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Sylvia Gendrop

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Nursing – Growth in Accountability

Sylvia Gendrop, R.N., M.S.

Mrs. Gendrop is the chairman of medical-surgical nursing at the Newton-Wellesley Hospital School of Nursing. She was co-editor of the November, 1977 Linacre, which featured the nursing profession.

Just twenty years ago, nurses perceived themselves, and correctly so, as care and comfort providers. Virginia Henderson's definition of nursing, published in 1955, states: "Nursing is primarily assisting the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible."¹

Miss Henderson's definition was widely acclaimed in nursing circles, because it focused on the primary relationship of the patient and the nurse, and was for this reason a trend-setting conceptualization. However, the emphasis remains on helping, caring in the activities of daily living.

The primary physician, usually well known to the patient, had sole access to admitting and treating the patient in the hospital or health agency. The nurse, accustomed to regarding the physician as teacher in schools of nursing, relied heavily upon him as mentor in clinical practice. Classes were taught by nurse instructors around a watered down medical model of text book signs and symptoms, diagnosis and treatment with little reference to the actual nursing care situations. The focus of nursing practice was on superficial understanding of the disease, physical care of the person while afflicted with this process, and assistance to the physician and hospital in their goals of care and/or cure.

Most behavior on the part of the nurse could be described in behavioral terms as respondent behavior. Travers, in discussing Skinner's behaviorism, describes two kinds of response: elicited and emitted. "When a response is elicited by known stimuli, it is called respondent behavior." The nurse acting upon a doctor's order or assisting the patient with daily hygiene are examples of respondent behavior.

Thus, nursing had no content of its own, no active, inner-directed behavioral process, no clear self-concept. Accountability was directly

to the physician (who evaluated her) for following orders, for keeping the patient clean, comfortable and available for his ministrations; and to the hospital administration (who paid her) for providing a clean, orderly, managed unit conducive to recovery. Clearly, nursing's claim to accountability, to professionalism, was pitifully unsound.

Mauksch and David comment on characteristics of the profession. "We suggest, therefore, that nursing practice must become noted for these characteristics:

- Accountability — a nurse considers herself the originator of her tasks and fully answerable for them.
- Primacy of client interest — the interest of the patient rather than the convenience of the functionaries or the expediency of the institution is given first consideration.
- Scientific competence — use of the newest knowledge, made available through research.
- Peer review — validation of performance quality through approval by occupational peers, rather than by institutional superordinates who may lack competence in practice, or worse yet, may not be nurses.
- Control over conditions of practice — a nurse decides or at least shares in the decision about the quantity and quality guidelines in her practice."³

During the sixties, society was caught up in a whirlpool of social, political and economic changes. Patterns of learning were analyzed, rejected and replaced. Students on basic levels no longer sat in class hour after hour, passively digesting lectured material, but were encouraged to actively participate, to seek out and discover concepts, knowledge, relationships. This new approach to learning is illustrated in Parker and Rubin who quote Jerome Bruner: ". . . insofar as possible, a method of instruction should have the objective of leading the child to discover for himself. . . . The virtues of encouraging discovery are of two kinds. In the first place, the child will make what he learns his own, for himself. Equally important, discovery and the sense of confidence it provides are the proper rewards for learning. They are rewards that, moreover, strengthen the very process that is at the heart of education-disciplined inquiry."⁴

Blossoming of Technology

At the same time, technology in hospitals blossomed. Monitors, respirators, intravenous lines and arterial and venous pressure systems appeared. Improved techniques of physical therapy, occupational therapy, diversional therapy, social therapy and pulmonary therapy became much in demand. New categories of health workers arrived to

bring specialized competence to the delivery of patient services in these areas.

So again nurses faced the task of making clear their contribution to patient care. Was it necessary to become an expert in this technology in order to be an "efficient" nurse? Was it necessary to provide all these special services when 5 p.m. arrived and all good therapists became pumpkins? Was the prime function of nursing to fill in and provide a nurturing environment for doctors, administrators, and now the newer expanded categories of health workers?

With the reality of a changing health field, the spirit of discovery and independent thinking, many nurses seriously analyzed their role. The question remained: are we merely helpers of the helpers — or do we actually offer some unique service to the patient?

