



OPTIMIZATION OF THE ROLE OF NURSE MANAGERS IN THE IMPLEMENTATION OF PRIMARY NURSING THROUGH EDUCATIONAL AND STRUCTURED OBSERVATION INTERVENTIONS

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ABSTRACT

Primary nursing is a care delivery model emphasizing continuity and individualized nurse responsibility. Although implemented at X Hospital West Jakarta since 2017 through MPKP, challenges remain regarding role clarity, documentation, and assignment consistency. Objective to optimize the implementation of primary nursing through educational interventions and structured observation using the POSAC managerial approach. This study used a case study and pilot study approach conducted from May 27 to June 30, 2025. The sampling technique used was purposive sampling, involving 21 nurses as participants. Data were collected via interviews, observations, and questionnaires. Problems were prioritized using the USG method and root causes analyzed using the Fishbone diagram (5M+1E), followed by a Plan of Action based on POSAC functions. Interventions such as fixed team assignment, role education via Zoom, bedside handover, nurse identification labeling, and dashboard utilization improved consistency of care. The dashboard scored 75 on the System Usability Scale (SUS), indicating good usability. Optimizing nursing management functions especially planning and control proved effective in enhancing the implementation of primary nursing and improving continuity of care in the inpatient unit.

Keywords: continuity of care; dashboard; nursing management; primary nursing; POSAC

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INTRODUCTION

According to the Law of the Republic of Indonesia No. 38 of 2014, nursing care is defined as a series of interactions between nurses, clients, and their environment aimed at achieving clients' independence and fulfillment in self-care. Ensuring high-quality service delivery is the main goal of nursing care provision. Patients' assessment of inpatient care quality in hospitals is strongly linked to their level of trust in nurses (Aiken et al., 2018). The importance of nurses in healthcare services is also demonstrated by research conducted by Coster et al. (2018), which found that having an adequate number of educated and trained nurses in acute care settings can reduce patient mortality risk, particularly for those managed in primary care. The delivery of optimal nursing care is closely tied to the nursing assignment model applied.

High-quality patient care is associated with the method of care delivery implemented by nurses. Selecting an appropriate nursing care delivery model is essential as it directly affects the quality of care patients receive. Nurse managers play a critical role in determining and managing the most effective assignment model in hospitals. The nursing assignment method forms part of the organizational function within nursing management. Nurse managers must determine and organize how best to plan and coordinate work activities to achieve organizational goals effectively and

efficiently, while shaping the organizational climate and patient care structure (Marquis & Huston, 2021). In addition to determining the assignment model, nurse managers are also responsible for its implementation, ensuring that the chosen model is properly executed to deliver effective and efficient results while maintaining nurses' job satisfaction.

The nursing assignment model represents an organizational structure for patient care delivery. The primary nursing model has been reported to have numerous advantages and positive impacts. Studies have shown that higher proportions of professional nurses are associated with lower mortality rates, better patient satisfaction, and fewer adverse care events (Aiken et al., 2017). In the context of maternity, childbirth, and postpartum care, the primary nursing model has demonstrated beneficial outcomes (Pitkänen, 2013). Additionally, the primary nursing assignment model reduces missed nursing care in the short term, thus enhancing patient-centered care quality (Moura et al., 2020).

However, there are limited data on the overall implementation of nursing assignment models across Indonesia, and reports on the application of pure primary nursing remain scarce. A study by Orienti et al. (2020) on the implementation of primary nursing care in a maternal and child hospital in Jakarta found that the adopted model was a hybrid between primary and beginner-level team nursing, adapted to the available staff qualifications. Similarly, Indriani (2021) found that two hospitals claiming to implement the primary nursing model were actually using the modular or MPKP model—a combination of team and primary nursing (Sitorus & Panjaitan, 2011).

The primary nursing assignment model promotes continuity of care, ensuring comprehensive and accountable nursing practice (Sitorus & Panjaitan, 2011). Professional nurses serving as primary nurses must possess advanced analytical and clinical judgment skills to support patients and families during discharge transitions, manage medications effectively, identify key symptoms early, and develop clear follow-up care plans (Smolowitz et al., 2015). However, the availability of skilled professional nurses remains a challenge. The Indonesian Ministry of Health (2022) reported that in 2021, the largest proportion of nursing graduates from Health Polytechnic (Poltekkes) programs were Diploma III holders (6,156 graduates).

