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The Nurse Manager's Role in the Primary Nursing Care Model: A Review of Clinical and Management Aspects

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Abstract: Implementation of the primary nursing care model requires a change in the role of the nurse manager from "a collector of information and responses" to a nurses' trainer in care planning and related decision-making and support. To describe the experience of introducing the primary nursing care model in a surgical setting; to describe methods designed to change the nurse manager's role; and to provide organizational elements and data based on practical experience. In order to apply the four cornerstones of primary nursing to a surgical setting, the staff was given full assistance by creating the necessary organizational and relational conditions and promoting the transition from "being a primary nurse" to "feeling a primary nurse" in their provision of care to, and relationship with patients, as well as in their experience with their respective families and social environment. The transition from a team nursing to primary nursing model was prepared by defining care standards, reshaping organizational processes, mapping nursing competencies, defining materials and resources, building instruments such as clinical care pathways, and administering a questionnaire for nurses and patients as both a fact-finding survey tool preceding the introduction of the model and an impact-assessment tool at one year's distance of such introduction. The application of the primary nursing model created a positive environment in professional relationships where nurses could test their accountability; in addition, patients' satisfaction with the care provided was higher; their perception of dignity improved with regard to privacy, autonomy and relational aspects; and, finally, pain perceived at rest and on movement dropped. The manager's satisfaction does not derive from knowing anything about his or her patients and controlling the situation at any time, but rather from seeing patients recognize and seek care from their attending nurses, who are closely involved in care provided to patients and feel comfortable about what they are doing and their own professional growth. The primary nursing model implies a necessary renewal in the cordinatoor's role to include clinical and managerial components in its leadership activities at the patient's bedside. When the model is applied, a nurse manager becomes a clinical manager who works out standards for the care practice, assesses the performance of his or her staff, teaches nurses, supports them in decision-making, oversees care, coordinates care activities, and has a direct experience in the relationship that a nurse establishes with a patient.

Keywords: Primary Nursing, Leadership Styles, Job Satisfaction Coaching, Nursing Competence

1. Introduction

Implementation of primary nursing in a ward implies the creation and/or change of a few professional roles. In particular, a real change in the role of the nurse manager is required from a central activity organizer and information owner (i.e. conventional duties) to a clinically involved professional. In M. Manthey's view, a nurse manager's function is one of clinical leadership and ongoing accountability for the management of patient care. [7] This means that the system is decentralized since, in a primary nursing model, the nurse manager should spend more time in managing staff and operational aspects rather than patient care. [8]

With primary nursing, the attending nurses take on the centralizing role of owning the clinical information of their attended patients. When a patient is assigned to an attending nurse, the nurse manager takes on this new clinically involved role and puts to good use his or her knowledge of the nursing team, their individual backgrounds, and the

various levels of care required by patients in a ward. The literature agrees about the need of support from a nurse manager in order to create a positive favorable environment and to improve nurses' performance. [3]

Oscar Wilde wrote: "*It is more difficult to talk about a thing than to do it*". This aphorism sums up what is often experienced when a change in the nursing care model has to be prepared to be introduced. It is easier to put a new care model into practice than to explain it.

Then, how and by which tools can the nursing team be supported? Which strategies should be adopted? How can this new role be implemented?

The purpose of this paper is to illustrate the nurse manager's role in a team when a change has to be made from a conventional to a primary nursing model, based on the experience gained from December 2016 to date in three surgical wards of the Trento Hospital (General Surgery, Cardiac Surgery and Vascular Surgery), and to share the nurse manager's experience as a leader in translating the founding principles of primary nursing into practice.

2. Background

In General Surgery, the transition from a team care to primary nursing model started with an action research project (May 2011 to October 2013) to assess the safety and quality of patient care in an innovative care organization model centered on patient management in a surgical setting. Through the collection of data on patients, healthcare professionals and care processes in a surgical setting, few elements were identified which required a redefinition of care organization and provision. Among the most significant findings of the action research project there were the fragmentation of patient pathway across various services, the high variability of interventions between caregivers, and around 50% of the care time spent at patient's bedside of which a only a minimum part was dedicated to the education of the patient and or caregiver.

