PRIMARY NURSING AND NURSING AUTONOMY

by

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CHAPTER I

INTRODUCTION

The growth of nursing from a vocation to a profession is not yet complete. In fact, some believe nursing will never be more than a semi-profession. Moreover, as the history of nursing is reviewed, there appears to be one key element missing from nursing that could change it from a semi-profession to a full profession. Marram, Barret, and Bevis (1979) identify that element as autonomy. In the various lists of criteria defining professionalism autonomy is consistently mentioned as essential along with specialized knowledge, ethics, collegiality, responsibility and accountability. Autonomy refers to independence of functioning at the level of the individual practitioner (Greenwood, 1966, as cited in Pankratz and Pankratz, 1974). Autonomy is that component of professionalism with which this study is concerned.

Can nursing be practiced in such a manner that autonomy can be achieved? Marram et al. (1979) state that autonomous practitioners have direct access to clients, are responsible for their own practice decisions, and are accountable to peers, clients, professional organizations and the courts for their conduct. The practice of primary nursing by promoting responsibility and accountability may be the means by which autonomy can be achieved.

Primary nursing is defined as that organization of nursing which designates the total care for an individual patient as the responsibility of one nurse, not many nurses. A primary nurse provides patient assessment, 24-hour planning of patient care, direct patient care, and evaluation and coordination for a particular case load of patients until

transfer and discharge. A primary nurse is responsible and accountable for all of the above. An associate primary nurse is one who provides 8-hour nursing care to patients who have no primary nurse or whose primary nurse is off duty. The main difference between an associate primary nurse and a primary nurse is the 24-hour responsibility which the primary nurse assumes. The associate nurse assists the primary nurse in giving continuity of care to primary patients.

The responsibilities of "total care" or "case" nurses resemble those of primary nurses in that they give medications and treatments, administer hygiene and comfort measures, and teach and communicate through charts, reports, and care plans. However, "total care" nurses are accountable for only an 8-hour shift rather than 24-hours as are primary nurses. The main difference between the associate primary nurse and the "total care" nurse is that the former works with a primary nurse under the primary nursing system, and the latter does not.

Marram et al. (1979) sees the attainment of autonomy as necessary for nursing's professional development. They also see autonomy as desirable in that it permits nurses to respond more directly and adequately to the patients' needs, rather than to the needs of agencies or other professionals.

Enthusiasm for primary nursing among many nurses is high at this time. Primary nursing has been hailed as a step toward increased professionalism by enhancing the autonomy of the individual nurse. However, to date, the relation of primary nursing to autonomy has not been specifically studied. It was the purpose of this research to help clarify this relationship.

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REVIEW OF THE LITERATURE

This review of the literature centers on three areas, namely, the relation of autonomy to primary nursing, the relation of the mode of nursing care delivery to professionalism, and personal characteristics affecting response to primary nursing.

Autonomy and Primary Nursing

Brown (1976) states that the autonomous nurse (a) provides personalized nursing care to patients and their families; (b) makes clinical decisions without ratification by a doctor or other nurses; (c) commands his or her own nursing practice; (d) gives patients and families an opportunity to participate in their own personalized care; and (e) participates on a professional parity with the physician and other health care team members. Logsdon (1973) suggests that, since both the nurse and physician have an in-depth knowledge of the patient, the physician learns to value the nurse's autonomous contribution to care of the patient. Brown (1976) and Payton (1979) closely link autonomy to authority, responsibility, and accountability, and Payton further defines accountability as legal responsibility.

Primary nursing in itself may be contributory to nursing autonomy by investing authority and accountability in the nurse closest to the patient (Brown, 1976; Logsdon, 1973). Ciske (1979) concludes that primary nursing does not exist if patients, staff, or members of other disciplines cannot perceive a difference in accountability between the primary nurse and non-primary nurses on a given unit. Alexander, Weisman and Chase (1981) state that primary nursing increases nurses' accountability to patients, authority and autonomy through the

reduction of task routinization, the increase of nurses' control over decisions regarding patient care, and the increase in decision based on professional judgment. A complementary relationship therefore exists between professional autonomy and primary nursing.

In summary, independent clinical decision making, based on professional judgment, is thought to be practiced by primary nurses. Since independent clinical decision making is one aspect of autonomy, it might be expected that primary nurses have more positive attitudes towards autonomy, and manifest more autonomous behavior than their counterparts using other modes of practice.

Relationship of Nursing Care Mode to Professionalism

A comprehensive study by Marram et al. (1979) was the only study found that compared all four types of nursing care modes--team, functional, total care, and primary--in terms of professionalism. The researchers used a structured questionnaire, informal commentary, and periodic performance evaluations to access the differences between primary nurses and case, team, and functional nurses. Cross-sectional and longitudinal data were utilized to compare the professional orientation of the four groups. Professionalism was defined as (a) an orientation toward quality care versus just getting the work done quickly; (b) a value placed on one-to-one patient-centered care versus object-oriented care; and (c) acknowledgment of expertise versus length of service. (It should be noted that this definition of professionalism parallels the definition of autonomy). Study results indicated that participation in primary nursing increased the nurses' professional orientation, and that those nurses already under a primary nursing

system seemed to hold a higher professional orientation than their counterparts on other units.

Walleck (1979) studied a neuro-surgical unit that changed from team to primary nursing for the purpose of increasing continuity of care. Continuity of care was increased and nurses experienced an increased sense of their "professional role" (this term not defined) and more collegiality with doctors. Additionally, the teaching and patient advocacy roles were enhanced after instituting primary nursing.

In summary, the literature suggests that primary nursing increases professionalism in nurses. Primary nurses are thought to have closer relationships with patients and more collegial relationships with physicians. The primary nurse is thought also to provide stronger patient advocacy.

Personal Characteristics Affecting Primary Nursing and Autonomy

Walleck's study (1979) noted that some older RNs who were first designated as primary nurses could not function in that role because they had been cautioned in their training in previous years not to become too involved with their patients. Marram et al. (1979) found that new graduates who were not primary nurses experienced a disparity between their idealism and their practice and suffered a loss in professionalism. Donahue, Weiner, and Shirk (1977) proposed that primary nursing lessens the reality shock of new RNs in that such nursing is closer to the case or total care nursing which is the method now used in many nursing schools rather than team nursing which is practiced in many hospitals. So it seems that age and recency of graduation are

variables that may affect the nurse's response to primary nursing and thereby the nurse's sense of professionalism or autonomy.