I recall one particular instance which stimulated me to raise this same question. I was a staff nurse on a large medical ward in a Boston hospital. Mr. S., a patient convalescing from a myocardial infarction, asked me to sit down and chat for a few moments. He wished to clarify his activity level and progression of activity before his discharge the following day. Deep into discussion, I heard a commotion in the hall, and soon the melodious voice of the chief of surgery: "Nurse, nurse, come get the equipment and help me do Mrs. O's dressing." This incident, so typical at this time, points to the physician receiving help, regardless of a patient's need. The patient had clearly expressed a need to know what activities he could reasonably assume were safe for him, and how and when he could increase these activities. My intervention would have been to discuss his activities, his home situation and relate the two to a planned time sequence determined by his tolerance. Which activity was patient-centered, accountable and based on scientific competence — helping the chief or teaching the patient?

So, thinking nurses began to isolate the need or problem theory of nursing. The patient, expressing directly or indirectly a need or problem, unable to independently cope due to physical inability or lack of knowledge, sought or required the assistance of the nurse in order to resolve his problem or meet his need. As overt needs and problems were isolated and dealt with, an evolving relationship between patient and nurse allowed for trust and the subsequent revealing of more covert needs.

It was clear that patients felt needs were often not the same needs we were overtly observing; or the same needs we *assumed* to be of priority. Patients with overwhelming physical problems often expressed needs related to emotional isolation, loneliness, family, lack of knowledge, fear of disfigurement, pain, dying. Hay and Anderson in studying patient's needs observe, "The needs which patients seemed to

expect nurses and other health personnel to help them meet were identified as: the need for knowledge about their condition and treatment, for medical and nursing care, for learning and carrying out skills associated with daily living, for encouragement and understanding, for relief of fear and anxiety, to be accepted with their illness or disability, and to belong to a group."⁵

However, the problem-solving approach implied a still somewhat passive, rote, respondent behavioral orientation. In other words, "If you have a problem, I'll help you." For instance, if the patient's chest tube after chest surgery stopped fluctuating, the nurse's usual expected behavior was to call the doctor. Only a rare nurse might assess the type of chest surgery, breath sounds, lung excursion and vital signs and then make a decision as to need for consultation. Along the same lines, if the post-operative patient vomited, intervention would be instituted. However, preventive assessment of the abdomen or bowel sounds was rarely practiced.

From the problem-solving approach, a more sophisticated framework of nursing practice evolved called the nursing process. Many theorists complained that nursing process was just another label for the old problem solving. But a subtle behavioral change was evident. Nursing process urged nurses to practice within the framework of assessment, planning, implementing and evaluating. Lucille Lewis states, regarding nursing process, "To determine a person's potentialities and needs for help and to help him with those problems with which he requires assistance, the nurse engages in a knowledgeable, purposeful series of thoughts and actions which can be referred to as the nursing process."⁶

Assessment, planning, implementation and evaluation not only imply but require action-oriented behavior, not respondent behavior but operant behavior. Travers reflects on operant behavior: "Some responses, however, are apparently unrelated to any discernible stimuli. These responses are emitted by the organism and Skinner specifies them as operant behavior."⁷ The nurse, as therapist, seeks with carefully constructed interviewing tools, to establish a baseline for nursing therapy and continues to evaluate this plan throughout the patient contact. To the current cardex system, a nursing care plan form was added and provides for a written plan of care based on knowledge of the problems and needs as validated by the patient. The nurse actively originates the process, thinks in preventive terms and is accountable for the resultant care.

So it would seem that nursing today "has come a long way, baby!" It has looked long and hard into the realities of its service. It has found its framework in an intellectual, operant process called nursing

process. In doing so it has taken full responsibility for its actions and results and has declared the patient its prime interest.

Theoretically, nursing's philosophical commitment to nursing process and its moralistic stand as accountable and responsible to the patient bring the long-sought right to claim professionalism. However, the gap between theory and current practice is great.