The primary nursing model emphasizes continuity of care by designating one nurse as primarily responsible for patients throughout their hospitalization. Although this model has been shown to improve communication quality, nurse engagement, and patient satisfaction, its implementation remains suboptimal in several hospitals, including hospital. Preliminary observations revealed inconsistencies in primary nurse assignments, limited staff understanding of the model, and insufficient documentation of continuity of care. Therefore, optimization efforts are needed through short educational interventions and structured observation during implementation. This field practice project aims to contribute to improving the quality of nursing care based on the primary nursing model at hospital.

METHOD

The method used in this project was a case study with a pilot study approach. The activities were conducted at a hospital in Jakarta from May 27 to June 30, 2025. The stages of the project included problem identification, analysis, development of a Plan of Action (PoA), implementation, and evaluation. Problem identification was carried out through interviews, observations, and questionnaires. The interviews were conducted with the Nursing Service and Work Team, including the Head Nurse of Inpatient Unit X, the Nursing Committee, Primary Nurses, and Associate Nurses in the same ward. The sampling technique used was purposive sampling, involving 21 nurses as participants. The pilot study encompassed a series of activities, starting from data collection to data analysis, followed by problem prioritization using the USG method (Urgency, Seriousness, and Growth). Once the priority problems were determined, a root cause analysis was conducted using

the fishbone diagram with the 5M + 1E approach (Man, Money, Method, Machine, Material, and Environment). The results of this analysis served as the basis for developing the Plan of Action (PoA). The PoA was formulated collaboratively through discussions and joint decision-making among the author, academic supervisor, field supervisor, head nurse, and daily operational staff in the Teratai Ward. The improvement plan was developed using the POSAC management approach, which includes Planning, Organizing, Staffing, Actuating, and Controlling.

Implementation was carried out according to the established PoA by: (1) forming primary and associate nurse teams, (2) conducting briefings and educational sessions on the roles of the primary and associate nurse teams, (3) installing identity labels for primary nurses in each room, (4) conducting mini supervisions and observations of team compliance using the Continuity of Care (CoC) Dashboard innovation, and (5) socializing the dashboard to Primary Nurses, Team Leaders, PPJAs, and other staff in the inpatient unit. After socialization, the dashboard was used for patient and nurse allocation for each shift, ensuring that the distribution followed the designated teams. Finally, evaluations were conducted qualitatively through discussions with the head nurse, primary nurses, and associate nurses, as well as through the assessment of the CoC Dashboard usability using the System Usability Scale (SUS).

RESULT

Interview Findings

Interviews with the nursing service work team revealed that the current assignment method implemented at Hospital, is a modified primary nursing model with a team-based approach. This model has been in place since 2017, coinciding with the introduction and implementation of the Professional Nursing Practice Model (MPKP) in the hospital. The adoption of this model aims to enhance the quality of nursing care through continuity of service and more structured patient monitoring and supervision.

However, the pure implementation of primary nursing has not been fully achieved due to several limitations, particularly in the uneven qualifications and educational levels of nursing staff across units. The evaluation of primary nursing implementation is conducted annually by the nursing service work team through management and care supervision visits to all wards. Guidelines for the Primary Nursing Care Method (MAKP) have been established since 2017, and the Standard Operating Procedure (SOP) for the Primary Nursing Method was formalized in 2023.

“Interviews with the head nurse, primary nurses, and associate nurses indicated that the organization of the Primary Nursing Care Method (MAKP) within the unit follows a modified primary nursing approach. Nursing resources are divided into teams based on patient numbers, with each team responsible for 8–10 patients and 6–10 nurses per shift. Despite this structure, several challenges were identified that hindered the model's effectiveness, including: Dual roles of primary nurses who also serve as associate nurses within the same shift. Lack of formal assignment of primary nurses responsible for patients in each room. Insufficient continuity of care, as patients are often attended by different nurses in each shift. Irregular implementation of nursing rounds. Limited monitoring and evaluation by the head nurse regarding primary nursing implementation”.

