

SEVENTH EDITION

# Professional Nursing Practice

Concepts and Perspectives



KATHLEEN KOERNIG BLAIS

JANICE S. HAYES

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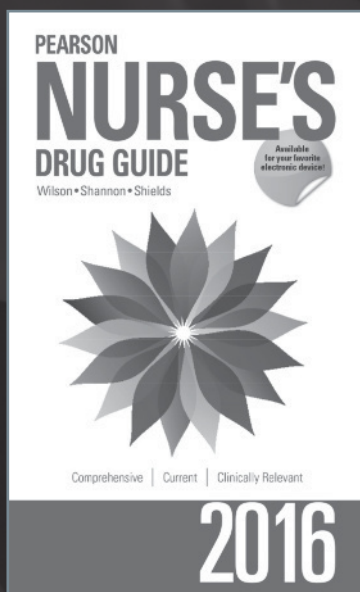
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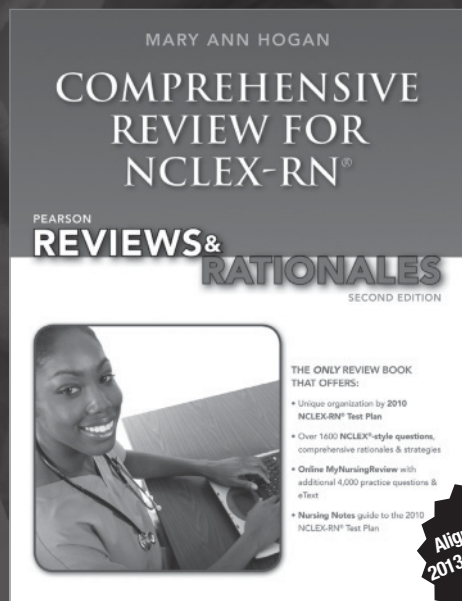
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# Professional Nursing Practice

Concepts and Perspectives

Seventh Edition

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## Dedication

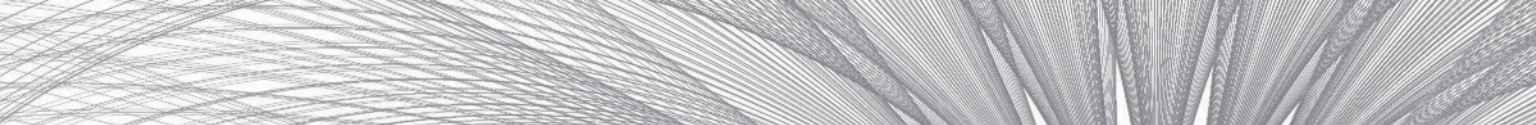
I dedicate this book to all who have taught me; my teachers past and present; my students, who continue to challenge me and make me a better teacher; and, most of all, David, Sarah, Harrison, and Margaret.

Kathleen Blais

This work is dedicated to Sierra, Marc, Otto, and Vinnie who motivate and inspire me to reach out to a new generation of nurses.

Janice S. Hayes

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# Thank You

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Thanks go to our colleagues from schools of nursing around the world, who generously gave their time to help create this book. These professionals helped us plan and shape our book by contributing their collective experience and expertise as nurses and teachers, and we made many improvements based on their efforts.

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## Preface

A dynamic healthcare environment requires growth and change in the nursing profession. Skills in communication and interpersonal relations are needed for nurses to be effective members of collaborative interdisciplinary healthcare teams. Critical thinking and creativity are necessary as nurses implement care with clients of diverse cultural and spiritual backgrounds in a variety of settings. Nurses must be prepared to provide care not only in hospital settings but also in community and residential settings, such as work sites, schools, faith-based communities, homeless shelters, and prisons. The nurse's unique role demands a blend of nurturance, compassion, sensitivity, caring, empathy, commitment, courage, competence, and skill that comes from a broad knowledge base of the arts, humanities, biological and social sciences, and the discipline of nursing. Nurses need skills in teaching, collaborating, leading, managing, advocacy, political involvement, and applying theory, research, and evidence to practice. An understanding of holistic healing modalities and complementary therapies used in the care of patients and clients is becoming more essential. Knowledge of global health includes the nurse's understanding of nursing and health care as practiced around the world and how health/disease conditions in other countries can affect the health status of citizens and residents of our own country. Quality and safety in health care are of primary concern to the profession.

This book addresses content by which nurses build their repertoire of nursing knowledge. This content includes, but is not limited to, wellness, health promotion, and disease/injury prevention; holistic care; multiculturalism, global health; nursing history; technology and informatics; nursing theories and conceptual frameworks; nursing research; quality and safety; and professional empowerment and politics.

*Professional Nursing Practice: Concepts and Perspectives*, 7th Edition, is intended as a text for registered nurses who are in transition or bridge programs to achieve a baccalaureate or higher degree in nursing. It may also be used in generic nursing programs or in transition or bridge programs for vocational nurses (LPNs or LVNs) to complete the professional nursing baccalaureate degree. This text addresses the areas of knowledge that professional nurses require to be effective in the changing healthcare environment.

The organization of this text emphasizes the foundational knowledge related to professional nursing, including nursing history, nursing knowledge development, ethics, and

legal aspects; the roles of professional nurses, including health promoter and care provider, learner and teacher, leader and manager, research consumer, advocate, and colleague and collaborator; the processes guiding nursing, including communication, change, and technology and informatics; nursing in a changing healthcare delivery system, including healthcare economics, holistic health care, global health, cultural and spiritual dimensions of client care, and nursing in a culture of violence; graduate education and advanced nursing practice; and nursing in the future.

