly wards and a response rate of 63 per cent was achieved. Of these, only five wards met five or more criteria for classification into one particular method of organising care — one practised task allocation, two team nursing and two primary nursing. The majority of ward sisters (71 per cent) used some aspect of team nursing.

Non-British research studies

Quality of care

These studies all audit the quality of nursing care delivered, comparing primary nursing with non-primary nursing. Felton (1975), Shukla (1981), Eichhorn and Frevert (1979) and Steckel et al (1980) all employed a Qualpacs assessment as part of their methodology. In addition, Felton and Shukla used Phaneuf's retrospective nursing audit and Slater nursing competencies scale. Steckel et al collected data on the length of patient stay in hospital and their dependency on discharge, staff satisfaction and staff turnover. Giovannetti (1980) measured the time nurses spent on direct nursing care, job satisfaction, nursing audit and nursing costs. Chavigney and Lewis (1984) used Phaneuf's nursing audit, Slater's competency scale and a patient questionnaire to assess the quality of care.

Felton (1975), Eichhorn and Frevert (1979) and Stechel et al (1980) report a positive result for primary nursing, while Shukla (1981) reported no significant differences between team and primary nursing. Chevigney (1984) and Giovannetti (1980) reported more positive results with team nursing than with primary nursing. The Felton and Eichhorn and Frevert studies were both conducted before 1980, but have been included as they are often cited in other papers. The four Qualpacs studies appear together in chronological order, with the exception of Shukla's study, which is a replication of Felton's work and therefore is placed next to it.

Felton (1975). Increasing the quality of nursing care by the introduction of the concept of primary nursing: a model project. Nursing Research, Vol.24(1): 27-32.

This study compared a primary nursing paediatric ward with a comparable control ward, where patients were assigned to a variety of nurses during their period in hospital. Qualpacs, Phaneuf's nursing audit and the Slater nursing competencies scale were used to assess the quality of care and the competencies of nurses working on both wards.

The overall Qualpacs and audit scores were significantly higher on the primary nursing ward. The Slater nursing competencies scale scores for individual grades of staff were higher on the primary nursing ward than for the corresponding grades of staff on the control ward. It was concluded that primary nursing had improved the quality of care.

Eichhorn and Frevert (1979). Evaluation of a primary nursing system, using the quality of patient care scale. Journal of Nursing Administration, Vol.9(10): 11-15.

Qualpacs assessments were conducted on four nursing units before and after the implementation of primary nursing. There was a significant increase in the Qualpacs scores for medical patients, but no change for surgical patients.

Giovannetti (1980). A comparison of team and primary nursing care systems. Nursing Dimensions, Vol.7(4): 96-100.

This study compares two surgical units, a 33-bedded general and cardiac unit which used primary nursing, and a 29-bedded general and plastic surgery unit.

Activity analysis was performed to determine the proportion of time spent by nurses on direct care activities (the time spent by the bedside) and indirect care activities. Level of job satisfaction was determined by administering two separate questionnaires. One

questionnaire contained 40 items and used a four point Likert scale and the second was a 72-adjective check list, known as a 'job descriptive index'. Patient satisfaction was assessed by using a 24-item Likert scale questionnaire completed at discharge. The quality of patient care was judged by using a concurrent nursing care review and an audit developed by Collins. Both units' nursing costs were estimated.

Significantly longer was spent at the bedside by all levels of nursing personnel on the team nursing unit than on the primary nursing unit during the day shift. There was no difference between the evening and night shifts. Job satisfaction was significantly higher in the team nursing unit than the primary nursing unit. Patients showed a high level of satisfaction with nursing care on both units, with patients from the team nursing unit appearing slightly more satisfied than those on the primary nursing unit. No difference was found in the quality of care on the two units. The nursing costs were found to be 7.5 per cent higher on the primary nursing unit. The conclusion drawn was that primary nursing will not automatically result in better nursing care.

Steckel, Barnfather and Owens (1980). Implementing primary nursing within a research design. Nursing Dimensions, 7(4): 78-81.

The purpose of this study was to determine the effect primary nursing had on the quality of care and patient outcomes. Primary nursing was implemented on two 25-bedded rehabilitation units and a 46-bedded medical-surgical unit; four units acted as controls. Qualpacs was used to assess the quality of care and data were collected on the length of patient stay and dependency at discharge (using the Horn-Swain health status dimensions scale). Staff satisfaction was assessed and details of staff turnover, absenteeism and tardiness were collected.

The primary nursing unit and the control unit implementing total patient care scored significantly higher than the team nursing unit on the overall Qualpacs section and all the Qualpacs sections except physical. There were no differences in absenteeism across the units. One unit showed significantly fewer overtime hours and this was attributed to the management style, but it was noted that the Qualpacs scores increased with the overtime hours. There were no differences in staff turnover rates or staff satisfaction.

Shukla (1981). Structure vs people in primary nursing: an inquiry. Nursing Research, Vol.30(4): 236-241.

This is a replication of Felton's study, but the competencies of nurses on the two wards were controlled for. Two comparable nursing units were identified. Primary nursing was introduced into one unit after the head nurse and staff unanimously decided to implement it; in the other unit the staff decided to remain with team nursing. The nursing competencies of the two units equalised over a six-month period and the quality of care on the two units was then measured using Qualpacs. There were no significant differences in the overall scores for both units. It was concluded that the improvement in nursing care was due to increased nurse competencies and such improvement could be achieved on team nursing units by nurse education programmes.

Chavigney and Lewis (1984). Team or primary nursing care? Nursing Outlook, Vol.32(6): 322-327.