The nurse's position and education are also factors affecting autonomy, according to Pankratz and Pankratz (1974). They found that the diploma graduate nurses in community hospitals served mainly as staff nurses, had relatively low autonomy scores and tended to be traditional. By contrast, nursing "leaders" generally held master's degrees, had the higher autonomy scores and manifested more progressive attitudes. University and psychiatric hospital staff held higher nursing degrees than community hospital staff and were more "specialized" (undefined). Their mean autonomy scores were higher than those of community hospital staff, but lower than those of the nurse "leaders". Pankratz and Pankratz (1974) concluded that higher educational degrees were associated with greater autonomy.

This literature review suggests that age, recency of graduation, education, specialization and leadership position may affect autonomy. Other personal characteristics not included in the literature review may also need to be considered. These include (a) work status (full versus parttime employment); and (b) length of time on a particular unit, since increased familiarity with the unit and unit routine may increase autonomy scores; (c) length of work experience since graduation from nursing school, since increased nursing work experience may cause the nurse to gain confidence in nursing practice and increase autonomy scores; (d) previous experience with primary nursing, since primary nursing may foster autonomy and increase the scores; and (e) shift, since the number of staff on each shift (more on day, less on

night) varies, and therefore the number of people available for consultation, may affect autonomy scores.

In summary, age, recency of graduation, nursing degree, leadership position, work status, specialization, length of work experience since graduation from a school of nursing, length of work experience on a particular unit, previous experience with primary nursing and shift worked were chosen as personal characteristics to be evaluated in this study in their relationship to autonomy.

Purpose of Study

The major purpose of this study was to examine the relationship of primary nursing to nursing autonomy. A secondary purpose was to examine the relationship of autonomy to the personal characteristics of nurses, specifically, their age, recency of graduation, nursing degree, leadership position, work status, specialization, length of work experience since graduation from a school of nursing, length of work experience on the unit, previous experience with primary nursing, and shift worked.

Hypotheses

1. Nurses who have been oriented to primary nursing through an inservice program will tend to have higher autonomy scores than those who have not been oriented.
2. Nurses who perceive themselves as primary nurses will tend to have higher autonomy scores than those who do not perceive themselves as primary nurses.

3. Nurses with a positive attitude toward primary nursing will tend to have higher autonomy scores than those who do not have a positive attitude toward primary nursing.

CHAPTER II

METHOD

Design

The design of this study was quasi-experimental without randomization, utilizing a non-equivalent control group (Campbell and Stanley, 1963). This design is regarded as controlling for history, maturation, testing, and instrumentation, and is one of the most widely used in educational research where the groups of interest are naturally occurring collectivities.

Procedure

The Nursing Autonomy Questionnaire (Pankratz and Pankratz, 1974) and the personal data form were completed by nurse subjects on both the control and experimental units during the period from January 18 to February 18, 1981. Following the pretest, nurses on the experimental unit received a primary nursing inservice program, consisting of lecture, readings and group discussions. Seven weeks after the initial test, the nurse subjects in the control and experimental groups completed the same Nursing Autonomy Questionnaire administered on the pretest, plus an abbreviated Personal Data Form. This was prior to a time when most experimental group nurses had been able to assume care of a primary patient. See Appendices A-E for the Nursing Autonomy Questionnaire, Personal Data Form, Primary Nursing Inservice Schedule, Personal Data Form II and the Informed Consent Protocol.

Subjects and Setting

Thirty nurses from a population of 50 nurses (60%) on three similar medical units comprised the sample. Eleven nurses on one unit

participated in an orientation to primary nursing, while 19 nurses on the other two units did not. No licensed practical nurses and few aides worked on these same units and none were included in the study.

Approximately 1½ years ago, primary nursing had been initiated on these three medical units but had then been abandoned, perhaps because of insufficient preparation for the change. The present slower attempt at the introduction of primary nursing was proposed by the staff in the unit that received an orientation to primary nursing. The staff on this unit helped plan for implementation.

The setting was a non-profit, acute-care, teaching hospital of approximately 450 beds, situated in metropolitan Portland, Oregon. A total of three medical units were used. The unit that received orientation about primary nursing contained a total of 20 beds, and the two other units had 20 and 24 beds. The same coordinator supervised nursing service on all three medical units. At the beginning of the study, the head nurse for the unit that received orientation about primary nursing was also, temporarily, head nurse for one of the other medical units. Later, a staff nurse from that unit assumed the position of head nurse. The head nurses were included in the study.

Dependent Variable--Autonomy

The dependent variable was autonomy. The degree of autonomy was measured by Pankratz and Pankratz's (1974) Nursing Autonomy and Patients' Rights Questionnaire. The questionnaire contains the Nursing Autonomy and Advocacy Subscale, the Patients' Rights Subscale and the Rejection of Traditional Role Limitations Subscale. Only the Nursing Autonomy and Advocacy Subscale was pertinent to the study, and

it alone was utilized; however, the entire questionnaire was administered to each nurse in the study, to retain proper scoring and question sequence.

The Nursing Autonomy and Advocacy Subscale "includes the nurse's perception of how much latitude nurses have, are allowed or would be willing to take, in functioning as a responsible professional" (Pankratz and Pankratz, p. 212). Pankratz and Pankratz claimed this subscale measured the "extent that nurses feel comfortable in taking initiative and responsibility in the hospital. It also measures the nurse's attitude toward the patient's right for control in the hospital. The factor seems to measure flexible attitudes toward nursing, toward patients and toward the hospital milieu with emphasis on the nurse's competence and accountability as an autonomous professional" (p. 213). Each of the 26 questions in the Nursing Autonomy and Advocacy Subscale had a 5-point response scale from 5 (strongly disagree) to 1 (strongly agree). (The full scoring procedure may be found in Appendix F). The items were differentially weighted, and total scores in principle could range from 26 (least autonomous) to 130 (most autonomous).

