

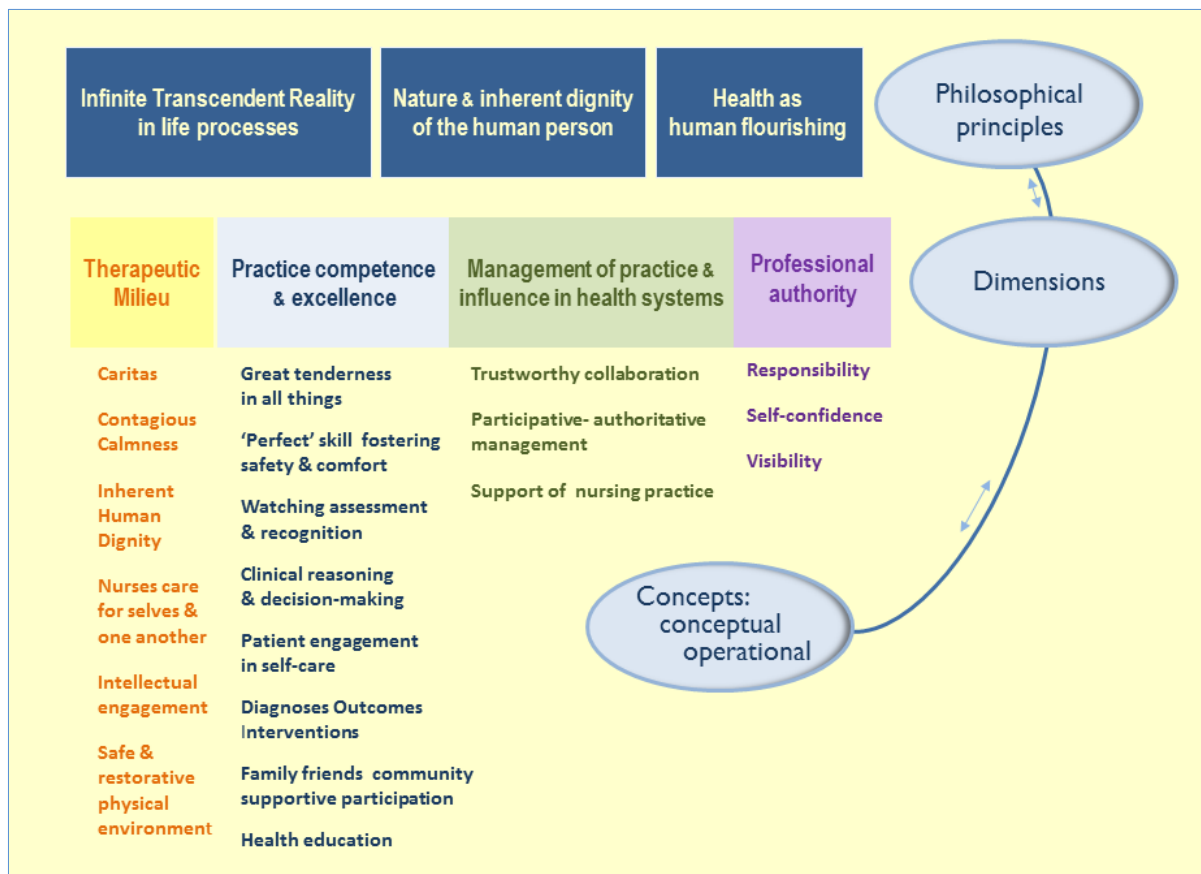
The Careful Nursing Philosophy and Professional Practice Model[®]: A Keystone for Nurses to Live Better, Laugh, and Care More

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Good morning. Céad míle beannachtaí – in Irish, a hundred thousand greetings. And, thank you for the opportunity to talk about Careful Nursing at this wonderful conference. I would like to commend the conference planning committee for including laughter in its title. Wittiness has long been considered a virtue, and a political virtue at that, because laughter spirals out to include everyone and helps facilitate agreement amongst people with various points of view – so well done.

Now to the matter at hand: the Careful Nursing Philosophy and Professional Practice Model[®]. I am going to mention briefly the background of Careful Nursing and how it came to be the way it is. Then I will talk about the three principles of the philosophy, how they underpin the four dimensions of practice, and for each dimension the practice concepts, that is, the actual attitudes and actions of practice.

In summary, this is what Careful Nursing looks like.



It has a philosophy, that is, principles which state what is important and distinctive about nursing and which guide how we practice – you see these across the top in blue. And, it has a professional practice model composed of dimensions and concepts which encompass the actions and attitudes of practice.

The history behind Careful Nursing. The philosophy and practice model have been constructed based on historical research which located and examined the journals and other documentary evidence of the work of early to mid-19th century Irish nurses, mainly Sisters of Mercy and Sisters of Charity. When they began their work in the 1820s, skilled nursing as a public service in The United Kingdom of Great Britain and Ireland had been virtually extinct for almost 300 years, following the Reformation and Henry VIII's dissolution of the monasteries, which had provided nursing and medical services. Medicine soon recovered but nursing was neglected – referred to in nursing history books as “the dark period in nursing”.¹ They began by working mainly in communities, and at times of crisis in hospitals and workhouses. As they developed their ideas about nursing and their practical skills, they developed what was then called a ‘system of nursing’. Basically, they re-formulated skilled nursing as a public service.

They didn't necessarily set out to form communities of religious sisters. In the early 19th century it was more or less a requirement for their work. It was unheard of for groups of women to take the initiative and organise themselves to operate a public service. In one case they were threatened with confiscation of their property if they did not form a religious order.