In Cardiac Surgery and Vascular Surgery, the introduction of the above model was meant to reply to a few care issues, such as poor knowledge of the patient, unaccountability in the professional practice, poor care continuity, etc., as identified by nurses and their nurse manager based on a bottom-up approach. Such introduction, however, also implied a top-down strategy proposed by the nursing management, who in the recent years have opted for 'global' patient-centered care models such as primary nursing. For this reason, the Local Health Trust of Trento embarked on the testing of this 'advanced' care model, preceded by a prior training course for nurse managers in order to present the model as well as by an information-exchange exercise with the major Italian hospitals where this model has already been implemented or is currently being tested.

Starting from a global patient care model for small teams applied to the three wards under review, in which nurses' accountability with regard to the patient's pathway was split between nursing shifts, primary nursing was organized as a relation-based approach to provide care at the patient's bedside, whereby the primary nurse is responsible and accountable for care decisions through care planning. The need was felt to work on relations within the team for the acceptance and visibility of nurses' accountability towards patients and their families, colleagues, doctors and other healthcare professionals.

3. Methods

Primary nursing is a care-provision model, which revolves around the relationship established between a nurse and an attended patient; in a surgical environment, this model is particularly useful in order to:

1. gain full control of the care pathway, which often involves various care settings (pre-hospital, intensive, surgical hospitalization, and at home care),
2. improve care safety and quality through clinical care pathways (from standard care planning to care customization),
3. improve direct care provided to patients by making the nurse accountable for his or her assigned patients.

The change in care model was preceded by the following steps:

1. team's training in the model, clinical decision-making, care planning and care relationships;
2. a change approach consisting in reshaping organizational processes, mapping nursing competencies, defining materials and resources, building instruments such as clinical care pathways and administering a questionnaire to nurses and patients meant both as a fact-finding survey tool preceding the introduction of the model and an impact-assessment tool at one year's distance of such introduction;
3. definition of global care standards in the primary nursing care model;
4. mapping of nursing competencies in order to draft a "Catalogue of Care Competencies" in a surgical setting.

In order to apply the four constituting elements of primary nursing to a surgical setting, the staff was given full assistance by creating the necessary organizational and relational conditions and favoring a shift from "being a primary nurse" to "feeling a primary nurse" in their provision of care to, and relationship with patients, as well as in their experience with their respective families and social environment.

3.1. The Place of Leadership

The experience so far gained suggests that, in a primary nursing model, a nurse manager is, first and foremost a, clinical manager (from the Greek *cline*, patient's bed). In particular, in the primary nursing model, the nurse manager fulfils managerial duties and assumes leadership at the patient's bedside. The patient's bedside is, therefore, a privileged place and a pivotal element around which all of the nurse manager's and nurses' activities revolve. The introduction of the new care model contributed to emphasize and to bolster such statement, as a

nurse manager collaborates in the care directly provided to a patient but does not replace a nurse. The nurse manager's viewing the situation from the patient's bedside perspective is an extremely effective way of assessing the quality of the care provided as well as the quality and value of the relationship that a nurse establishes with a patient. For instance, a nurse manager may also directly observe the nursing care practice and share his or her experience with nurses. A nurse manager improves his or her credit record whenever he or she has to give feedback or assess caregivers. At the patient's bedside, a nurse manager takes on a support and reference role and checks that care is given in accordance with the defined standards.

Table 1. *Example of global care standards in a primary nursing care model.*

	Involved healthcare professional (s)			When		
Global care standards linked to the primary nursing model principles	**Nurse**	**Coord.**	**Doctor**	**Morning (M)**	**Afternoon (A)**	**Night (N)**
To ensure that clinical care information is compared and shared at least once in the morning and in the afternoon with the doctor / surgeon	X	(X)	X	X	X	
To ensure patients' allocation within 24 hours for urgent hospital admissions, and as previously defined for scheduled admissions		X				
To ensure written planning, with outcomes and interventions related to the hospitalization period	Xpn	X		Within 24 hours of admission		
To update documentation on changes in patient planning (new issues, closing resolved issues, adding unscheduled interventions, etc.)	X					
To ensure resource planning and coordination in situations of difficult discharge	X					
To ensure an interview with the patient/family to share the care pathway and give behavioral advice	Xpn			Within 24 hours of admission		
To provide customized training in lifestyles and areas where training is required as identified in writing in the PCA (patient care assessment) plan	X		X	As planned by the primary nurse		
To ensure that information at patient's bedside is passed on at every shift, with a focus on current issues and/or departures from standard pathways	Xpa			At every shift		