Independent Variables Related to Primary Nursing

When this study was first designed, it was anticipated that autonomy scores of nurses who practiced primary nursing could be compared with the autonomy scores of nurses who did not. This proved impossible because of delays in implementing primary nursing on the unit where orientation to primary nursing took place. Instead, this study examined the relationship of autonomy scores to (a) perception of

whether one practiced primary nursing or not, (b) participation in an orientation towards primary nursing, and (c) favorability towards primary nursing.

The perception of whether one practiced primary nursing or not was obtained by asking nurses in the sample both on pretest and posttest whether they practiced primary, total, team, functional or a mix of these nursing modes. Primary nursing was defined as providing total care for a small group of patients, usually 4 or 5, for 8-hours as well as providing 24-hour planning, evaluating and coordinating for these same patients until transfer or discharge. Total care nursing was defined as caring for the total needs of a small group of patients, usually 4 to 8, including planning, evaluating, and coordinating for only 8-hours, or one shift. Team nursing was defined as nursing care provided by an RN and a number of nurse aides. The team leader (RN) assumed final responsibility for patients for one shift. Functional nursing was defined as responsibility for certain designated tasks for a single shift by an RN or other medical personnel. Ciske's (1979) definitions for primary nursing and total care nursing were provided to the nurses in the sample to help them distinguish between these two similar modes of nursing care. (See Appendix G for definitions).

Participation in a primary nursing inservice program was ascertained on the posttest by asking each nurse in the sample if he or she had attended the lecture or read the assigned literature on primary nursing.

Favorability towards primary nursing was indicated by the degree of positive or negative response to the following statement about

primary nursing: "I prefer (or would prefer) to perform primary nursing rather than total care nursing." A 5-point scale from 1 (strongly disagree) to 5 (strongly agree) was used.

Independent Variables Related to Personal Characteristics

Data on age, recency of graduation, nursing degree, leadership position, length of time on the unit, experience with primary nursing, specialization, work status, length of nursing work experience and shift were obtained. Work status was determined by asking the respondents how many hours they usually worked in a 2-week period. (In this setting, 72 or more hours per 2 week period constituted full time work, and less than 72 hours per 2 week period constituted part time work). Specialization was ascertained by the nurse's response to the question: "Do you have a nursing area (such as surgery, orthopedics, or oncology) in which you consider yourself specialized? If so, what is that area?" Nursing work experience was determined by counting the total number of years worked, both full time and part time, since licensure as a nurse. The nursing degrees were stipulated as AS, BS, MS or Diploma.

Data Analysis

For the data analysis, both descriptive and inferential statistics were employed. Some personal characteristics were evaluated on the pretest only and some (those that may have significantly changed during the study period) were evaluated on both the pre and posttest. Although the analysis of the data centers around determining a relationship between autonomy and perceived nursing mode, attitude toward primary

nursing and primary nursing inservice, the relationships between the selected personal characteristics and autonomy were also studied.

CHAPTER III

RESULTS

Description of Sample

Nurses on the unit that received an orientation to primary nursing (experimental group) were compared to nurses on the two units that had not received that orientation (control group). The nurses in both groups had similar autonomy scores and personal characteristics on the pretest. The mean pretest autonomy score of the experimental group was not significantly different from the mean pretest autonomy score of the control group (88.5 versus 90.2, respectively, t=.34). Neither were there significant differences in age, length of nursing work experience (in years), recency of graduation (in years), work status (hours worked per 2 week period), or length of time on the unit (in months). (See Table I).

Most nurses in the sample (64% in the experimental group and 68% in the control) held bachelor degrees, the remainder holding diploma or associate degrees. Forty-five percent of the nurses in the unit receiving orientation to primary nursing reported themselves as leaders and a similar number, 42% of the un-oriented nurses, reported themselves as leaders. Seventy-three percent of the nurses in the experimental group worked the day shift compared to 53% of the nurses in the control group. However, the difference in the two distributions among shifts was found not to be significant by chi-square test.

In the experimental group, 45% of the nurses had previous experience with primary nursing, whereas 74% had previous experience with primary nursing in the control group. This difference was not

Table I

Description of Sample and Comparison of

Experimental and Control Groups at Time of Pretest

Characteristic	Total (N=30)	Experimental Group (N=11)	Control Group (N=19)	Significance of Difference*
Age (mean years)	32.4	31.5	32.9	n.s.
Work Experience (mean years)	6.0	6.3	5.9	n.s.
Time since graduation (mean years)	7.7	8.5	7.2	n.s.
Time on unit (mean months)	23.0	14.2	28.0	n.s.
Work Status				
Full Time	23	9	14	n.s.
Part Time	7	2	5	
Specialization				
Yes	15	2	13	$\chi^2=10.1$
No	15	9	6	
Nursing Degree				
Master	0	0	0	
B.S.	20	7	13	n.s.
A.S.	7	3	4	
Diploma	3	1	2	
Previous Experience With Primary Nursing				
Yes	19	5	14	n.s.
No	11	6	5	
Leadership Position				
Leader	13	5	8	n.s.
Staff	17	6	11	
Work Shift				
Day	18	8	10	n.s.
Evening	8	2	6	
Night	2	0	2	
Other	2	1	1	

Table 1 (continued)

n.s. = not significant

*p < .05. Significance of difference determined by t-test for age, work experience, time since graduation and time on unit, and by chi-square technique for remaining characteristics. Nursing degrees were dichotomized into B.S. versus A.S. and Diploma; work shift categories were dichotomized as day versus evening, night and other.

significant. The only characteristic for which a significant difference was found between experimental and control groups was specialization (18% among the nurses receiving primary nursing orientation versus 68% among those who did not receive orientation). ($\chi^2=10.1$, df=1, $p<.05$).

In general, as may be noted from Table I, the sample consisted of young, full time nurses, recently graduated from baccalaureate programs. They had spent a short time (about two years) on their units and had about four years of nursing work experience. Most had some previous experience with primary nursing. Most were staff nurses, working on day or evening shifts. About half considered themselves specialists.

