THE ROLE OF THE UNIT SISTER — EMPHASIS ON QUALITY OF CARE AND ACCOUNTABILITY

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OPSOMMING

Drie belangrike konsepte word bespreek, naamlik die rol van die eenheidsuster, die gehalte van sorg en verantwoordbaarheid.

'n Model word voorsien waarin die rolle van die eenheidsuster uitgebeeld word — die fokus van haar werk (die pasiënt, span, agentskap, gemeenskap en die professie) word aangetoon sowel as die inhoudsgebiede (kliniese sorg, bestuur, onderwys en beleidsbepaling). Die doelwit van gehaltesorg is eie aan al haar rolle — wat fokus sowel as inhoud betref.

As professionele in wie groot vertroue gestel word, moet die eenheidsuster vir haar eie werkverrigting en van dié oor wie sy toesig hou, verantwoordbaar wees. Om dit te kan doen, moet sy die nodige vermoë, verantwoordelikheid en gesag hê.

INTRODUCTION

The subject of this paper includes three important concepts. They are: role of the unit sister (or head nurse), quality of care and accountability. Each of these will be dealt with briefly and an attempt made to show the interrelationship between them.

THE UNIT SISTER

The sister or head nurse, whether she is in a hospital ward, ambulatory clinic, public health centre or long-term institution, plays a cardinal role in the effectiveness and efficiency of patient care. She also has a major impact on the satisfaction, morale and general well-being of patients, staff, and families. The ward sister serves as the primary link between patient and care-giver, staff and administration nursing and other professionals. She also co-ordinates her unit with the total institution as well as with the extramural community. Her heterogeneous functions include provision of patient care as well as management of human and material resources.

Many questions have been raised about the unit sister's role. Should the management of the facility be her responsibility, or can these duties be carried by non-nurse managers, thus permitting the sister to concentrate on patient care and staff supervision? Should she be an expert clinician and participate in direct patient care — particularly for patients needing complex nursing care? How much of her time should be given to teaching of staff, students, patients and families? What are her responsibilities for continuity of care of patients after they leave the unit? Should she be concerned with people in the community who are potential consumers of nursing — in line with the concept of *outreach?* Should she accept policy and procedures as they are, or function as a change agent? What is her role in relation to agency policy making? Some people have even raised doubts about whether the sister is needed at all in the primary nursing system where each nurse carries full responsibility for a group of patients.

These questions, as well as the difficulty of attracting candidates to management positions in Israel, led to a research project to examine the unit head nurse role in Israel. Answers were sought to the following questions:

What is the desired role of the unit head nurse?

What criteria should be used in selecting the unit head nurse?

How should the candidate be prepared for the desired role?

What factors impede employment of suitable candidates and implementation of the desired role?

This paper deals with the first question only — the desired role of the unit head nurse.

Based on an extensive review of the literature, observations in various types of units and discussions with nurses, we envisioned the unit head nurse's role as two-dimensional. These dimensions were: the **focus** (or for whom) of the unit head nurse's activities — patient, team, agency, community, profession, and the **area** (or content) of her work — clinical, managerial, human relations, educational.

The interview instrument was de-

veloped on the basis of this concept. It was decided to seek answers by learning how this role was perceived by the unit head nurse herself, those whom she supervises, and the people who supervise her and make policy. Accordingly 279 people from different settings were interviewed according to the model shown in figure 1.