Notably, from 1854-1856 eleven Irish nurses worked with, or alongside, Florence Nightingale at the Crimean war hospitals, a fact that is not well known because of the cultural and political conflict of that time. The name, Careful Nursing, comes from a letter written by the nurses for delivery to the British War Office in 1854, in which they state that “Attendance on the sick is, as you are aware, part of our Institute; and sad experience amongst the poor has convinced us that, even with the advantage of medical attendance, many valuable lives are lost for want of careful nursing”.²

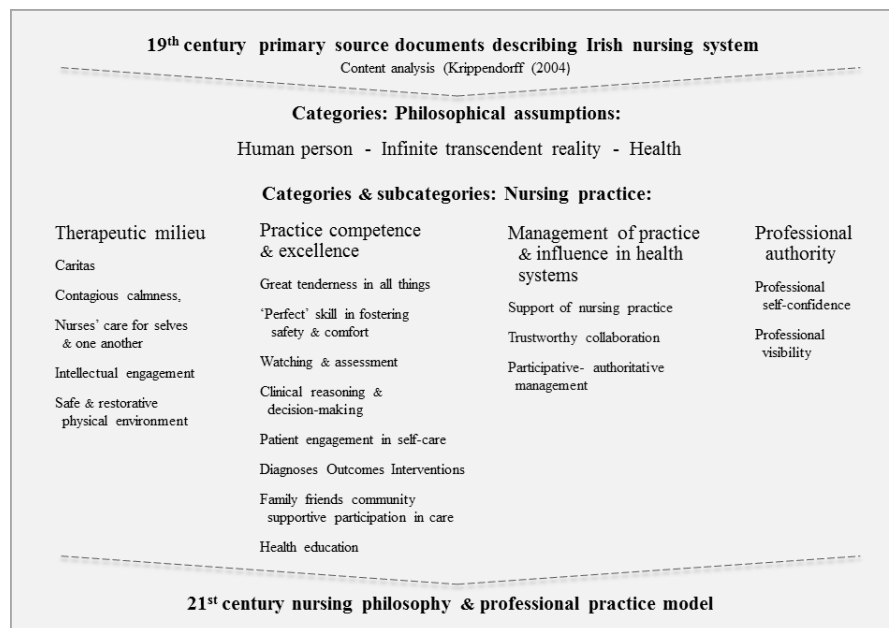
This is a well-known Crimean war painting, which shows Nightingale receiving a wounded soldier at Scutari, and you can see in the shadows to your left one of the Irish nurses.



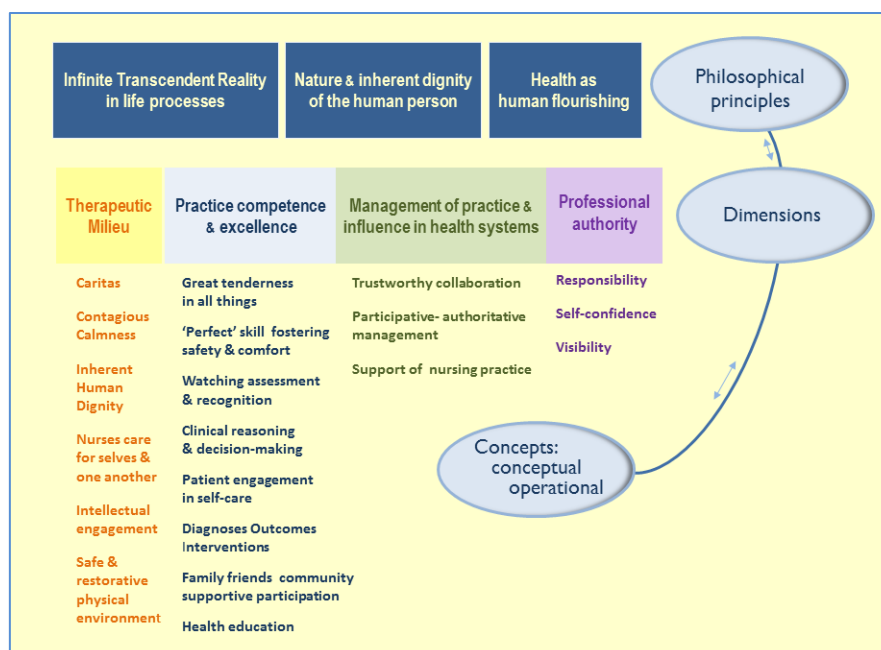
Mission of Mercy: Florence Nightingale Receiving the Wounded at Scutari

This is Mary Clare Moore, who Nightingale admired particularly. (I think of this painting as an early example of Emergency Department nurse triage, with the nurses deciding how serious the soldier's injuries are and where he should be treated). Nightingale and Moore corresponded privately over a number of years. Nightingale expressed her admiration for Moore, observing in one letter "how I should have failed without your help".³

