Primary Nursing: Person-Centered Care Delivery System Design describes the one system of care delivery that provides the highest possible level of person-centered care for patients and their loved ones. This book provides everything you need to know about the inspiration, infrastructure changes, educational needs, and outcome measures necessary to bring Primary Nursing to life in your organization or department. If your aim is to mount a full-scale implementation of Primary Nursing or simply to learn more about how Primary Nursing improves the experience of patients, their families, and those providing care, this is your book.

Susan Wessel, MBA, MS, RN, NEA-BC
Susan earned her BSN and MS degrees in Nursing Science from the University of Illinois and her MBA magna cum laude from Xavier University. She has served in roles from staff nurse, to vice president of patient care, to faculty, and she now works to improve health care world-wide with Creative Health Care Management.

Susan's work with first-line staff, physicians, and executive teams has given her a system-wide view of health care. She has been an advocate of Primary Nursing since she was privileged to work as a Primary Nurse in her first job as a nurse. Her work in helping nursing staffs implement Primary Nursing has been some of the most gratifying work of her career.

Marie Manthey, PhD (hon), MNA, FAAN, FRCN
Marie is one of the pioneers of Primary Nursing. She earned her BS and MS in Nursing Administration from the University of Minnesota, where she remains adjunct faculty. She's taught thousands of nurses in seminars and workshops throughout the world. Whether in her role as a staff nurse, VP in a hospital, or as the founder of Creative Health Care Management, the first nurse-run consulting firm in the nation, she has always been guided by two simple ideas: 1) Always make decisions in favor of the patient, and 2) Never do anything that violates common sense. She has spent her career developing, outlining, and explaining Primary Nursing practices and developing and refining processes that help nurses excel and grow.
Dedication

This book is dedicated to Florence Marie Fisher, a nurse who cared for me when I was hospitalized at the age of five with scarlet fever, in St. Joseph’s Hospital, Chicago. Although I never saw her again, her personalized and very humane care of me became a model that I have followed throughout my life and professional career.

This dedication is also made to all those nurses who recognize the profound influence this special kind of nursing practice can have on the lives of their patients and who, by practicing it themselves, preserve the proud tradition and invaluable legacy of all of the nurses like Ms. Fisher, which is ultimately the highest tribute of all.

MARIE MANTHEY

This book is also dedicated to the first organization I joined as a new graduate nurse, Rush Presbyterian–St. Luke’s Medical Center in Chicago. I was hired in a unit just beginning Primary Nursing. Nursing at Rush proved to be an exquisite introduction to professional practice. I learned what it meant to accept ownership for leading the care of patients as a Primary Nurse, and I felt the fulfillment of having that special bond with patients. The legacy of Luther Christman, Nurse Executive extraordinaire, and his successor, Sue Hegyvary, proved to be the perfect environment to begin a career. Rush was far ahead of its time with clinical ladders, shared governance, and Primary Nursing. I will always consider myself a “Rush nurse.”

SUSAN WESSEL

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First and foremost, we’d like to thank the seven Primary Nurses who allowed us to interview them about their work and to use their responses in this book. We know that it is their words that will inspire readers more than anything else, but the value of their contribution to the two of us, as we assembled this book, cannot be overstated. It is fortunate that they were so eloquent because the avalanche of validation of the value of this work that came out of those interviews left us speechless. These Primary Nurses, identified as exemplars by their managers, are Jane Czekajewski, BSN, RN, CNOR; Kathleen Fowler, BSN, RN; Kelly Lehmkuhl, BSN, RN, OCN; Kirsten Rollee, BSN, RN, OCN; and Dena Uscio, BBA, RN, OCN, of The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC—James); and Heidi Nolen, BSN, RN; and Nicole Vance, BSN, RN, of UC Davis Medical Center in Sacramento, California.

Our heartfelt gratitude goes to developmental editor Rebecca Smith for amplifying and beautifying the content of this book. She approached her work on this book with one audacious aim: that everyone who reads it would become an evangelist of Primary Nursing.

Numerous other people had a hand in ensuring that this book would fulfill its dual purpose of helping readers understand the essential role Primary Nursing plays in any culture that presumes to be relationship-based or patient-centered and in instructing readers in the hands-on implementation of Primary Nursing. We’d like to thank Chris Bjork for project management; Jay Monroe for designing the cover and interior of the book; Marty Lewis-Hunstiger, BSN, RN, MA, and Mary Koloroutis, MSN, RN, for editing assistance; and Fred Dahl, Cathy Perrizo, and Kary Gillenwaters for proofreading assistance.
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Finally, we wish to acknowledge all of the talented people who have made significant contributions to professionalizing nursing in hospitals in the 1970s. Only a few people, however, will be mentioned here specifically. Beginning in the early 1970s, June Werner of Evanston Hospital in Evanston, Illinois, and Joyce Clifford of Beth Israel Deaconess Medical Center in Boston implemented Primary Nursing with such integrity that the level of professional practice achieved during their tenure stands as an eternal flame, forever reminding us of the importance of leadership. More recently, Carol Robinson at UC Davis Medical Center in Sacramento, Georgia Persky at New York–Presbyterian Hospital/Columbia University Medical Center in New York City, and Susan Brown and Jamie Ezekielian at OSUCCC—James in Columbus have demonstrated sustained and comprehensive implementation of Primary Nursing with stellar outcomes.
Part I
Why Primary Nursing?
I've been kind of shocked at the patient feedback in the audits. I remember assessing whether one gentleman knew who his Primary Nurse was, and he named her right away. I asked him what kind of difference it has made and if there was anything he wanted me to know about the kind of care she was giving him. He got choked up and couldn't even talk. You can't ask for anything better. He was so moved by the things we do here. He was so appreciative of everything.