In summary, the experimental and control groups were very similar at the time of pretest with respect to all the selected personal characteristics except specialization. Most importantly, the two groups did not differ significantly in their mean autonomy scores at pretest. Because of the basic similarity of the two groups, any changes observed following the experimental intervention cannot be attributed to extraneous differences other than specialization.

Over the 7-week course of the experiment, one nurse in the control group was transferred, another nurse was terminated, and one became a head nurse. Overall, then, there was very little change in any of the personal characteristics in the total posttest sample. Most nurses continued to work the day and evening shifts; one nurse changed from the evening to the day shift. No nurses changed work status, and there was only one leadership position change of consequence to autonomy. (The staff nurse who became a head nurse increased her autonomy score

on the posttest by 16 points). In summary, the experimental and control groups were very similar at pretest and posttest.

Effect on Autonomy of Nurses' Perception of Nursing Care Mode

One independent variable was the nursing mode as perceived by nurses, whether primary, team, functional, total or other. It may be seen that the majority of nurses in both control and experimental groups perceived themselves at the time of the pretest as performing total, primary or combinations of nursing modes. (See Table 2). Functional and team nursing were cited only once each on the pretest. Team nursing was cited once again on the posttest and functional nursing twice.

Total care nursing was cited most often as the perceived nursing mode on the pretest by the experimental group and primary nursing was cited most often by the control group. Individuals in the experimental group may have recognized they were not practicing primary nursing because they were scheduled to receive an orientation to primary nursing. Individuals in the control group may have perceived themselves as practicing primary nursing because primary nursing had been tried 1½ years earlier.

Only the nurses in the experimental group were exposed to the inservice program on primary nursing. All indicated on the posttest that they had indeed attended the lecture on primary nursing and had read at least part of the reading material given to them. While three of these nurses reported practicing primary nursing at present, none reported practicing it at posttest. Of the group receiving orientation, the five who perceived themselves as practicing total care nursing on

Table 2

Comparison of Nurses' Perceptions

of Nursing Mode on Pretest and Posttest

Type of Nursing Care	Pretest			Posttest		
	Total	Exp.	Control	Total	Exp.	Control
Functional	1	0	1	2	0	2
Team	1	1	0	1	1	0
Total	6	5	1	9	8	1
Primary	15	3	12	10	0	10
Combinations	7	2	5	6	2	4
Total	30	11	19	28*	11	17

*Two nurses were lost to the study over the 7-week experimental period due to termination and transferral.

the pretest continued that perception on the posttest and the three nurses in the group who perceived themselves as practicing primary nursing at pretest shifted their perception of practice to total care nursing at posttest, perhaps due to a greater understanding of primary nursing.

In contrast to the experimental group, 12 of the nurses in the control group perceived themselves as practicing primary nursing at the time of pretest and 10 of these nurses continued to perceive this as their mode of practice at the time of the posttest. It would appear that the lectures and readings about primary nursing changed the perceptions of nurses about what primary nursing entailed. Table 3 shows that there was no significant difference on either pretest or posttest between the mean autonomy scores of nurses who perceived themselves as primary nurses and those who did not. Also, there was very little change (pretest and posttest) in the mean autonomy scores of the group identifying themselves as primary nurses and the group identifying themselves as non-primary nurses.

Primary Nursing Inservice Program and Its Effect on Autonomy

Table 4 compares autonomy scores of those receiving an orientation to primary nursing (experimental group) and those not receiving orientation to primary nursing (control group). It can be seen that there was no significant difference (using a t-test) in the mean autonomy scores between the two groups on either the pretest or posttest. There also was no significant change over the 7-week period for either group. In short, both groups exhibited similar degrees of autonomy, at pretest and posttest, and neither group exhibited any change.

Table 3

Comparison of Mean Autonomy Scores Between Nurses Who Perceived Themselves As Primary Nurses and Those Who Did Not: At Pretest and Posttest

	Pretest			Posttest		
Autonomy Scores	Primary (N=14)*	Other (N=14)*	Significance of difference	Primary (N=10)	Other (N=18)	Significance of difference
Mean	89.1	89.9	t=.19	93.8	88.0	t=1.03
S.D.	12.6	9.1		14.6	11.6	

*Two nurses were lost to the study over the 7-week experimental period due to termination and transferral.

Table 4

Comparison of Mean Autonomy Scores Between Nurses Receiving Orientation To Primary Nurses (Experimental) and Other (Control) Pretest and Posstest

	Pretest			Posttest			Pretest and Posttest Difference		
	Exp. (N=11)	Control (N=17)*	Significance of Difference	Exp. (N=11)	Control (N=17)*	Significance of Difference	Exp.	Control	Significance of Difference
Mean	88.5	90.2	.34	89.8	90.5	.51	1.3	.03	.76
S.D.	5.6	11.8		4,9	11.3				

* Two nurses were lost to the study over the 7-week experimental period due to termination and transferral.

Since there was little evidence that the experimental group in fact practiced primary nursing, and since no nurse within the group perceived herself as practicing primary nursing at the time of the posttest, the basic assumption on which the study was designed was not met. Hence, what was actually tested was whether or not autonomy scores were related to lecture and reading material about primary nursing, rather than the actual practice of nursing. No significant difference in autonomy was found between the experimental group which received orientation to primary nursing and the group that did not, at either pretest or posttest.

Attitude Toward Primary Nursing and Its Relationship to Autonomy

A high percentage of nurses in the pretest sample (82% in the experimental group and 89% in the control) reported favorable attitudes toward primary nursing (there were no favorable attitudes indicated, only favorable and undecided). After the orientation and 7-week period of trial, some slight change occurred in the overall attitude toward primary nursing with an increase in the percentage of undecided and unfavorable votes in both control and experimental groups (73% favorable in the experimental group and 53% in the control). This was a significant difference by chi-square ($\chi^2=5.1$, df=1, $p<.05$). This change may have been caused by an increased awareness on the part of the experimental group of what primary nursing entailed. Another factor may have been the loss of two of the control group nurses on the posttest who were positive to primary nursing on the pretest.