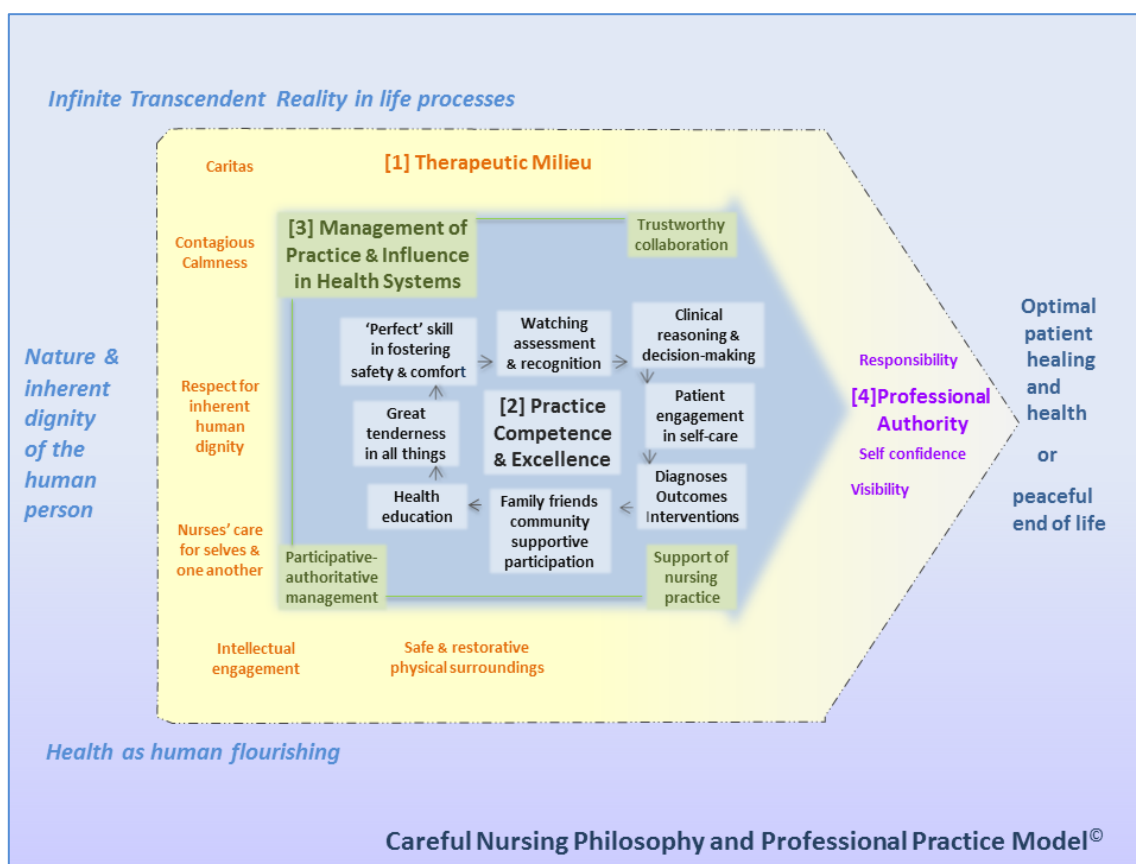
Translation of historical records into a contemporary philosophy and practice model. Content analysis of the historical documents was used to identify categories and subcategories of nurses' knowledge and practice. These were then translated into the contemporary philosophical principles, and the dimensions and concepts of the professional practice model, as shown in this diagram:



To conceptualise the philosophy the thinking of Thomas Aquinas was used, and by association that of Aristotle. This work began in 2003 and over time some minor changes that have been made to improve clarity based on experiences with implementing the model and suggestions of a philosopher, who acts as an adviser on the philosophy. Current listing of principles, dimensions and concepts:



Current diagram of the philosophy and practice model that we work from:



You can see the three philosophical principles at the outside to the left, top and bottom. In the shape you see the practice model with its four dimensions, the therapeutic milieu in yellow, practice competence and excellence in blue in the middle, which is surrounded by management of practice and influence in health systems in green, and to the right professional authority in purple. On the far right you see the proposed outcome of the implementation of Careful Nursing, optimal patient healing and health, or a peaceful end of life. Now let us look at these in some detail.

The philosophy: The term philosophy is used here to refer to a system of principles, not to philosophy as a discipline. Understanding the nature and inherent dignity of the human person is of central and essential importance in nursing. Because human persons have a nature; a body and senses; they sometimes need nursing. They can become sick or injured or their nature can make them vulnerable and not able to care for themselves. Also, human persons are defined by a property pertaining to dignity. Persons by definition have inherent dignity.⁴ When this dignity becomes threatened during times of illness, injury or vulnerability, nurses have a central role in ensuring the inherent dignity of all persons is recognised and respected. Human nature together with inherent human dignity is a 'why' of nursing.

The human being is defined as a human person because the idea of 'person' encompasses the deeply relational nature of human beings, and a defining characteristic of nursing practice is that it takes place particularly within the context of nurse-patient relationships. It is widely recognized that the quality of these relationships can have a significant influence on the effectiveness of nursing practice and patient healing.

Also, the human person by definition is a unitary substance; an inseparable whole with no parts. At the same time, the unitary person encompass two explicit realities, a bio-physical reality and a psycho-spiritual reality. The person is not composed of these realities but is a unitary being in whom these realities can be distinguished. We commonly use the term holistic for this idea, but this term is

used very loosely in nursing and usually well wide of its original meaning. The life of the person is experienced as two-fold; an outward life of the body and senses and, simultaneously, an inward life of the mind, spirit and communion with an infinite transcendent reality, or spirituality. The outward life predominates in consciousness – we think mainly in terms of bio-physiology and senses. We don't always pay attention to our inward lives but this is emphasised in Careful Nursing because it is mainly through the inward life that we engage in relationships with patients. Awareness of the inward life can be developed through daily short periods of meditation, inner reflection, silence, stillness or prayer.

This leads to the second philosophical principle, that there exists an Infinite Transcendent Reality which is the source of all creation, unitary wholeness, and healing in the universe. Aquinas argues that this reality is immensely loving, infusing all persons abundantly with a spiritual love and goodness which draw all persons to it. It can be apprehended through the psycho-spiritual reality or inward life, and through the sensitive perception of splendid beauty, for example in nature or a musical symphony. Everyone has the capacity to respond to this love and goodness, within themselves and in their relationships with others. It can be thought of as spiritual experience.

This principle can be thought of as the spiritual in nursing – and there are two main points here. One is that symbols and prototypes of nursing, which can be traced back at least seven thousand years, are invariably associated with spirituality. Even though the spiritual aspect of nursing was more or less abandoned as nursing developed as a professional discipline over the past sixty or so years, it has recently emerged again and is now of wide interest. The second point is that amongst nurses there are many different definitions of and approaches to spirituality. In addition, the literature shows that many atheists and secular humanists also maintain that they are deeply spiritual.

This principle brings us face to face with how we understand spirituality in our lives and in our practice. For any given nurse this may be in accordance with the Careful Nursing viewpoint or with any of a range of spiritual viewpoints that converge on Careful Nursing. In a sense Careful Nursing seeks to allow for all things spiritual for all nurses while at the same time maintaining its own understanding of spirituality.