—Kelly Lehmkuhl, bsn, rn, ocn
Primary Nurse at OSUCCC—James
Primary Nursing is Your Most Direct Route to a Better Health Care Experience

As we approached the writing of *Primary Nursing: Person-Centered Care Delivery System Design*, we were struck by the vast difference between what it's like to write about a care delivery system only a decade or so after its invention and writing about it after it has been practiced not merely adequately, but beautifully, for well over four decades all over the world. It is no longer necessary to spend ink on dispelling the myths and misknowings associated with Primary Nursing. While its merits as a care delivery system may still be a mystery to many of those who have not yet experienced it firsthand, it has proven to be nothing short of a miracle to the hundreds of thousands who have.

Primary Nursing was born directly out of the dissatisfaction that one group of nurses was experiencing in their professional roles. They began to see, too clearly for comfort, that functional and team nursing systems were designed to accommodate caregivers and those supervising caregivers, not patients and their families. In what amounted to a collective flash of insight, a small group of like-minded nurses realized not only that patients and families weren't getting what they needed most—the unshakable knowledge that one smart, capable person has accepted responsibility for their care—but that they were working in an environment where the systems and processes that shaped activities on the unit were working against their ability to show up as professionals and accept responsibility for anything beyond compliance with rules and regulations. We will never know exactly how many nurses said, “This is not right,” before the small off-campus gathering took place that gave birth to Primary Nursing. The world of nursing changed subtly but inexorably that day, when a group of nurses on Unit 32 at the University of Minnesota Hospital recommended to Marie Manthey that they try a new way of providing care. Marie said yes, taking a risk. She was wise enough to have experts study the new delivery system and measure its impact right from the start. Primary Nursing was born, and it was quickly shown neither to cost more nor to require any changes in staffing or skill mix.

We have all come a long way since then. The obstacles those first nurses had to overcome to design and practice Primary Nursing are beyond what anyone implementing Primary Nursing will ever have to deal with again.

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Still, when we talk with nurses practicing Primary Nursing today, their excitement at the prospect of redesigning how care happens on their units is no less immediate than the excitement experienced by those who pioneered it. Even on units where Primary Nursing finds itself in the doldrums because of new initiatives or other factors threatening to derail it, nurses who understand Primary Nursing go to great lengths to save it. We have seen repeatedly that nurses who have practiced Primary Nursing are never again completely content to practice within a less person-focused system of care, and the incontrovertible truth is that all other systems of care delivery are less person-focused than Primary Nursing.

In preparing to write the much anticipated follow-up to Marie Manthey’s seminal work, *The Practice of Primary Nursing*, we interviewed seven nurses selected by their managers as exemplary Primary Nurses. In these interviews, we were struck by something that happened in every encounter: As nurses spoke about the logistical realities of Primary Nursing, they dutifully told us about patient assignment algorithms, color-coded teams, and other scheduling practices that have worked well on their units. Later in the interviews, when we asked them about the impact of Primary Nursing on their patients and families, they exhaled deeply, smiled (audibly), and told us story after story about the difference it makes to their patients. When we asked them about the impact it has on nurses, we got a similar response. Their gratitude for the privilege of getting to know their patients as people and to really deeply understand each patient’s condition was evident in every interview. They are more respected by their team members—particularly their physician team members—because they are highly knowledgeable about their patients. They are experiencing the satisfaction that is known only by those who are willing to enter into the privilege of accepting responsibility for leading the care of another person. We know that if you haven’t experienced it firsthand, it’s hard to imagine it. That is the challenge in writing this book.

Perhaps you should hear about Primary Nursing from those who are practicing it every day:
On the Impact of Primary Nursing on Unit Culture

**Kirsten Roblee, bsn, rn, ocn**

In a high-stress situation you know the patient so well that you rattle off their history without having to dig through their chart. We are very knowledgeable because we are so entrenched in our patients’ treatment and care. In critical situations, being able to see the team at their best helps build mutual respect on the unit.

On the Impact of Primary Nursing on Patient Safety

**Kathleen Fowler, bsn, rn**

I have a patient who refers to me as “My Katie.” I’ve taken care of her almost sixteen times straight, so I know her very very well. If she came in and had just a subtle change—say she had nausea—it might not be a red flag to anybody else, but it’s going to be a red flag to me because it’s something new for her. Primary Nursing allows you to give safer care because you might catch something early on. I think that’s one of the highlights of Primary Nursing; it sets the patient up to get better care.

**Dena Uscio, bba, rn, ocn**

We had a medication issue with a patient where they may have gotten too big a dose. The Primary Nurse knew the patient’s home dose and was able to adjust it so that we wouldn’t spend all this money doing all this testing (and delay correcting the problem) when the Primary Nurse already knew what the cause was.

**Nicole Vance, bsn, rn**

We’ve had kids being taken care of by float nurses who didn’t know anything about them, and the kid radically deteriorated. It was only when someone who knew the child walked by the room that somebody said, “Wait a minute, that’s not how that child is supposed to look.” And a doc might say, “Well, hold on, that still could be his baseline ...” Maybe he’s a very developmentally delayed child, so it can be hard to know. One of the benefits of Primary Nursing is that you have a guaranteed person...
to say, “No! This is not his baseline; where he's at now is dangerous, and if we don't nip it in the bud, we have about two hours before we'll be sending him to the ICU.”