## NEW TO THIS EDITION

All chapters have been revised to reflect current professional nursing knowledge based on foundational knowledge:

- A new chapter, Chapter 11, “The Nurse’s Role in Quality and Safety,” addresses quality and safety education for nurses (QSEN). Regulations, quality indicators, and benchmarking are discussed as they apply to professional nursing.
- A new chapter, Chapter 19, “Global Health,” describes the goals of global health, demographic and epidemic shifts, communicable and noncommunicable diseases around the world, health systems models in the global environment, and nursing roles, responsibilities, and opportunities in global health.
- New content on healthcare reform and implementation of the Affordable Care Act of 2010 as it has implications for nursing has been added to this edition.
- New content on nursing knowledge development and evidence-based practice has been added.
- Chapter summaries are now presented as a bulleted list of chapter highlights to facilitate student preparation for exams.

## Hallmark Features

The seventh edition of *Professional Nursing Practice: Concepts and Perspectives* retains several of the features that have been well received by faculty and students who have used previous editions:

- All new to this edition, Research Currents (formerly called Evidence for Practice) boxes that describe quantitative and qualitative research studies relevant to chapter content and relate them to clinical or professional practice.

- Critical Thinking Exercises that require readers to apply concepts from chapters to exemplar situations.
- Reflect On . . . sections that ask the reader to contemplate her or his own practice and beliefs about professional nursing in relation to the chapter content.
- Interviews of practicing nurses, which can be found in two chapters: Chapter 19, “Providing Care in the Home and Community,” and Chapter 24, “Advanced Nursing Education and Practice.” The profiles include information about why these practitioners chose their specific practice areas, what qualities they think are necessary to be a nurse in that area, what their practice entails, and what encouragement they would offer a nurse considering practice in this area. The profiles provide useful first-person perspectives for readers.
- InfoQuest, which directs students to Internet-based information resources related to chapter content.

## Organization

This edition is organized into five units, with an introductory chapter preceding the first unit. Units and chapters can be used independently or in any sequence. Some nursing programs use this text for first-semester nursing students in a professional socialization course. Other nursing programs use the text at the end of their nursing program in a professional transition course. And yet other programs use the text as a primary text in one course and a secondary text in other professional role courses.

- Chapter 1, “Beginning the Journey,” was created to assist registered nurses as they return to school. It provides information regarding factors influencing nurses’ return to school for baccalaureate and higher degrees and overcoming barriers that may interfere with student success. New content in this chapter includes learning with technology and evaluating Internet sites.
- Unit I, “Foundations of Professional Nursing Practice,” focuses on professionalism, including socialization, and historical, legal, ethical, and knowledge development of nursing.
- Unit II, “Professional Nursing Roles,” includes information on the professional roles of health promoter and care provider, learner and teacher, leader and manager, research consumer, advocate, and colleague and collaborator. It also addresses quality and safety in providing health care.
- Unit III, “Processes Guiding Professional Practice,” focuses on communicating effectively, managing change, and using technology and informatics.

- Unit IV, “Professional Nursing in a Changing Health Care Environment,” includes chapters devoted to healthcare economics, providing care in the home and community, global health, holistic health care, nursing in a culturally diverse world, nursing in a spiritually diverse world, and nursing in a culture of violence.
- Unit V, “Into the Future,” looks at the nurse’s professional development and the future of nursing. It includes chapters on advanced nursing education and practice and concludes with visions for the future of nursing and health care.

We hope this book helps learners appreciate the proud heritage of professional nursing, understand what is meant by *professional*, view nursing as a profession, and develop knowledge and abilities that will contribute to the advancement of the profession. In addition, we hope the knowledge gained will help nurses provide quality care in a constantly changing healthcare environment.

## ACKNOWLEDGMENTS

We extend our sincere thanks to the many talented and committed people who assisted in the birthing of this text:

- Barbara Kozier and Glenora Erb, without whom this text would never have been conceived. Every day that we write, we think of them with fondness and respect.
- The reviewers who provided many discerning comments and suggestions that expanded our thinking and writing.
- Barbara Price, Developmental Editor, who provided suggestions and encouragement throughout the process of this revision. Her commitment to the manuscript, understanding of writing demands, and technical and personal support throughout the project contributed positively to this revision.
- Pamela Fuller, Acquisitions Editor, who initiated the work on this edition.
- Peggy Kellar of iEnergizer Aptara®, Ltd. for vital attention to details and Margaret Ritchie for copyediting.
- To all who helped create and manage the media supplements. Their work provides a contemporary dimension to readers’ use of this edition.
- Most importantly, our many students, who have challenged and taught us and, in doing so, have helped to guide the direction of this book.



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# 1

## Beginning the Journey

### Chapter Outline

#### **Factors in Society That Promote the Nurse's Return to School**

Changing Trends of Nursing as a Profession

#### **Factors That Influence the Nurse's Return to School**

Education for Initial and Continuing

Licensure

Credentialing Requirements

#### **Professional Role Transition**

Bridges's Model of Transition

Spencer and Adams's Model of Transition

#### **Strategies for Success: What It Will Take to Get There**

Time Management

Money

Social Supports

Working With Faculty

Technology Skills

Study Skills

#### **Pedagogic Features for Using This Text**

#### **Chapter Highlights**

### Objectives

1. Examine changes in society that promote the nurse's return to school for further education.
2. Examine changes in the profession that promote the nurse's return to school for further education.
3. Apply models of transition to professional role change.
4. Identify strategies that will assist the nursing student in the formal academic setting.
5. Identify helpful approaches to academic success.
6. Implement personal lifestyle and study strategies to promote success.
7. Use pedagogic features to enhance learning.