Key. Xpn: primary nurse - Xpa: pre-admission nurse

3.2. How the Leadership Is Exercised: Translating the Four Primary Nursing Principles into Practice

3.2.1. Assignment and Acceptance by Each Professional of Personal Accountability in Decision-Making

A nurse manager helps the staff develop their decision-making autonomy and problem-solving skills, oversees the quality of the care provided, provides resources to ease the staff's growth and development, promotes the team sense of belonging, and supports team members in resolution of conflicts experienced in interpersonal relations. As an instructor, a nurse manager has to ensure that each nurse has the necessary knowledge and skills to operate safely; as an individual involved in continuing education, a nurse manager becomes a model to be followed for the staff's professional and personal development; as a validator of care-related decision-making, a nurse manager approves any decisions made or gives reasons for his or her disagreement with such decisions while suggesting alternative approaches for new decisions; finally, as a human resource, a nurse manager is able to meet the leadership requirements of his or her role. Within the system, a nurse manager is better placed to activate areas of competence, human resources and various types of care. When faced with a patient-management issue, a good nurse manager will be able to propose different problem-solving alternatives to be considered [4].

That is why it is crucial to invest in the development of nurses' clinical competencies and their evaluation, such as diagnostic-reasoning and decision-making skills, planning skills and the ability to document the complexity of care.

3.2.2. The Daily Allocation of Patients to a Nurse Is Made in Accordance with the Case Method

Nurses' accountability, which is based on the allocation of a limited number of patients to each nurse, becomes visible to colleagues (and the team as a whole) as well as to patients, through:

a) the nurse's presentation to patients and their families as the attending (or 'reference') nurse for the patient's full hospitalization period,
b) his or her ability to make choices that affect the care process.

A key role for a nurse manager is to help nurses cope with the "loss of anonymity" and take on the risks implied by their accountable role (to be recognized as such by all). In Manthey's view, the necessary elements that support nurses in becoming accountable include building a trust relationship with the members of their team and making sure that patients are correctly assigned (case method) [4]

The quality of care in patient management is ensured by the assignment of each patient to a reference nurse, which is the nurse manager's task in accordance with the case method. Manthey maintains that the allocation of cases should take account of two fundamental elements, i.e. the complexity/criticality of a patient and the individual nursing competencies. Based on this approach, patients who are more complex should be allocated to a nurse with better competencies and skills, which ultimately results in the best possible matching between patients' needs and available competencies. [7]

In order to define the degree of surgical patients' complexity, in the preparatory phase of the model

implementation, an observational trial was conducted on 120 surgical patients. Patients' characteristics were described and care commitment data were collected by identifying a data set defining the patient's complexity, which was largely affected by the type of surgery. Then, surgical patients were allocated to various level of complexity; each surgery was combined with the patient's elements of complexity by referring to the MAP model (*Modello Assistenziale Professionalizzante*, or "professional care model", Silvestro et al.) [13] and 3 levels of complexity were defined: low, medium and high. The type of surgery is the invariable complexity component, whereas personal characteristics are variable components that are likely to increase the initial complexity level. The concept of clinical instability is not meant in contingent or static terms, but rather as a potential risk. As a result, the care response shall mainly be addressed towards preventing and detecting complications.

In defining complexity, nurses put much emphasis on factors linked to the patients' cognitive state and degree of collaboration, which aspects are likely to impair safety, make the relationship difficult and interfere with the applied educational processes.

By way of example, the chart below shows a "right hemicolectomy" surgery from which our clinical care pathway was developed, i.e. "Right-left Colon with or without rescission or ostomy", and the relevant surgery preparation procedure.