On Primary Nursing as a Means to Create a Safe Haven for Patients and Families

Heidi Nolen, bsn, rn

It really takes almost a whole shift to get families to even want to talk to you and trust you, and if we give them different nurses every day, they never really get the feeling of a trusting relationship or safety in the hospital. Once the relationship is established and they understand my role and the commitment that goes with it, the parents feel confident that it's okay to leave their child with me and go and nurture their other relationships and take care of themselves. Even if it's just to go get some coffee or have breakfast, it's the security in knowing that I am giving their child the right medications—and that, yes, I do sincerely love their child, and they know that if they walk away for a second everything will be okay.

On Nurse–Physician Relationships, Professionalism, and Advocacy

Nicole Vance, bsn, rn

Nothing will turn a specialist's head like a Primary Nurse respectfully disagreeing about something based on six years of experience with the patient and family. The docs want to hear that. The continuity, the time with the family—that's time they don't get. They get 15 minutes at a time with the patient, and they know that someone who has had hours and hours and hours with them will have a perspective that is pure gold. We've had Primary Nurses change the tide of a patient's entire hospital course because of one fact they found out from a grandparent in the hallway.
WHY PRIMARY NURSING

**Kelly Lehmkuhl, bsn, rn, ocn**

The physicians see what strong advocates we are and how much we care. They see the great relationships we develop with our patients and how that makes us go the extra mile. I think the Primary Nursing role in general has really increased our autonomy as nurses, our self-confidence, our decision making. Physicians see how we are in our role, and it inspires confidence. It didn't happen overnight, but once we developed the consistency of the team and physicians could see our competence and commitment, over time they developed greater trust in us.

**Kirsten Roblee, bsn, rn, ocn**

Our nurse–physician relationships were always great. The attending would tell the interns, “You need to listen to the nurses because they’re going to save your butts.” Now that they’ve experienced our role in Primary Nursing, the level of respect the physicians show nurses has increased. They include us in more lengthy, in-depth conversations. There is more collaboration. Instead of talking with us about patient care on a surface level, physicians are talking about the specific strains found in blood cultures and educating us on what to expect with each strain. We have more influence now because we know the patient’s history, in-depth knowledge of lab and test results, etc. Growth on the relational side is obvious but is now apparent on the technical side; we have a bigger part of taking care of the patients.

On Primary Nursing Being Easier Than Other Systems of Nursing

**Dena Uscio, bba, rn, ocn**

In the beginning, our little tagline to “sell” Primary Nursing to our staff was, “Primary Nursing isn’t about doing more; it’s about being more.” It worked because it’s true. We’re not adding tasks. There’s not another step. It’s about being more involved. It’s easier for the charge nurse to make
assignments because it takes out the whole question of where to start, and it lays out a whole framework on how to make the assignment. For the Primary Nurse, it’s easier because you know these patients. You know their preferences, you can anticipate their needs, and you can help physicians; it can really make your day easier.

Heidi Nolen, BSN, RN

There may be a time when I have four primary patients on the unit, and I wonder whether I’ll be capable of caring for all of them because of the acuity. A lot of times, for me personally, even with the acuity, I’d be more open to taking care of those patients I’ve had as primaries before because I already know them and that’s half the battle. Sometimes half the challenge of being busy is just not knowing the family dynamics or their preferences, so I would still rather care for them even if the acuity was higher because I’ve already established the relationship.

On the Impact of Primary Nursing on Patients and Families

Kirsten Roblee, BSN, RN, OCN

It’s comforting for the patients to know that they have one nurse who is a consistent participant in their care. On our unit, the attending doctors change every two weeks and Nurse Practitioners change every two days, causing anxiety in many patients. The Primary Nurse is the most consistent person in their hospital stay, and they all verbalize that it’s very comforting. They know who is on their side; they don’t have to look through their caregivers’ business cards at a time when that’s the last thing they want to do. Our name is on the board; sometimes our picture is in the room; they know who we are.

Jane Czekajewski, BSN, RN, CNOR

I think it’s great that we can go up and see our patients after surgery. It kind of gives the OR Primary Nurse a connection because it’s nice to be able to convey, “I took care of you for ten hours... but you didn’t really know it.” So again we’re building the relationship, and people are really moved that the nurses are reinforcing that connection.
WHY PRIMARY NURSING

Kathleen Fowler, bsn, rn

We have a really good relationship, and a lot of times that’s why our patients want to come in here by themselves. They’re out in the community and people feel bad for them, and the patients almost end up taking care of the people who are in grief over their condition. But they can come in and I’m here, and for that period of time, they can have not one worry in the world. Sometimes they cry with me or other members of their team because they can’t cry with their spouse. That’s big. It’s not like they would cry with every nurse; it’s because we have a relationship. They cry with us because we’re “family,” but we’re family they don’t have to take care of.

Dena Uscio, bba, rn, ocn

I’ve had patients cry when I explain who I will be to them as their Primary Nurse. A lot of our patients are coming in with a new diagnosis. They’ve got a cough that won’t go away and all of a sudden they’re diagnosed with cancer. They’re scared, they’re vulnerable, and we are telling them, “I am here for you. You have support in here. You have someone you can ask questions of. You have someone who will help interpret all of this medical craziness that you don’t understand.” That act of saying, “I am your Primary Nurse,” to the patient—I have had families cry. It’s been a wonderful reaction.

Is that what nursing looks like in your organization?