**T**he evolution of nursing has been dramatic in recent history. While most of the changes in nursing are in response to changes in society and in the healthcare system, there are also changes related to the evolution of the profession. The reciprocal relationships among nursing, medicine, health, and society require that nursing must change as society changes, and as the nursing profession changes, nurses must also transform in response to professional and societal demands.

### Factors in Society That Promote the Nurse's Return to School

Changes in society place new demands on nurses. An aging population results in older patients with more complex health problems. Changing reimbursement practices result in patients being discharged more quickly from hospitals, even though they still need skilled nursing care either in long-term care facilities or in their homes. With the passage of the Patient Protection and Affordable Care Act of 2010, health care is available to a greater percentage of the population, but there are still those who are uninsured or underinsured. More care is being delivered in community and outpatient settings. A more diverse population requires nurses to be more knowledgeable about cultural and social influences on health. New technology and scientific discoveries require nurses to update their knowledge and skills continuously. New diseases

related to social and environmental problems require nurses to have a greater, integrated knowledge of the biological, psychological, and social sciences to promote health, to prevent illness or injury, and to care for those who are already ill or injured. Many of these societal changes will be discussed in more detail in later chapters.

## Changing Trends of Nursing as a Profession

Changed views of men's and women's roles are at the foundation of some of the profession's internal changes. Historically, nursing was considered a woman's occupation; however, that has been changing since the 1980s. In 1980, 2.7% of registered nurses (RNs) were male (U.S. Department of Health and Human Services, 2004); by 2000, the percentage increased to 5.4% (U.S. Department of Health and Human Services, 2004); and in 2013, 7% of RNs were male (Budden, Zhong, Moulton, & Cimiotti, 2013). As more men entered nursing, the image of the profession changed.

Use of traditional identifying symbols of nursing, such as nurses' caps and white uniforms, declined. There also has been less acceptance of the passive behaviors associated with the historical "handmaiden" role, when the nurse was viewed as the submissive and unquestioning assistant to the physician. As members of the healthcare team, RNs contribute from their area of expertise and are expected to be accountable and responsible for their work. These expectations require a more assertive and proactive role for the contemporary professional nurse as she or he participates in a more collaborative healthcare system.

Other factors have also accounted for changes in the role of the professional nurse. The average age of RNs has increased. In 2000, the average age of RNs was 45.2 years (U.S. Department of Health and Human Services, 2004); in 2013, the average age of RNs had increased to 50 years (Budden et al., 2013). Of concern is the fact that 11% of licensed RNs are retired, and that percentage is expected to increase as the baby boomer nurses approach retirement. Based on data from the Department of Labor, the American Association of Colleges of Nursing (2014) predicts a continuing shortage of RNs. The number of individuals graduating from nursing programs is not keeping up with the number of nurses leaving the profession because of retirement or other personal reasons. However, even as nurses retire, 8% of RNs 65 years of age and older continue to work full or part time in nursing. In the past, a nurse may have been more likely to work until having children and then stop working or work only part time or short term when additional income was needed. In 1980, 52% of RNs were working full time in nursing. By 2004,

the percentage of RNs working full time in nursing had increased to 58% (U.S. Department of Health and Human Services, 2004), and by 2013, that percentage had increased to 60% (Budden et al., 2013).

The minimum educational requirement for entry into nursing practice has been debated within the profession for the last five decades and thus has influenced professional identity. Hospital-based diploma training was the mainstay of nursing education until the mid-20th century. Between 1980 and 2013, the percentage of nurses who received a diploma in nursing as their entry preparation declined from 63.2% to 14% (U.S. Department of Health and Human Services, 2004; Budden et al., 2013). Many diploma nursing programs closed or affiliated with colleges or universities offering associate or baccalaureate degrees in nursing. However, as enrollment in diploma nursing programs declined, enrollment in associate and baccalaureate degree programs increased. Between 1980 and 2004, enrollment in associate degree nursing programs increased from 19% to 40%, and the percentage of RNs receiving their basic nursing education in baccalaureate degree programs increased from 17% to 37% (U.S. Department of Health and Human Services, 2004; Budden et al., 2013). Educational preparation in institutions of higher learning socialized nurses to formal education and even to the idea of continuing their career development through graduate education. In 1980, 5% of nurses had master's or doctoral degrees (U.S. Department of Health and Human Services, 2004). By 2013, 13% of nurses had master's degrees in nursing (MSN) and 1% had doctoral degrees in nursing or another discipline (Budden et al., 2013). This increase in the numbers of RNs achieving academic degrees beyond their initial nursing preparation has been influenced by the availability of employer-provided tuition reimbursement programs.

The focus of professional nursing practice is shifting from acute hospital-based illness care to primary outpatient-based community care emphasizing health promotion and illness/injury prevention. Between 1980 and 2013, the percentage of RNs working in hospitals decreased, specifically down from 66% in 1980 to 57% in 2004 (U.S. Department of Health and Human Services, 2004; Budden et al., 2013). This trend has given nurses more autonomy in institutions with less rigid organizational structure and hierarchy. Many of these positions require a minimum of a baccalaureate degree for employment. See Table 1–1 for selected characteristics of RNs in 2013.