A significant relationship was found between attitude toward primary nursing and autonomy score. By chi-square median test

(χ^2=8.9, df=1, $p<.05$) those nurses with autonomy tended to favor primary nursing to a greater extent than nurses with autonomy scores below the median.

Personal Characteristics and the Relationship to Autonomy

Pearson's correlation coefficients were computed between autonomy scores and scores on all other measures of interval scale. These characteristics included age, years of nursing work experience, years since graduation, time in months on the unit and work status (hours per two week period).

The characteristics of work status, shift, and leadership position were evaluated at pretest and posttest, since it was believed that these might change significantly during the study time. This was not the case, however, since no one changed work status; one nurse in the control group began working day shift instead of evening and one staff nurse became a head nurse in the control group.

From Table 5, it may be seen that at the time of pretesting, none of the correlations between autonomy score and any of the interval scale characteristics were significant in the experimental group. For the control group and total group at the pretest, age, work experience and time since graduation were all significantly and negatively correlated to autonomy score. In short, younger nurses, those more recently graduated and those with less work experience had significantly higher autonomy scores than did their counterparts.

The relationships of the several non-interval scale characteristics to autonomy scores were then examined. Analysis by chi-square median test showed no significant difference between the number of specialized

Table 5

Pearsonian Correlation Coefficients Between Autonomy Scores and Scores on Selected Characteristics at Pretest

Characteristics	Experimental (N=11)	Control (N=19)	Total (N=30)
Age	-.34	-.47*	-.43*
Work experience	-.47	-.46*	-.45*
Time since graduation	-.44	-.53*	-.50*
Time on unit	-.50	-.17	-.20
Work status (hours per two week period)	.09	-.16	-.10

* $p < .05$

and non-specialized nurses scoring above the median autonomy score. A similar analysis showed no significant association between nursing degree (B.S. versus all other) and autonomy score. Similarly, previous experience with primary nursing, leadership position and shift were found to be unrelated to autonomy.

Summary

No significant differences were found between the mean autonomy scores of nurses perceiving they were primary nurses and those who did not. No nurses in the group receiving an orientation to primary nursing perceived they were practicing primary nursing at posttest, while 57% of the unoriented nurses thought they were. The autonomy scores of nurses who were oriented to primary nursing were not significantly higher than the scores of those who had not been oriented to primary nursing. It was impossible to measure the relationship of autonomy to practice of primary nursing on pretest and posttest since nurses on the experimental unit had not yet implemented primary nursing. The hypothesis that nurses who perceived themselves as practicing primary nursing would have higher autonomy scores was not supported; neither was the hypothesis that nurses receiving orientation to primary nursing would have higher autonomy scores than those that did not. Favorability toward primary nursing was the only primary nursing variable significantly related to autonomy score.

Significant relationships were found between autonomy scores and age, years of work experience and years since graduation from a school of nursing. Younger, more recently graduated nurses and nurses with fewer years of work experience had higher autonomy scores. No

significant relationships were found between autonomy scores and full or parttime work status, previous experience with primary nursing, leadership position or shift worked.

CHAPTER IV

DISCUSSION

As noted previously, only one of the original three hypotheses was supported by the analysis. Those nurses with primary nursing orientation and those who perceived themselves as primary nurses were not found to have higher autonomy scores than nurses without orientation or without the perception of practicing primary nursing. This finding appears to disagree with that of Marram et al. (1979), who concluded, "nurses under the primary nursing system seemed to possess and retain a greater number of professional values" when compared to counterparts on other units. (p. 181). However, in Marram et al.'s study, subjects actually practiced primary nursing on primary units, whereas in this study subjects did not work on a designated primary care unit but only perceived themselves as practicing primary nursing. Marram et al.'s study was also long-term, whereas this study covered only a seven week period.

However, the finding is congruent with that of Alexander et al. (1981), who found autonomy not significantly related to the nursing care delivery system. However, once again, primary nursing practice was examined on units that had been utilizing that method of nursing care delivery for at least six months. It was noted that these primary nursing units also used alternate nursing care modes on the night shift due to R.N. shortage. These units were based on Gwen Marram's model. Alexander et al. (1981) studied the effects of primary nursing practice on a wide range of factors, one being autonomy. Although they did not use the same measure of autonomy as in the present study, their

findings were similar in that primary nurses did not have significantly higher autonomy scores than non-primary nurses. Alexander et al. (1981) concluded that "the impact of an organizational change, such as the adoption of primary nursing is difficult to measure, control, and thus, evaluate in realworld settings" (p. 87). This factor was apparent in the slow implementation of primary nursing in the present study, which made it impossible to test whether primary nursing practice was related to autonomy. There was not enough support for primary nursing so that primary nursing was not implemented for the whole unit; it became only an individual, occasional event.

Since primary nursing had been tried before on all the units involved in this study, some residual effects could have clouded the results, causing any difference between groups to be dampened. It could also be that the perception of total care versus primary nursing was so slight, that there really was no "event" to warrant an increase in autonomy scores in the experimental group, even though an inservice had been given. Most units do not change directly from functional or team nursing to primary nursing since this would require a very large shift in staffing and practice--too much to attain all at once, without first going through an intermediate step such as total care nursing.

Ambiguity regarding the nature of primary nursing could have contributed to lack of autonomy score increase in the experimental nurses and failure to obtain a significant difference in mean autonomy scores of the experimental and control groups. It was evident from the variety of answers to the question on nursing mode, in both control and experimental groups, that much ambiguity existed in the minds of many

of the nurses. The fact that some nurses in the experimental group thought they were doing primary nursing and then changed their opinions to total care nursing on the posttest shows how similar those two types of nursing care delivery systems seemed, and how easily they were confused. Ambiguity in the minds of the control group nurses also may have contributed to the lack of difference found in autonomy scores between primary and non-primary nurses. This ambiguity was also found as a factor in a study by Arnsdorf (1977) where "unfamiliarity of the responding nurse with the terminology" clouded questionnaire results (p. 101). In the present study, it was hoped to reduce this factor by providing nursing care delivery mode definitions.