As you begin to have conversations with colleagues at all levels about Primary Nursing, here is what you will discover: Those who have experienced it firsthand tend to be enthusiastic advocates of it, and those who have not experienced it firsthand can be pretty negative about it. “It’s too hard,” they will tell you, having never done it.

In 1980, Marie Manthey published the first edition of The Practice of Primary Nursing. One of the most satisfying aspects of her long career has been assisting strong, capable nurse leaders in their efforts to establish Primary Nursing on their units and in their organizations. Over that long tenure, she and her consultant colleagues have seen nurses at every level of licensure overcome seemingly insurmountable obstacles because they understood the value of the work they were doing to create and nurture
an infrastructure that provided the time, space, and systems for relationships with patients and their families to flourish and team relationships to deepen into gratifying partnerships.

*Primary Nursing: Person-Centered Care Delivery System Design*, written more than 35 years later, is a new book for a new generation of nurses. The concepts are the same, the work is the same, and the same level of commitment and persistence are necessary, but the world has changed, and nurses have changed and are still changing.

We spend a lot of time with nurses of all ages. We know what they’re thinking because we ask them about it. What we see in this current generation of nurses, as exemplified by the voices of the nurses you just heard, is a deepening of the commitment, which has always existed to some degree in nurses, to connect authentically with the patients and families in their care. There is often nothing in the experience of these nurses to suggest that there is *time* for authentic connection. It seems, however, that this generation of nurses intuitively knows that they will simply not survive in the profession if they don’t figure out how to create and sustain meaningful relationships with their patients and families, as well as with each other. Nurses used to tolerate poor collegial relationships because they thought they had to. Nurses used to tolerate impersonal, task-based nursing practice because they didn’t know there was a better way. Things are changing. Many nurses are hungry for a reconnection to the meaning and joy in their profession.

This book was written to address the changes we are seeing in health care, in nursing, and in nurses themselves. New information has been added to address the myriad advances that have been made in Primary Nursing due to its expansion into milieus such as ambulatory and surgical settings, as well as into interdisciplinary departments. Because brilliant, tenacious staff nurses all over the world have embarked on the work of designing and practicing Primary Nursing since the late 1960s, the body of knowledge has grown significantly.

Still, nursing is for the most part practiced within largely bureaucratic institutions, and these institutions, like most of the rest of the developed world, are operating under a “domination paradigm” (Eisler & Potter, 2014). If you work in the world of health care, you probably readily acknowledge that there are hierarchies within your organization. What you may not so readily acknowledge is that those hierarchies may also exist in your own
WHY PRIMARY NURSING

mind. Because you were born into a domination paradigm, unless you’ve consciously worked to change this paradigm within yourself, it’s very likely that you view the world through a domination paradigm lens without even realizing you’re doing so.

In *Primary Nursing: Person-Centered Care Delivery System Design*, care has been taken to ensure that rather than a domination paradigm, it is a partnership paradigm that is reflected. A partnership paradigm doesn’t mean a flat org chart; hierarchies still exist in a partnership paradigm. What’s different is the *way of being* of the people involved. You know when you’re being partnered with, and you know when you’re being dominated. The much harder thing to notice, however, is when *you* are—sometimes ever so subtly (and perhaps even “for the greater good”—being the dominator.

As we look at Primary Nursing through the lens of the partnership paradigm, it comes alive in new ways. Primary Nursing is and has always been about creating healthy partnerships between nurses and other clinicians in order to best serve patients and their families. As we approach this work with all of the implications of partnership in the front of our minds, we are reminded of the adage, “How I do anything is how I do everything.” Since the goal is for Primary Nurses to forge productive, empowered, inspired partnerships with patients and families, the system in which these partnerships are expected to exist must be created by a group of productive, empowered, inspired partners. The core of Primary Nursing is a therapeutic partnership with patients. If this is what the unit or organization desires, it must then actively support the creation of systems and processes that promote this relationship every step of the way.
Chapter 1

The Historic Ebb and Flow of Nurse Autonomy

Marie Manthey

Adapted from The Practice of Primary Nursing (1980, 2002, updated 2015).

Primary Nursing in acute care hospitals is a delivery system for nursing at the department level that facilitates person-centered professional nursing practice despite the bureaucratic nature of hospitals. The practice of any profession is based on an independent assessment of a person’s needs, which determines the kind and amount of service to be rendered. Services in bureaucracies are usually delivered according to routine preestablished procedures without sensitivity to variations in needs. In bureaucracies, functions are grouped into service lines or departments and headed by leaders who usually retain decision-making authority.

Here’s where Primary Nursing comes in: For professional nurses to thrive within a bureaucracy, the system used to deliver care must be designed to minimize the bureaucratic impact and maximize the empowerment, accountability, and authority of professional nurses.

Within a bureaucracy, many different delivery systems may coexist to accomplish the numerous functions of the various
departments. These systems will support either bureaucratic or professional values, depending largely on the design of the system and the philosophy of leadership in the organization. Before Primary Nursing was established at the University of Minnesota in 1968, the delivery systems used for hospital nursing reflected bureaucratic rather than professional values. Both functional nursing systems (in which one nurse passes all medications, another does all treatments, and several people give all baths) and team nursing systems were designed according to a mass-production model of service delivery; the least complex tasks are assigned to the least trained workers, the more complex to more skilled workers, and so on up a hierarchy of task complexity. In those systems, registered nurses were assigned two functions: (1) to administer the most complex tasks and (2) to coordinate and supervise the tasks done by the lesser prepared workers. Registered nurses in this system were not professional caregivers; rather, they were “checker-uppers of cheaper-doers.” This sort of dynamic might make great sense in a factory setting in which temporary workers are asked to do unskilled work, but in the world of nursing where critical thinking and experience are extremely valuable, it is an unconscionable misapplication of talent. Also, nowhere in this formula is room made for the nurse to establish a therapeutic relationship with the patient.