The purpose of this study was to compare primary and team nursing care through the patient's health status (that is, post-operative complications, patient complaints and length of stay in hospital) and the quality of nursing care using Phaneuf's retrospective nursing audit and Slater nursing competency scale. Two questionnaires were designed

to measure the patient's knowledge of illness and health maintenance and the level of patient satisfaction. Data were also collected on the amount of time nurses spent in direct contact with patients, costs of nursing care and the registered nurses' perceptions of job satisfaction. The study was undertaken in an acute hospital and matched wards were randomly assigned to team or primary nursing care.

There was no difference in the number of post-operative complications in the two groups, or in the patients' knowledge of their diseases or their satisfaction. Time spent in direct nursing care indicated that there was more nurse/patient contact under team nursing. The overall costs showed no differences between the two groups, although estimates of individual ward costs showed conflicting results. It was concluded that the only additional cost of primary nursing was extra staff salaries.

Analysis of the staff questionnaires did not show any perceived difference in the quality of care between the two groups; however, the nurses perceived primary nursing as difficult and stressful. This subjective response was sustained in an increase in sickness, and 73 per cent of registered nurses expressed the opinion that primary nursing should not be adopted as a method of delivering nursing care in the study hospital.

Patient and staff satisfaction

All the studies in this section attempted to evaluate the levels of patient or staff satisfaction (or both) within a primary nursing structure. Roberts (1980), Blair et al (1982), Blenkarn et al (1988) and Perala and Hentimen (1989) reported an increase in staff satisfaction after implementation of primary nursing; however, results from studies by Carlsen and Malley (1981) and Sellick et al (1982) were inconclusive.

Sellick et al (1982) reported increased patient satisfaction with primary nursing but Blair et al (1982) and Ventura and Fox (1982) reported no differences between patient satisfaction when nursed under primary nursing compared with other care delivery systems.

Roberts (1980). Primary nursing. Do patients like it? Are nurses satisfied? Does it cost more? The Canadian Nurse, Vol.76(11): 20-23.

An acute medical care unit was divided into a 24-bedded experimental primary nursing unit and a 24-bedded team nursing control unit. Patient satisfaction, job satisfaction, a patient record audit and staff costs were then compared for the two units.

Patient satisfaction, assessed using a 20-item questionnaire designed to elicit the patients' perceptions of continuity of care, how individualised the care was and their satisfaction with the care, showed no differences between the two units with regard to patient satisfaction. The patients on the primary nursing unit, however, perceived more continuity of care. A job satisfaction inventory designed to be sensitive to differences in nursing care delivery systems indicated that nurses on the primary nursing unit were more satisfied with their jobs — with the exception of their relationships with physicians. An audit of nursing records showed slightly more continuity of care in the primary nursing unit. There was no difference in costs, staffing overtime and sick time, between the two units. It was concluded that primary nursing is at least as effective as team nursing, and more effective in terms of continuity, staff satisfaction and the individualisation of nursing care.

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Alexander, Weisman and Chase (1981). Evaluating primary nursing in hospitals. Examination of effects on nursing staff. Medical Care, Vol.19(1): 80-89.

This study compared absenteeism, staff turnover and satisfaction in primary and non-primary nursing units in two American university-affiliated hospitals located in one metropolitan area. All the units involved in the study had operated their particular systems for delivering nursing care for at least six months prior to investigation. Personal interviews with staff nurses and hospital data were collected. No significant differences were found between primary nursing and non-primary units with respect to job satisfaction. However, one hospital did show lower rates of absenteeism in primary nursing units.

Carlsen and Malley (1981). Job satisfaction of registered nurses in primary and team nursing delivery systems. Research in Nursing and Health, Vol.4(2): 251-260.

A 22-item questionnaire was used to assess the job satisfaction of nurses working in a primary and team nursing setting. Each item was composed of three parts: part (a) measured present satisfaction; part (b) desired satisfaction; and part (c) the importance of each item. Data for team and primary nurses were compared in homogenous nurse sub-groups of age, education and marital status. Seven items of the questionnaire (including overall satisfaction) showed no significant differences and these were therefore not included in any comparisons.

No significant differences were found between primary and team nurses under the age of 25; in the age group 26-35, primary nurses reported more unmet needs in supervision than team nurses. In the age group 36+, team nurses reported greater deficits in the use of skills, self-fulfilment and accountability, and also indicated less satisfaction in their jobs. Across the age range, sub-groups' accountability showed no change under the team nursing system. However, in a primary nursing system satisfaction increases with age.

There were no differences between primary and team nurses with a baccalaureate degree but among nurses with a diploma, the primary nurses appeared more satisfied. It was concluded by the researchers that primary nurses were more accountable than nurses working in a team nursing system. Neither group of nurses was fulfilled or had sufficient opportunities for decision making and the unmet supervision needs of primary nurses were a weakness in the primary nursing system.

Blair, Sparger, Watts and Thompson (1982). Primary nursing in the emergency department: Nurse and patient satisfaction. Journal of Emergency Nursing, Vol.8(4): 181-186.

This study compared nurse and patient satisfaction in the emergency department of a 1,000 bed university hospital, before and after the implementation of primary nursing. A large private teaching hospital acted as a control.

Twelve volunteer full-time registered nurses from both hospitals completed a job satisfaction questionnaire before, and one month after, the implementation of primary nursing in the university hospital. There was no difference in job satisfaction between the two groups before implementation of primary nursing; the experimental group showed higher job satisfaction than the control group after the implementation of primary nursing.

