HOW PRIMARY NURSES OPERATIONALIZE ACCOUNTABILITY

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Primary nursing has been suggested as a method of nursing care delivery that promotes individualized care (Marram, Schegel & Bevis, 1979), higher quality patient care (Felton, 1975), continuity of nursing care, professional practice and accountability (Ciske, 1980; Zander, 1980). The authors suggest that 24-hour accountability is the essence of care in primary nursing. However, the concept of accountability has not been clearly defined; hence, this study was conducted to determine what 24-hour accountability means to primary nurses and how they operationalize it in their practice.

Background research in primary nursing

The concept of primary nursing is not new. It was developed at the University of Minnesota Hospital in the early 1960s and was introduced in the literature by Manthey, Ciske, Robertson and Harris, (1970) from the University of Minnesota. In an extensive literature review it was found that only 21% of more than 150 articles on primary nursing were classified as research (Giovanetti, 1982). The majority of the articles (56%) contained no emperical data and 23% were classified as descriptive-evaluative. Most of the research studies have evaluated the effectiveness of the primary nursing care system when compared to functional or team nursing. These studies focused on several variables: patient-centered variables including patient satisfaction and patient-outcome criteria; process-outcome criteria related to the quality of patient care; cost effectiveness; and, job satisfaction.

Studies focusing on patient-centered variables

Several studies (Daeffler, 1975; Marram et al., 1979; Sellick, Russel and Beckman, 1983) reported more patient satisfaction with primary nursing care system than the team nursing system. Daeffler (1975) compared patients' perceptions of care under team and primary nursing, using 52 non-random patients from two acute medical-surgical nursing units in a 160-bed hospital

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in the Southwestern United States. Patients in the primary nursing unit reported higher satisfaction with care and fewer omissions in expressive activities than those in the team nursing unit. In another study, Hedegus (1980) investigated 160 patients from four medical units in one hospital: two primary nursing units and two units practising functional nursing. Results from this study revealed that stress scores of patients in primary nursing units were significantly lower than those of patients in functional nursing units. Marram et al. (1979) compared patients' perceptions of nurses' behaviour in primary nursing, case method, team nursing and functional nursing units. This study involved 360 patients from two different hospitals, using 120 patients from primary nursing units 120 patients from team nursing units, 60 patients from case method nursing units and 60 patients from functional nursing units. Results revealed that patients in the primary nursing care units reported higher levels of satisfaction with their care, valued the ability of the nurse to know and treat them as individuals and perceived their care to be more highly individualized and personalized. In contrast, studies done by Hamera and O'Connell (1981) and by Ventura, Carley and Mercurio (1982) found no difference in patient satisfaction between the team and primary nursing patients.

Studies focusing on quality of care

Felton (1975) evaluated the quality of care patients received, comparing a primary nursing unit with a team nursing unit of a large children's hospital. Nursing competence and quality of care were found to be higher in primary nursing than in team nursing. The author used the Qualpac Phaneuf nursing audit and Slater nursing competencies instruments. Using the same instrument, Frevert and Galligan (1975) published findings consistent with those in Felton's study.

In another study, Gross-Miller (1981) published the results of a survey of 48 patients were from an 80-bed rehabilitation center, with varying diagnoses; 19 patients from primary nursing units and 29 patients from team nursing groups not randomly assigned. Results revealed fewer urinary tract infections, a lower incidence of skin breakdown and fewer patient falls in the primary nursing unit than with team nursing. In contrast, Giovanetti (1980) reported that there was no significant difference in the quality of care between the primary nursing unit and team nursing unit. This was the first study to report that primary nursing care system does not necessarily provide a higher quality of care. However, the instruments used in this study were different from those used in the previous studies on quality of care,so comparisons of the results of these studies is difficult. A similar study by Shukla (1981) showed that primary nursing did not influence the quality of care the patients received. The findings implied that the nursing competencies of the staff nurses might have affected the quality of nursing care, not the nursing care delivery system that was used.

Studies on cost effectiveness

Several studies reported no increase in cost in implementing primary nursing (Gross-Miller, 1981; Hedegus, 1980; Marram, 1976). Marram compared a primary nursing unit with an all R.N. staff and another team nursing unit with various categories of health care provider and found no difference at all in the cost of operating each unit. Costs of operations included sickness, vacation, inservice education and number of positions filled and budgeted. This study is one of the most comprehensive studies done on cost-effectiveness, taking into consideration the long-term expenses incurred in inservice education. Furthermore, the investigation was done over a longer period of time than most studies use. In contrast, Giovanetti (1980) reported that nursing care cost more in a primary nursing than in a team nursing unit. One limitation of this study was that data were collected for only 40 days and the hidden costs of nursing care, such as orientation of new staff and inservices for continuing education, were not considered.

Studies focusing on job satisfaction

A number of studies indicated greater satisfaction among nurses in primary nursing than in other nursing care systems (Carey, 1979; Marram et al. 1979). On the other hand, Giovanetti (1980) reported that nurse job satisfaction was higher in team nursing than primary nursing. More recently, McPhail, Pikula, Roberts, Browne and Harper (1990) reported finding that there is no differerence in the levels of nurses satisfaction in work environment between primary and team nursing.