Primary Nursing is a delivery system that creates the opportunity for nurses to develop a professional role in which their technical and relational skills are equally valued and supported. In short, a care delivery system will either actively support nurses in the full expression of their professional roles or contribute to the deprofessionalization of nursing.

There are four characteristics generally agreed on by sociologists as descriptive of the ways a profession can be differentiated from another endeavor or occupation. They are

1. An identifiable body of knowledge that can best be transmitted in a formal educational program.

2. Autonomy of decision making.

3. Peer review of practice.

4. Identification with a professional organization as the standard setter and arbiter of practice.
Clearly, nursing has an identifiable body of knowledge, peer review of practice, and identification with an appropriate professional organization. It is most often the extent to which the second characteristic—autonomy of decision making—is supported within an organization that determines whether the professionalism of nursing is being promoted or undermined. This support cannot just be lip service. Again, an organization’s care delivery design will facilitate autonomous decision making by professional nurses, or it will contribute to the deprofessionalism of nursing.

Deprofessionalization continues to be a major problem, not only in nursing but within other professions as well. In the last four decades, macro political and economic changes have profoundly influenced society, health care, and nursing. The three most prominent drivers of change were financial, regulatory, and technological factors. Health care in the United States became a business rather than a social program. For-profit hospitals, multihospital systems developed through mergers and acquisitions, complex reimbursement schemes, and elaborate marketing campaigns became the visible signs of system changes in the 1980s and 1990s. In the early 21st century, economic recession and a major reform of the health care system drove us back to centralized decision making. Integrated health systems and Accountable Care Organizations have multiplied in an effort to bring the full continuum of care under one structure. Large numbers of uninsured people and intense competition among health care systems have driven revenues down, while health care costs overall continue to rise faster than the GNP as a whole. Reimbursement regulations drive clinical decisions and reduce the autonomy of physicians and other health professionals. Standardized care protocols and financial/government regulations erode professional autonomy in every allied health discipline. Thus, the deprofessionalization that nurses first experienced when their practice moved into hospitals is now being experienced by people in many professions within and outside of the health care system.
How the Pendulum Has Historically Swung Between Task-Based and Relationship-Based Nursing

The history of nursing from the 1870s to the 1930s marks the slow evolution of the nurse from practicing with the autonomy and whole-patient focus that characterize private duty nursing to practicing in salaried positions as employees of bureaucratic institutions.

The earliest period of nursing in the United States, from the 1870s until the Great Depression, was somewhat paradoxical in that task-based nursing was exclusively used in hospitals where nursing education took place and most of the care was delivered by student nurses. The majority of registered nurses in that era were employed as private duty nurses for individuals in private homes, a setting which is inherently relationship-focused. In the late 1930s, when large numbers of these nurses moved from private duty back to hospital-based nursing, they must have felt as though they had taken a full step backward professionally because they had all at one point literally graduated from the task-based practice they experienced as student nurses to the relationship-based practice of private duty nursing. In this era, the pendulum swing from relationship-based practice to a focus on tasks was driven by the migration of nursing back into a bureaucratic setting.

It is important to note that nurses did not come into these institutions by choice. Since it was the Great Depression that caused the displacement of these private duty nurses, many of them initially worked in hospitals for no wages, just room and board. Eventually they would be paid a stipend of just $5/month. Because they entered into these bureaucratic institutions in positions of utter powerlessness, they did what they were told to do and they did it the way they were told to do it, or they faced disciplinary action. The emphasis was on maintaining order.

That’s what it’s like in a domination paradigm. At that point in our history, it did not seem to occur to anyone to partner with or engage the collective wisdom of a group of women in the workforce, no matter how competent or experienced they were. Even women in positions of authority didn’t dare to breech the unwritten rules of this rigidly hierarchical paradigm because to do so was to jeopardize their own positions of authority and, in fact, their livelihoods.

Most professional leaders believed that as soon as the Great Depression was over, these RNs would go back into private duty. Instead, of course, the
United States entered World War II, and the whole system of health care changed dramatically.

Changes in the health care system during and after WWII can be summarized as follows:

- The complexity of care increased exponentially due to technological advances.
- Hospitalization insurance was provided by employers to attract employees during the severe wartime labor shortage, and hospitalization rates increased.
- Large numbers of ancillary workers were trained during the war, and care delivery systems were designed to incorporate these lesser prepared caregivers into patient care.

These developments and many others resulted in the phenomenal growth of the health care system in complexity and size. Further fueling this growth, federal grants and low interest loans made available by the Hill-Burton Act of 1946 were available for hospital expansions and for the construction of new hospitals. At that time, there was a sense that there would never be enough hospital beds to meet the need. The unprecedented building boom put enormous pressure on human resources. An early fear that military nurses would return to American hospitals and flood the labor market, thus reducing salaries, was not borne out in reality. Instead the opposite occurred. The post–World War II era was heralded as a “return to normal,” when women left their wartime employment, got married (or stayed married), stayed home, and had babies. This combination of a wave of young women leaving the field of nursing and the subsequent population explosion resulted in a dire nursing shortage.