A sample of patients attending each facility was asked to complete a questionnaire about satisfaction with the nursing care and perceived anxiety levels before, and one month after, the implementation of primary nursing in the experimental hospital. There was no

significant difference in patient satisfaction in either group before or after the implementation of primary nursing. There was, however, a significant fall in anxiety levels in the experimental group (where primary nursing had been implemented) which was not exhibited in the control group.

Ventura, Fox, Coley and Mercurio (1982). A patient satisfaction measure as a criterion to evaluate primary nursing. Nursing Research, Vol.31(4): 226-230.

This study examined a primary nursing unit with a team nursing unit as a control. The units were identified because they both had a majority of orthopaedic beds, the remainder being for ophthalmic patients. Patients who had been receiving care on both units for more than three days were asked to complete a satisfaction questionnaire 48 hours before discharge. The questionnaire consisted of 25 items divided into three sections: technical-professional (physical care for the patient and expertise in implementing medical care); interpersonal-trusting (sensitivity to people and listening to problems); interpersonal-teaching (social aspects of nursing and exchange of information between patient and nurse). These sections were evaluated on a Likert scale, a low score being indicative of a high level of satisfaction. There was no significant difference between the two units.

Discounting the possible deficiencies in the scale used, it was suggested that either there were no differences in patient satisfaction, or patients may have been reluctant to express negative feelings about the staff if they expected to be dependent on them in the future.

Sellick, Russel and Beckmann (1983). Primary nursing: an evaluation of its effects on patients' perceptions of care and staff satisfaction. International Journal of Nursing Studies, Vol.20(4); 265-273.

This Australian study evaluated the effects of primary nursing on patients' perceptions of care and staff satisfaction. It was conducted on two general medical wards in an acute hospital. Both wards had a similar physical design, bed capacity and patient population. One ward utilised task allocation and the other had introduced primary nursing three months prior to the beginning of the study. A patient satisfaction questionnaire was administered on the day of discharge by a non-nurse interviewer. All nursing staff were asked to complete a satisfaction scale. Significant differences between the two groups in favour of primary nursing were evident in 6 out of 11 items which assessed patient satisfaction. Examination of the results from the nurse questionnaire indicated a higher score in 17 out of 23 items.

It was concluded that there was some support for greater patient satisfaction in patients nursed in a primary nursing system than in a more traditional nursing system. Results from the staff satisfaction survey were more difficult to interpret. Primary nurses were significantly more satisfied with their ability to participate in decision making and to set the pace of their work.

Blenkarn, D'Amico and Vertue (1988). Primary nursing and job satisfaction. Nursing Management, Vol.19(4): 41-42.

Registered nurses on two psychiatric units were asked to complete a nurse satisfaction questionnaire before, and three years after, implementation of primary nursing. On one unit the questionnaire was also completed one year after the change to primary nursing.

Overall job satisfaction increased on both units after the introduction of primary nursing

but this was only statistically significant on one unit. On one unit all areas of nursing satisfaction had improved after a year and three years, but significant differences were found after three years in professional status, administration, nurse-physician relationships and autonomy. On the other unit significant improvements were found in nurse-physician relationships and autonomy.

There were differences between the two units: the unit which showed the greater improvement in staff satisfaction had a head nurse and nurses who were very positive about the concepts of primary nursing. On the other unit the head nurse was more sceptical, but felt compelled to adopt primary nursing. The more positive ward had a written plan for the implementation of primary nursing and adopted an eight-hour shift pattern. The other unit operated 12-hour shifts which resulted in long periods of time when nurses were away from their patients.

Perala and Hentinen (1989). Primary nursing: opinions of nursing staff before and during implementation. International Journal of Nursing Studies, Vol.26(3): 231-242.

This Finnish study was designed to determine the effects on staff before and after the implementation of primary nursing on a medical, a surgical and an ENT ward. Before implementation, all the units operated a combined team and task allocation nursing organisation.

Data on the opinions of the nursing staff were collected on the three wards before and five months after implementation, using a self-completed questionnaire with structured and non-structured questions. The opinions of physicians, unit secretaries and student nurses were also sought using a non-structured interview. Improvements were recorded by nurses in respect of the care given to patients after the introduction of primary nursing, although these did not reach a statistically significant level. Nurses reported more paper work and inconveniences in unit management as disadvantages of primary nursing.

The physicians and ward secretaries stated that they received more information about patients after the implementation of primary nursing and that this information was more relevant to them. Secretaries reported that the families of patients were better informed. Student nurses reported that they were better acquainted with the patient. Head nurses, physicians, ward secretaries and students reported difficulties in communication between staff, and physicians complained that nurses might be unwilling to attend patients if they were not assigned to them.

Eighty per cent of registered nurses and 50 per cent of practical nurses described their attitudes to primary nursing as favourable throughout, or had changed from being critical to non-critical. Only one practical nurse considered that the implementation of primary nursing had strengthened her critical outlook.

Evaluation and effectiveness of primary nursing

The following two studies attempted to assess the extent to which primary nursing had been implemented. Bailey and Mayer (1980) evaluated the implementation of primary nursing and made recommendations for areas of care which could be improved. Kent and Larson (1983) examined the relationship between the implementation of primary nursing and the quality of care and nurse satisfaction.