In-depth interviews with two primary nurses revealed that the primary nursing model has not yet been optimally applied. They reported that their role as primary nurses were not fully executed since they also had to serve as associate nurses. *Furthermore, not all patients undergo comprehensive reassessment to evaluate nursing problems thoroughly. Variations in patient dependency levels and the large scope of responsibilities significantly increased their workload.*

Meanwhile, two associate nurses reported that patient progress reporting to the primary nurse was not conducted regularly. Communication occurs only when issues arise that they cannot resolve independently. They also admitted to having limited understanding of the concept of continuity of care in the context of primary nursing.

These findings suggest that although the hospital has formally adopted the primary nursing system, its functional implementation and care continuity remain suboptimal. Therefore, there is a strong need for role strengthening, structured education, and enhanced monitoring systems to ensure effective primary nursing practice.

Observation Findings

Direct observations were conducted in Inpatient ward of hospital, for three consecutive days prior to the intervention. Observations focused on nurse assignment patterns, inter-shift communication (handover), and the involvement of primary nurses in patient care delivery. The results indicated that nurse assignments per shift were inconsistent with the designated primary–associate nurse system. Patients were often cared for by different nurses across shifts, without clear identification of the primary nurse responsible for ongoing care. This reflects suboptimal continuity of care in daily nursing practice. Furthermore, handover practices between shifts were general and clinically oriented, emphasizing vital signs and completed procedures rather than follow-up plans or evaluation of prior interventions. Handover was not conducted at the bedside, and primary nurse introductions to patients' families were absent, reducing the effectiveness of communication and continuity of information. Observations also revealed that primary nurses did not fully function as team leaders or care coordinators. In some cases, associate nurses performed interventions without reporting directly to the primary nurse, and supervision of nursing documentation was limited. Additionally, there were no visual aids or dashboards displaying the identity of the primary nurse assigned to each patient. A detailed summary of the observation results is presented in Table 1.

Table 1.

Observation of Primary Nursing Implementation

No.	Aspects observed	There is	There isn't any	Notes
1.	MAKP (primary nurse, associate) information board.	√		Not yet updated to the latest version
2.	Consistency of primary nurses and Associate Nurses in managing patients according to their team on daily shifts.	√		Still found PA Team 1, managing Patients managed by Team 2
3.	There is coordination between primary nurses and associates.	√		
4.	The head of the room supervises the MAKP.		√	Management supervision is carried out once a year.
5.	Documentation is written by the primary nurse consistently.		√	Not all documentation is done by PP, still assisted by PA.
6.	Patients know who the nurse in charge is.	√		The majority of patients/families do not know who their primary nurse (PP) is.
7.	Nurse communication between shifts is clear and documented	√		Hand over is not SBAR, there is no bedside hand over between PP/PA.

Questionnaire

Based on the results of the study using the questionnaire distribution method, the target respondents were nurses in room X, Hospital X, West Jakarta, from the head of the room to the implementer.

Table 2.

Distribution of Respondent Characteristics by Gender, Education, and PK Level

Respondent Characteristics			
		f	%
Type Sex	Man	1	5
	Woman	20	95
Education	S1 Nursing	11	52
	D3 Nursing	10	48
PK Level	PK 1	11	52
	PK 2	4	19
	PK 3	6	29

Table 2 shows that the number of female respondents was 20 people (95%), while the number of male respondents was 1 person (54%). The number of respondents based on S1 Nursing education was 11 people (51%) and D3 was 8 people (48%). Based on the level of clinical nurses, it consists of from PK 1 amount to 11 person (52%), PK 2 amount to 4 person (19%) And PK 3 totaling 6 people (29%).

Table 3.