The literature reviewed revealed that the components of primary nursing and the implementation and evaluation of this nursing system have been inconsistently defined (McPhail et al., 1990). The lack of description of how well the elements of primary nursing are being operationalized is evident in most of the research studies. Variations in the practice of the original concepts of primary nursing were noted by Servellen (1981), who did a survey of 118 hospital practising primary nursing in the United States. These findings suggest that the operationalization of the elements of primary nursing, especially accountability, needs further clarification. This is essential before conclusions regarding the effectiveness of the primary nursing care system can be documented.

Accountability is one of the most difficult concepts to operationalize in nursing practice. It is unclear, both to the public and to nurses themselves, what nurses are accountable for and how they maintain and operationalize accountability in their practice (Zander, 1980). This lack of clarity could be attributed to the fact that, in their traditional role, nurses had responsibility but not personal accountability. Primary nursing makes the distinction

between task responsibility and case-outcome accountability. According to Zander, accountability can only be determined in the context of results (i.e. patient care outcomes). Passos (1973) emphasized that responsibility differs from accountability in the sense that it is a means to an end, while accountability implies that actual performance will be judged against expected performance. Ciske (1980) defined accountability as being answerable for ones acts and being willing to live with the results or outcomes of one's practice. Increased consumer attention to the quality of nursing care and nurses' desire to establish credibility have created demands on individual nurses to be accountable for their practice. However, in the past only lip service was paid to this concept.

The American Academy of Nursing, in its 1990 Scientific Conference, focused on "Differentiated Nursing Practice" - the basis of which is primary nursing. Primary nursing, for the purpose of this paper, is defined as a nursing-care system in which each patient is assigned to a registered nurse, the primary nurse, who is accountable for the total nursing care provided to the patient 24 hours a day, from admission to discharge (Manthey at al., 1970). Primary nurses also act as associate or co-primary nurses for patients other than their primary patients. The associate nurse, who is either a registered nurse or certified nursing assistant, represents the primary nurse in her or his absence. All primary nurses in this study assumed the role of associate nurse as well as their primary duties. Primary nursing is believed to provide the nursing profession with a mechanism for accountability (Ciske, 1974). We suggest that it results in quality care because it demonstrates individual competencies: "It puts nurses on the line; their actions can be studied, audited and evaluated" (Zander, 1980, p. 126). With primary nursing, strengths and weaknesses in practice can be clearly traced, allowing practice to be more accurately evaluated. The research problem for this study, then, was: How do primary nurses define accountability and how do they operationalize it in practice?

Method

The research approach used in this study was grounded theory, in which hypotheses emerge rather than being stated (Glaser, 1976). In grounded theory, constant comparative analysis of qualitative data is directed toward the generation of theory. This involves overlapping processes of formulation, testing and redevelopment of propositions until a conceptual framework is generated; one that is integrated, consistent with the data and can be operationalized for later testing (Glaser & Strauss, 1967).

Sample

The population sample was composed of 21 registered nurses working in medical, surgical and psychiatric units of two large teaching hospitals in

Montreal, Quebec. Eligible participant nurses were selected by the principal investigator from among those primary nurses in each hospital who wanted to be part of the study. Inclusion criteria consisted of the ability to speak and understand English and experience working as a primary nurse for at least six months at the time of the interview (the principal investigator believes that it takes a nurse at least six months to operationalize the concepts of primary nursing care system fully). All but two of the primary nurses who volunteered were included in the study (the two were excluded to allow for a balance of sampling from the participating areas). Participants' length of experience as primary nurses varied, with 65 percent of the informants having worked as primary nurses for one to two years and 35 percent having done so for six months to less than one year. The participants' mean experience as a primary nurse was one year and five months. Approximately 30 percent of the participants were graduates of baccalaureate nursing programs, 5 percent had non-nursing baccalaureate science degrees and 65 percent had completed a diploma nursing degree.

Ethical considerations

The study proposal was approved by the ethics committee of Dalhousie University's, Faculty of Health Professions. A general explanation of the interview procedure and purpose was given to all participants. Each participant was asked to give written consent to be interviewed and audiotaped. Participants were advised that they could refuse to answer any questions without reprisal and could withdraw from the study at any time with no risk involved.

Data-collection procedure

Each nurse took part in one interview lasting from forty-five minutes to an hour. Interviews consisted of open-ended questions so as to allow the nurse's freedom of response, as well as to enable the investigator to clarify issues. Questions were directed at the nurses' perceptions of what accountability meant to them, what they were accountable for and to whom, how they maintained accountability in their practice, standards of care and how they evaluated the outcome of patient care. Special attention was also directed at how they felt about accepting the responsibility of being held accountable, and how they prepared themselves to accept and handle that responsibility. As well, the nurses' perception of clients' expectations of primary nurses was an important part of the interview.