Specialty certification for nurses creates rewards in terms of both recognition by employers and peers and self-fulfillment for the nurse. Specialty certification validates a nurse's knowledge and experience in a nursing specialty. In recent years, requirements for taking specialty certification exams include having extensive experience and continuing

**TABLE 1–1 Selected Results of the 2013 National Workforce Survey of Registered Nurses (*n* = 42,294)**

| Number of Registered Nurses                          |                                               | Approximately 3 million* |
|------------------------------------------------------|-----------------------------------------------|--------------------------|
| <b>Employment status</b>                             | Actively employed in nursing                  | 82%                      |
|                                                      | Full time                                     | 60%                      |
|                                                      | Part time                                     | 15%                      |
|                                                      | Per diem                                      | 7%                       |
|                                                      | Actively employed in field other than nursing | 8%                       |
|                                                      | Full time                                     | 4%                       |
|                                                      | Part time                                     | 3%                       |
|                                                      | Per diem                                      | 1%                       |
|                                                      | Unemployed                                    | 7%                       |
|                                                      | Seeking work as a nurse                       | 3%                       |
|                                                      | Not seeking work as a nurse                   | 3%                       |
|                                                      | Working in nursing only as a volunteer        | 2%                       |
|                                                      | Retired                                       | 11%                      |
|                                                      |                                               |                          |
| <b>Gender</b>                                        | Male                                          | 7%                       |
|                                                      | Female                                        | 93%                      |
| <b>Age</b>                                           | Average age                                   | 50 years                 |
|                                                      | <34 years                                     | 18%                      |
|                                                      | 35–44 years                                   | 19%                      |
|                                                      | 45–54 years                                   | 26%                      |
|                                                      | 55–64 years                                   | 30%                      |
|                                                      | 65 years and older                            | 8%                       |
| <b>Ethnicity</b>                                     | American Indian/Alaska Native                 | 1%                       |
|                                                      | Asian                                         | 6%                       |
|                                                      | Black/African American                        | 6%                       |
|                                                      | Native Hawaiian or Other Pacific Islander     | 1%                       |
|                                                      | White/Caucasian                               | 83%                      |
|                                                      | Hispanic/Latino                               | 3%                       |
|                                                      | Other                                         | 1%                       |
| <b>Initial nursing education (<i>n</i> = 34,467)</b> | Certificate                                   | 4%                       |
|                                                      | Diploma                                       | 14%                      |
|                                                      | Associate degree (ADN)                        | 40%                      |
|                                                      | Baccalaureate degree (BSN)                    | 37%                      |
|                                                      | Master's degree (MSN)                         | 3%                       |
|                                                      | Doctor of Nursing Practice (DNP)              | .04%                     |
|                                                      | PhD nursing                                   | .05%                     |
|                                                      | Doctorate-nursing other                       | .08%                     |
| <b>Highest education (<i>n</i> = 33,764)</b>         | Certificate                                   | .04%                     |
|                                                      | Diploma                                       | 8%                       |
|                                                      | Associate degree (ADN)                        | 29%                      |
|                                                      | Associate degree—other field                  | 0.6%                     |

*(Continued)*

**TABLE 1–1 Selected Results of the 2013 National Workforce Survey (Cont.)**

| Number of Registered Nurses                                       |                                                     | Approximately 3 million* |
|-------------------------------------------------------------------|-----------------------------------------------------|--------------------------|
|                                                                   | Baccalaureate degree (BSN)                          | 36%                      |
|                                                                   | Baccalaureate in another field                      | 7%                       |
|                                                                   | Master's degree (MSN)                               | 13%                      |
|                                                                   | Master's in another field                           | 5%                       |
|                                                                   | DNP                                                 | 0.5%                     |
|                                                                   | PhD nursing                                         | 0.4%                     |
|                                                                   | Doctorate-nursing other                             | 0.1%                     |
|                                                                   | Doctorate in another field                          | 0.6%                     |
|                                                                   |                                                     |                          |
| <b>Country where initially licensed as RN or LPN</b>              | United States                                       | 95%                      |
|                                                                   | Canada                                              | 1%                       |
|                                                                   | Philippines                                         | 2%                       |
|                                                                   | India                                               | <1%                      |
|                                                                   | Other                                               | 2%                       |
| <b>Primary nursing practice position setting<br/>(n = 34,596)</b> | Hospital                                            | 57%                      |
|                                                                   | Nursing home/extended care/assisted living facility | 6%                       |
|                                                                   | Home health                                         | 6%                       |
|                                                                   | Correctional facility                               | 0.6%                     |
|                                                                   | Academic setting                                    | 3%                       |
|                                                                   | Public health                                       | 0.2%                     |
|                                                                   | Community health                                    | 2%                       |
|                                                                   | School health service                               | 3%                       |
|                                                                   | Occupational health                                 | 0.7%                     |
|                                                                   | Ambulatory care setting                             | 9%                       |
|                                                                   | Insurance claims/benefits                           | 1%                       |
|                                                                   | Policy/planning/ regulatory/ licensing agency       | 0.4%                     |
|                                                                   | Other                                               | 9%                       |
|                                                                   |                                                     |                          |
|                                                                   |                                                     |                          |
| <b>Participants with multiple licenses</b>                        | Single license                                      | 86%                      |
|                                                                   | Multiple licenses                                   | 14%                      |

\*Note: Because nurses can have a registered license in multiple states or be part of a multistate licensing compact, it is difficult to determine the actual number of registered nurses in the United States.