Table 2. *Patient complexity classification example.*

Elective Right HEMICOLECTOMY Removal of the last 10 cm of small intestine, ascending colon, caecum, right colic corner and a part of the transverse colon.		
Surgical complexity: medium		
Surgery complexity	Intraoperative phase	Approach: open or laparoscopic or robotic. Position: supine with closed legs. Duration. 90/180 minutes for the open approach to 150/180 minutes for the laparoscopic and robotic approaches.
	Postoperative complications	Hemorrhage, bleeding. Anastomotic dehiscence on days 5-7. Duodenal-jejunal fistula as a consequence of the resection of the mesentery adjacent to the duodenum with a possible laceration. Fistula of side-to-side ileocolic anastomosis. Volvulus → occlusion → intestinal loop rotation → extracorporeal anastomosis. Fistula → intracorporal anastomosis → from the used mechanical suturing device. Surgical site infection. OTHERS: Acute pancreatitis, ureteral injuries, obstructive uropathy, vessel injuries.
	Device	Drainage: 0 to 1 or 2 (perianastomotic + Douglas). SNG (not always).
	Postoperative symptoms and problems	Pain. Fever →due to pneumonia or fistula (abdomen-related symptoms), complications. Nausea and vomiting → linked to food resumption (day three).
	Educational need	Canalization Low
Expected care response	Monitoring	Clinical parameters (including pain) every 4-6 hours for the first 24 hours. Quality (hemorrhagic – enteric) and quantity of drained material: daily check. Canalization of gas and faces and evaluation of faucal characteristics.
	Education with regard to:	Low-residue diet in the first weeks and regular bowel movement.
	Multidisciplinary	Not envisaged
	Postoperative standardization	Possible standardization – possibility to apply an integrated PCA. Favoring the natural recovery of intestinal function.
	Notes	Monitoring patient compliance (patient stands, moves, drinks or does not drink liquids, eats). Lack of uniformity in the definition of device positioning or management, monitoring frequency.

For an ideal "patient-nurse" interaction, a nurse manager also takes account of the complexity of managing a patient with regard to clinical, care-giving and educational aspects as well as of the competencies gained by a nurse. For this reason, still during the preparatory stage of the primary nursing introduction process, competencies were mapped to produce a "Catalogue of Care Competencies". Numerous definitions of Nursin Competece are described in literature.

There is still considerable confusion about the definition of clinical competence and most of the methods in use to define or measure competence have not been systematically developed and issues of reliability and validity have barely been addressed. [15] According to one concept analysis study, nursing competency can be divided into the following three theories: behaviorism, trait theory, and holism. Behaviorism refers to competency as an ability to perform individual core skills, and is evaluated by demonstration of those skills. Trait theory considers competency as individual traits necessary for effectively performing duties (knowledge, critical thinking skills, etc.). Holism views competency as a cluster of elements, including knowledge, skills, attitudes, thinking ability and values that are required in certain contexts.

Nursing competency is generally viewed as a complex integration of knowledge including professional judgment, skills, values and attitude, indicating that holism is widely accepted. In nursing practice, nurses are required to apply their acquired knowledge, skills and innate individual traits to each situation and be able to adapt that knowledge and those skills to different circumstances [4]

The "Catalogue of Care Competencies" describes the clinical care competencies that a nurse working in a surgical setting has to gain, develop and put into practice when providing care to patients of varying degrees of complexity. The catalogue of nursing competencies in a surgical setting is structured into three patient-complexity levels (low, medium and high), which are defined on the basis of the type of surgery and the elements of complexity specified in the care complexity analysis model (MAP) [13]. For each complexity level, competencies were identified in line with the nursing process logic (assessment, planning, care and surveillance, invasive procedure management and drainage). In addition to these, two other competences were added, i.e. patient and/or caregiver education and discharge. Tasks, or processes, are grouped into macro-areas, based on the principle of logicality and homogeneity; each task or process is described by observable behaviors explaining how such task shall be carried out by an expert professional. The full group of observable behaviors, for each task or process, are a reference standard to identify what a "proper accomplishment" of a task means.