Figure 1 Model for study of unit head nurse

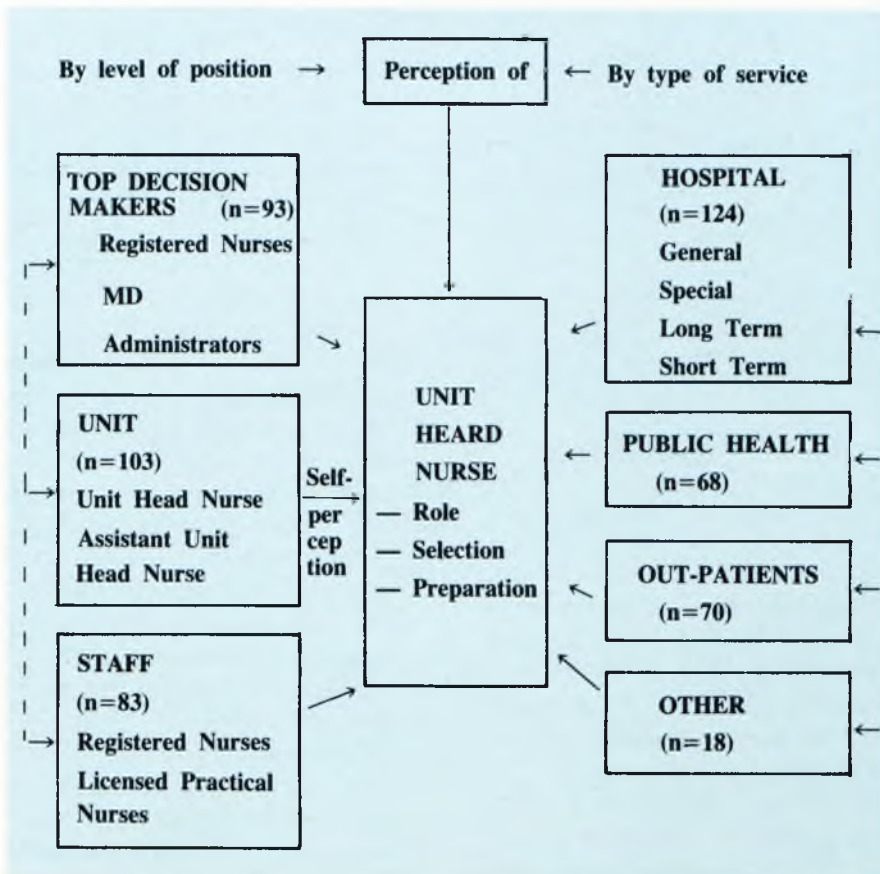cerned with the community and the profession.

We assumed that the first spontaneous responses were drawn from what the unit head nurse does now, while the second set, which was in reaction to specific situations, revealed a much broader approach.

Of interest is the high value given to clinical patient care by the unit

policy and in co-ordination with other professions and services. The community is a recipient of unit head nurse outreach activities and is also a provider of resources, such as volunteers, to the unit. The unit head nurse is a citizen and functions as such in the community. The profession draws upon and contributes to the unit head nurse in setting standards and expanding nursing knowledge. All of these interactions take place within a frame of human relations which is integral to every human endeavour.

By use of this model, the activities of the unit head nurse are mainly with the team, but these and other activities eminate from, and are directly related to the patient-/client and his needs. Examples of the implementation of the model of unit head nurse roles are given in table 1.
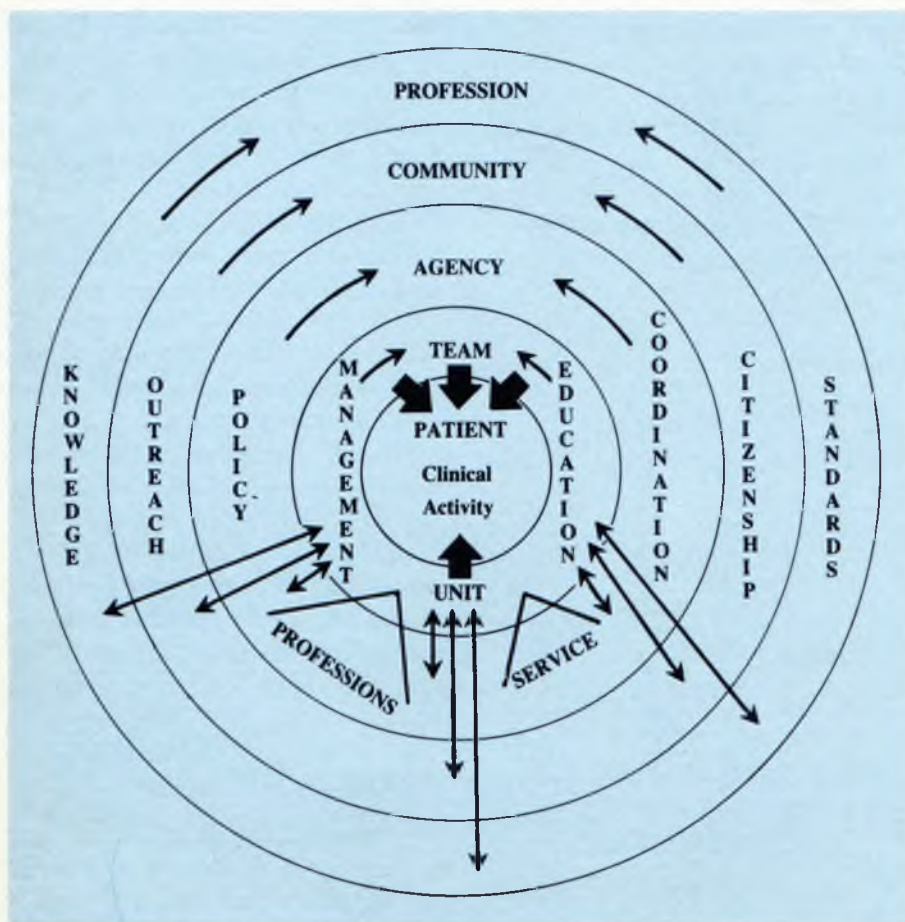
QUALITY OF CARE