Source: "The 2013 National Nursing Workforce Survey of Registered Nurses by the National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers," by J. S. Budden, E. H. Zhong, P. Moulton, and J. P. Cimiotti, 2013, *Journal of Nursing Regulation*, 4(2), July 2013 Supplement.

education in the specialty. Currently, for certification in an area of advanced nursing practice such as nurse midwifery, nurse anesthesia, or nurse practitioner, a master's degree is required in addition to extensive supervised clinical experience in the area.

The result of all these changes has been a dramatic increase in the number of nurses returning to school. In 1980, just over half of all RNs held a hospital diploma as their highest level of nursing preparation, and about 22% held a Bachelor of Science degree in Nursing (BSN). According to the

2013 National Workforce Survey of Registered Nurses (Budden et al., 2013), 50% of RNs had a baccalaureate or higher degree in nursing. Additionally, 12% of nurses had baccalaureate or higher degrees in a nonnursing field. The National Advisory Council on Nurse Education and Practice (1995) urged that two thirds of the nursing workforce have a baccalaureate or higher degree in nursing by the year 2010.

In 1996, the American Association of Colleges of Nursing issued a position statement recognizing the degree of Bachelor of Science in Nursing as the minimum educational

**RESEARCH CURRENT****The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses**

This study was conducted with the support of the U.S. Department of Health and Human Services to examine the supply, composition, and distribution of nurses both nationally and on the state level. The study identified the characteristics of all RNs with active licenses to practice in the United States, whether or not they were employed in nursing at the time of the study. Data describe the following: the number of RNs; their educational backgrounds and specialty areas; their employment settings,

position levels, and salaries; their geographic distribution; and their personal characteristics, including gender, racial/ethnic background, age, family status, and job satisfaction.

*Source: The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses, by the Health Resources and Services Administration, U.S. Department of Health and Human Services, 2008, Washington, DC: Author. <http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyinitial2008.pdf>*

requirement for professional nursing practice. (See boxes on page 6.) A BSN is seen as critical for a career in professional nursing. The BSN nurse is prepared for a broader role; increasingly, the bachelor's degree is required for employment in many healthcare settings such as community health, case management, and leadership positions. The BSN curriculum includes a broad spectrum of scientific, critical-thinking, evidence-based-practice, research, humanistic, communication, and leadership skills (American Association of Colleges of Nursing, 2006).

**Reflect On . . .**

- the factors that contributed to your decision to become a nurse.
- the changes occurring in your professional life that require a return to school.
- the changes occurring in your environment (workplace, community, nation) that require new knowledge about nursing and health care.

**Factors That Influence the Nurse's Return to School**

As nursing responds to societal influences on health care, it continues to make decisions to enhance the profession through changes in the education, credentialing, and practice of nurses. Some of these changes include new mandates about the education of nurses for initial licensure as RNs, continuing licensure at both the RN and advanced practice levels, and the certification of nurses for nursing specialization.

**Education for Initial and Continuing Licensure**

Increasingly, there have been calls for the baccalaureate degree in nursing (BSN) to be the entry-level of education for RNs. A study by Aiken, Clarke, Sloane, Lake, and Cheney (2008) found a strong link between the educational level of RNs and patient outcomes. An increase in baccalaureate-prepared nursing staff was associated with a decrease in patient mortality in the hospital setting. In 2009,

**RESEARCH CURRENT****2013 National Workforce Survey of Registered Nurses**

This study was a collaboration of the National Council of State Boards of Nursing and the Forum of State Nursing Workforce Centers conducted over a 3-month period in spring of 2013 to provide a portrait of the nursing workforce. The study examines the supply, composition, and distribution of nurses both nationally and at the state level. A random sample consisting of 42,294 RNs "stratified by state was drawn from all licensed registered nurses in the United States and its territories." The study identified the characteristics of all RNs with active licenses to practice in the United States, whether or not they were

employed in nursing at the time of the study. Data describe the following: the gender, age, and ethnicity of the participant nurses; their educational backgrounds and licensing; their employment settings, position levels, and employment specialty. Additional data provide characteristics of foreign-educated nurses, RNs nearing retirement, and advanced practice RNs.

*Source: "The 2013 National Nursing Workforce Survey of Registered Nurses by the National Council of State Boards of Nursing and The Forum of State Nursing Workforce Centers," by J. S. Budden, E. H. Zhong, P. Moulton, and J. P. Cimiotti, 2013, *Journal of Professional Regulation*, 4(2), July 2013 Supplement.*



## CRITICAL THINKING EXERCISE

Access *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses* at the website for Health Resources and Service Administration (HRSA) and the *2013 National Workforce Survey of Registered Nurses* at the website for the Journal of Nursing Regulation.

Review the data in each study. What trends do you see in the characteristics of the nursing workforce that

you would consider positive? What concerns do you see reflected in the data regarding the nursing profession? For example, do you find that the percentages of male nurses and nurses who are members of minorities are reflective of the general population? What recommendations do you have to improve the nursing profession? How do you see the data affecting you and your nursing career?

Benner, Sutphen, Leonard, and Day recommended that all entry-level RNs be prepared at the baccalaureate level and that all RNs be required to earn a master's degree within 10 years of initial licensure. In 2010, the Tri-Council for Nursing, an alliance of the American Nurses Association, the American Association of Colleges of Nursing, the National League for Nursing, and the American Organization of Nurse Executives, urged “all nurses, regardless of entry-point into the profession, to continue their education in programs that grant baccalaureate, master's, and doctoral degrees,” stating that such educational advancement is a “personal responsibility critical to the academic progression of the nursing profession.”