Data analysis

The first stage was to examine the transcriptions of the interviews, in which topics and themes were identified. This was the beginning of open coding, in

which the investigators coded each datum incident (response of participant) to create as many codes as possible, sometimes using the participants' words as the code. Stern (1980) refers to these codes as substantive codes, because they are from the "substance of the data" (p.21). For example, when a participant, on being asked how she ensured that her plan of care was carried out in her absence, replied, "I write specific instructions in my care plans," this data was coded specific instructions. During open coding, more than 80 codes were extracted from the data. These codes were then examined to determine their similarities in order to form categories (i.e. coded data that seem to cluster together or belong in the same class). For example, the substantive codes *rapport*, *respect*, *trust* and *intimacy* were grouped under the category of *one-to-one relationship* with the patient. Further categories were developed similarly.

Once the categories were developed, each was examined and compared with others to see how they clustered or connected with each other. As the "linkages" (Schatzman, 1973) emerged, the categories were further collapsed to form more general categories. In this study, the categories of *teaching direct physical care* and *coordinating* were grouped under the major category of *Care Giving*. Other categories were reduced in a similar manner.

Theoretical sampling was used to develop the hypothesis and identifying the properties of the core or central variable. For example, all the participants identified specific instructions in the nursing care plans as a means of ensuring accountability. However, further discussion revealed that specific instruction was not enough. The elements of *trust, respect, reciprocity, collaboration* and *flexibility* were identified as other means of ensuring 24-hour accountability. These were called *Peer Relationship*.

During this phase additional data from the literature and field work were meshed to develop the hypotheses further. The categories were reduced further, to a higher order of categories of *nursing process, communicating* and *consequences*. Communicating and nursing process were were found to be the co-core variables that explained accountability.

Once again, we examined the data to determine the fit of the co-core variables, in order to integrate them into a well-constructed theory. Two processes dominated this phase: theoretical coding and memo writing. Codes that were written in descriptive terms were explained in theoretical terms, for a more abstract discussion of the variable. Writing memos is important as a way to preserve hunches, abstractions, analytical schemes and ideas for the emerging hypotheses. These memos serve as the basis of the research report.

Communicating

Nurses in the study reported that 24-hour accountability for primary nursing care is achieved through a process of communicating. The communication process involves a number of categories, oral and written methods and negotiating. For primary nurses, accountability means being responsible for assessing, diagnosing, implementing and following up a patient's care on a 24-hour basis. They operationalize accountability through communicating the nursing process. In their perceptions, accountability and patient care outcomes are linked intrinsically in the nursing process, which necessarily involved the care of patients, thus binding the nurses to the patients' welfare throughout their hospital stay.

Oral and written communications

All participants emphasized that it is essential to write specific instructions in their Kardexes and care plans, concise and informative documentation in the progress notes, and sometimes "very specific notes" for the associate nurse:

> Well, it's really up to me to have an up-to-date nursing plan in the Kardex and it's really up to my charting to tell people where I am going in terms of planning and what's happening to the patient. It's up to me to communicate how I see things should go, and what my plans are for the patients, gain their cooperation in following through my plans.

Nurses in this study emphasized that nursing care plans should ensure effective communication between nurses and other health care personnel.

> There is one fact that has to be emphasized in primary nursing and that is communications. You have to know how to communicate. You're not here for 24 hours. There are several ways of communicating: giving messages, taping and discussion with the associate nurse. You delegate what you want followed up when you are away. Discuss with the other nurses long-term and short-term goals and what you want to focus on.

The data reveal that written or spoken shift reports provide another means of communicating the 24-hour plan of care. There is also one-to-one discussion between primary and associate nurses concerning the priorities of care. As well, primary and associated nurses hold nursing conferences which allow for consultation and discussion.

The primacy of communication as a means of operationalizing accountability is demonstrated in this study. Our participants who had worked in other nursing care systems, such as functional or team nursing, said they were not always provided the opportunity to communicate their plans of care because of the very nature of the nursing care system. As an example, the medication nurse in a functional system is not expected to communicate the total plan of care for each patient. The essential role of the primary nurse as a communicator should be reflected in the development of performance standards for primary nurses (Beck, 1990, p.37).

Negotiating the care plan

In addition to written and oral communication, peer relationships between primary nurses and associate nurses play a vital role in maintaining accountability in primary nursing. It was evident from the data that writing down specific instructions in the care plans was not enough to ensure that the 24-hour plan of care was carried out. Nurses in this study negotiated with associate nurses to carry out their plans of care. Participants claimed that negotiating is achieved through the establishment of peer relationships that involve the properties of respect, trust, reciprocity, colleagueship, collaboration and flexibility.

Respect. Primary nurses claimed that in order to communicate effectively, nurses must respect one another. Respect means belief in the value and potential of a person (Gazda, William & Richard, 1982). As one nurse stated:

> I respect others' opinions and I expect the same thing from them. I expect that someone will not change my plans of care without justifiable reasons. On the other hand, there are different ways of doing things with the same basic principles. I have to respect that as well.