The second concept which appears in the title, is quality of care. The author hopes that assuring quality of care has been implicit in the unit head nurse role as discussed up to this point. What is missing, perhaps, is a concrete approach on how to put this concept into operation. An example from Israel will be used for this purpose.

In the light of the increased longevity, accompanied by a greater need for care of the aged population in Israel, an inter-agency committee was set up to study methods by which quality care could be promoted. Most of the conclusions are relevant to patients in all age-groups and are an indivisable part of the role of the unit sister.

The committee first formulated a statement of belief with the following points:

- Quality of care is comprehensive in nature and should be examined in terms of:
  — psycho-social and physical aspects;
  — the individual and the environment
  — structure, process and outcome of services.
- Measures for assessing quality of care should include both objective measures and subjective im-

Early in the interview, the respondents were asked to spontaneously state the three most important roles of the unit head nurse. Next they were presented with a series of 36 real-life situations, representing various roles concerned with *who* (focus) and content (arca), and they were asked to grade how important it was that the unit head nurse carry out these roles.

In the first set of spontaneous answers the main focus was the team (40 %) and the main content was administration (44 %). The second approach (situations) produced much more importance for the roles related to education and clinical care and the need for the unit head nurse to also be con-

head nurses themselves and the nursing supervisors while nurses at staff level and doctors felt that this was not her realm. Possibly each was claiming the *patient* for his own domain.

As a result of the study findings, a model of five concentric circles and an encompassing frame for the role was developed. (See figure 2). In it the patient (individual, family, group; sick or well) and his care are the purpose of the system. The unit is the major arena of the unit head nurse's activities which are team focused, utilising management and education as the media to serve the patient through the team. The unit head nurse has reciprocal relationships with the agency (institution) in developing and implementing

FIGURE 2: Model for the role of the unit head nurse

pressions.

- ● Perceptions of aspects of quality of care are influenced by:
  - — values of the individuals concerned and of society;
  - — needs or purpose of those examining the quality of care (aged client, his family, the care giver, owner or administrator, funding or authorising agency, educational or research body);
  - — setting in which the care is provided (home, clinic, hospital, long term institution).
- ● Quality of care is primarily dependent on the caregivers who to a large degree control the human environment and manipulate the material resources. Special attention must therefore be given to the selection, preparation, roles, satisfaction and work conditions of the personnel.
- ● Assessment of care should examine the degree of flexibility of the services and programs in order to meet the varied and changing individual and group needs (routine must be adapted to individual and group needs).
- ● Sufficient resources should be

available and accessible so that those who need them can select services appropriate for their needs and not be dependent on a specific institution or agency.

- ● A simple, workable tool is needed to evaluate care:
  - — to be acceptable such a tool should be developed and recommended by a well-qualified, recognised, objective authority;
  - — the tool could be used for planning and decision making;
  - — it could be used in various settings such as home care, ambulatory care, short and long term institutional care;
  - — it should list indicators or cues to be considered in the light of each specific situation, as well as accepted measures;
  - — the cues should be categorised in several major domains to permit an overview of the various areas of care. These domains include the physical environment, psycho-social environment, basic personal care, health

care, family involvement and manpower.

The first six points in the statement of philosophy were operationalised in the seventh item which called for the development of an appropriate tool, and this became the next task of the committee.

The tool included six domains to be examined for quality, each with many sub-categories.