The details and methods of primary nursing vary from hospital to hospital. The primary nursing practiced by subjects in Marram et al.'s study (1979) may have been formulated differently than the program at the hospital in the present study. Primary nursing was also newer at the time that Marram et al. conducted their study (1973-74), and could have created a small "Hawthorne effect". Some question might be raised concerning the sensitivity of the nursing autonomy questionnaire , whether it was sensitive enough to show the slight changes that may have occurred in as short a period of time as seven weeks.

In summary, the sensitivity of the instrument, the incomplete change to primary nursing through lack of staffing support, the seemingly slight difference between primary nursing and total care nursing practiced on the experimental unit, the short time frame, the previous attempt at primary nursing and the ambiguity regarding the value of primary nursing all may have been factors contributing to the

rejction of two of the hypotheses, regarding the significance of the relationship, between perceived nursing mode and autonomy and between primary nursing inservice and autonomy.

However, in support of one of the hypotheses, a significant correlation was found between a positive attitude toward primary nursing and a higher autonomy score. This supported the suggestion made in the literature review that autonomous nurses would like to employ primary nursing as a means of implementing professionalism. However, it should be remembered that almost all the nurses in this sample on both pre and posttests were favorably inclined to primary nursing and differed only in degree of favorability. Perhaps this favorability was the idea that primary nursing is a panacea, the "right way" to nurse or an idealistic state. As noted earlier, Marram et al. (1979) believed recency of graduation was an indicator of idealism in their study. Since most of the nurses in the present study graduated from nursing school less than five years previously, it is not surprising that most had favorable attitudes toward primary nursing.

It was noted that the negative correlations between autonomy and age, length of time since graduation (the less time since graduation, the higher the autonomy score) and length of nursing work experience were not found for the experimental group. One reason for this may be the small size of the experimental group, which would increase the difficulty in arriving at a significantly significant different correlation level. There could also be differences between the groups that were not perceived in this study. Age, more nursing work experience and less recent graduation were related to lower autonomy scores.

No significant relationships were found between autonomy scores and type of nursing education, previous experience with primary nursing, leadership position, work status, specialization, length of time spent on the unit and work shift. (Hence, specialization was not the reason for failure to get a difference between control and experimental groups).

Since the characteristics of age, years since graduation and length of nursing work experience were significantly and negatively correlated with lower autonomy scores, it is suspected that the longer a nurse participates in the hospital system, the less autonomous he or she becomes, or perhaps the older nurses were trained to be less autonomous in their nursing program.

In summary, the only hypothesis supported by this study was that nurses with a positive attitude toward primary nursing had higher autonomy scores than those who did not have a positive attitude. The only personal characteristics significantly correlated with autonomy were age, recency of graduation and length of nursing work experience, which were negatively correlated.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study set out to examine the relationship between primary nursing practice and autonomy in nurses. It became apparent that this was not possible in the setting chosen. Instead, the relationship between nurses' perceptions of nursing mode, primary nursing inservice program, attitude toward primary nursing and autonomy were examined along with various personal characteristics.

The essential findings of this study on primary nursing were: 1) Nurses with a positive attitude toward primary nursing were more autonomous than those who did not have a positive attitude toward primary nursing, and 2) Age, time since graduation from a school of nursing, and length of nursing work experience were inversely related to autonomy score. The findings about relationships between perception of nursing mode and autonomy and between orientation to primary nursing and autonomy were not significant.

It is suggested a cross-sectional and longitudinal study of primary nurses could be done using the other two components of the Pankratz and Pankratz Nursing Autonomy and Patients' Rights Questionnaire (1974), Traditional Role and Patients' Rights. This would help to clarify the effect of primary nursing practice on nurses.

It was noted by a few nurses in this study that the nursing autonomy questionnaire had questions either inappropriate to their situation at work or questions that they felt uneasy answering with just a check mark. Perhaps more research on the components of nursing autonomy or professionalism in the hospital setting may be

necessary to improve the validity of an instrument to use in the hospital setting.

Finally, it has been noted by this author that primary nursing units in the same hospital, started at different periods of time, have different problems in the practice of primary nursing that seem to be linked to the length of time primary nursing as been practiced. A study looking into this phenomenon should produce interesting and helpful results, especially with anticipation of problems in starting and maturing a primary nursing unit. Many other studies could be devised involving primary nursing since only a few truly scientific studies have been done so far.

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Appendices

A. Nursing Autonomy and Patients' Rights Questionnaire (Pankratz and Pankratz, 1974).

B. Personal Data Form I.

C. Orientation Schedule for Primary Nursing on the experimental unit.

D. Personal Data Form II.

E. Informed Consent Protocol.

F. Scoring procedure for Nursing Autonomy and Patients' Rights Questionnaire (Nursing Autonomy Scale) (Pankratz and Pankratz, 1974).

G. Definitions (Ciske, 1979).

APPENDIX A

Nursing Autonomy and Patients' Rights Questionnaire

(Pankratz and Pankratz, 1974)

Name:_____

Unit:_____

Questionnaire: #_____

We would like to know what you think about these statements. For each opinion statement, place a check in the box to the right of the question that comes closest to how you feel. There are no right or wrong answers. Please answer every item.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. I feel that patients should plan their own activities.					
2. I have fulfilled my responsibility when I report a condition to a physician.					
3. I would feel free to try new approaches to patients care without the "permission" of an administrative nurse.					
4. I feel free to recommend non-prescription medication.					
5. If I requested a psychiatric consult for a patient, I would feel out of bounds.					
6. I believe a patient has a right to have all his questions answered for him.					
7. If I am not satisfied with the doctor's action, I would pursue the issue.					
8. I am the best person in the hospital to be the patient's advocate if he disagrees with the doctor.					
9. If a patient is allowed to keep a lot of personal items, it becomes more trouble than it is worth.					
10. I don't answer too many questions of the patient because the doctor may have another plan in mind.					
11. I feel the doctor is far better trained to make decisions than I.					
12. I would never call a patient's family after discharge.					