Accountability, Responsibility Not Encouraged

Current patterns of practice in institutions do not encourage accountability and responsibility on the part of the nurse. The team method of nursing is reminiscent of a military, hierarchical system. Getting the job done and sharing the tasks on a hierarchical basis are often the thrust of the team concept. Although theoretically this method encourages team conferences and the writing of care plans, in practice the task of the "job" interferes. Team conferences and nursing care plans become the bailiwick of the student nurse and therefore an intellectual, impractical process for the professional. As an aside, the student picked this overt message up, filed it away as expected professional behavior—the last laugh on the diligent and naive instructor of nursing! Thus, we have a self-destructive system of non-accountability.

Following is an example of a day on a given team. The team leader often takes the task of "medicine nurse" or may even have "assigned" herself several patients. The team members are each assigned six or more patients, the "work" is pretty well in hand by noon; just in time for the onslaught of discharges and admissions. Conferencing is done by social workers, clinical nurse specialists, students and interns while the "team" carries on. The nurse who has had valuable contact with the client for eight hours rarely attends conference. She rarely feels she has valuable input because she may not have any further goals than to get the tasks done.

Even the terminology used in the system aborts the sense of accountability. Patients are "assigned." To be assigned conveys the passive occurrence of being given something. It does not convey reaching out through one's own expertise in therapy for the well-being of a chosen patient. The term "task" conveys work to be done. It does not conjure up the vision of a creative analytic process. The term "team leader" denotes the team nurses in lead! Marran *et al* observe, regarding the team concept, "When functional and team nursing became common delivery modes, nurses could not only pass decision-making responsibility to physicians and administrators, they could pass it to team leaders. The game, 'You make the decisions, and I'll do the

gripping,¹ became popular because care givers could, according to both tradition and policy, allow others to make decisions concerning the care of their patients. Then, when things did not go well, the care-giver could persecute the person in higher authority for making a wrong decision."⁸

Under this system, staffing fluctuates from day to day, continuity of care is frankly impossible. A nurse may be assigned six patients one day, six different patients the next day, and float to the opposite team on the following day. Remember it's the work, the tasks, that must be dealt with! A nurse may, and occasionally does, request to continue to remain with a certain patient and formulate a meaningful plan of care. Most often, however, one hears, "Don't assign me him again. Give me a change." So the patient receives nursing care from three care-giving nurses, three team leaders and several medication nurses, all in a given twenty-four hour period. The following twenty-four hours might see the pattern repeated — with all new nurses!

Patterns of Irresponsibility

The awful product of this pass-the-buck system is preference for patterns of irresponsibility. Who is responsible for a medication error inscribed erroneously by the M.D., transcribed by the head nurse, passed on to the team by the team leader, and finally given to the patient by the medication nurse? Isn't it too easy for the medication nurse to abdicate accountability? The head nurse transcribed the error, the team leader passed it on! Another common example is this: the patient is NPO (nothing by mouth) post surgery, the IV is kept KVO (running slowly to maintain potency) throughout the eight-hour day shift. The care-giving nurse states she did not start the 24 hour ordered total of 3,000 cc, because she was not informed by the team leader until 2:30 p.m. The team leader states the head nurse was too busy to transcribe the new orders which were written on surgical rounds at 7 a.m.!

Is it possible that the care-giving nurse is not aware that NPO patients must be hydrated? No. It simply exemplifies the expected behavior of the system that says, "Since I am not ultimately responsible, I will hold ground until I am told from above." Marran *et al* state: "Hierarchical line authority has permeated nursing culture for most of its existence, making it easy for nurses to abort the development of autonomy. The nurse could relinquish all responsibility simply by following physicians' orders or supervisors' dictates. Autonomy is inseparable from the assumption of responsibility and accountability for one's own acts, which are both marks of professionalism.

Therefore, when nurses allowed others to take the responsibility, they surrendered their autonomy!"⁹