By way of example, the table below shows the "care and surveillance" competency area structured into the three complexity levels.

Table 3. *"Care and Surveillance" are structured into three complexity level.*

	CARE AND SURVEILLANCE
Low complexity	a) To ensure the provision of care in accordance with standards defined in the PCA and/or a customized care plan b) To inform and support patients and families in order to reduce their concern c) To perform monitoring: state of consciousness, respiratory, cardiovascular and neuromuscular functions, temperature, pain, diuresis, any complications (nausea, vomiting, shivering, arrhythmia, dyspnea,...), based on the PCA or customized plan d) To understand collected data and assess expected results e) To identify main changes in the patient's lab and diagnostic test results, with due account taken of the reference range, and to involve the doctor f) To recognize in advance signs and symptoms of clinical instability that need prompt medical intervention and act accordingly g) To promote care information flow by using available tools (NMDS) h) To maintain ADLs (activities of daily living) by using the support staff
Medium complexity	In addition to the tasks above, a) In the event of a body change, to help the patient become aware of that change and help him or her find coping strategies, e.g. by using specific resources b) To recognize signs of emotional instability c) To assess and collaborate in the maintenance of the hydro-electrolytic balance d) To involve other professionals concerned with the patient's care pathway (e.g. other clinical specialists, a physiotherapist, a dietician or an enterostomal therapist) e) To promote the recovery of compromised ADLs after hospitalization/a surgery, as prescribed in the PCA and/or customized plan
High complexity	In addition to the tasks above, a) To detect as early as possible any 'vague' signs of clinical instability implying prompt medical intervention even before an express confirmation of clear clinical signs and to act accordingly b) To promptly recognize signs of emotional instability and, if need be, seek advice for the involvement of specialists c) To involve the team in situations when difficult choices have to be made or in case of ethical conflict (e.g. appropriateness of the treatment)

In addition to its usefulness for allocating a patient to the most suitable nurse, the Catalogue helps a nurse manager in the assessment of competencies achieved by individual nurses in order to fix individual improvement targets every year. The annual assessment of nurses' performance is based on observable and objective data collected from various sources, such as direct observation, analysis of clinical documentation, and feedback received from patients and families. So is important to identify the developmental process of nursing competency for continuous professional development after obtaining a nursing license. [4] Nurses' competencies are documented and rated by a grading system, which describes the competence level achieved by a single nurse, for the nurse manager to:

a) keep track of the team's competencies and assess the gap between those already achieved at a given time and those needed to respond to patients' needs
b) identify improvement areas suited to each professional in order to set individual annual targets to be achieved

Table 4. *The grading system.*

The grading system

0	The process or task has not been assigned to, or experienced by the nurse in his or her working environment
1	The nurse controls the process/task by partially adhering to the required standard, and requests help from an experienced colleague
2	The nurse controls the process/task by fully adhering to the required standard, and occasionally asks for support from an experienced colleague/nurse manager in the same area
3	The nurse controls the process/task by fully adhering to the required standard, and is in a position to support colleagues
4	The nurse controls the process/task by fully adhering to the required standard, and supervises and trains colleagues

When allocating patients to a nurse, a nurse manager needs to know the entire nursing team and their competencies as well as the various levels of care required by patients. This knowledge can only be obtained by sharing experiences within the nursing team and exercising clinical leadership at the patient's bedside.

At the time of patients' allocation, in addition to taking account of the nurse's competencies and the clinical complexity of a patient, a nurse manager should also consider other elements, such as:

a) to ensure that care is provided uninterruptedly, which means to allocate a nurse that will be on duty for a given number of working days, for he or she to manage the patient from admission to discharge;
b) to distribute the workload evenly across the nursing team members, considering a given number of patients per nurse and the patients' degree of complexity;
c) to ensure that a patient is allocated within 24 hours of being admitted to the ward, in case of urgent hospitalization, whereas for scheduled admissions, allocation will be defined in advance.