1 of the Questionnaire on the Role and Function of the Head of the Room in the implementation of primary nursing with the POSAC and 5M + 1 approaches

No	Statement	STS	TS	N	S	SS
1.	I understand the plan to implement the <i>Primary Nursing model</i> in the ward where I work.	5%	5%	0%	45%	45%
2.	The structure of the division of roles between primary and associate nurses is clear and understood by the team.	5%	5%	5%	40%	45%
3.	The number and competence of nurses in my unit are sufficient to support the implementation of <i>Primary Nursing</i> .	10%	10%	0%	65%	15%
4.	The head of the room provides direction/motivation regarding the role as (primary nurse/associate).	10%	5%	5%	40%	40%
5.	I receive regular supervision or evaluation regarding the implementation of my role in <i>Primary Nursing</i> as a (primary nurse / associate nurse).	5%	15%	5%	50%	25%
6.	I feel capable of carrying out my role in accordance with my function in <i>Primary Nursing</i> as a (primary nurse/associate).	5%	5%	5%	40%	45%
7.	I have received training or supplies related to the implementation of <i>Primary Nursing</i> .	5%	10%	10%	30%	45%
8.	SOPs or written guidelines on the implementation of <i>Primary Nursing</i> are available and easy to understand.	5%	5%	5%	40%	45%
9.	Supporting facilities such as primary nurse nameplates, care forms, or documentation formats are available in the treatment room.	5%	0%	10%	65%	20%
10.	Documentation systems (manual/electronic) support <i>continuity of care</i> by primary nurses.	5%	5%	15%	40%	35%
11.	The work environment, including culture and workload, supports the optimal implementation of <i>Primary Nursing</i> .	5%	5%	10%	45%	35%

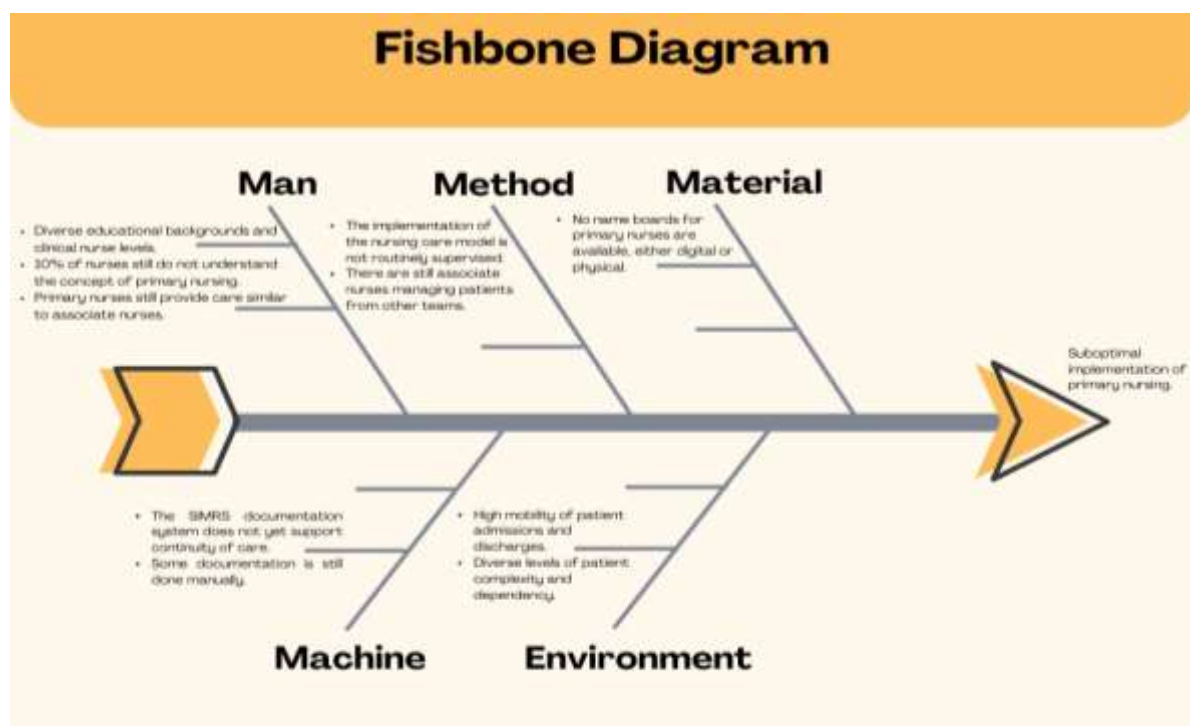


Figure 1. Analysis of Study Results in a Fishbone Diagram

The results of the assessment through interviews, observations, and questionnaires on the role and function of the ward head in the implementation of *primary nursing* were then analyzed using a *fishbone diagram*. Based on the results of the analysis using *the fishbone diagram*, it was found that the direction and control function of the ward head in the implementation of primary nursing was not optimal. The results of the analysis of the role and function of the ward head in the implementation of primary nursing are explained in Figure 1.