Bailey and Mayer (1980). Evaluation of the implementation of primary nursing. Nursing Dimensions, Vol.7(4): 82-84

The purpose of this study was to evaluate the implementation of primary nursing on 14 medical and surgical wards, focusing on the following objectives:

1. To assess the primary nurse's 24 hour accountability to her patients according to the consistency of assignment, documentation, nursing care plan and role perception. This was achieved by examining the nurse/patient assignment for a 20-day period prior to the study in order to assess how often the primary nurse was on duty and giving care. Daily nursing records were examined in order to assess documentation by the primary nurse and other nursing personnel.
2. Twenty-four hour accountability as practised by the head nurse was assessed by a questionnaire containing multiple choice and open ended questions. Data on how the head nurse assigned nurse/patient caseloads, and whether she undertook a patient caseload, were collected.
3. Whether or not patients could identify their primary nurses was assessed by a questionnaire. Those patients unable to name their physician were excluded to eliminate confused patients, as well as those who did not remember names or faces.
4. Communication patterns between head nurse and primary nurse, primary nurse and supervisory personnel, and primary nurse and physician, were evaluated by a questionnaire containing multiple-choice and open-ended questions.
5. Patient care conferences were evaluated.

Results suggested that nursing staff demonstrated a cognitive understanding of the concept of primary nursing. Care plans were used to ensure accountability and continuity of care. All patients had a primary nurse assigned to them. The more experienced nurses gave the largest number of positive answers relating to 24-hour accountability. Half the head nurses assumed a patient caseload as a method of role modelling.

The study revealed some areas of practice that needed improving. These were the visibility of the primary nurse's name, consistency of assignment, increased accountability of primary nurses in care planning and documentation, and a more defined role for middle management within primary nursing.

As a result of this study two model wards were established within the hospital, and all head nurses rotated through them to undertake a mini course which provided objectives and learning activities. Every ward now has a comprehensive primary nursing plan, and job descriptions have changed.

Kent and Larson (1983). Evaluating the effectiveness of primary nursing. The Journal of Nursing Administration, Vol.13(1): 34-41.

The purpose of this study was to evaluate the degree to which primary nursing was meeting the standards which had been set during its initial implementation. It took place in a 350-bed hospital where primary nursing had been in operation for between four and seven years.

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An observation and interview audit was used to collect data in the following categories:

1. observation of the general nursing unit;
2. observation of physician rounds;
3. interview with the head nurse;
4. interview with staff;
5. chart review;
6. care plan review;
7. review of data from the nursing office.

The data were organised into the following groups:

structural standards: which reflected the extent to which primary nursing was being practised;

process standards: which reflected the extent that the activities carried out by nurses represented good nursing care;

implementation standards: the factors considered to contribute to the smooth operation of a primary nursing unit.

An inventory evaluated the level of job satisfaction among nurses who had been employed for over two months on day and evening shifts. It was a 48-item questionnaire divided into subsections of accomplishment, workload, relationship with head nurse, relationship with physician, and knowledge and skills. A patient questionnaire was designed to determine patients' understanding of, and involvement in, the activities carried out by the primary nurse.

There was a strong correlation between structural standards and high scores on the nursing process and patient knowledge, and also between nursing process and job satisfaction. The units whose scores indicated a high quality of care also expressed higher job satisfaction. The correlation between structural standard scores and nursing process indicated that a positive relationship existed between how well primary nursing was working on a unit and the quality of patient care. It was not possible to conclude that primary nursing caused an improvement of patient care, since the same factors which tended to improve care on a particular unit may also have facilitated the implementation of primary nursing. However, there was a statistically significant relationship between the extent of primary nursing implementation and improved patient care.

Crossover trials

Both studies in this section are Canadian and represent an attempt to introduce a randomised crossover design into the study of primary nursing. Wilson and Dawson (1989) report an increase in quality of care after the introduction of primary nursing; McPhail et al (1990) could find no difference between primary and team nursing.

Wilson and Dawson (1989). A comparison of primary nursing and team nursing in a geriatric long-term care setting. International Journal of Nursing Studies, Vol.26(1): 1-13.

This two-year study evaluated primary and team nursing on two 45-bed care of the elderly units using a crossover design so that each unit could act as control to its unit as well as a control to the other unit. At the start of the study both wards practised team nursing and base line data were collected for four months. One unit then implemented primary nursing and the other continued to operate team nursing; after nine months the nursing organisation of the units was reversed.

A patient's tranquillity and agitation scale, a staff reliability rating scale, a personal control rating scale and a modified geriatric residents' goal scale (with sub-scales of dressing, grooming, communications) were applied to ascertain the patient's well-being. An audit of nursing notes was performed to elicit consistency in care giving and the patients' knowledge of nurses' names. A job satisfaction questionnaire was administered, and data collected on absenteeism and staff turnover. Nursing costs were collated.

No differences between primary and team nursing were found on patient vitality and personal control. The geriatric residents' goal scale showed a significant improvement when primary nursing was practised on one unit. The tranquillity agitation scale showed no differences on one unit but the other unit showed a significant improvement. Nursing care plan entries increased significantly after the introduction of primary nursing on one unit. The continuity of assignments increased on both units, as did the patients' knowledge of their nurses' names.

Additionally, no differences were found when comparing primary and team nursing for absenteeism, staff turnover or nursing costs. Data from the staff questionnaire indicated that nurses showed a preference for primary nursing both six months and a year after implementing the system.

McPhail, Pikula, Browne, and Harper (1990). Primary nursing. A randomised crossover trial. Western Journal of Nursing Research, Vol.12(2): 188-200.

This study compared two halves of a 35-bed unit, in which one sub-unit practised team nursing and the other primary nursing for five months. The organisation of nursing care was then reversed. Nursing staff were assigned randomly to one of the two units. Job satisfaction and nurse absenteeism were measured, and nurses were asked to express a preference for team or primary nursing. Doctors and paramedics were asked to complete a questionnaire comparing the quality of care on the two sub-units. Patients were asked to complete a patient satisfaction questionnaire. In addition patient characteristics were obtained.