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
13. Patients should not have any responsibility in a hospital.					
14. Patients should be permitted to go off their unit and elsewhere in the hospital.					
15. If a patient asks why his medication is changed, I would refer him to his doctor.					
16. If a policy change effects patient care, I want to understand why the change is necessary.					
17. Patients should be encouraged to show their feelings.					
18. I should be able to go into private practice like a doctor if I wish.					
19. I feel patients should be told the medications they are taking.					
20. I should have a right to know why a change is necessary before it is accepted.					
21. Patients should be told their diagnosis.					
22. If I make conversation with the patient, there is no need to explain procedures and treatments before they are started.					
23. I generally know more about the patient than the doctor.					
24. Patients in a hospital have a right to select the type of treatments or care they wish.					
25. If I disagree with the doctor, I keep it to myself.					
26. I feel the patient has the right to expect me, as a nurse, to effectively utilize my time in improving my skills by taking advantage of educational opportunities offered.					

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
27. I would feel comfortable in authorizing a patient to leave the unit to go to another part of the hospital.					
28. The patient has a right to expect me to regard his personal needs to have priority over mine.					
29. I feel the patient has a right to refuse care.					
30. It should be the doctor who decides if the patient can administer his own drugs.					
31. I would never refuse to carry out a doctor's order.					
32. I feel that patients should be informed as to what constitutes quality health care.					
33. The patient has a right to expect me to accept his social cultural code and to consider its influence on his way of life.					
34. Patients should be permitted to wear what they want.					
35. I would never interact with a patient on a first name basis.					
36. I rarely give in to patient pressure.					
37. Nurses should be held solely legally responsible for their own actions and not expect to come under the umbrella of the doctor or hospital in a malpractice suit.					
38. Doctors must decide what nurses can and cannot do in the delivery of health care.					
39. It is the perogative of the nurse to decide whether or not to wear a uniform.					
40. I would give the patient his diagnosis if he asks.					

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
41. It should be the nurse's decision when to talk to the terminal patient about his condition.					
42. I think it is my responsibility to initiate public health referrals on patients.					
43. I feel that I should suggest to patients, family, and doctor any community resources that I know are available.					
44. Patients can expect me to speak up for them.					
45. I would never ask a patient about his or her sexual life.					
46. I would talk very little to patients about their past.					
47. I rarely ask a patient a personal question.					

APPENDIX B

Personal Data Form I

PRIMARY NURSING AS A MEANS OF DEVELOPING
AUTONOMY IN NURSES

Name:_____

Unit:_____

Questionnaire #:_____

1. Date of Birth_____
   mo. day year

2. Circle the highest nursing degree you have obtained:

   RN/AA or AS RN/Diploma RN/BS RN/MS or MN

3. What is the date of your most recent graduation from a school of nursing?

4. Length of work experience in nursing, full or parttime since nursing licensure (in years):_____

5. How many hours do you usually work in a 2 week period?_____

6. How many years or months have you worked on your present unit?_____

7. On what 8-hour shift do you usually work? Please check one.

   AM_____

   PM_____

   Night_____

   Other_____(10 hour shift, etc.)

   If you checked other, please indicate actual shift hours:

   _____. Be sure to designate am or pm.

8. Are you presently participating in: (please check one)

   Total care or case nursing_____ Primary nursing_____

   Functional nursing_____ Team nursing_____

9. If you checked primary nursing in question #8, please answer the following, if not, go on to #10.

   I am currently a primary nurse_____ associate primary nurse_____. Please check one. (Associate primary nurse means you do not have primary patients of your own).

10. Have you had previous clinical experience in primary nursing either in nursing school or at any place you may have worked?

    Yes_____ No_____

11. What is your current nursing position? (staff nurse, charge nurse, head nurse, etc.)_____

12. Do you have a nursing area (such as surgery, orthopedics, pediatrics, oncology, etc.) in which you consider yourself specialized?

    No_____ Yes_____ What area is it?_____

13. Please check your feeling of agreement or disagreement to this statement. Please check only one.

    I prefer (or would prefer) to perform primary nursing rather than total care nursing.

    1-strongly disagree

    2-disagree

    3-undecided

    4-agree

    5-strongly agree

APPENDIX C

Orientation Schedule

Primary Nursing Inservice

45B

February 18	Discussion/presentation by Sue Davidson, RN, MSN, on primary nursing. Receive readings packet including: Model for Primary Nursing on 45B Job Descriptions Selected readings Bibliography
February 23-27	Completion of readings Group discussions re readings Questions answered Informal conference time available
March 2-6	Every nurse will assume care of one primary patient following model discussed.
Remainder of March	Primary nurses will eventually be responsible for 2 to 3 primary patients as they feel qualified. Conference time will be available for primary nurses and associate nurses to assess care plans and discuss primary nursing concepts.
April 6-10	Initial evaluation of implemented primary nursing process will occur during the first week of April. Evaluation will occur at regular intervals thereafter.

APPENDIX D

Personal Data Form II

Name:_____ Primary Nursing as a Means

Unit:_____ of Developing Autonomy in

Questionnaire #:_____ Nurses.

1. Are you presently participating in: (please check one)

   Total care or case nursing_____ Primary nursing_____

   Functional nursing_____ Team nursing_____

2. If you checked primary nursing in question #1, please answer the following, if not, go on to #3.

   I am currently a primary nurse_____ associate primary nurse_____

   Please check one. (Associate primary nurse means you do not have primary patients of your own).

3. Please check your feeling of agreement or disagreement to this statement. Please check only one.

   I prefer (or would prefer) to perform primary nursing rather than total care nursing.

   1-strongly disagree_____

   2-disagree_____

   3-undecided_____

   4-agree_____

   5-strongly agree

4. Please check any of the following that apply.

   I attended the discussion/presentation by Sue Davidson on primary nursing February 18, 1981. Yes_____ No_____

   I have read the reading packet materials on primary nursing.

   Yes_____ No_____ Read it partly_____.

   I have been primary nurse to at least one patient. Yes_____No____

5. How many hours do you usually work in a 2 week period?_____

6. On what 8-hour shift do you usually work? Please check one.

   AM_____

   PM_____

   NOC_____

   Other_____(10-hour shift, etc.) If you checked other, please indicate actual shift hours:_____

   Be sure to designate am or pm.

7. What is your current nursing position? (staff nurse, charge nurse, head nurse, etc.)_____.

Thank you for filling out this last questionnaire and participating in the study.