Trust. One very striking belief voiced by the majority of nurses was a trust in their peers to carry out their plans of care in their absence. One nurse explained it this way: "I trust my peers. I know that I can rely on them to give the best care and follow my plans. I depend on their sense of integrity and they know they can depend on me." Most nurses stated that, to carry out 24-hour accountability, they and their associates must adopt a "give and take" attitude towards one another. One nurse said, "As an associate, if the primary nurses asked me to do something specific, I know what she expects of me. Next time I might have to ask the same thing from her."

Flexibility. Most nurses mentioned that flexibility was vital in maintaining a peer relationship. To be flexible means to be capable of being modified. This requires an open-minded point-of-view. One nurse commented, "Although I

am accountable for the plan of care, it does not have to all come from me. I am open to suggestions and use others' experience and resources."

Colleagueship. The majority of nurses have indicated that colleagueship exists amongst them. Ciske (1980) pointed out that colleagueship in primary nursing entails peer support and being accountable to each other. One nurse stated:

> I'm accountable to my peers for letting them know what I am doing for my patients. I expect the same thing from them. We share each others' ideas and experience, give a lot of feedback. Someone will say, 'I'm having trouble getting Mr. so-and-so up, I've tried this and that and it's not working'. So we consult one another. There is some sort of colleagueship.

Collaboration. All of the nurses in this study claimed that collaboration is essential to maintain 24-hour accountability.

> Although you are the one specific person accountable for the plan of care, you need to work together and collaborate. The primary nurse, alone, can not maintain the 24-hour plan of care without collaboration from peers.

The process of communicating that maintains 24-hour accountability is illustrated in Figure 1.

Nursing process: basis for 24-hour accountability

Although the nurses in this study did not mention "nursing process" as the area of their accountability, it was evident from the data analysis that they were made accountable for its total application. As perceived by the informants, accountability and patient care outcomes are linked intrinsically in the nursing process. This includes knowing the patient, developing a 24-hour care plan, care giving and following through (evaluation). The nurses said that, because they were in direct contact with their primary patients while they gave direct care, they could assess, plan, implement and evaluate the nursing care being rendered. Primary nurses differ from nurses in other modalities of nursing care delivery because primary nursing involves application of the nursing process over time, rather than task completion per shift (Beck, 1990). Nurses developed a one-to-one relationship while "knowing the patient." Primary nurses possessed a "global view"; as such, they had the knowledge necessary to develop a 24-hour care plan throughout the patient's hospitalization. The data from this study indicate that one nurse --the primary nurse -- assesses, plans, implements and evaluates 24-hour care: "I was accountable for all my patient's care, which means that I was the one who,

after I got to know the patient, wrote up the nursing care plan." This finding is congruent with the view of Manthey et al. (1970) that one nurse, the primary nurse, who knows the most about the patient, develops the care plan. In contrast, in team and functional nursing, more than one nurse may develop a plan and no single nurse is held accountable for either the plan itself or the actual total care of the patient.