3.2.3. Direct Interpersonal Communication for Information Sharing and Case Reviews

The primary nursing model provides the opportunity to a establish a direct communication channel between team members, and between these and each patient, which ultimately flattens the communication pyramid and removes filters in the nurse-to-nurse and nurse-to-patient relationships. Caregivers on various levels need to directly communicate with other caregivers. The pivotal role of a nurse manager is to encourage case reviews at team level and ease consultations on patients' problems (i.e. a patient-focused approach) in order to highlight any doubts and improve the therapeutic programmed as a whole. This approach is also designed to improve communication between caregivers for it to be direct, linear and without filters, and for each team member to learn from others' experience.

Table 5. *Elements of a patient-focused approach.*

LOGISTIC AND ORGANIZATIONAL ELEMENTS	CLINICAL CARE ELEMENTS
1. Scheduled discharges or transfers	1. Additional blood tests and diagnostic Highlighting the patient's problems
2. Transfers from the intensive care unit (ICU)	2. Defining examinations
3. Scheduled admissions	3. Patient's priority/complexity
EDUCATION DELIVERED TO PATIENTS AND CAREGIVERS	PATIENT'S PROGRAMME/PATHWAY
Defining educational requirements, i.e. managing anticoagulation or insulin therapy, and delivering training in how to avoid incorrect lifestyles (alcohol drinking, smoking, etc.)	Identifying possible variations in the patient's clinical pathway

3.2.4. To Ensure That Professionals Who Are Accountable for the Quality of Care Provided to the Patients of a Given Ward Are Available 24 Hours a Day, Seven Days a Week

Care accountability on a 24/7 basis is ensured by the coordinated scheduling of working shifts for attending nurses to be permanently available for patient management, with a special focus on the competence mix (reference nurses and assistant nurses with various levels of competence).

The nurse manager's accountability differs from that of the nurse in that a nurse manager controls the general quality of the care provided. In this case, clinical and managerial duties are combined together in a form of leadership, which includes accountability for competent nursing practice, 24 hours a day, all the year round.

In primary nursing model, a nurse manager should recognize and respect the nurse's better understanding of a patient's case; to that end, for instance, a nurse manager should avoid answering questions asked by doctors about the clinical state of a patient and refer them to the attending nurse, who will be more familiar with the patient's condition [7].

4. The Coaching Role

The nurse manager must have strong leadership skills to navigate through change with a focus on the patient and the provision of safe and reliable care. The historical term for those leading change is "change agent". Change in today's health care landscape is daily, so the idea of "change coach" is emerging, building on the nurse manager foundational skills of coaching and weaving this concept into the manager's role in change. The role of a"change coach" is divided into 3 categories: guidance, facilitation, and inspiration. In the first area (guidance), the nurse manager focuses on setting individual expectations for the staff related to their performance. As a facilitator, a nurse manager encourages the staff to share in decision making and change by promoting the exploration of creative solutions As an inspiration for change the nurse manager facilitates change by expressing confidence in the abilities of the staff and then recognizing their contributions in bringing about and sustaining the change. [14].

In the primary nursing model a nurse manager acts as a nursing team's coach and is permanently responsible for the general management of care provided to inpatients. A nurse manager also acts as an 'instructor', i.e. a clinical expert providing support to nurses in their decision-making process, and supervising/controlling the quality of the care provided [6]. To do so, a nurse manager should spend a considerable amount of time in the patients' room with other nurses. Similarly, to a sports coach, a nurse manager runs and trains with other team members in order to:

a) support and facilitate nurses in planning care tasks on an ongoing basis, reaching decisions, and achieving professional autonomy,

b) take on a support and reference role,
c) encourage nurses to take back a few core tasks in the provision of care,
d) encourage nurses to be accountable,
e) encourage nurses to introduce themselves to patients saying their name and surname, and to declare their accountability towards them.

As an instructor, a nurse manager has to ensure that each nurse has the basic knowledge and background to work safely in a ward. Each time that a knowledge gap is identified, a nurse manager should deliver the required training personally.