APPENDIX E

Informed Consent Protocol

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Office of the Associate Dean for
Academic Affairs

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-7893

INFORMED CONSENT

PRIMARY NURSING AS A MEANS OF DEVELOPING
AUTONOMY IN NURSES

I, _____, hereby
(First Name) (Middle Name) (Last Name)

agree to serve as a participant in the investigation named, "Primary Nursing as a Means of Developing Autonomy in Nurses," conducted by Janice Thurnhofer, R.N., B.S., under the supervision of Linda Kaeser, R.N., M.S.W.

The investigation aims at discovering how participation in primary nursing affects nursing autonomy. I will be expected to fill out a 47-item questionnaire again in 7 to 8 weeks. These questionnaires will be administered during a unit conference time and should take about 30 minutes to fill out. Although I may not benefit directly, my participation in this investigation will help evaluate nurses' response to primary nursing.

The information obtained by the investigator will be kept confidential. My name will not appear in the report and anonymity will be insured by the use of code numbers. Janice Thurnhofer has offered to answer any questions that I might have about my participation or to withdraw from participation in the study at any time without effect

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing 3181 S.W. Sam Jackson Park Road Portland Oregon 97201 (503) 225-7682
Office of the Associate Dean for
Academic Affairs

on my relationship with or employment at Emanuel Hospital. I have read the foregoing and agree to participate in this study.

_____ (Date)

_____ (Participant's Signature)

_____ (Witness's Signature)

APPENDIX F

Scoring Procedure for Nursing Autonomy and

Patients' Rights Questionnaire

(nursing autonomy scale)

(Pankratz and Pankratz, 1974)

Scoring Procedure

Pankratz and Pankratz Nursing Autonomy Scale

Description:

Nature and content: This instrument consists of 47 statements designed to elicit information about nurses' attitudes toward their professional role and patients' rights. Nursing autonomy and advocacy is operationalized by responses to 26 items; patients' rights is operationalized by responses to 14 items; and rejection of traditional role limitations is operationalized by responses to 13 items.

A 5-point response scale is used where 1-strongly agree, 2-agree, 3-undecided, 4-disagree, and 5-strongly disagree. Data are also collected regarding the position of the nurse (staff nurse, head nurse, etc.).

Administration and Scoring: This instrument is designed to be completed by a nurse. Instructions are provided as part of the questionnaire.

Nursing autonomy and advocacy is scored by adding the scores on the following 15 items: 1, 3, 4, 8, 14, 18, 23, 24, 27, 34, 37, 39, 40, 41, 42. Subtract the total score on these items from 90. Add the preceding results to the total score on the following 11 items: 5, 9, 10, 11, 12, 15, 30, 36, 38, 45, 46. (The range is 26-130).

Patients' rights is scored by adding the scores on the following 14 items: 6, 16, 17, 19, 20, 21, 26, 28, 29, 32, 33, 34, 43, and 44. Subtract the total score on these items from 84. (The range is 14-71).

Rejection of traditional role limitations is scored by subtracting the subject's score on item 7 from 6. Then add the preceding result

to the total score of the following 12 items: 2, 5, 10, 11, 13, 22, 25, 31, 35, 45, 46, and 47. (The range is 13-65).

Except for comments in parenthesis, the above was quoted from Pankratz and Pankratz (1974) in Instruments for Measuring Nursing Practice and other Health Care Variables, 1979.

APPENDIX G

Definitions

(Ciske, 1979)

DEFINITIONS

Primary Nursing: The hospital unit organization and philosophy that assigns the RN responsibility and accountability for planning, giving, evaluating and communicating all phases of care for a particular case load of patients until discharge or transfer from the unit.

Primary Nurse: An RN, usually full-time, who is assigned to provide primary nursing to specific patients during their stay on the unit. Twenty-four hour accountability is expected.

Associate Nurse: The nurse who provides 8 hour total care to patients whose primary nurse is off duty. She may be an RN or LVN.

Total Care: The professional accountability to meet the needs of assigned patients during an 8 hour shift. It includes giving medications, treatments, hygiene and comfort measures, teaching, communicating through charts, report and care plans.

These definitions taken from:

Ciske, K. L. Implementing primary nursing a study guide. Arden Hills, Min." Primary Nursing Development, 1979.

AN ABSTRACT OF THE THESIS OF

JANICE R. THURNHOFER

For the MASTER OF NURSING

Date of Receiving this Degree: June 11, 1982

Title: PRIMARY NURSING AND AUTONOMY IN NURSES

Approved: _____

Linda Kaeser, Ph.D., Associate Professor, Thesis Advisor

It has been suggested by Marram et al., (1979) that primary nursing increases professional development. One component of professionalism is autonomy. The present study was undertaken to determine if three major factors were significantly related to nursing autonomy, namely, primary nursing inservice program, perception of nursing care mode and attitude toward primary nursing. Several personal factors were also identified to determine their relationship to autonomy. The subjects were divided into those receiving primary nursing inservice orientation and those not receiving primary nursing orientation by inservice. The hypotheses generated were: 1) Nurses that had been oriented to primary nursing through an inservice program would be more autonomous than those who were not, 2) Nurses who perceived themselves as primary nurses would be more autonomous than those who did not, and, 3) Nurses who had a positive attitude toward primary nursing would be more autonomous than those who did not. Both groups were tested on perception of nursing care mode and attitude toward primary nursing via a personal data questionnaire. Autonomy scores were ascertained on both groups by

the Nursing Autonomy and Patients' Rights Questionnaire (Pankratz and Pankratz, 1974). Questionnaires were distributed before the primary nursing inservice and seven weeks afterwards. Major findings of the study were: 1) Only one of the original three hypotheses was supported by the findings, 2) Nurses with a favorable attitude toward primary nursing had higher autonomy scores than those who did not have a favorable attitude toward primary nursing, and 3) Evaluation of personal characteristics showed that those nurses who were younger, had less nursing work experience and were more recent graduates of a school of nursing had higher autonomy scores than older, more experienced and less recently graduated nurses.

Research questions raised by this study center on the above findings concerning primary nursing and autonomy.