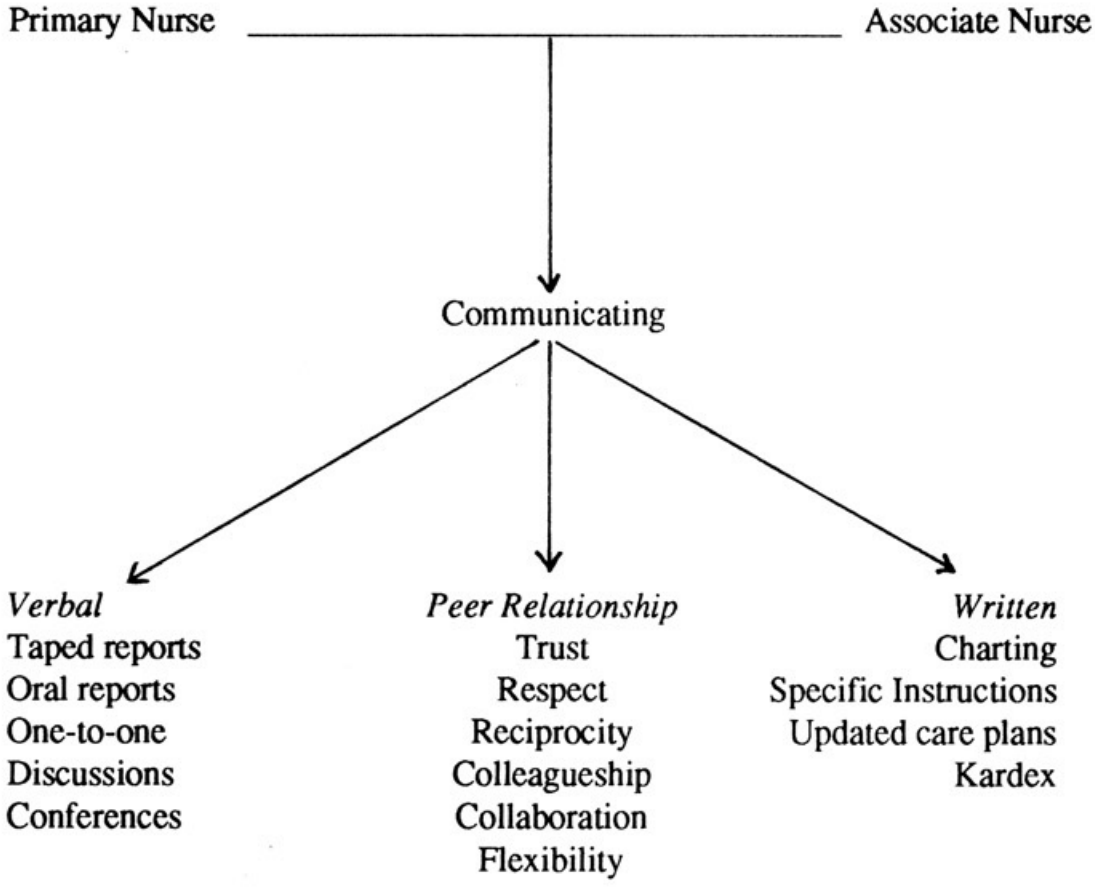

Figure 1

Communicating: the process that maintains 24-hour accountability

Knowing the patient

Nurses in this study claimed that knowing their patients involves establishing a one-to-one relationship with the patient and her or his family, performing a thorough assessment and identifying the patient's problems (nursing diagnosis). As one nurse stated, "It is important that I establish trust and rapport initially, which sets the tone of my relationship with the patient and family throughout the hospitalization." While every nurse must know the patients in order to care for them, the nurses in this study claimed that they develop what they call a "global view" and a "total picture" of their patients. The following are typical descriptions of the primary nurse's attempt to "know the patient".

> When I admit my primary patient, I do an assessment and evaluate the person. I find out what brought the patient to the hospital and then begin to consider those relevant aspects in his life that affects his well-being. What I am basically doing is sifting through pieces of information, physical, social, psychological and emotional aspects and trying to provide diagnostic nursing assessment, then developing appropriate nursing plans for my patients.

Developing a 24-hour care plan

All participants indicated that developing the 24-hour care plan is one area of their accountability as primary nurses. This includes setting up specific written goals and expected outcome of care, discharge planning and consultation referral. As one participant put it, "As a primary nurse, I am accountable for planning the patient's 24-hour care. Since I am not here all day, I have to make it clear in my care plan what I want done or how I want my patients cared for in my absence." According to Kaban and Thompson (1990), in other nursing care systems, no one nurse is accountable for patient care planning, so no one takes responsibility to ensure that all aspects of nursing care are carried out.

Care giving (implementation)

All nurses in this study claimed that they are accountable for all aspects of care giving, which includes *direct physical* care when possible, *patient teaching, coordinating* and *advocating*. Care giving in the nursing process is commonly known as implementation. This refers to the action or actions initiated to accomplish defined goals (George, 1980). To help individuals and families accomplish these goals requires staff who are involved with the caring, and who possess knowledge of teaching-learning theory, psychology, anatomy and physiology, pathology and sociology, to meet clients' needs accurately (Gross-Miller, 1981). While registered nurses possess these skills, it is often the nursing assistants who give the physical care.

Direct physical care. All participants in this study claimed that they are the ones who provided direct physical care to their patients. One nurse stated that the only instance in which she did not care for all her patients while she was on duty was when one of her patients became very ill and required her full attention. The philosophy of primary nursing requires that primary nurses give direct care whenever on duty, which is ideal but in some situations impossible.

Patient teaching. The nurses in this study indicated that, because they were in direct contact giving physical care, it was easier to implement other planned nursing actions such as patient teaching and discharge planning. According to these nurses, patient teaching focused on providing patients with knowledge of their illness, medications, diet, exercise, activities and any psychomotor skills required to care for themselves when discharged. How to maintain health and prevent illness were also stressed as important aspects of patient teaching. One nurse commented:

> Most of the time, teaching the patients is done by the primary nurse, because it is one of these "intangible" things expected of her. I find it difficult to do patient teaching when I work nights, so I have to collaborate with the associate.

These nurses stated that in other nursing delivery systems which are task-oriented, patient teaching is often given low priority because it has low visibility.

Coordinating and advocating. Traditionally, the role of coordinating patient care belonged to the team leaders or the nurse-in-charge. Nurses in this study claimed that they were the "hub" or centers of communication between the patients and other members of the health care team. One nurse described herself as, "the pole in the middle who is responsible for making sure that things go well for the patient." Participants indicated that they were accountable in coordinating their patients' care. Another aspect of care giving (implementation) that primary nurses claimed they were accountable for was advocating for their patients. Advocating in primary nursing differs from that in other nursing systems because the primary nurse is better prepared through knowing the patient and more obligated to be the patients' advocate due to her accountability for the outcomes of care (Zander, 1980).