Examples of sub-categories by domain are:

- — **physical environment:** safety, comfort, private space, communal space, equipment, heating and ventilation, transportation, aesthetics;
- — **psycho-social environment:** individualised approach, tone of speech, common language; encouragement of independence, participation in decision making; meaningful activity; leisure time recreation; interpersonal relationships between clients and staff, among clients, and among staff;
- — **basic personal care:** hygiene of skin, mouth, feet, nails, hair etc; nutrition-quantity, quality and aesthetics of food and feeding; rest and mobility; clothing — cleanliness, suitability, aesthetics; body discharges — regulation and care;
- — **health care:** prevention of illness and complications, continuity of care, rehabilitation, pain control, terminal care and comfort;
- — **family involvement:** family as a client — dealing with stress, guilt, deteriorated health; family as a care-giver — teaching families, involving them in care and decisions;
- — **manpower:** ratio of staff to clients, level of staff, supervision, work organisation, interstaff relationships, career development opportunities, work conditions and rewards, satisfaction and attrition.

As it is impossible to present the complete cue table within the scope of this paper, one example will be given of a sub-category in each domain, with cues to be considered in short and long term institutional settings.

Privacy (physical environment domain) was perceived by the work-

TABLE 1: Examples of implementation of model of unit head nurse roles

		GENERAL HOSPITAL	SPECIALISED HOSPITAL	PUBLIC HEALTH	OUT-PATIENTS DEPARTMENT
Patient	**Purpose of Care**	Patient in emergency room	Patient in psycho-geriatric unit.	Working mother with young baby.	Patient with pacemaker.
	Direct Care of Unit Head Nurse	Assess patient's condition	Determine patient's ability for self-care	Counsel multi-problem mothers	Work with individual patient in planning.
Team (Unit)	**Management**	Organise emergency equipment to ensure immediate care.	Match staff to patients for individualised care.	Set up evening clinics for working women.	Arrange home visit to each new pacemaker patient.
	Education	Train personnel to recognise physiological and psycho-social needs of patients.	Conduct regular case conferences with staff.	Conduct seminar with staff to review studies on working women.	Send team members to pacemaker speciality clinic for orientation.
Agency	**Co-ordination**	Assure system of communication in relation to transfer of patient (To wards, home and OPD)	Co-ordinate patient handicraft activities with occupational therapist.	Work with social worker or employers of at-risk working mothers.	Regular exchange of information between OPD clinic and speciality clinic on patient's condition.
	Policy	Recommend employment of a liaison nurse to work with families of patients (under stress).	Request agency to rotate staff to other types of units.	Recognise working mothers as priority group for service.	Request agency to obtain notification from hospitals on all new patients with pacemakers.
Community	**Outreach**	Follow-up on patients sent home from emergency room. (What happens to them? How do families manage?)	Alert community nurses on needs of patient's families who are undergoing crisis.	Invite working pregnant women to special classes for anticipatory guidance.	Initiate contact with new patients and renew contact with drop-outs.
	Citizenship	Examine availability of emergency care in community. (Ambulance on call)	Examine moral and legal aspects of institutional commitment.	Influence legislators to deduct baby care expenses from income tax.	Inform authorities on need for telephones and appropriate housing for patients with pacemakers.
Profession	**Standards**	Develop criteria for specialisation in emergency nursing (education, experience).	Participation in Association Committee to determine work conditions of staff in psycho-geriatric units.	Develop tool to measure problems of working mothers in specific community.	Develop protocol of routine nursing examination for patients with pacemakers.
	Knowledge	Participate in study on psychological needs of patients in emergency room	Examine impact of nursing interventions on order to reduce use of psychotropic drugs.	Study scope and type of physical tiredness of working women with young babies.	Examine impact of nursing care on stress of patients and use of specialist services.

group as cardinal for evaluating quality of care. Hayter (1981) states that patients should be helped to protect their privacy as long as they remain in their homes. If hospitalised, the nurse should help the patient establish a temporary territory of physical and personal space. Evaluation of privacy in the various settings include the following cues:
— for short-term care — privacy during examination, interview, treatment, toileting;
— in long-term care — personal space for private belongings,

area to receive guests, place to be quiet and alone when so desired.

Meaningful activity is used to illustrate the domain of **psycho-social environment.** Zyl (1980) states that *the optimal aged, according to the activity theory, is the person who stays active and manages to resist the shrinkage of his world. As roles change the individual finds substitutes for the activities involved in these roles. Activity throughout the life span seems to be an important determinant of life satisfaction.*

— In short-term institutional care, the patient can participate in activities related to his recovery, such as breathing exercises, physical therapy, learning to manage his medication and treatment regime.
— In the long-term setting he can take part in group cultural activities as a teacher or learner, work in the occupational programme to earn pocket money or prepare gifts for his family. Volunteer work with retarded children is an area that has

reaped benefits for both parties.