### Credentialing Requirements

As knowledge and technology increase and nurses are more likely to specialize in specific practice areas, there is an increasing demand to obtain national certification either to obtain jobs in a specialty or to advance in the specialty. At the present time, RNs can obtain specialty certification through the American Nurses Credentialing Center (ANCC) and through other specialty nursing organizations, such as the Association of periOperative Registered

Nurses (AORN) and the American Association of Critical-Care Nurses (AACN). To be eligible to take the certification exam, the nurse must demonstrate extensive experience and continuing education in the specialty area. Advanced practice nurses can obtain certification through ANCC as advanced nurse practitioners, through the American Midwifery Certification Board as nurse midwives, and through the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA) as nurse anesthetists. To be certified as an advanced practice nurse, the nurse must demonstrate having earned a graduate nursing degree from an accredited program in the field where the nurse is seeking certification. Advanced practice nurses must have national certification in order to be reimbursed by Medicare and Medicaid for services provided.



**InfoQuest:** Search the Internet to find the criteria and process for certification in your area of nursing interest or practice. Remember that there may be more than one organization that certifies nurses in your specialty.

### American Association of Colleges of Nursing Position Statement: The Baccalaureate Degree in Nursing as Minimal Preparation for Professional Practice

Rapidly expanding clinical knowledge and mounting complexities in health care mandate that professional nurses possess educational preparation commensurate with the diversified responsibilities required of them. As health care shifts from hospital-centered, inpatient care to more primary and preventive care throughout the community, the health system requires registered nurses who can practice across multiple settings—both within and beyond management—providing direct bedside care, supervising unlicensed aides and other support personnel, guiding patients through the maze of healthcare resources, and educating patients on

treatment regimens and adoptions of healthy lifestyles. In particular, preparation of the entry-level professional nurse requires a greater orientation to community-based primary health care and an emphasis on health promotion, maintenance, and cost-effective coordinated care.

Accordingly, the American Association of Colleges of Nursing (AACN) recognizes the Bachelor of Science degree in nursing as the minimum educational requirement for professional nursing practice.

*Source:* American Association of Colleges of Nursing, 1996, approved by the Board of Directors. Reprinted with permission.



## Professional Role Transition

As changes in the healthcare system affect society's expectations of nursing care and nurses respond to these expectations, nurses are returning to school to acquire new knowledge and skills to be more effective in their changing roles. Changes in nursing roles represent a shift in the view of nursing from simply an occupation or job to a profession with a commitment to the role. As nurses transition from novice nurses to expert nurses, they experience challenges related to the change process (Benner, 1984). Bridges (2004) and Spencer and Adams (1990) describe models of transition that consider the personal and professional challenges, the internal struggles, and the external influences that occur when people experience change.

### Bridges's Model of Transition

Bridges (2004) describes a model of transition that consists of three phases: the ending, the neutral zone, and new beginnings. He believes that individuals move through all three phases as they experience change.

The *ending phase* is the initial stage of transition. In this phase, the individual must discontinue a connection to or let go of the past. For the new nursing student, this phase occurs with the transition from being a nonnurse to becoming a student nurse. For the RN, it occurs with a change in the employment setting or a change in roles within the same employment setting. It occurs whether the nurse makes the choice for change or the change is imposed externally, such as by the employer or by new professional mandates from accrediting agencies (e.g., the Joint Commission [formerly the Joint Commission on Accreditation of Healthcare Organizations]) or professional regulatory agencies (e.g., boards of nursing). Even when change is viewed in a positive way, there is an ending of old ways of thinking and behaving with the expectation of new ways of thinking and behaving.

Within the ending phase, Bridges describes four components: disengagement, disidentification, disenchantment, and disorientation. *Disengagement* occurs when the person is separated from previous familiar settings or roles. Previous relationships may also change during this phase; for example, a nurse who was in a peer relationship with colleagues may now assume a managerial role with a responsibility for evaluating those same colleagues. If the change is related to a change in employment settings, supportive relationships in the previous employment setting may be lost, and the need to develop new relationships occurs. *Disidentification* is the loss of self-definition. People have a sense of who they are. When one experiences role change, there is a challenge to this sense of self and the

need to identify the new self within the context of the new role. This challenge can be difficult if the individual feels uncomfortable in the new role.

*Disenchantment* is the understanding that the individual's world has changed. The cause of the change may be minor or major, as defined by the individual (e.g., the retirement of a coworker, the implementation of a new policy). The nurse may initially feel honored at being offered a promotion to a leadership position but later may find that there are differences in role requirements that had not been understood. For some nurses, changes in their personal lives may be the impetus for change. The nurse may believe that the birth of a new baby will have minimal effect on her career, but realizes that when the baby arrives, the demands of caring for the child require organizational changes not only at home but also at work. The last component of the ending phase is disorientation. *Disorientation* is the sense of confusion that occurs with change, the period of emptiness as one moves from the previous or old phase to the new phase. The nurse may question why she or he accepted the new role or her or his ability to handle the new role.

The *neutral zone* is the second phase of transition. The neutral zone is, in itself, a transition between the ending phase and the phase of new beginnings. In this stage, the individual has moved from the old to the new, at least superficially. The nurse has outwardly accepted the change—the new role—but the responsibilities and behaviors associated with the new role have not yet been internalized. Old ways of thinking and viewing the world must give way to new values, new ways of thinking, and new ways of viewing the world. This is the inner acceptance of the role change. For example, if the nurse has been promoted from staff nurse to nurse manager, she or he must accept not only the title but also the responsibilities and behaviors associated with the role change. The superficial transition is the new title. The inner transition requires new perspectives (worldview) on the role (responsibilities and actions) of the manager in the effective functioning (values) of the nursing unit. The inner transition also requires an acceptance of the changed relationship with colleagues from a peer to a supervisor.