Of the 55 per cent of nurses who completed the questionnaire there was no significant difference between primary and team nursing, and no difference in the absenteeism rates between the two groups. A majority of nurses expressed a preference for team nursing. There was no difference in the perceived quality of nursing care under primary or team nursing by other health professionals or patients.

An audit of nursing records indicated compliance with team and primary nursing according to the criteria set by the research team. As the trial continued, charting showed an improvement in both systems, particularly in the areas of patient discharge, planning and patient education. It was concluded by the researchers that there was no advantage in introducing primary nursing.

Support services

The only study in this section (Shukla 1983) concludes that for the implementation of primary nursing to be effective in terms of increasing the time that registered nurses spend in contact with patients, the hospital support systems have to be in place so they are not spending time in supportive activities.

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Shukla (1983). Technical and structural support systems and nurse utilisation: systems model. Inquiry 20(4) 381-389.

This study examined the relationship between registered nurse utilisation under team nursing and primary nursing, and the support system available (that is, the distribution of supplies and communication systems being either centralised or decentralised).

When a primary nursing unit was compared with a team nursing unit, both having centralised support systems, the registered nurses on the team nursing unit spent 4 per cent more time in direct patient care, than registered nurses in the primary nursing unit. Primary nurses spent 7.6 per cent less of their time in co-ordinating patient care than the team nurses, but this was not translated into direct patient care time. This was because, in the absence of nursing aides, primary nurses were spending a greater amount of time in supportive activities than their team nursing counterparts. Changing from a centralised support system to a decentralised support system in a team nursing context allowed registered nurses to spend 19 per cent, and licensed practical nurses 12 per cent, more time with patients.

Implementing primary nursing within the context of a decentralised support system allowed primary nurses to spend 61.1 per cent of their time in direct care activities. This was 6.5 per cent more than the registered nurses on the team nursing unit, allowing fewer nurses to be employed as they were used more efficiently. An increase of 35 per cent in direct care given to patients by registered nurses, and 21 per cent given by licensed practical nurses and nursing aides, was reported when primary nursing was introduced and the support system was altered from a centralised to a decentralised system. It was concluded that the decision to adopt primary nursing should not be made independently of the nature of support services available.

Summary of research reviewed

Twenty-two of the twenty-seven studies reported in section 3 are concerned with either the quality of nursing care or patient and nurse satisfaction. Fourteen report positive benefits for primary nursing; five are inconclusive or report no significant differences; only two (Giovannetti 1990, Chavigney and Lewis 1984) demonstrated negative results when primary nursing was compared to team nursing. When the British studies are excluded from this analysis, nine report positive results, four are inconclusive, and two report negative results. It could be argued, therefore, that the British studies are more likely to report positive outcomes for primary nursing.

Ventura et al (1982) suggested that the lack of reported difference in patient satisfaction between primary and team nursing may be due in part to patients being unwilling to express negative feelings about care provided, particularly if they expect to be dependent on the nurses at some time in the future.

Kent and Larson (1983) question whether patients are in the best position to judge the quality of care and suggest that patients will perceive quality of care by observations such as whether the nurses are kind and gentle. Bond et al (1990), noticing that the Neugarten life satisfaction index had failed to measure any significant differences in their study (and also in Pearson's nursing unit study, 1989), doubt its appropriateness.

Summaries of topics covered by review of research

section 3

Topic	Author	Year	Page No.
Quality (contd)	Giovannetti	1980	59
	Kent and Larson	1983	65
	McPhail et al	1990	67
	Mead	1990a	54
	Pearson	1989	54
	Pearson et al	1989	54
	Shukla	1981	60
	Steckel et al	1980	60
	Wainwright and Burnip	1983	51
Qualpacs	Eichhorn and Frevert	1979	59
	Felton	1975	59
	Manley	1989	54
	Reed	1988	52
	Shukla	1981	60
	Wainwright and Burnip	1983	51
Monitor	MacGuire	1988	52
		1989a,b,c,	52
		1991	53
	MacGuire and Botting	1990	53
Phaneuf	Chavigney and Lewis	1984	60
	Felton	1975	59
	Reed	1988	52
	Shukla	1981	60
Slater	Chavigney and Lewis	1984	60
	Felton	1975	59
	Shukla	1981	60
Patient outcomes	Pearson et al	1989	54
	Steckel et al	1980	60
Dependency on discharge	Pearson	1989	54
	Pearson et al	1989	54
	Steckel et al	1980	60
Patient satisfaction	Blair et al	1982	62
	Chavigney and Lewis	1984	60
	Giovannetti	1980	59
	McPhail et al	1990	67
	Pearson et al	1989	54
	Pearson	1989	54
	Roberts	1980	61
	Sellick et al	1983	63
	Ventura et al	1982	63

Topic	Author	Year	Page No.
Staff views			
Staff relationships	Bond et al	1990	55
	Kent and Larson	1983	65
	McMahon	1990a,b	57
Staff communication	Bailey and Mayer	1980	65
	Bond et al	1990	55
	McMahon	1990a,b	57
Stress in staff	Bond et al	1990	55
Job satisfaction	Alexander et al	1981	62
	Blair et al	1982	62
	Blenkarn et al	1988	63
	Bond et al	1990	55
	Carlsen and Malley	1981	62
	Chavigney and Lewis	1984	60
	Giovannetti	1980	59
	Kent and Larson	1983	65
	Manley	1989	54
	McPhail et al	1990	67
	Perala and Hentinen	1989	64
	Reed	1988	52
	Roberts	1980	61
	Sellick et al	1983	63
	Steckel et al	1980	60
	Wilson and Dawson	1989	63
Staff turnover/absenteeism	Alexander et al	1981	62
	McPhail et al	1990	67
	Steckel et al	1980	60
	Wilson and Dawson	1989	63
Clinical settings			
Care of the elderly	Bond et al	1990	55
	MacGuire	1988	52
		1989a,b,c	52
		1991	53
	MacGuire and Botting	1990	53
	Reed	1988	52
	Wilson and Dawson	1989	63
Paediatrics	Felton	1975	59
Intensive care unit	Manley	1988	54
Emergency department	Blair et al	1982	62