Nutrition is given as an example of a cue to be examined in the domain of **basic personal care.** Food is a major source of energy, tissue building and maintenance of physiological equilibrium. In specific health conditions such as diabetes, food may be an important mode of treatment. It is often a source of sensory stimulation and cultural gratification. Food selection may be one of the few areas where the patient can make choices and express his independence. As such, it should be seen as a measure of quality of care. Examples of quality of nutrition in different settings are:

— short-term care: sufficient fluids, easy access to bedside tray, help in feeding if needed;

— long-term care: variation of diet, selection of menu, aesthetic, social environment for meals, cutlery and dishes adapted to individual abilities, early morning drink and evening snack, facilities to purchase and store fruits, sweets, etc.

In the **health domain, prevention of illness and complications** was chosen as the subject to be illustrated.

— Short-term care: provision of health education, specific to the condition for which the patient was hospitalised, which will help him avoid a recurrence or exacerbation of his illness.

— Long-term institutionalisation: routine health examinations including an assessment of ADL functional level, review of use of medications.

The domain of **family involvement** is often neglected. **The family as a client** was selected as the example. Families often have guilt feelings about their aged member, especially if he has been institutionalised. They have to deal with new roles for themselves and the older person, as well as emotional, physical and financial burdens.

— In short-term care the family may be exhausted by the need to visit and make the required administrative arrangements. They may be worried about impending death or serious handicaps. A measure of quality will be the readiness of staff to listen to families, to encourage them to express their needs and to provide guidance or referral.

— The family of the long-term institutionalised patient will need continuing support as their family member deteriorates. Over-identification with or rejection of the aged person by the family are frequently encountered. Strow and MacKieth (1980) describe a programme of group work with families *to create a more open and more mutually accepting bond between a nursing home and members of patients' families.*

In the domain of **manpower** the **level of staff** can illustrate cues of quality of care.

— In the short-term setting, availability of expert staff during 24-hours is essential.

— In the long-term setting humanistic characteristics take predominance, with a back-up of specialists at a good professional level.

These examples point to the kinds of items to be measured. Someone has to observe, listen, ask questions. Someone has to analyse the data, and see where quality is good and where it needs to be improved. Someone also has to make plans, find resources, and implement the desired changes to improve quality. The author submits that the key *someone* is the unit sister. It is part and parcel of her roles as practitioner, teacher, manager, researcher and policy maker.

ACCOUNTABILITY

The last of the three concepts with which this article deals is accountability. Murray and Zentner in their book *Nursing Concepts for Health Promotion* (1975) defined accountability as *1) being responsible for one's acts, and 2) being able to explain, and 3) to define or measure the results of decision making.*

The author believes that in order to be accountable there are several preconditions that must be fulfilled. They can be visualised as a pyramid, each forming a base for the higher levels as illustrated in figure 3.

— The basic precondition is to have the **ability** (knowledge, skill, values) to decide and act on a specific issue;

— then you must be given, or take, the **responsibility** to carry out that action;

— next you need the **authority**, that is formal backing and legal right, to carry the responsibility;

— then, with the preconditions, you can be **accountable** for the action you take.

All too often nurses are given responsibility (and expected to be accountable for same) when they are lacking the ability base and/or the formal authority.

What are the preconditions for a unit sister of an oncological unit, for example, to be accountable for her role in preparing the staff to deal with problems of death and dying?

First she must have the ability. This means knowledge of the meaning of dying for the patient, the