As a personal guide, a coach has to fulfil a key role as a leader in each learning context under his or her responsibility. A coach has to train staff to achieve specific skills and a specific performance level by motivating them on a permanent basis. [16]

Figure 1. *Coaching actions.*

5. Evaluating Competencies and Professional Improvement

The evaluation of competencies is among the most important skills of a nurse manager. A constant process of evaluating the development and the retention of competencies can add value to a healthcare professional's work by identifying any weakness or area for improvement and growth. The annual assignment of improvement targets is also an effective driver of development and change.

By encouraging the professional growth of nurses, the coach of a team detects educational needs and collaborates in care provision. He or she will not replace the nurse but rather take an active part in specific tasks. Education planning starts from an ongoing analysis of the staff's individual educational needs. This is by no means a type of evaluation to be made from time to time; it is rather a permanent process that a nurse manager has to carry out day after day in the clinical practice at the patient's bedside, while being prepared to listen to patients, their families, doctors and nurses. In so doing, educational needs and/or aspects that need to be reviewed and/or improved can be more easily identified. In fulfilling an educational role, a nurse manager does not merely analyses educational needs, but also develops and plans educational events and defines targets and any possible repercussions for the care practice. The involvement and exploitation of professionals with advanced skills should also be encouraged (e.g. nurses, senior nurses, physiotherapists, dieticians, etc.) for them to make available their experience gained over the years to learners for a practical 'experience-based' type of learning.

6. The Role of Innovator and the Introduction of New Tools

As coach and leader, a nurse manager needs to promote and drive processes of change and innovation. With the introduction of primary nursing, several 'change-support' tools were introduced in the clinical practice, such as:

a) delivery at the bedside, as a primary nursing practice designed to pass on responsibilities and information from one shift to the next, promote a clear focus on the patient as well as full, permanent accountability and exchanges between attending nurses, and, ultimately, improve patients' and nurses' satisfaction [1];
b) clinical care pathways, as fundamental clinical care planning tools of the primary nursing model.

As planning tools, clinical care pathways are the product of a multidisciplinary team consisting of doctors, nurses, anesthetists, chief medical officers and nurse managers. These tools originate from the need to standardize the care practice in view of uniform tasks and products based on reference standards and evidence-based information, for care to be provided seamlessly and for behavioral changes to be minimized [9]. Clinical care pathways, in our case, were developed based on the following three elements:

a) a definition of the patient's clinical condition for which a pathway had to be developed;
b) specification of the diagnostic, therapeutic and care-giving practices and their sequencing;
c) an *ex-ante* definition of expected care outcomes and objectives.

Clinical pathways are used to manage the quality of care in healthcare concerning the standardization and organization of care processes. Implementation of clinical pathways reduces the variability in clinical practice and improves clinical outcomes in acute care. A quasi experimental research study evaluated the effect of implementing a clinical pathway guideline on the clinical outcomes of patients with acute coronary syndrome. (ACS) The study shows patients with ACS who managed by using a clinical pathway had a significant improvement in the mean scores of body temperature, pulse and respiration rate than control group

from admission to discharge. The Clinical Pathway (CP) group had low percentages of complications compared to the control group. The study shows a decrease of the mean Hamilton Anxiety Score in the CP group than its level in the control group on discharge. [11]

7. The Nurse Manager's Day-by-Day Exercise of Leadership

Leadership is a key element in the development of the relationship-based professional practice. A leader is required to decide relationship types within a given care unit and define rules for interpersonal relationships. When a leader understands how crucial this task is and has sufficient knowledge to ease sound interpersonal relationships, the quality of care improves. With regard to the management team, M. Manthey says: "*It is really important for us to learn how to identify the leaders within any group and use that leadership energy. It's a source of energy for change that we need to know how to use skillfully. (...) The wonderful thing about leadership energy is that it creates more energy. Management allocates energy; leadership creates energy. (...) We need to learn how to regularly inspire. Inspiration means taking in energy, and we need to have leaders who understand the importance of inspiring the staff*". [8]

Within the entire process, the nurse manager plays a key role, which consists in translating the principles of primary nursing into practice, motivating nurses on a daily basis and supporting an environment favoring change and exchanges between healthcare professionals. This role is not limited to triggering change but rather extends to "*day-by-day leadership*" exercised through daily presence and encouragement. A primary nursing model requires a long time to be organized, improved, assessed and revised within a nursing team, usually around 5 to 10 years [12].