Along the same line, even the nursing care plan is a sham. Most often they are barren spaces left to testify to the abdication of the nurse in planning an individualized approach to the patient. Even if the care plan is present, it is utilized only by nurses, representing a costly waste of analytic effort which is not shared by the patient's other care-givers (doctors, therapists, social workers, clergy). Berni and Readey state: "... clinical personnel frequently did not take the time to share findings already perceived, even on a verbal basis. All was left to the time-consuming process of trial and error. It was not unusual for any one patient to have at least three different nurses and therapists each day attempting to discern his or her problems and trying the same approach with little or no success. It must have been obvious to the patient that very little effective communication existed in the health care system. On some occasions, conscientious personnel did share ascertained problems on flip card holders or in case files, but these records were not included as part of the patient's permanent chart."¹⁰ How then does nursing practice take on a philosophical commitment to nursing process and the direct moral stand as accountable to the health care consumer? Catherine Norris states: "A significant element in this crisis is the fact that, except in rare instances, everyone — patient and professional alike — must wait until the physician has seen the patient. The physician is the gatekeeper of the health care system and he continues to marshal considerable support to maintain that role. Not only does he control the entry into the health care system, he provides the only pathway through the system. Other health professionals who might offer great relief or meaningful benefits to the patient may never see him because from the doctor's perspective, he is not sick or his health needs are not the kind that the doctor recognizes or understands. No matter how many other professionals are available, patients must wait and professionals must wait until the doctor screens, refers or writes orders."¹¹

Nurses must gain direct access to the patient. They must demonstrate instances of care in which the nursing assessment, plans, action and evaluation have significant impact in progressing the patient from illness to health. Cooperation and collaboration between members of the health team imply a sharing of responsibility for patient progress and a determination of which member assumes leadership within the team. The person who actually assumes leadership within the team should be dictated by the patient's problems and situation, not by autocratic tradition. For example, the surgeon often coordinates the care of the patient admitted on a private surgical service and who progresses without complication. The family medical physician coordinates care for the patient who is admitted with a chronic medical

problem. In both instances a strong supportive relationship with the physician and the physician's previous knowledge of the patient's physical problems, patterns of interacting and emotional-social needs dictate that he assume leadership. On the other hand, the visiting nurse might assume leadership on the team when admitting a patient with a chronic medical problem. Also, when the patient develops complications which require several consultants, physicians, multiple medical therapists, sophisticated supportive machinery, the nurse often assumes leadership to coordinate the patient's care. So, too, is the case in the situation where the patient requires psychological, social and physical rehabilitation after a stroke or ileostomy. Again, in these instances, a strong supportive relationship with the nurse, the nurse's knowledge of the patient's physical problems, patterns of interacting, and emotional-social needs dictate that he assume leadership.

Patterns of practice must be changed to admit direct patient access. Nurses must initiate patient interaction, provide continuity in the care situation and communicate assessed problems, needs and plans on a peer basis to other members of the health team. In acting directly on the conditions of practice, nursing takes control from hospital and agency administration and fulfills the last of the characteristics of a profession as previously stated by Mauksch and David. "Control over conditions of practice — a nurse decides or at least shares in the decision about the quantity and quality of her practice."¹²

Movement Toward 'Primary' Nursing

Some nurses have been moving toward a system of delivery in which the nurse admits the patient, takes the nursing history and assessment and continues to follow the patient throughout his contact within the health care system. This "primary" nurse writes nursing orders and takes primary responsibility for the patient's progress. Other nurses or assistants work with the primary nurse to implement the care plan. The patient is the center of the system; the primary nurse, directly accountable to him. Manthey *et al* comment on this type of nursing and its relationship to professionalism: "Professional practice has traditionally been characterized by the one-to-one client professional relationship. Primary nursing establishes a one-to-one nurse-patient relationship in a highly complex care context. It is a design concept that embodies an arrangement of nurse and patient that facilitates professional practice and the delivery of nurse care. . . ." ¹³

Carefully constructed nursing records must be shared with all members of the health team. The problem-oriented medical record, as

described by Weed, puts in writing the fruits of process-oriented practice. Berni and Readey state: "The POMR can be equated to the open classroom approach to learning, where the course places emphasis on creativity rather than memorization, on planning rather than conforming to the plans made by others, on problem solving rather than recall." And further, "Since allied health team members enjoy a greater degree of participation by pooling of expertise, they experience a more satisfying feeling of accomplishment regarding patient progress. From the viewpoint of nurses in general, the majority agree that a well-informed nurse is a 'better' nurse. Job satisfaction and the feeling of confidence nurses gain are readily conveyed to the patient. They undoubtedly take pride in the strides made in the resolution of problems that they helped solve. They feel the impact of being a partner in health care, since all disciplines are invited to help solve patient problems. They are being heard at long last and their contributions are being acknowledged. Since the POMR sanctions and encourages the use of nursing process, the nurse now assesses plans, implements and evaluates patient care and documents her contribution to the team with authority."¹⁴