The third philosophical principle, health as human flourishing, is the person's unitary experience of personal dignity, harmony, relative autonomy, contentedness and sense of purpose in life. It is ideally associated with the relative absence of disease but can still be fully experienced in states of disability or chronic illness. This definition comes from linking the historical data with the dictionary definition of flourishing. It actually needs to be merged with the philosophical understanding of human flourishing which is discussed extensively in the virtue theories of Aristotle and Aquinas, and in contemporary theories of virtue ethics.

I won't say any more on the philosophy other than there is immense depth in each principle and much work still to be done to further develop and refine them. In nursing we have a tendency to dive right into practice and start doing things. But a philosophy is like a compass – a nursing philosophy keeps us on a distinctively nursing course.

Professional Practice Model: Let us turn now to the professional practice model with its four interrelated dimensions and their concepts. Overall, the model merges a spiritual approach to practice with clinical competence and excellence, nursing management and professional authority.

The spiritual approach is emphasised in the therapeutic milieu dimension through five of its six concepts, which you see in the cream and amber colours. This is a distinctively nursing surrounding and atmosphere that nurses and their assistants create for patients. It is more than just an environment. It is a culture that is rich in healing interpersonal relationships, cooperative attentiveness to patients, and physical features which are protective, calming and restful. Its aim is to

foster patients' optimal safety and healing, but it also influences and engages everyone who enters the ward or patient care area.

Its six dimensions are first, *caritas*, which is nurses' expression of unreserved benevolence and kindness toward patients. It arises from their spiritual awareness and encompasses sensitivity, compassion, graciousness and joyfulness. It is a type of unconditional love that empowers human helping relationships.

Then, *contagious calmness* is closely related to caritas. It is a calm disposition, associated with peacefulness, which is constantly maintained, even under the most stressful circumstances, and is communicated naturally to patients and others in the therapeutic milieu. It is expressed in measured actions, a soothing voice and an impression of quiet dependability. It helps develop an attitude of composed self-confidence and alertness to the ever-changing needs of patients

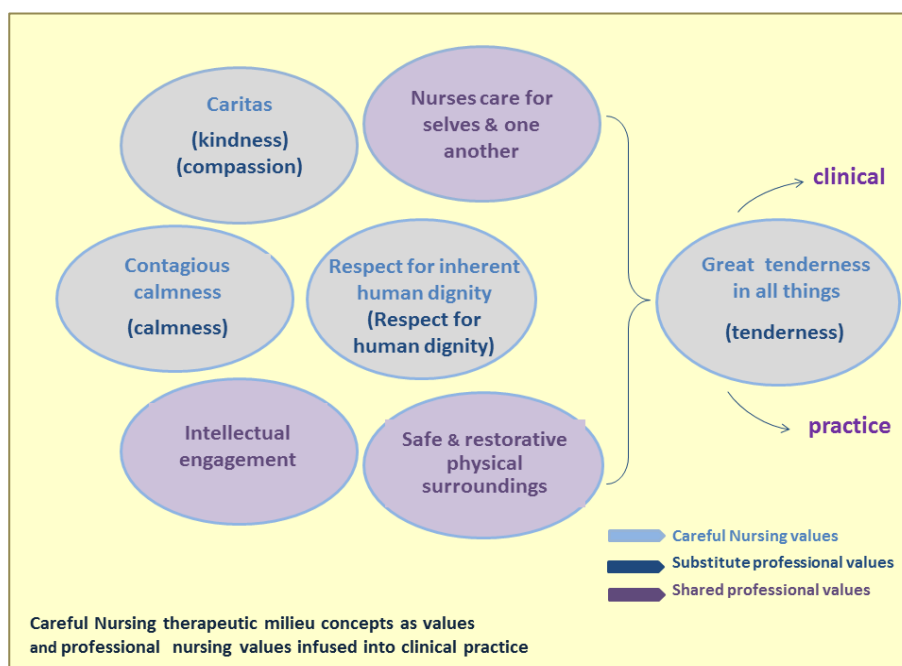
Then, *respect for inherent human dignity*, that is, for the fundamental value of the human person which derives from the person's spiritual nature.

Then, *nurses' care for themselves and one another* which highlights the importance of nurses treating themselves and one another with respect, kindness, patience and thoughtfulness. This is an important prerequisite for implementing Careful Nursing, especially considering concern in the literature with burnout and nurses engaging in subtle forms of aggression toward one another.

Then, *intellectual engagement* which concerns not only the use of objective, scientific knowledge, logical analysis and the accuracy of clinical judgements in everyday practice, but also empathy, natural reason and what we call intuition.

And finally, *safe and restorative physical surroundings*. Together with physical safety of patients, which is paramount, for example in relation to falls and infection control, healing elements such as light, colour, fresh air and sound, contribute to the quality of the therapeutic milieu.

Because most of these concepts have a spiritual quality and because nurses have a range of perspectives on the spiritual in their lives, with some rejecting spirituality, these dimensions can also be viewed as nursing values. Nurses share their professions values, although they may name them differently according to different perspectives. This diagram shows the concepts as nursing values.



This therapeutic milieu might seem somewhat challenging to accomplish in the very stressful and pressed settings in which we mostly work. Nurses sometimes say, “we don’t have time” to do this. But, it is not a matter of time. It doesn’t take any longer to do something with loving kindness and calmness than it does to do something in a stressed and detached way. It matters how nurses are in themselves. And, this relates very much to their inward lives. What our philosophy tells us is that it is essential that we attend to our inward lives as a source of knowing who we are as nurses and how we create a therapeutic milieu in our practice.