The final phase of Bridges's model is called *new beginnings*. In this phase, there is an acceptance of new knowledge, values, attitudes, and behaviors associated with the role change. The first phase of ending or letting go is complete, and the individual is ready to move forward. The challenge in this phase is to keep moving forward, avoiding the temptation to go back to old ways of thinking and behaving because they are more comfortable. For the nurse returning to school, the challenge of managing work, family, and school obligations and of finding the time to

accomplish everything creates the temptation to give up and move back to the familiar and therefore more comfortable way of doing things. Finding support during the transition from colleagues, family, and faculty can help the nurse overcome these challenges.

Spencer and Adams’s Model of Transition

Spencer and Adams (1990) developed a model of transition that includes seven stages: losing focus, minimizing the impact, the pit, letting go of the past, testing the limits, searching for meaning, and integration. The first four stages compare to Bridges’s ending phase. In stage 1, *losing focus*, the individual has difficulty keeping things in perspective and experiences feelings of being overwhelmed. Some individuals may feel panic in this stage, whereas others may feel excitement.

In stage 2, *minimizing the impact*, the individual feels the need to go back to what was normal or comfortable. In this stage, the individual tries to avoid the full effect of the change and may question what was wrong with the old ways of doing things. She or he may resist the change or ignore the need for change. This stage compares to Bridges’ components of disenchantment and disorientation.

In stage 3, the *pit*, the individual experiences self-doubt. She or he may have feelings of depression and grief over losses (the old ways of thinking and behaving, former relationships), anger, or powerlessness. In this stage, the individual must move from powerlessness to strength, from anger and grief to optimism about the new.

In stage 4, *letting go of the past*, there is a move toward optimism. The past has been let go, and there is a focus on

the change and the benefits to be obtained by the change. It is a stage of forward vision.

In stage 5, *testing the limits*, the new identity is established. New behaviors and new skills are tried. Success in the new behaviors or roles brings about a sense of self-confidence. New relationships develop with colleagues, family, and friends—all those involved in the change. There is a greater sense of comfort about the change. This stage compares to Bridges’s neutral zone phase.

In stage 6, *searching for meaning*, there is a period of self-reflection and finding meaning in the experience. New roles, new relationships, and new skills are being established. There may be a reconnection with old friends and colleagues. There may also be a desire to help others who are experiencing a similar situation. For nurses returning to school, it may be helpful to share the story of their experience with nurses who are contemplating returning to school, to share the feelings associated with the transition. The final stage, *integration*, is the completion of the transition. The individual experiences satisfaction and self-confidence. She or he has accepted the change and is willing to consider new risks. The values and behaviors associated with the change are internalized so that new role behaviors occur automatically. See Table 1–2 for a comparison of the behaviors and feelings associated with the various phases and stages of Bridges’s and Spencer and Adams’s models of transition.

Nursing students who are starting their professional nursing education and RNs who are returning to school to obtain the baccalaureate degree experience many of the challenges described by Bridges and Spencer and Adams.

TABLE 1–2 Comparison of Bridges’s and Spencer and Adams’s Models of Transition

| Bridges (2000)                                                                                                                                              | Spencer & Adams (1990)     | Behaviors and Feelings                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Three Phases:                                                                                                                                               | Seven Stages:              |                                                                                                                                                                                                  |
| 1. Ending <ul style="list-style-type: none"><li>a. Disengagement</li><li>b. Disidentification</li><li>c. Disenchantment</li><li>d. Disorientation</li></ul> | I. Losing focus            | <i>Behaviors</i> can be mixed and include inability to think clearly, resistance to change.                                                                                                      |
|                                                                                                                                                             | II. Minimizing the impact  |                                                                                                                                                                                                  |
|                                                                                                                                                             | III. The pit               | <i>Feelings</i> can be mixed and include confusion, feeling overwhelmed, loss of sense of self, excitement, disappointment, emptiness, grief, powerlessness, numbness.                           |
|                                                                                                                                                             | IV. Letting go of the past |                                                                                                                                                                                                  |
| 2. Neutral zone                                                                                                                                             | V. Testing the limits      | <i>Behaviors</i> include the establishment of new skills and behaviors associated with the change.<br><i>Feelings</i> include optimism, self-confidence, and a sense of comfort with the change. |
| 3. New beginnings                                                                                                                                           | VI. Searching for meaning  | <i>Behaviors</i> include self-reflection, greater reinforcement of new roles, skills, and relationships; internalization of new role behaviors.                                                  |
|                                                                                                                                                             | VII. Integration           | <i>Feelings</i> include self-confidence, satisfaction.                                                                                                                                           |

New nursing students and RNs returning to school may have difficulty in managing the dual roles of college student and nursing student. In the college student role, the nursing student attends lectures and simulated laboratory experiences, reads textbooks and other assigned and supplemental readings, and learns new knowledge and skills and ways of looking at things. The nursing student also assumes professional role behaviors as she or he provides care to real patients and clients in clinical settings. During this transition, the nursing student juggles additional roles related to work and family obligations. Often, nursing students must reorganize their schedules to accommodate the many demands on them in order to be successful in their nursing studies. Sometimes, these many demands result in nursing students questioning their decision to become a nurse.