Team nursing became the care delivery model of the era. In fact, in order for a school of nursing to be accredited by the National League of Nursing, it had to be affiliated with a hospital that was practicing team nursing. In team nursing, RNs continued to perform the unfortunate role of checker-uppers of cheaper-doers, and ultimate responsibility for each patient was transferred to a different RN every shift, none of whom had an incentive to learn about who the patients were or what they were experiencing. The shared responsibility in team nursing may sound both democratic and fair, but in nursing, shared responsibility essentially means that no one
is responsible. The team leader assigned all tasks but was also accountable for making sure that everything was done on time. A team member who failed to perform a certain procedure when it was due could say to the team leader, “You forgot to remind me.” This sharing of responsibility for performing care tasks meant that if something was not done, no one person was truly accountable.

Team nursing is something that evolved because of changes in the settings in which nursing was practiced and in response to an influx of lesser prepared caregivers after the war. It provided a practical fix for the exact problems it addressed, and the nurses working within the system were too overworked and underempowered to spend much time assessing its pros and cons. It was a care delivery system designed to make things easier for nurses and the people who supervised nurses; it wasn’t designed to address what patients and families wanted and needed.

I entered nursing school in 1953, so this is where the story of the pendulum swing between task-based practice and relationship-based practice becomes a firsthand account. Like nearly all of my peers, I spent from 1953 all the way through most of the 1960s as an obedient, eager-to-please, well behaved nurse. But there were rumblings in our culture during that time that were making their way into nursing, and while there were always people who pushed to keep things the way they were, there was eventually too much “power to the people” thinking in the culture to completely ignore the fact that we were far from empowered, even when it came to the things we knew better than those who were denying us the power to do them.

In my own life, from 1961 to 1968, I had an education going on in my house that was far better than anything I could have gotten in school. My then husband was a political science and philosophy major, and I typed his papers, read a fair number of his books, and took part in lots of discussions. I was introduced to a great variety of thinkers, and I became less blind in my obedience and much more open-minded. I attended community meetings, read radical authors, and went to protests, but always with one foot planted firmly in the system.
A real turning point came in 1966, when John Westerman became the director of University Hospitals and Clinics at the University of Minnesota. He was brought in to guide a big expansion project, and he and his associates taught me about decentralization and the fundamentals of how complex systems work. They opened a new way of thinking that became, for me, a new way of looking at just about everything.

When it became my job to develop ways to improve the practice of nursing at the direct care level in our institution, I looked at the issue through a systems lens as well as through the lenses of all of the authors I was reading at the time. At that time, author and social critic Paul Goodman talked about centralized and decentralized decision making. He pointed out that when the product being created requires a knowledge-based worker because of its unpredictability, you needed someone with the knowledge to handle that unpredictability, but when you're looking for a mechanized outcome, decision making can be centralized without ill effect. It was suddenly obvious to me that health care was and always will be characterized by the kind of unpredictability that makes decentralized decision making necessary. At about that same time, author Jay Hall made a big impression on me with the idea that people who design work systems typically organize for incompetence. We assume incompetence, build systems to accommodate it, and set them in motion; if instead we organized so as to expect people to be competent, we would foster competence. It's easy to see how all of this would prepare the soil for Primary Nursing and also provide all of us with the intellectual capital necessary to take what Primary Nursing was on day one and mold it into what would eventually become a sustainable care delivery system.

In 1966, when I was an assistant director doing special projects at the University of Minnesota Hospital, I read a journal article that, in my opinion, provided nurses with their first real invitation to create for themselves a more professional practice. It was called “Existentialism: A Philosophy of Commitment,” written by Sister Madeleine Clemence and published in the American Journal of Nursing (1966). In this piece, Sister Madeleine, who was both a nurse and a philosopher, spoke of the difference between moving through life as a spectator and deciding instead to be involved with the people and situations with whom we come into contact. She wrote:

In existentialism, commitment means ... a willingness to live fully one's own life, to make that life meaningful through acceptance of,
rather than detachment from, all that it may hold of both joy and sorrow. (Clemence, 1966)

Remember, this is a nurse talking. When she’s talking about “acceptance of, rather than detachment from, all life may hold,” she’s talking about accepting and staying fully present to some things that may be very hard to bear. As a nurse herself, she knew that the work of the nurse is sacred, but it is sacred only for those who are really committing themselves to being present with people in their suffering.

It was a radical call to action, particularly for nurses working within systems in which they were expected to be obedient, dispassionate workers as opposed to capable, authentic human beings with critical thinking abilities. Here was Sister Madeleine challenging us to look at whether we were simply “solving problems” as task-focused nurses or truly entering into the mystery of what it means to be with people who are suffering, vulnerable, and afraid. She quotes philosopher Gabriel Marcel: “A mystery is a reality in which I find myself involved … whereas a problem is [merely] in front of me” (Clemence, 1966). This article appeared just as many of us were seeing how infantilizing much of the bureaucracy we worked within really was. Hospital leaders certainly weren’t encouraging us to bring our authentic, critically thinking selves to work, but we were beginning to figure out that they couldn’t actually stop us from doing so either.

Reaching the Boiling Point

In 1968, I was project director on Unit 32 at the University of Minnesota Hospital. Like every reputable hospital in the United States, we were doing team nursing, but the world was changing, and the nurses on Unit 32 were changing with it. The unrest in the culture at large shook things loose, and the empowerment we were finding in the women’s liberation movement was beginning to mobilize us in ways that nothing previously had.