This requires a commitment to making time each day, at least five minutes, to be still and quiet and *listen* to our inner spiritual self. This “quiet time” can be thought of in different ways:



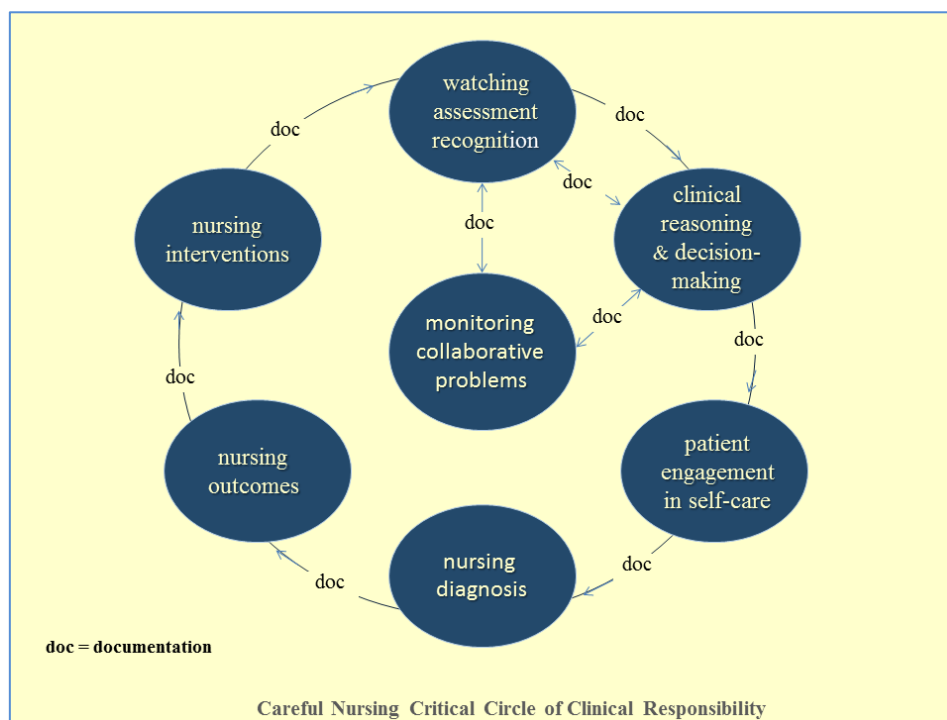
Nurses who do this each day consistently, over time will develop an awareness of their inward life that will remain with them in any circumstances without them having to think about it. It will become a natural part of who they are. This is essential for practicing Careful Nursing.

Practice competence and excellence: Referring back to the diagram on page 4, you see this dimension in the centre in blue. Its interrelated concepts concern attitudes and actions that are carried out at least with competence and always with the intent of developing excellence. Most of its concepts are aspects of practice that we are all very familiar with; what we often called clinical care or the nursing process. But in Careful Nursing the depth and details of each dimension are emphasised.

Taking the dimensions from the left, *great tenderness in all things* is the application of the values and qualities of the therapeutic milieu directly into every aspect of clinical practice, from the most elementary personal care to the most complex interactions and procedures. The phrase comes directly from the historical documents, where it is particularly emphasised.

'Perfect' skill in fostering safety and comfort concerns nurses' meticulous attention to detail, again, in all aspects patient care. It includes precision in intellectual skills, such as theorising about processes of care and clinical decision-making. The quotation marks around 'perfect' emphasise that although faultless detail can be essential, for example in administration of medications, perfection is also an ideal to be worked towards.

Continuing clockwise, the next four dimensions are very closely related and are critically important to patient safety, especially in acute care settings. They can be thought of as a critical circle of clinical responsibility:



This is very important in acute care but would also be important for patients at high risk in primary care practice settings.

Watching, assessment and recognition is a composite of nurses' constant visual and perceptive attentiveness to patients and alertness to their bio-physical and psycho-spiritual condition and needs in order to be aware as immediately as possible of any changes in their conditions and needs. It provides the foundation for the processes and strategies of *clinical reasoning and decision-making*. These processes are also used to identify needs for assessment and intervention by other health professionals.

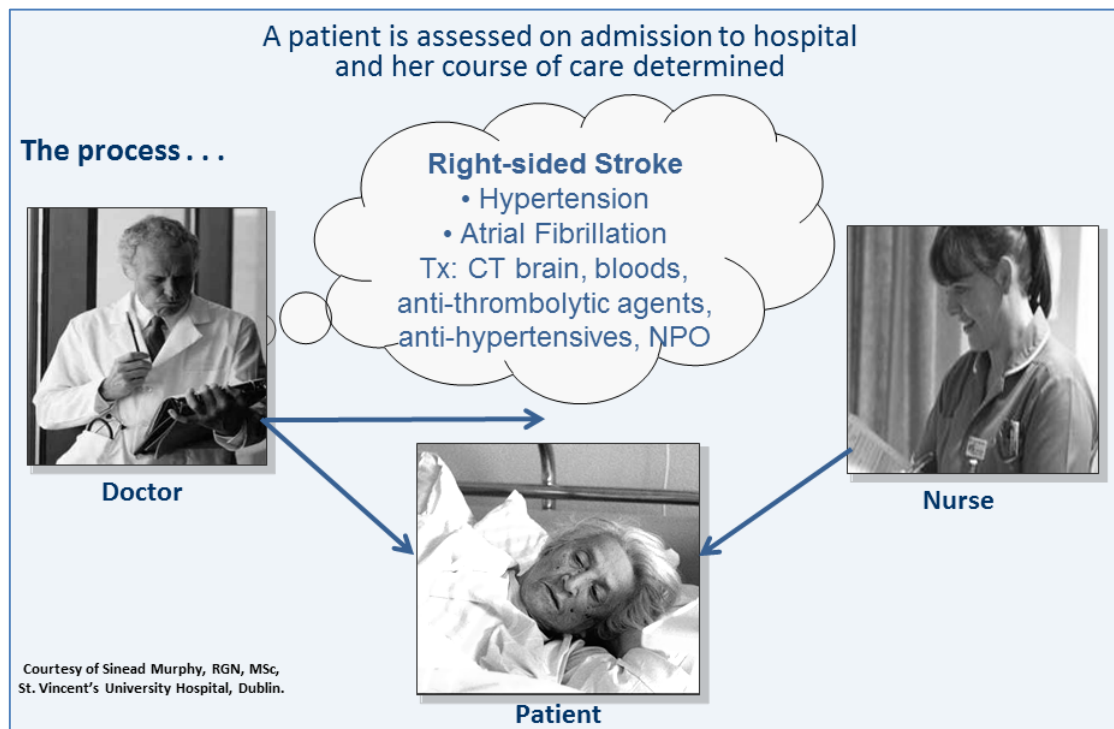
In this process, the widely recognised, internationally standardised nursing languages are used. These are a *nursing diagnoses* language, a *nursing outcomes* language and a *nursing interventions* language and each is clearly specified and defined in detail. Nursing diagnoses are specific clinical judgements about actual and potential patient responses to health problems and/or medical diagnoses that are within the scope of nursing. These are linked to desired nursing-related patient outcomes which are measurable. Then evidence-based nursing interventions are selected and implemented to achieve the outcomes and the entire process is continuously evaluated. These languages enable nurses to clarify how they make patient care decisions, articulate clearly their contribution to patient care and measure its effectiveness.^{5,6,7,8} This might sound like an unlikely analogue of 19th century nursing practice, but it is an accurate modern interpretation of it.