Figure 3 Pyramid to illustrate preconditions for accountability
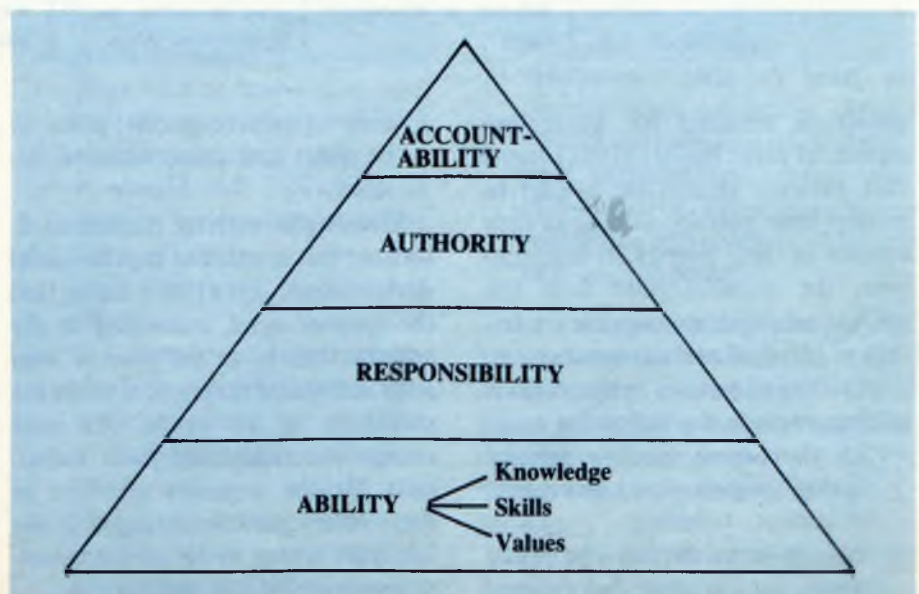
family and the staff. She also needs skill as a clinician in working with such patients, and as a teacher to convey the theory and practice to her staff. She must clarify what her values are — for instance, when does dying with dignity take precedence over prolonging life? What does she believe about truth telling regarding impending death?

Next, is the unit head nurse ready to undertake responsibility for this task which will draw heavily on her emotional and intellectual resources, as well as take time from other aspects of her work and her private life? Is she ready to organise the logistics, implement the teaching, plan and evaluate outcomes?

Does she have the authority to set up such an inservice programme? Does this plan conflict with the functions of the director of nursing or the school of nursing? Will the medical staff object to the content (such as truth telling) if it is not in line with their philosophy?

Only when these three preconditions have been satisfied, can the unit sister undertake the programme and be accountable for it.

Other questions of accountability are: who is accountable, to whom, for what? The who-to-whom have almost endless combinations. The unit sister is accountable to the patient, his family, the nursing staff, her nursing peers, the doctor, other professionals in the ward, students, teachers, her supervisors, the employment agency, society and the nursing profession. All of these relationships are two-directional — that is from unit sister to staff and *vice versa*. They may also have a triad relationship, with ongoing accountability between the sister, staff nurse, and the patient.

The patient-sister diad is probably one of the most important realms of accountability. Patients are no longer blindly submissive to whatever staff decide to do with them. They want and should be partners in care. The ward sister has to be a patient advocate and make sure that patients are fully informed of their care and given every opportunity to share in decision making. The sister is responsible to the patient for ensuring a high level of nursing care. The patient is accountable to the sister, via the nursing staff, for informing her of his needs and his reaction to treatment and for carrying out those aspects of care that are within his abilities.

The ward sister is accountable to the nursing staff for many of her roles. This includes informing staff about ward policy and giving them opportunities to contribute to same. She should assist staff in keeping up-to-date in clinical knowledge and skills. She is responsible for providing a physical and emotional work environment that enables them to give quality nursing care. Staff are accountable to the sister for carrying out their assignments, for showing initiative and for continued growth.

As an educator, the sister is accountable to learners' as a role model and formal teacher. Students are responsible for selecting and fulfilling the programme.

The ward sister is also accountable to the profession, through the Nurses' Association and other channels. She must contribute to setting standards of quality care in nursing practice. It is her duty to contribute to the body of nursing knowledge by analysing and reporting experiences of nursing practice and administration, and by co-operating in nursing research. The profession — as an organised body, in return, is responsible to its members for serving as the unified voice of nursing and providing a support system for nurses individually and collectively.

CONCLUSION

In summary, a model has been presented which depicts the roles of the unit sister — showing the focus of her work (the patient, team, agency, community and the profession) and the content areas of clinical care, management, education and policy setting.

Inherent in all her roles, in both focus and content, is the objective of quality care.

The unit sister, as a professional in whom great trust has been placed, must be accountable for her own performance and of those whom she supervises. To fulfill this purpose she must have the necessary abilities, responsibility and authority.

Role fulfillment, quality of care and accountability are within the scope of our potential. They demand our continuous interest, investment of intellectual, emotional and physical resources, as well as the support and co-operation of colleagues and administrators. These are a challenge to all of us — whether practitioners, teachers, supervisors, administrators or researchers. It is a challenge in which each accomplishment is not the end of the road, but the entrance into new vistas. Our roles continuously change and expand to adjust to social and scientific progress. Quality has no limits, and accountability grows with professional advancement.

This is the nature of professional nursing in today's and tomorrow's world. We have chosen this profession and we will achieve its ends.

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