I believe nursing is an intellectual process, based on the physical and behavioral sciences; that its service to humanity is delivered through application of a problem-oriented approach which is called nursing process. I believe that to be a nurse requires a special kind of caring, an exceptional commitment to the individuality and rights of each human being, and a vulnerability which opens one's self uniquely to the world of another. Thus, nursing may be defined as intelligent tenderness. Critical analysis of the patient situation is the crux of nursing practice and provides intelligent vigilance concerning patient ongoing needs and problems. The nurse is the patient advocate. She assumes accountability and responsibility for long-term assessment of patient progress. When a problem is assessed, intervention may fall within the nurse's independent function or may call for consultation with the physician, social worker, psychiatrist, nutritionist, minister, etc. While the nurse remains close to the patient — his problem, his family and social network — the other members of the health team are often consulting therapists who spend short periods of time providing care-cure parameters.

Philosophically, in summary, nursing has committed itself to an active operant approach. Morally, it has traced the origin of its contract for excellence directly to the patient; it has assumed responsibility for dictating the terms of its delivery system in order to control quality of care. Theoretically, nursing has achieved the characteristics of a profession as stated by Mauksch and David. In reality, the problem remains — to bring theory into practice.

Nursing Role and Functions Compared

Patient considered — assist doctor and provide comfort.

1956

Patient having a myocardial infarct on a general medical ward.

Nursing Role and Functions

Assist to undress, clothes list.
Provide some degree of comfort.
Follow M.D. orders with pain medication q 4.
Take vital signs.
Perform absolutely all tasks of ADL for 2-3 weeks.
Provide humanness while recovering/dying.

Theoretical Framework — No understanding of why the patient was perspiring, dizzy, nauseated, confused, output V—VS V; consequently nurse anxious and unable to inter-

Patient and family considered — critical thinking judgment and nursing intervention. Collaboration with physician and other members of the health team.

1977

Patient infarcting in CCU.

Nursing Role and Functions

Assist to undress.
Explain monitoring equipment/monitor — assess strip.
Assess for arrhythmia complications.
Intervene with medication for arrhythmia.
Assess pain/explain/medication (describe pain and collaborate with physician).
Intervene with CPR and defibrillation for V. fib. and cardiac arrest.
Confer with physician for further Rx.
Evaluate effect of pain medication; confer with physician if not effective.
Physical assessment and history. Note on Nursing History Form.
Allay patient anxiety — consider family anxiety, discuss Rx plan, tests, and progress with patient and family.
Assess for CO — confer immediately with physician sign of decreased CO.
Read and interpret hourly EKG strip. Confer with physician any changes.
Provide comfortable environment.
Perform comfort and ADL tasks as nursing judgment dictates.
Space activities to O₂ expenditure while assessing monitor and patient reaction.
Teach activities to avoid valsalva maneuver, vagus stimulation, stasis of venous supply in extremities.
Begin patient-family teaching concerning MI, activities — stress diet — medications.
Provide humanness, personal caring to patient-family during recovery.

Theoretical Framework — Knowledge of physiological and psychological reaction to infarct/pain. Nurse minimally anxious, intent on proceeding to alleviate pain, arrhythmia,

vene to reduce patient's anxiety/pain and counteract sympathetic reaction. Experience in past recalls that most MI patients die; therefore, goal is comfort, outlook pessimistic. No understanding of cardiac physiology — ECG — etiology of complications; minimal knowledge of cardiac drugs/dosage ranges/effects/dangers. Intuition going out to patient and family lastly. Collaboration with physician and other health team members limited due to lack of scientific knowledge and inability to utilize the scientific method (assessing, planning, implementing and evaluating).

complications, anxiety. Experience points to majority of patients recovering; therefore, goal is to assess needs and problems, to prevent complications, intervene when necessary, alleviate pain and anxiety of patient and family — outlook optimistic. Clear and informed concerning possible drug therapy. Inclusion of patient and family as person who must know and participate in care and planned effort to teach patient, family. Communicates effectively with nursing through NCP and with medical team. Nursing care plan through SOAP format. Collaboration with physician and other health team members maximized by scientific knowledge and use of the scientific method.

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