I was appointed to co-direct a project designed to improve the delivery of hospital departmental services to the nursing units. We conducted several studies to collect baseline data so that innovations could be evaluated for their cost savings and effectiveness. For over a year, multiple projects were conducted, and many of those piloted were quickly implemented throughout the hospital.
A major goal for this project was to reduce the amount of time nurses spent in non-nursing activities to improve the quality of patient care and nurses’ job satisfaction. (Our RN turnover rates were a major problem.) Surprisingly, we found that all of the improvements we made to reduce non-nursing activities had very little impact on the way nurses spent their time; most notably, the time thus freed up did not result in nurses spending more time with patients. This led us to begin looking more directly at the work of nursing, which ultimately resulted in a major redesign of the way nursing work in hospitals was conceptualized, defined, and delivered.

In looking at the actual work nurses were engaged in, expectations for a more comprehensive approach to practice were surfacing. However, the task-based work organization of team nursing was a fundamental barrier to creating a more comprehensive and professional focus on patient care. Consequently (and unknowingly), the intrusiveness of the project itself—of the reality of being studied and assessed and asked to make many changes in a short period of time—created enormous pressure on the nurses, affecting all levels of the staff. Although they were originally enthusiastic about the project, this new intense focus on their day-to-day work activities proved intolerable, and they rebelled. One day the staff announced they had decided as a whole to resign if the project wasn’t stopped.

It is important to note that this unit was selected in the first place because of the excellent leadership of its nurse manager and because the staff was highly competent and had very high morale. This rebellion can be understood partly in the context of overall societal unrest at the time, combined with the ongoing pressure created by the project. Needless to say, this rebellion looked to most of us like a major catastrophe.

The clinical nursing director of the service and I decided to call an emergency meeting of the staff that evening at my home. Nearly all staff members from all different levels came. We sat around the fireplace and talked about what was going on and about the kind of care we really wanted patients on Unit 32 to be getting. The staff RNs asked if they could please not be “team leaders” the next day. The director and I reluctantly, and with full awareness of the risks we were taking, said yes. That “yes”—a “yes” that acknowledged that the people closest to the work were in the best position to decide how it should be done—was the beginning of Primary Nursing. It did not have a name, and it did not even have a structure on day one. The nurses reorganized the way things were done and the way patients were
assigned. Keeping within appropriate and licensed scopes of responsibility for the various levels of staff, the reorganization of work took place in the best way possible, by the design of those highly qualified people. This was a true re-engineering of nursing care delivery.

In my capacity as co-director of the project, I had access to some of the finest minds at the University of Minnesota in the fields of sociology, philosophies of management, industrial relations, nursing theories, industrial engineering, and research into hospital administration. The next several months were a period of intense creative development. The entire staff, along with individuals from a broad spectrum of expertise, engaged in a conversation that led to the development of the delivery system called Primary Nursing.

The impact of the change was seen and felt almost immediately. The pace of the unit seemed to slow down almost miraculously. Nurses stayed in patient rooms for longer stretches of time, resulting in a dramatic shift in the energy of the unit. People asked me whether Unit 32 now had more staff because things seem so much calmer. Several physicians started asking to have all of their patients admitted to Unit 32. They didn’t know why; they just knew things were working better.

The individuals who were available to help us think through the organizational implications were very active during this time. We were soon able to identify some fundamental principles of organizational changes that were occurring organically on the unit. Even though we didn’t have the language to name it then, it was a change in focus from task-based to relationship-based practice. Eventually we understood that one historic “yes” resulted in the design of a new care delivery system. The principles of that system began to emerge from the quickly evolving daily practice of the staff nurses, coupled with the conceptual contributions of our expert advisors.

The principles identified all those years ago are still the fundamental structure of the delivery system of Primary Nursing as it is currently practiced throughout the world. The core concept of the RN taking full “responsibility, authority, and accountability” for his or her patients became the foundation of a movement that continues to progress throughout nursing and throughout other complex organizations.

As time went on, it became apparent that the two competing theories of management exemplified by team nursing and Primary Nursing could not exist simultaneously in a healthy system. For this reason, we made sure
that transforming the authoritarianism of the traditional head nurse role was part of the immediate change process. It became clear that head nurses who were comfortable with an empowered staff could easily implement Primary Nursing, whereas those who needed to control their staff members’ practice themselves had a very difficult time with it.

Over the next ten years, my work involved changing the administrative structures within nursing departments from the command-and-control philosophy of the past to one of growth and development based on clarity of responsibility, delegation of commensurate authority, and nurses holding themselves accountable for the quality-of-care decisions they make.

Interestingly, just as we were developing Primary Nursing at the University of Minnesota Hospital, three other nurse leaders in four separate venues across the country simultaneously studied the idea of decentralization. It was during a conversation at a national conference that this convergence surfaced. During the late sixties, Joyce Clifford was teaching in a master’s program in nursing administration at the University of Indiana. She taught her students about the theory of decentralization and its potential impact on the way nursing departments operated. Simultaneously, Janet Kraegle, Virginia Mousseau, and their colleagues were implementing the decentralized organization of supplies and care support materials, revising the physical characteristics of a unit to achieve a point-of-use supply distribution system. At the same time, Rosamunde Gabrielson implemented a decentralized administrative structure at what was then called Good Samaritan Hospital in Phoenix, Arizona. Decentralization was clearly an idea whose time had come.
And the Pendulum Continues to Swing …

It’s extremely important to remember that the adoption of Primary Nursing was the choice of the nurses who implemented it. Every previous care delivery system was created and implemented in response to changes in the culture and skill mix, without consideration of what would be best for patients and families or what sort of work culture would keep nurses physically and emotionally healthy. Primary Nursing wasn’t owned by any leadership association or individual. It was organic, and this organic expression of nursing—one that safeguards the nurse–patient relationship—was replacing team nursing and functional nursing all over the country … until another societal change came in the late 1980s and 1990s. This era was marked by increased patient acuity levels and decreases in hospital staffing, as well as technical and financial drivers, increased regulation, and the redesign of the health care system based on the capitalistic mindset. These factors drove us back toward the task-based practice and mindset that is all too prevalent today.