Table 4.
Problem Priorities

No.	Problem	Urgency	Seriousness	Growth	Score	Rank
1	The implementation of primary nursing care methods (<i>Primary Nursing</i>) is not yet optimal	5	5	4	14	1
2	Documentation of nursing care is not optimal	4	4	4	12	3
3	The implementation of SBAR communication related to nursing care is not yet optimal.	4	4	3	11	4
4	Monitoring and evaluation (monev) of nursing care documentation is not yet optimal	5	4	3	13	2

In accordance with the priority of the problems above, an improvement and repair program will be carried out as described in the following action plan:

Table 5.
Plan of Action

Activity	Description	Objective	Indicator	Target	Method	Time
Planning (Mapping & Formal Patient Team Establishment)	Create a permanent list of patient assignments based on the primary & associate teams in each room.	Establish clear patient ownership for continuity of care	100% of patients have an assigned primary team & associates	Head of room, primary nurse, associate nurse	Discussion & validation	1 day
Organization and Staffing (Briefing and Education on the Role of Primary & Associate Teams)	Provides an understanding of the concepts and roles of each	Improve understanding & commitment of the nursing team	≥ 90% of nurses passed the team role post-test	Head of Room, Primary & associate nurses	Group Discussion, Online Zoom	1 day
Organization and Staffing (Installation of Primary Nurse Identity Labels in Patient Room Area)	Posting of primary nurse name in patient area	Make it easier for patients and staff to identify the main person in charge	≥ 90% of beds have primary nurse identity labels	Patients, families, nurses	Direct Implementation of primary nurse name label installer	1 day
Direction (Mini Supervision & Compliance Observation)	Direct observation of who is caring for patients each shift	Control the implementation of the primary team system	≥ 90% of patients are cared for by nurses from his team	Head of room, primary nurse and associate	Observation and recording via COC dashboard	3 days
Control (Evaluation & Reflection with Staff)	Discussion of obstacles and feedback from staff	Continuous improvement of model implementation	≥ 80% of nurses stated that the model helps continuity of care	Head of room, primary nurse and associate	FGD, Brainstorming	1 day

During the planning stage, activities focused on establishing primary and associate nursing teams for each ward, planning refresher education on team roles, designing primary nurse identification labels to be placed in s, and developing a spreadsheet-based patient allocation dashboard to monitor continuity of care. The planning discussion was conducted collaboratively with the head nurse and daily supervisors on June 20, 2025. In the organizing and staffing stages, structured education and role refreshers were carried out for head nurses, primary nurses, and associate nurses via online sessions (Zoom), preceded by a pre-test and followed by a post-test. The sessions were interactive and involved all nursing staff in Inpatient Ward X. Primary nurse name labels were installed on each patient room door to facilitate identification and strengthen therapeutic relationships. Patient allocation was conducted by primary nurses and team leaders based on the dashboard, considering the number of patients, dependency levels, and the nurses' professional levels. Two primary nurse teams (PP1 and PP2) were assigned to ensure continuity of care, with team placement adjusted according to room distribution and shift scheduling. However, individual nurse ownership per room remains limited due to pre-existing shift schedules.

During the actuating stage, the head nurse and daily supervisors provided direction to the primary nurses, team leaders, and staff nurses regarding the use of the dashboard and the importance of bedside handovers aligned with assigned primary nurse teams. The briefing also emphasized the role of nurse name labels as a communication and identification tool for patients and their families. At the controlling stage, monitoring of continuity of care was conducted through the patient allocation dashboard, which recorded the alignment between assigned teams and the patients cared for in each shift. Bedside handover supervision was carried out by the head nurse and delegated to team leaders for evening and night shifts.

Evaluation was performed to assess the effectiveness of continuity of care implementation based on the primary nursing model. The evaluation methods included direct observation, mini-supervision, document review, and staff feedback through discussions and the System Usability Scale (SUS) instrument. Overall, results indicated that the implementation was reasonably effective, demonstrated by improved alignment between nurses and patients, as well as increased staff understanding of their respective roles. The establishment of PP1 and PP2 teams facilitated better distribution of responsibilities and enhanced nurse accountability in providing care. The installation of primary nurse identification labels strengthened professional identity and improved therapeutic relationships with patients and families.