Following through (evaluation)

Nurses in this study stated that they monitored and followed through the effectiveness of the nursing care given to their patients and that they were held accountable for patient care outcomes. They did this in several ways: observation, written documentation in the patient's charts, identifying

specific goals met by the nursing actions, patient and family feedback, nursing care plans and nursing grand rounds. They agreed that accurate, precise and informative notes are expected, so that primary nurses and their associates are informed of the progress of care:

> If a nursing care plan was changed because of the change in the patient's condition or if the plan was not effective, I expect the other nurses to chart it and let me know about it. I expect my associates to comment in the progress note how my patient is meeting the goals.

It was evident from that data that the primary nurses were held accountable for the total and systematic application of the nursing process, hence were made accountable for patient care outcomes. According to Kaplow, Ackerman and Outlaw (1989), primary nurses have the most consistent contact with the patient and are best able to assess efficacy of therapies, monitor clinical status and revise the plan of care.

Consequences of 24-hour accountability: positive and negative aspects

According to primary nurses, assuming 24-hour accountability has its joys and miseries. The joys emerge from being more involved with the patients and their families and caring in a professional manner. Our participants perceived that, because they are held answerable for the outcomes of nursing care from admission to discharge, the patients received professional, continuous and individualized care and hence were satisfied. Negative aspects include frustrations and the physical and emotional stress that come from increased demands and expectations that go with 24-hour accountability.

The integrated findings of this study

The conceptual framework developed from the study is illustrated in Figure 2. The diagram illustrates that communicating is the fundamental process that maintains 24-hour accountability. It is manifested in written and oral communication and peer relationship. As the arrows indicate, the communication process threads through every phase of the nursing process. The diagram details that the areas of accountability of the primary nurses we studied involve the total application of the nursing process. This consists of knowing the patient, developing 24-hour care plans, care giving and following through. Primary nurses were made accountable for the total application of the nursing process; as such, they were answerable for patient care outcomes.

The arrow at the bottom of the figure points to the consequences of 24-hour accountability for both the nurse and the patient, as represented by sphere A and B. The primary nurses (sphere A) have indicated their satisfaction in