You will notice in the centre of the Critical Circle diagram 'monitoring collaborative problems'. These are potential physiologic complications in patients that doctors and nurses identify, and nurses monitor on a 24/7 basis, to detect onset or change in status.⁹ Collaborative problems can be life-threatening so the process of monitoring them and preventing them or minimising them is crucial to patient safety.

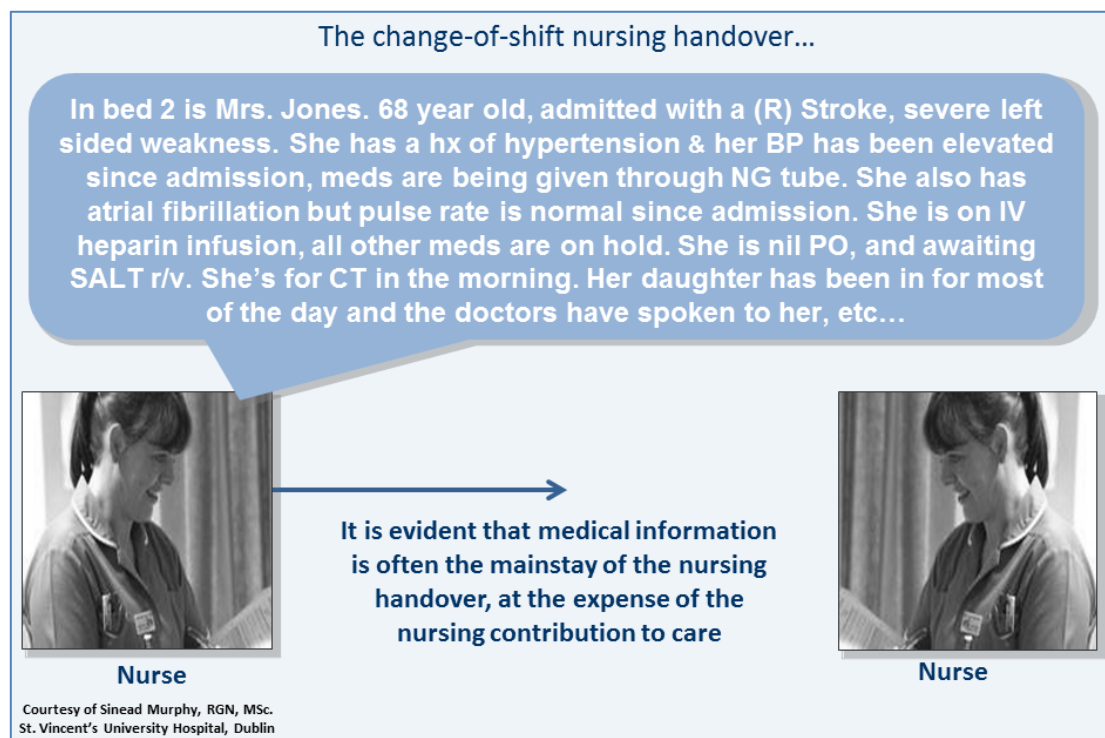
I'm aware that you mostly don't use a nursing language system here but I'm going to run through how it works briefly and simply because we find it invaluable in implementing Careful Nursing in

Ireland. The scenario is a change of shift nursing handover in an acute care setting, but the principles are the same in any primary care setting. The illustrations are by Sinead Murphy, a practice development co-ordinator at St. Vincent's University Hospital in Dublin. The first two illustrations show the handover without the standardised languages.