The bedside handover practice was adopted by most shifts, although not yet consistently across all teams. Online education via Zoom proved effective, as post-test results showed that over 90% of participants regained understanding of the roles of head nurses, primary nurses, and associate nurses. The use of the spreadsheet-based patient allocation dashboard effectively supported the implementation of continuity of care by displaying clear information about patient assignments according to teams, work shifts, and nurse identities. Evaluation of dashboard monitoring over eight days of implementation showed that 79.62% of patients were cared for by the appropriately assigned nursing team. The usability evaluation of the dashboard was conducted using the System Usability Scale (SUS), which consists of 10 items and was completed by six respondents. The results showed a score of 75, which falls into the “good” category according to the interpretation by Brooke (1996).

DISCUSSION

The implementation of the improvement program for the primary nursing method in this residency project had a positive impact on enhancing continuity of care, nursing staff accountability, and inter-shift communication effectiveness. These findings align with previous studies that reinforce the validity of the interventions conducted. The establishment of primary and associate nurse teams within the service unit proved effective in strengthening nurses' ongoing responsibility for their

patients. This finding is consistent with the study by Dal Molin et al. (2017), which reported that primary nursing significantly improved patient clinical outcomes and enhanced staff perceptions of a more structured and controlled work environment. The model also provides greater role clarity among nursing staff, facilitating the consistent and personalized delivery of nursing care. Similarly, Parreira et al. (2021) emphasized in their systematic review that continuity of care in primary nursing is reinforced by individual accountability and the therapeutic relationship between nurses and patients. The study highlighted the importance of involving primary nurses in clinical decision-making and in providing care from the beginning to the end of the patient's care episode. This aligns with the current implementation, where nurse identification through name labels and bedside handover strengthened active nurse engagement in maintaining care continuity.

A fixed assignment model also positively influences patient and family satisfaction, as demonstrated in a randomized controlled trial by Edwards et al. (2022). The study found that families of patients treated by a consistent primary team (the same doctors and nurses throughout the hospital) reported higher levels of satisfaction and perceived more meaningful relationships with the care team. Nurses also reported an increased sense of accountability and more effective communication. However, the successful implementation of primary nursing is highly dependent on structural and managerial factors. Carvalho Moura et al. (2019) pointed out that low staffing levels and high workloads can lead to missed nursing care, directly reducing care quality and service continuity. Similar challenges were encountered in this residency project, including the dual roles of primary nurses, uneven patient distribution, and inconsistent implementation of bedside handovers across shifts. The evaluation of the team allocation dashboard in this project also yielded promising results. The SUS score of 75 indicated that the system was user-friendly and effective in supporting team-based patient assignments. This finding aligns with The Effects of the 2014 Primary Nursing Implementation Study, which highlighted that the success of primary nursing implementation depends not only on human resource factors but also on the availability of supportive tools that help nurses recognize and sustain their responsibility for patients.

CONCLUSION

The residency program demonstrated positive and realistic outcomes, particularly in establishing a foundation for continuity of care through the strengthening of team systems and the introduction of supportive tools such as the Continuity of Care Dashboard and primary nurse identification labels. Although the results have not yet reached the ideal quantitative target, the improvement of team assignment accuracy to 79.62% over eight days and the observed behavioral changes among staff indicate that this model has strong potential for broader adaptation in other units. To optimize the implementation of primary nursing in inpatient care, several follow-up actions are recommended. From a managerial perspective, structured mini-supervision sessions two to three times per week are recommended to ensure team consistency and continuity between shifts. Task allocation should be based on patient dependency levels and nurse competency rather than patient count alone. Regular briefings and periodic role refreshers can sustain staff understanding and motivation, supported by simple recognition programs and educational visuals. Furthermore, documenting primary nurse identification in the hospital's medical record system would strengthen accountability. Finally, the implemented model can serve as a pilot project or best practice for replication in other units and as a reference for hospital management in improving overall nursing care quality.

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