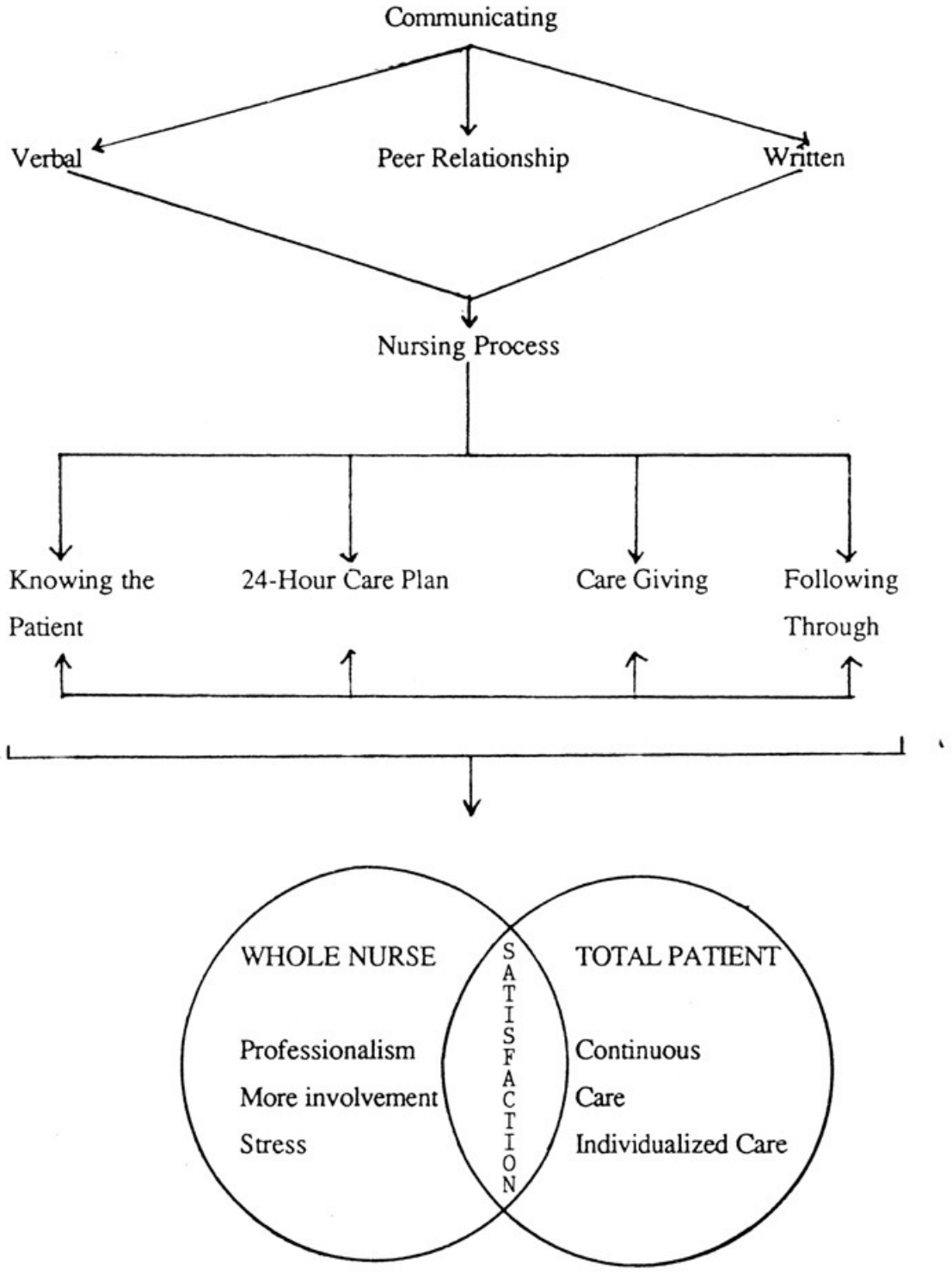

Figure 2

Accountability in Primary nursing

assuming accountability and have also perceived that their patients were satisfied. They have identified increased professionalism through the total application of the nursing process that made them accountable for patient care outcomes. While most participants perceived some benefits from assuming accountability, some indicated that stress is a result of the increased expectations of 24-hour accountability. Sphere B represents the nurses' perceptions of the effects of 24-hour accountability for the patient. These consist of continuous and individualized care as a result of considering the total patient in the delivery of nursing care.

Therefore, the analysis of communicating as the key to accountability; nursing process as the basis for 24-hour accountability; and, the consequences of accountability revealed that these factors are interrelated in the definition and operationalization of accountability in primary nursing. According to our participants, accountability in primary nursing means being answerable for the outcomes of patient care through the total application of the nursing process. This 24-hour accountability is maintained by communicating all aspects of the nursing process.

Implications and Conclusion

Our data indicate that the ability of the primary nurse to communicate with the patients, families, peers and other health care members is essential to their maintaining accountability in providing nursing care. Nurses, regardless of the nursing care system in any setting, should be held accountable for communicating each aspect of the nursing process to patients, families and peers.

Our findings suggest that the primary nurse is accountable for the total application of the nursing process; hence, outcomes of patient care. Therefore, it becomes essential for them to update their nursing knowledge in order to assess the patient, to develop the 24-hour care plans, to give direct nursing and to evaluate patient care. This accountability must be expected, not only from primary nurses, but from all practising nurses.

Data indicate that the demands of primary nursing can be stressful to some nurses, physically and mentally. We suggest that establishing support and interest groups may help primary nurses cope with these stresses. Similar support groups that already exist in such highly stressful units as critical care and oncology nursing can be adopted in primary nursing.

Based on the findings of this study, we recommend that further testing of the concept of accountability be done with a different population using a comparative study, to provide broader generalizability of the present findings; that further comparative studies be done to determine the quality of

communication that exists between nurses and patients, other nurses and other health care workers in primary nursing systems and other nursing systems; that further studies be carried out to investigate the differences in the total application of the nursing process in primary nursing and other nursing systems, focusing on nursing assessments, nurses' decision-making skills, patient teaching, discharge planning, method of documentation and evaluation of patient care; and, that a further study to measure the degree of accountability be conducted, in order to correlate the degree of accountability to the outcomes of patient care.

The accountability that the primary nurses assumed in this study has broader implications for all nurses, in any setting. Nurses must define and operationalize accountability for the application of the nursing process and they should maintain accountability by means of communication. Nursing process is the professional standard by which patient care outcomes are produced; hence, it is a tenent of accountable practice. Primary nurses are more closely involved with their patients; as such, they are in a better position to identify problems in the clinical areas, thus providing more stimulus to nursing research in this area.

REFERENCES

Beck, S. (1990). Development of a primary nursing performance appraisal tool. *Nursing Management, 21*(1): 36-38, 42.

Carey, G. (1979, JuNy). Evaluation of a primary nursing unit. *American Journal of Nursing, 79,* 1253-55.

Ciske, K.L. (1974). Primary nursing evaluation. *American Journal of Nursing, 74,* 1436-1438.

Ciske, K.L. (1980). Introduction of seminar and clarification of accountability in nursing. *Nursing Dimensions, 7,*Winter, 1-11.

Daeffler, R. (1975). Patients perceptions of care under team and primary nursing. *Journal of Nursing Administration, 5*(2), 20-26.

Felton, G. (1975). Increasing the quality of nursing care by introducing the concepts of primary nursing: A model project. *Nursing Research, 24*(1), 25-32.

Frevert, E.I. & Galligan, K.A. (1975). Evaluation of nursing care: A primary nursing care project. Part 2. Experiences of non-participant observers. *Supevisor Nurse, 6*(1): 40-43.

Gazda, G., William, C. & Richard, P. (1982). *Interpersonal Communications*. Rockville, MD: Aspen Publishers.