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The future of primary nursing in the UK

British literature on primary nursing has been increasing rapidly in recent years, and within it there are many signs that primary nursing will be a strong feature of British nursing developments in the coming years. The literature reflects an increase in the number of research projects related to primary nursing, with suggestions of areas for further research from many writers.

Girvin (1991) sees primary nursing as '*a revitaliser of the nursing profession*'. Both Graham (1991) and Drummond (1990) want primary nursing to be a fundamental aspect of nurse education in the future. Walsh (1989) feels that primary nursing will enable nurses to cope better with the increased throughput of patients in hospital and will equip them with skills in liaison which will be necessary when patients are increasingly cared for in the community as a result of early discharge from hospital.

Although some of the writing about research into primary nursing has been of a critical nature, most of it has provided suggestions about how more constructive research could be carried out in the future. Thomas and Bond (1990), for example, point out the lack of an operational definition of primary nursing, but take some steps to overcome this problem by developing a questionnaire so that units may be selected for research projects according to how they organise the delivery of nursing care. Mead (1991) developed their work even further to allow for variations between units which are officially using the same way of organising nursing care, and suggested that large-scale surveys involving many sites could be initiated in the future.

Several writers question whether primary nursing will be a viable method of organising nursing care in the future, judging by the trends they see in nursing today. Melia (1990), looking back over nursing during the 1980s, asks whether problems in recruiting qualified nurses will make primary nursing an impossible ideal for the future and wonders whether new trends will replace primary nursing during the 1990s and beyond. She also looks to the problems being faced in America today with implementing primary nursing and wonders whether similar problems may reach British nursing in the near future.

In spite of attempts from a variety of sources to encourage British nurses to establish primary nursing on their wards and units, many workers warn against forcing nurses to take up primary nursing (Vaughan 1990, Wright (cited by Tattam 1989). Equally, nurses are warned against trying to implement primary nursing without adequate resources, facilities and managerial supervision (Chudley 1983, Pearson 1983a, Swaffield 1983b, Singleton and Gamlin 1989, Stevenson 1989), good basic and post-basic nurse education (Bowman and Thompson 1986, Lathlean 1988, Sturt 1989) and adequate staffing levels (Turnock 1987). In relation to this, Coe-Legg et al (1990) warn against indiscriminate promotion of primary nursing, since nurses may either not wish to carry out primary nursing or not feel adequately supported to do so. Both Biley (1989) and Burnard (1991) look at the place of primary nursing in Britain today. Biley (1989) sees primary nursing as 'still in its infancy' and suggests that it will remain as such until nurses are allowed more control over their work by their managers. Burnard (1991) points out that most nurses in Britain are in a 'romantic' phase, not yet questioning the true value of primary nursing.

Only time will tell whether primary nursing will become the new 'norm' of how nursing work is organised. Four particular areas are highlighted in the debate concerning primary nursing which deserve recognition.

The potential for the marginalisation of some nurses in a primary nursing structure should not be overlooked. Not all qualified nurses may be able to become primary nurses. This may be because of such things as insufficient experience, part-time hours or working night shifts.

The identified accountability of a primary nurse for the prescribing of appropriate nursing care, may mean a new level of independent practitioner will emerge. This in turn may require different supervisory structures from those currently in place.

The introduction of primary nursing has led clinical staff to reconsider their working relationsips and staff support systems. Better collegial structures which are emerging in primary nursing settings give the opportunity for practitioners to experiment with better ways of nursing their patients and may remove the fear of initiating creative practices.

Primary nurses have the opportunity not only to prescribe and carry out nursing care, but also to evaluate it in an accountable way. This process of evaluation carries with it the opportunity and permission to reflect on nursing practice. The need for critical debate about primary nursing is highlighted by Reed (1992). She considers that if nurses do not examine properly what individualised nursing care means, both to patients and nurses, then nursing will be restricted in its development.

QUICK REFERENCE GUIDE TO

- history, philosophy, change process
- roles
- relationships
- clinical specialties

GLOSSARY

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References

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These references refer to both research and anecdotal literature.
Full references for articles commence on page 86.