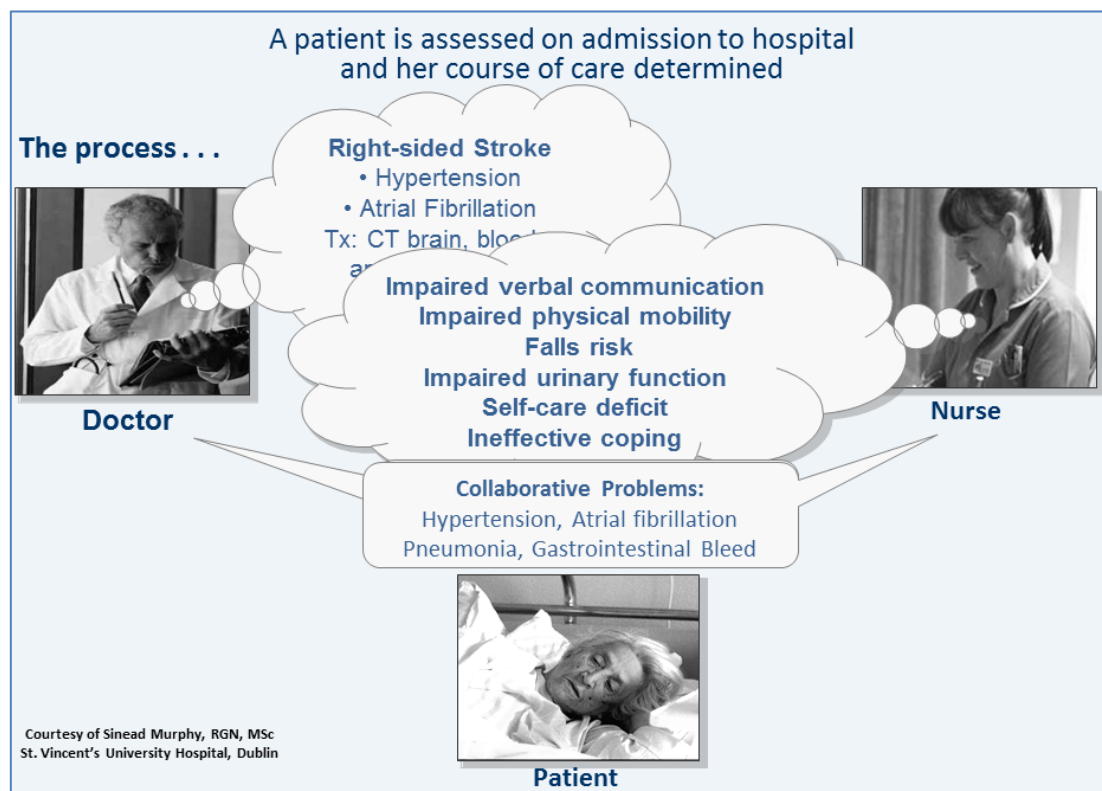
The patient is assessed on admission primarily in terms of her medical condition:



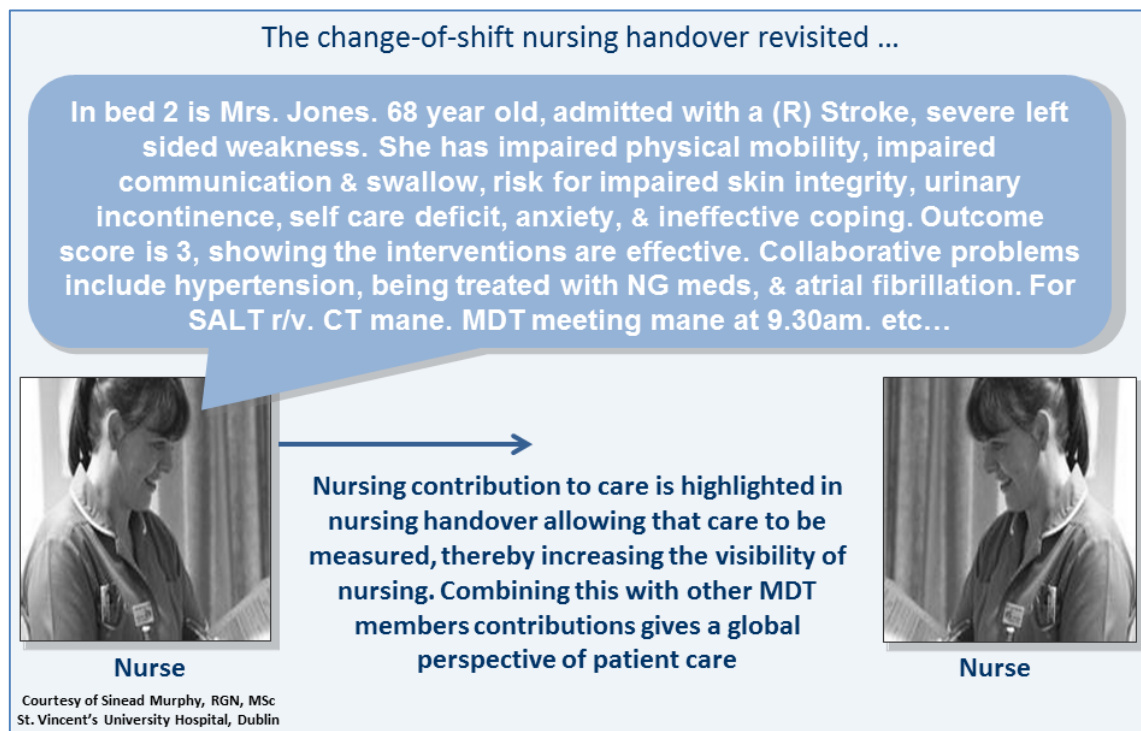
Change-of-shift nursing handover is medically focused:



Now the same scenario using nursing standardised languages. The patient has a medical and distinctively nursing assessment. Both nurse and doctor assess the patient for collaborative problems:



The change-of-shift nursing handover again:



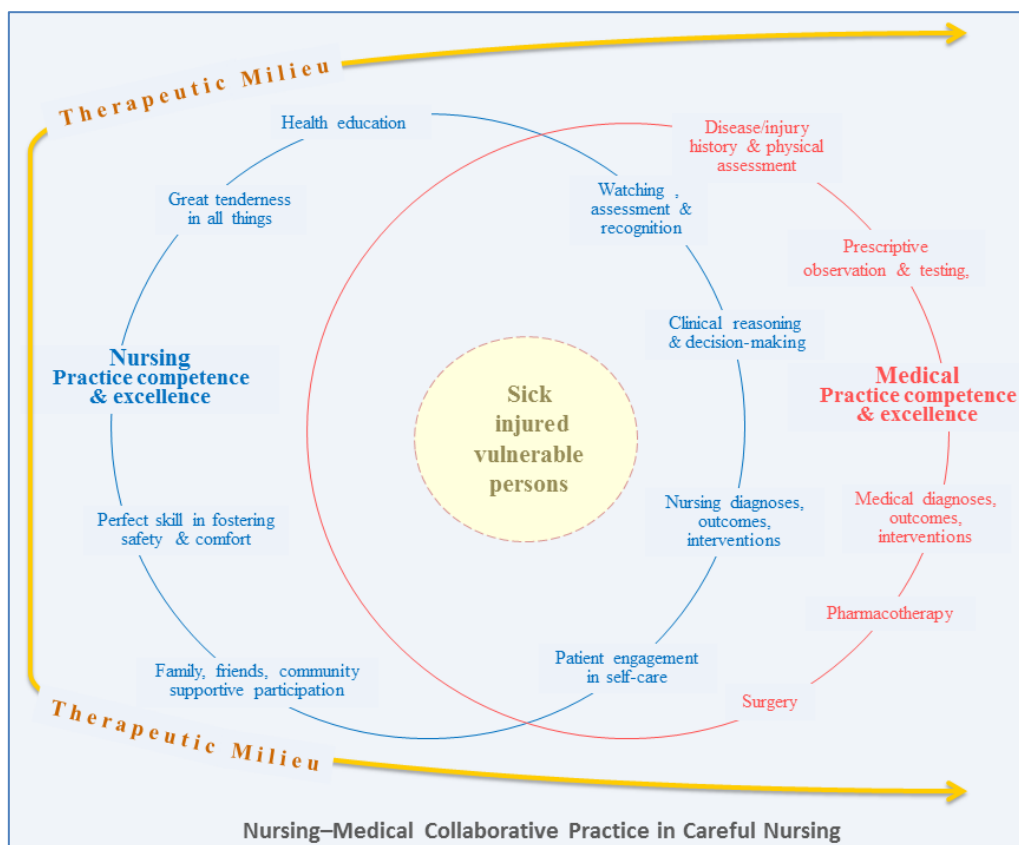
Clearly, a nursing assessment has been done and there is a distinct, recordable nursing contribution to the woman's care. The nurses have responsibility and authority for their nursing practice.

Use of these standardised languages can make a significant difference for nurses. Take a care of the elderly ward which had multidisciplinary patient rounds. On rounds, the doctors gave their diagnoses and interventions, the physiotherapist would say what they were treating and how the patient was doing, the nutritionist would talk about what they were doing for the patient and the psychologist would talk about the patient's psychological status. Then the nurses would say how the patient was doing from their point of view. They found this difficult because most of the patients' problems and treatments had been spoken about by other members of the multidisciplinary team and the nurses were, in their words, "left with the left-overs" – but they provided most of the patient care. They had difficulty describing their practice in a clear and consistently organised way and were dissatisfied with this situation.

But, once they had the standardised languages they took the initiative to come in right after the doctors and say what the nursing diagnoses were. Then, for each diagnosis what the planned outcome was and how it was being measured, and what intervention/s they were using to achieve the outcome. They had a language to talk about nursing, define what they were doing and measure its effectiveness. Their control over their practice and professional-self-confidence was greatly enhanced.

Continuing with the last three concepts, *patient engagement in self-care* is always encouraged and supported to the extent that patients are able to and desire to do so. Also, nurses encourage and support *patients' family members, friends and community services to participate in patients' care*, according to patients' wishes and as this is possible and appropriate. Finally, providing patients, as well as supportive persons, with *health education*; that is, the knowledge needed to maximise patients' self-care care, healing and health.

In most health care settings, the nursing and medical professions, of course, work closely with one another and with other professional groups. The Careful Nursing model assumes collaborative practice overall, as illustrated here:



Even though this diagram shows only nursing and medicine, all health professions would be included.

Management of practice and influence in health systems. Just briefly, this third dimension which you see in green (page 4) with its three concepts; *support of nursing practice*; *trustworthy collaboration*, which is how nurses work with other health professionals, and *participative-authoritative management* which is how nurses work with care assistants.

Professional authority. And also briefly, this fourth dimension which you see in purple (page 4), with its three concepts: *professional responsibility* which concerns nurses being accountable for their practice and fulfilling their social mandate to provide a nursing service in society. In as much as this is achieved, nurses have *professional-self-confidence* and *professional visibility*. Professional authority, in turn, feeds back into the former three dimensions and enhances further nurses' development of their professional knowledge and skill.

Use in Nursing. Careful Nursing has been implemented in hospitals in the Ireland and the United States, beginning in 2006. Evaluation of a pilot implementation in Ireland, currently being prepared for publication, showed that it significantly improved efficiency and specificity of practice documentation and increased nurses' control over their practice. Questionnaire data indicated that it made nursing practice more visible and allowed nurses to spend more time with patients. Focus group data revealed nurses' enthusiasm for implementing the philosophy and practice model. Overall, it demonstrated the feasibility of its implementation in an acute care setting and its popularity with nurses. A phased implementation across the hospital is now in progress, funded by the Dublin Mid-Leinster Nursing Planning and Development Unit of the Health Service Executive. It has very enthusiastic support within the hospital from all quarters and on all levels.

In 2012 Careful Nursing was introduced into the academic paper embedded in the Nurse Entry to Practice (NetP) Programme at Victoria University of Wellington. It has proved popular with students and has been positively evaluated by lecturers, students and district health board partners. One hospital is planning to adopt it formally as its nursing model. Based on visits with nurses in primary health care practices, I feel sure that it could also be very useful in these settings

In conclusion, this presentation has provided a brief overview of the Careful Nursing Philosophy and Professional Practice Model. There remains much work to be done to develop it further and evaluate its effectiveness. You can learn about it in more detail from the Background, Overview and Publications sections of the Careful Nursing website: www.carefulnursing.ie I wish you well as you continue to develop your commitment to primary health care nursing in New Zealand. Thank you.

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