Which style of leadership to adopt? The nurse manager adopts a transformational leadership that is defined as a leadership approach that causes change in individuals and social systems. In its ideal form, it creates valuable and positive change in the followers with the end goal of developing followers into leaders.

A systematic review of the literature, examined the relationship between the style of leadership and the intention of the staff to remain in their position. This study supports a positive relationship between transformational leadership, supportive work environments and staff nurses' intentions to remain in their current positions. Incorporating relational leadership theory into management practices will influence nurse retention. [2].

The application of Primary nursing does not seem to have a direct correlation with job satisfaction. In a cross - sectional study have been examined the differences in work - related motivational and stress factors between two nursing allocation models (the primary nursing model and the individual patient allocation model). There were no significant differences in motivational characteristics between the different models. The nurses working according to the individual patient allocation model were more satisfied with their supervisors. The work itself and turnover caused more stress to the nurses working in the primary nursing model, whereas patient - related stress was higher in the individual patient allocation model. [10]. Instead, a study examined the relationship between leadership style of nurse managers and nurses' job satisfaction. The mean scores of the subscales of transformational leadership style were slightly higher than the mean scores of the subscales of the transactional leadership style, which leads us to conclude that nurses prefer the transformational leadership style. Transformational leadership differs from transactional leadership in that it is concentrated on development and progress, authorization, selfcompetence, solidity and strategic thinking [5)

8. Discussion

The experience of introducing the primary nursing model proved to be positive in that it created a favorable professional environment, where nurses attempted to assume direct responsibility for patients allocated to them. Primary nursing neither defines nor ensures nursing care quality, but in any case, promotes a very high-quality level by giving people the conditions and power to make the most of their capabilities.

In this care organization and provision model, the nurse manager's satisfaction does not derive from knowing anything about patients and controlling the situation at any time, but rather from acknowledging that patients recognize and seek their reference nurse, i.e. one who is closely involved in the allocated patient's pathway and is comfortable about what he or she is doing in view of professional growth [7].

The primary nursing model implies a shift in the nurse manager's role. A nurse manager becomes a team coach who trains the team members' in the ability to responsibly relate to patients and their reference network, to make and support care decisions influencing the patients' pathways, and to solve conflicts experienced in interpersonal relations. A nurse manager is responsible for the general quality of care; in this respect, the nurse manager's role differs from that of the team. A nurse manager is therefore a manager who instructs nurses from the patient's bedside, supports them in the decision-making process, supervises care, coordinates care tasks, and is personally involved in the relationship established by the attending nurse with his or her patient. Otherwise said, a nurse manager is a clinical manager who fulfils his or her duties, by developing care practice standards, and assesses team members' performance.

The survey conducted before and after the model introduction shows that patients' satisfaction with the care provided was higher, their perception of dignity with regard to privacy, autonomy and relational aspects improved and, finally, pain perceived at rest and on movement dropped. The improvement of some of the nursing care outcomes on

patients confirms the validity of this model and, in particular, gives credence to the notion that the principles on which the model is based help achieve better quality in the provision of care. Nurses' approach in care-related decision making has not changed. What is needed now is a stronger movement towards organizational decentralization, for nurses to fully exploit their potentials within a primary nursing model by achieving constant, autonomous accountability.

A strategic approach to encourage change consists in changing actions first and, only then, the way of thinking. Each system resists change. Making the system aware of change before introducing it ultimately increases that resistance. A useful suggestion for nurse managers wishing to introduce this model is to prepare change by putting less emphasis on explanations and giving priority to the feelings and reactions elicited from the experience of change, which builds up while action is being taken.

9. Conclusions

To take on this new role, a nurse manager has in turn to be suitably trained [3] and supported by the various levels of the hospital organization in order to prepare change and to build tools that are instrumental in the management of care and organizational processes, such as care planning, passing on information from one shift to the next, and assessing competencies. To exercise the authority suited to the responsibility level required by primary nursing, a nurse manager also needs to be involved in the staff recruitment and selection process and in the allocation of the nursing staff.

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