TOPIC	AUTHOR	YEAR
History, philosophy, change process		
History of primary nursing	Bowers	1989
	Ersser and Tutton	1991
	Johnson	1981
	Kratz	1979
	Lee	1979
	Melia	1990
Difficulties with primary nursing	Johnson	1981
	Jones E	1977
	Jones W	1977
	Matthews	1975
	Plumpton	1978
	Sparrow	1986
Resistance to change and primary nursing	Bowers	1987
	Castledine	1985a
	Castledine	1985b
	Caville and Johnson	1981
	Chudley	1983
	Crowder	1989
	Gilbert	1989
	Green	1983
	MacGuire	1989c
	Malby	1989
	Rogers	1987
	Sparrow	1986
	Swaffield	1983a
Overcoming resistance	Johns	1990
	Wheeler	1989
Accountability in primary nursing	Batey and Lewis	1982
	Bergman	1981
	Biley	1990
	Ersser and Tutton	1991
	Goulding and Hunt	1991
	Johns	1990
	Matek	1977
	Zander	1980
Philosophy	McKee	1991
	Paterson and Zdarad	1976
Development of primary nursing	Bowers	1989
	Ersser and Tutton	1991
	Manthey	1980
	Melia	1990

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TOPIC	AUTHOR	YEAR
Research and methodological difficulties	Giovannetti	1986
	Johns	1991
	Mead	1991
	Thomas and Bond	1990
Difficulties with old system	Binnie	1987
	Gibbs	1988
Definitions of primary nursing	Ciske	1974
	Hegyvary	1982
	Kratz	1979
	Manthey	1980
	MacGuire	1989a
New concepts in nursing	Bowers	1989
	Ersser and Tutton	1991
	Melia	1988
	Turnbull	1978

Roles

Development of nursing staff	Binnie	1987
	Binnie	1989
	Bowers	1987
	Campen	1988
	Clarke and Gorton	1990
	Gibbs	1988
	Johns	1990
	Jones E	1977
	Jones W	1977
	Kemp	1991
	Lathlean	1988
	Lidbetter	1990
	Marks-Maran	1978
	Matthews	1975
	Milne	1988
	Pembrey	1975
	Plumpton	1978
	Preston	1989
	Swaffield	1983d
	Vaughan	1990
	Wright	1987b
Enrolled nurses and primary nurses	Cole	1989
	Ersser and Tutton	1991
	Walsh	1989

TOPIC	AUTHOR	YEAR
Who can be a primary nurse?	Ashley	1984a
	Bowers	1987
	Burns	1988
	Gilbert	1989
	Green	1983
	Pearson	1988
	Wheeler	1989
	Wright and Khadim	1989
Associate nurses	Burns	1988
	Elhart	1978
	Geen	1986
	Gibbs	1988
	Hegyvary	1982
	Lidbetter	1990
	MacGuire	1988
	McMahon	1990a, b
	Sparrow	1986
	Wilson	1990
	Wood	1990a
	Zander	1980
Ward sister role	Ashley	1984a
	Binnie	1987
	Binnie	1989
	Campen	1988
	Ersser and Tutton	1991
	Fox	1988
	Fradd	1988
	Gibbs	1988
	Green	1983
	Hunt	1988
	Lathlean	1988
	MacGuire	1989
	Malby	1989
	Manthey	1980
	Milne	1988
	Pearson	1983
	Singleton and Gamlin	1989
	Sparrow	1986
	Swaffield	1983b
	Wheeler	1989
Students and primary nursing	Ashley	1984a
	Binnie	1987
	Bowman	1990
	Burke and Elliot	1989
	Carlisle	1988
	Chudley	1983
	Drummond	1990
	Fox	1988
	Fradd	1988

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TOPIC	AUTHOR	YEAR
	Gilbert	1989
	King	1989
	Lidbetter	1990
	Ritter	1985
	Singleton and Gamlin	1989
Night staff	Kemp	1991
	Khadim	1991
	Manthey	1980
	Remington	1989
Health care assistants	Care Sector Consortium	1990
	Easton	1989
	Fox	1988
	MacGuire	1989a
	Pearson	1988
	Sparrow	1986
	Wright	1990
Management aspects	Binnie	1987
	Bowers	1987
	Cavill and Johnson	1981
	Chudley	1983
	Clarke and Gordon	1990
	Ersser and Tutton	1991
	Green	1983
	Hunt	1988
	MacDonald	1988
	Malby	1988
	Manthey	1988
	Pearson	1988
	Sears and Williams	1991
	Waterworth and Luker	1990
Job satisfaction	Blair et al	1982
	Blenkarn et al	1988
	Bond	1990
	Bond et al	1990
	Carlsen and Malley	1981
	Chavigney and Lewis	1984
	Eaton and Thomas	1991
	Giovannetti	1980
	Manley	1989
	McPhail et al	1990
	Perala and Hentinen	1989
	Reed	1988
	Roberts	1980
	Sellick et al	1983
	Steckel et al	1980
	Weisman and Chase	1981
	Wilson and Davison	1989

TOPIC	AUTHOR	YEAR
Organisation of nursing care	Armitage	1991
	Lee	1979
	Manley	1990
	Manthey	1980
	Manthey	1988
	Turnbull	1978

Relationships

Nurse/patient relationships	Benner	1984
	Biley	1989
	Campen	1988
	Casey	1988
	Castledine	1985b
	Curtin and Flaherty	1982
	Davis	1985
	Ersser and Tutton	1991
	Jones W	1977
	Lathlean	1988
	Manley	1990
	Marks-Maran	1978
	Matthews	1970
	Matthews	1975
	McMahon	1989
	Melia	1988
	Muetzel	1988
	Orr	1985
	Pearson	1988
	Plumpton	1978
	Raatikainen	1989
	Rogers	1987
	Schrock	1980
	Swaffield	1983a
	Thomas	1979
	Tutton	1987
	Waterworth and Luker	1990
	Webb	1986
	Williamson	1981
	Wright	1990
Relationship of nursing staff	Bond et al	1990
	Gibbs	1988
	McMahon	1990
Stress	Bond et al	1990
	Campen	1988
	Courtnay-Thompson	1989
	Gilbert	1989
	Hunt	1988
	Johns	1990
	Lathlean	1988
	Mcdonald	1988
	MacGuire	1989d