In this truly painful era, role differentiation and specialization were obliterated, and generic categories of health care workers were created. Work redesign projects purporting to streamline the work were actually thinly disguised changes in the skill mix designed to save salary dollars by reducing the numbers of RNs. That insidious trend was ironically termed “patient-centered care.” The outcome was highly fragmented, task-based nursing that reduced morale and dispirited even the most dedicated nurses.

Not surprisingly, the 1990s left many nurses feeling overworked, underappreciated, and uninspired. “I love patient care,” bedside staff nurses frequently said, “but I hate my job.” However, as the 21st century started, nursing began once again to own its destiny. Extreme staffing shortages have forced a reidentification with the fundamental values of the profession, and society speaks loudly and clearly of its frustration with today’s health care system, demanding humane treatment and identifying nurses as the purveyors of that treatment. Studies began demonstrating the impact of staffing and percentage of professional nurses on patient mortality and morbidity. Researchers such as Linda Aiken and Colleen Goode contributed important evidence that professional nursing impacted the quality and safety of patient care. Hospital administrators began to recognize the contribution of nursing to patient experience scores and core

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measures. The intense drive toward positive patient experience being led by the Centers for Medicare and Medicaid (CMS) has refocused attention on relationships and the impact of professional nurses. The Magnet® standards (instituted in the early 1990s), which require structural empowerment to achieve successful designation, have further driven decentralized decision making within nursing departments. These structures have given an additional boost to professional practice.

Nursing’s Covenant with Society

As I look back at the long history of nursing, I’ve come to appreciate how constant nursing’s covenant with society is, despite the phenomenal changes within society as a whole. Changes in the world forced us, as a profession, to alter many aspects of our practice. Technological advances have shortened hospitalizations. The Internet gave the public access to vast amounts of information formerly owned only by health care professionals. Health care is now a business. Nursing sought none of these changes; nevertheless, we own our response to them. As a profession, nursing has the right and responsibility to decide the amount, degree, and kind of nursing care we will deliver to patients within the constraints that society and health care systems set. As the profession matures, we as nurses are moving toward the understanding that, in the real world, it is our right and responsibility to deliver our services in a way that is consistent with our fundamental contract with society. There is a new courage among nurses, and it is translating into positive change.

The successful implementation of decentralization principles within a hospital bureaucracy means that, forevermore, the nursing profession knows it has a choice between task-based nursing care and relationship-based nursing care. We also know there are forces that impact the ease or difficulty of making that choice. The intense pressure of using complex data in a highly technical activity often drives the caregiver’s attention away from the human dimension of the practice. The pendulum continues to swing: Continuity of care becomes more challenging due to shortened lengths of stay, coupled with 12-hour shifts; with financial concerns rather than patient acuity dictating skill mix; and with CEOs, CNOs, and COOs philosophically uncomfortable with giving direct care nurses authority over
patient care. These factors and others challenge the sustained implementation of Primary Nursing.

Remember, however, that it is in the nature of a pendulum to swing back and forth almost equally. Although the pendulum seems to have swung from task-based nursing toward relationship-based nursing at this point in our history, there is always the risk (or perhaps even the inevitability) of people arriving on the scene who will try to cause it to swing back. It is my opinion that the predominant factor in moving the pendulum away from relationship-based practice in any organization is a change in administrative philosophy. New leaders seem to feel the need to generate a shift in the fundamental orientation of the institution. This need is often expressed by changing structures, moving people around in the top positions, letting a few people go, and cutting budgets to improve margins. Although it is possible that no injury to relationship-based practice is intended, these changes often do more to reduce the commitment to relationship-based practice than other factors. We see in the history of nursing, over and over, that in times of change, it is far less risky to just do the tasks—to do what can be measured and documented and therefore valued and rewarded.

While Primary Nursing may seem to some to be an unrealistic dream, the reality is that versions of it are thriving all around us. The principles of professional autonomous practice are continuously being re-envisioned, sometimes through the formation of new positions such as care coordinator and care manager. It doesn’t matter what the role is called. What matters is that the patients and their families know the name of the nurse who is responsible for managing their care over time. If that is known, then the system is in place. It is all about the nurse-patient relationship.

Today, increasing numbers of courageous health care administrators are investing in transforming the cultures of their organizations to focus on relationships. They are reaping the benefits of engaged and committed employees and patients who experience personalized and compassionate care. Are you satisfied with this being only a temporary change—a mere trend we enjoy for a period of time, only to lose it when the next big wave of societal or professional change comes? Are you seeing the swing of the pendulum back to task-based practice as an inevitability? If so, remember this: It is also the nature of a pendulum to stop when an outside force stops it.

As this book goes to press, the pendulum is swinging toward relationship-based practice once again. Patients and families are demanding it, and
thanks to superb resources like Koloroutis and Trout’s *See Me as a Person: Creating Therapeutic Relationships with Patients and Their Families*, nurses and clinicians in all disciplines now have a blueprint for making authentic connections. Each time the pendulum returns to a relationship-based practice delivery system, patients receive the kind of coordinated and humane care they deserve. Isn’t it time to reach out and stop the pendulum right where it is?

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