George, J. B. (1980). *Nursing Theories: The Base for Professional Practice*. Englwood Cliffs, NJ: Prentice-Hall.

Giovanetti, P. (1980). A comparison of team and primary nursing care system. *Nursing Dimensions, 7*(4): 96-100.

Giovanetti, P. (1982). Primary nursing: The number one solution. Published in Zilm, G. & Hilton, H. *Nursing Service and Education*. Proceedings for the National Research Conference, Victoria, B.C.

Glaser, B.G. (1976). *Theoretical Sensitivity*. Mill Valley: Sociology Press.

Glaser, B.G. & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Co.

Gross-Miller, J. (1981). Primary nursing in a rehabilitation hospital. *Rehabilitation Nursing, 6*(2): 19-22.

Hamera, E. & O'Connell, K.A. (1981). Patient centered variables in primary and team nursing. *Research in Nursing and Health, 4*, 183-192.

Hedegus, K.S. (1980). Primary nursing: Evaluation of professional nursing practice. *Nursing Dimensions, 7*(4): 85-89.

Kaban, L. & Thompson, G. (1990). Primary nursing on a psychogeriatric unit. *Nursing Management, 21*(7): 79-81.

Kaplow, R., Ackerman, N. & Outlaw, E. (1989). Co-primary nursing in the intensive care unit. *Nursing Management, 20*(12): 41-42.

Manthey, M.; Ciske, K.; Robertson, P. & Harris, I. (1970). Primary nursing: a return to the concept of "my nurse" and "my patient". *Nursing Forum, 9*, 65-84.

Marram, G. (1976).The comparative cost of operating a team and a primary nursing unit. *Journal of Nursing Adminstration, 6*(4): 21-24.

Marram, G.; Schegel, M. & Bevis, M. (1979). *Primary nursing: A Model for Individualzed Care*, (2nd Edition). Toronto. CV Mosby.

McPhail, A.; Pikula, H.; Roberts, J.; Browne, G. & Harper, D. (1990). Primary nursing a randomized cross-over trial. *Western Journal of Nursing Research, 12*(2):188-200.

Passos, J.Y. (1973). Accountability: myth or mandate? *Journal of Nursing Administration, 3*(3): 16-21.

Schatzman, L. (1973). *Field Research*. Englewood Cliffs, N.J.: Prentice-Hall.

Servellen, G.M. (1981). Primary nursing: variations in practice. *The Journal of Nursing Administration, September*, 40-46.

Sellick, K.J.; Russell, S. & Beckman, J. L. (1983). Primary nursing: An evaluation of its effects on patient care and staff satisfaction. *International Journal Nursing Studies, 20*(4): 265-273.

Shukla, R. (1981). Structure vs. people: An inquiry. *Nursing Research, 4*(30): 235-240.

Stern, P.N. (1980). Grounded theory methodology: Its uses and processes. *Image, 12*(1), 20-30.

Ventura, M.; Fox, R.; Carley, M. & Mercurio, S. (1982, July-August). A patients' satisfaction measure as a critieria to evaluate primary nursing. *Nursing Research, 31*(4), 226-230.

Zander, K.S. (1980). *Primary Nursing: Development and Management*. Georgetown, MD: Aspen System Corporation.

RÉSUMÉ

La reddition de comptes et le personnel infirmier

Selon les auteurs, l'obligation de rendre compte de l'exécution de sa tâche 24 heures sur 24 est l'essence même des soins infirmiers de première nécessité. Toutefois, le concept de reddition de comptes n'a pas été clairement défini; c'est pourquoi on a réalisé cette étude pour déterminer ce que signifie la reddition de comptes 24 heures sur 24 pour le personnel infirmier primordial et pour savoir comment ce personnel intègre ce concept dans ses activités. La méthode de recherche utilisée a été celle de la théorie fondée, qui est une analyse des données qualitatives en vertu de laquelle on élabore une théorie à partir des données. Vingt-et-une infirmières primordiales ayant un niveau de formation variable et appartenant à deux grands hôpitaux d'enseignement de Montréal ont été interrogées pour connaître leur point de vue sur la reddition de comptes 24 heures sur 24 dans les soins infirmiers primordiaux et savoir comment ce concept se manifeste. L'analyse des données a fait ressortir trois grands paramètres : a) la communication comme étant essentielle à la reddition de comptes; b) le processus infirmier comme fondement de la reddition de comptes; et c) les conséquences de la reddition de comptes. Les résultats nous révèlent que la communication est le meilleur moyen de rendre compte de l'exécution de sa tâche 24 heures sur 24 et que le personnel infirmier primordial dans cette étude est tenu responsable de l'application intégrale du processus infirmier dans l'exercice de son métier. Les infirmières ont souligné les conséquences négatives et positives d'être tenues responsables de l'intégralité des soins infirmiers durant toute l'hospitalisation de leurs clients. Cette étude est lourde de conséquences pour l'administration, l'exercice, l'éducation et la recherche dans le domaine des sciences infirmières.