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TOPIC	AUTHOR	YEAR
	Rogers	1987
	Salvage	1989b
	Singleton and Gamblin	1989
	Sparrow	1986
	Wheeler	1989
Multidisciplinary teams	Castledine	1980
	Chapman	1985
	Courtenay-Thompson	1989
	Fradd	1988
	MacGuire	1988
	MacGuire	1989a,c
	Preston	1989
	Sparrow	1986
	Tutton	1986
Support for staff and students	Ashley	1984a
	Fradd	1988
	Green	1983
Relatives	Carlise	1988
	Malby	1988
	Milne	1988
	Thornett	1991
Development of nursing staff	Binnie	1987
	Binnie	1989
	Bowers	1987
	Campen	1988
	Clarke and Gorton	1990
	Gibbs	1988
	Johns	1990
	Jones E	1977
	Jones W	1977
	Kemp	1991
	Lathlean	1988
	Lidbetter	1990
	Marks-Maran	1978
	Matthews	1975
	Milne	1988
	Pembrey	1975
	Plumpton	1978
	Preston	1989
	Swaffield	1983b
	Vaughan	1990
	Wright	1987b

TOPIC	AUTHOR	YEAR
Clinical specialties		
Cardiac	Giovanetti	1980
Community hospital	Bond et al	1990
		1991
	McMahon	1990
Elderly care	Bond et al	1990
	MacGuire	1988
		1989a,b,c
		1990
		1991
	Reed	1988
	Wilson and Dawson	1989
Elderly care (acute)	MacGuire	1988
		1989a,b,c,d
	MacGuire and Botting	1990
Emergency	Blair et al	1982
ITU	Manley	1988
		1989
		1990
Medical care	Bailey and Mayer	1980
	Binnie	1987
	Roberts	1980
	Sellick et al	1983
Orthopaedic	Ventura et al	1982
Paediatrics	Eaton and Thomas	1991
	Felton	1975
Plastic surgery	Giovannetti	1980
Psychiatric	Armitage et al	1989
	Blenkarn et al	1988
	Green	1983
Psychiatric (long-stay)	Armitage	1985
		1989
		1990
Rehabilitation	Steckel et al	1980
Surgery	Bailey and Mayer	1980
	Giovannetti	1980
	Grantham and Biley	1989

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Glossary

Likert scale (1932): Answers to questions are graded in a variable number of degrees — for example, from a little extent or strongly disagree to a very great extent or strongly agree.

Phaneuf's retrospective nursing audit (Phaneuf 1976): This is a retrospective audit of nursing records and documentation, designed to be performed on patients who have been discharged from hospital. It consists of 50 items, divided into seven functions of nursing:

1. Application and execution of physicians' legal orders.
2. Observation of signs, symptoms and reactions.
3. Supervision of the patient.
4. Supervision of those participating in care.
5. Reporting and recording.
6. Execution of nursing procedures.
7. Promotion of physical and emotional health.

Numerical values have been ascribed to items. Each nursing function is evaluated by totalling the score of items within the function. The seven sub-section scores are totalled, giving an overall score.

Qualpacs — quality of patient care scale (Wandelt and Ager 1974): This is a concurrent audit of nursing care made by direct observation. It consists of 68 items divided into six sections.

1. Psychosocial individual: actions directed at meeting the psychosocial needs of a patient as an individual.
2. Psychosocial group: items directed at meeting the psychosocial needs of a patient as a member of a group.
3. Physical: actions directed towards meeting the physical needs of a patient.
4. General: actions directed towards meeting either psychosocial or general needs.
5. Communication: communication on behalf of the patient.
6. Professional implications: actions carried out that reflect the professional responsibilities of the nurse.

Each interaction with a patient is rated and any number of items may be scored. A five point rating system is used, ranging from poorest care to best care. Average care is the standard expected of a newly-qualified first-level nurse. The average score of each section is found, and then a mean of means is calculated to obtain an overall score.

Senior Monitor (Goldstone L and Maselino-Okai C 1986): This is an anglicisation of the American quality assessment 'Rush-Medicus'. It consists of a set of questions which require a yes/no or sometimes answer. It relies heavily on nursing records and direct observation, although some questions may be asked directly of patients or nurses. It consists of 232 questions divided into seven sections:

1. Planning nursing care.
2. Meeting patients' physical needs.
3. Meeting patients' non-physical needs.
4. Meeting patients' needs for rehabilitation.
5. Care of the dying patient.
6. Last offices.
7. Evaluation of nursing care objectives.

A ward profile is also completed which gives information on staffing and support services available, and a set of questions is completed relating to management and organisation of the ward.

Slater nursing competencies scale (Wandelt and Stewart 1975): Rates a nurse's performance in the clinical setting. It is an 84-item scale. Qualpacs was derived from it and the two are very similar.

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Where has it come from? How can it be implemented? Does it provide a better way of organising nursing care? Does the patient receive better nursing care in a primary nursing structure? This guide tries to address these and many other questions which clinical practitioners ask concerning primary nursing. It is divided into four sections.

Section 1 looks at the history, philosophy and structural organisation of a primary nursing system. It provides examples of role profiles for the unit team.

Section 2 discusses the management of the unit environment, skill mix, the place of carers, clinical nurse specialists, learner nurses and the multidisciplinary team. The actual process of implementing a primary nursing structure is outlined.

Section 3 looks at the outcomes of primary nursing. It provides an overview of the research concerned with primary nursing and includes major British and non-British studies.

Section 4 contains quick reference guides for the reader together with extensive bibliographic references.

Primary Nursing: An introductory guide guides the clinical practitioner to an in-depth consideration of what primary nursing means for nursing.

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