For RNs returning to school, there are similar challenges in managing family and work obligations while attending school. In addition, they may experience challenges from other nurses who question their choice to return to school with comments such as “Why are you doing that? You won’t get any more money,” or “How do you find the time to do that with everything else you are doing?” Nurses may question their own decision, considering their basic preparation sufficient to practice as a good nurse or to achieve their current position. Nurses may have to discontinue or let go of beliefs such as “There is no difference between nurses prepared at the diploma-, associate-degree, or baccalaureate-degree level,” or “What can I learn that I don’t already know?,” and move to thoughts such as “With more education, I can be a better nurse.” Nurses often experience anger about going back to school. At the same time, they may feel excitement with the hope and expectation that something new is happening. As they expand their thinking about the roles of nurses in a changing healthcare system, they may realize new ways of thinking more holistically about the care of clients. The adage “knowledge is power” may be realized as nurses feel greater power and control over their own roles and the roles of nursing within the changing healthcare system.

Whether one is a nursing student starting professional nursing studies or an RN returning to school, the following strategies can help the student make a successful transition from old ways to new ways of thinking and behaving.

- **Choose a mentor.** Identifying a mentor who has successfully transitioned from one nursing role to another can provide support for the nurse in transition. A mentor can serve as a sounding board for new ideas, a support when negative feelings arise, and a cheerleader when positive successes occur. A mentor is not always a friend. Rather, a mentor can be a senior colleague or

a faculty member—one who has the best interests of the student in mind.

- **Keep a checklist of accomplishments.** Identify the targets throughout the program and throughout each course. The checklist reminds you of what you have to do and when it needs to be done by. Check off accomplishments on your visual checklist as each activity/course is completed. The checklist helps you track your progress toward your goals.
- **Obtain support from family and friends.** Family and friends can provide emotional support when the student experiences self-doubt. Family and friends may also provide physical and financial supports.
- **Celebrate the successes.** Celebrate each accomplishment with classmates, friends, or family.

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### Reflect On . . .

- the reasons that you have chosen nursing as your profession. What are your professional goals?
  - the reasons that you have decided to return to school. What are your educational goals?
  - the reactions of colleagues, family, and friends to your decision. Are they supportive to your decision? If yes, in what ways will they help you to achieve your goals? If no, what are the reasons for their lack of support? Is there something you can do to help them be more supportive?
  - the personal values associated with your decision. What meaning does this transition have for you? How do you believe that the achievement of this goal will make you feel?
  - the supports you have to ensure your success in role transition. What will you need from your various supports to achieve your educational and professional goals?
- 

## Strategies for Success: What It Will Take to Get There

Advancing one’s education in nursing provides the professional advancement that nurses seek. It represents a commitment to goals of both professional and personal growth. Meeting those goals requires lifestyle and role changes. Many students beginning their professional nursing studies may be attending nursing school to pursue a second career in nursing; they may have been away from the academic setting for many years. RNs attending school may also have been away from a formal

education setting for some time and may be anxious about becoming a student again. Fitting into the academic environment represents a substantial transition from work and practice roles. Because many students have family obligations and continue to work while going to school, they must be able to schedule their time realistically if they are to be successful. Concerns about academic skills, such as library searches, using the Internet or electronic library databases for academic assignments, scholarly writing, and test taking are often sources of stress. Blending the student role with the work role and the family-member role represents great challenges. Learning to deal effectively with the stressors that create barriers to success is important. Some of those barriers include managing time effectively to meet the commitments of family, work, and school; finding financial resources to pay for tuition, books, and educational supplies; finding and maintaining effective social support systems, including family, work colleagues, and student colleagues; learning to work with faculty who require academic excellence in spite of the many demands on the nursing student's time; and developing effective study skills.

## Time Management

Time-management skills are a necessary tool for survival and success. Organizing, planning, and setting priorities are crucial to managing time and achieving success. Students must learn to balance school, family, work, meals, sleep, exercise, and spiritual and personal time. Keeping balance among physiological needs, professional and personal roles, and expectations is essential and requires clear priorities. Procrastination creates a domino effect when there are multiple tasks related to multiple roles. Developing a time plan that includes keeping up with assigned readings, ongoing study throughout the course (not just when exams are imminent), and preplanning for papers and projects that must be completed by a deadline can help reduce the stress experienced with multiple courses and numerous assignments. The ability to handle interruptions goes hand in hand with time-management techniques. Setting limits allows one to be goal focused and keep the load realistic. This kind of clear focus permits the streamlining of things to be done. Nursing students who are assuming multiple roles with high expectations of their performance in each of these roles often forget to maintain one of their major resources: their health. Adequate sleep, good nutrition, and recreation are necessary for maintaining the energy level and motivation to succeed. See the accompanying Critical Thinking Exercise to plan your own time.

## Reflect On . . .

- the activities you enjoy that relieve stress. Which of these activities could be used as a short-term break to refresh a tired body and mind? Which of these are long-term fixes requiring greater planning? Devise a schedule that allows you to take advantage of these stress-relieving strategies.

## Money

For students returning to school, money to pay tuition and fees and to purchase textbooks and other supplies is often a concern. Many employers provide tuition reimbursement as a benefit of employment. Information can be obtained from human resources or personnel departments. Many civic groups and nursing organizations provide scholarships. There are also various state and federal loan opportunities; some may have forgiveness programs if the nurse works in a specific location or specialty for a period of time after graduation. The university or college financial aid office can provide information about scholarships and other forms of assistance. Students may also want to do their own Internet search using key words such as *scholarships* or *nursing scholarships* to identify scholarships that may be available based on unique characteristics related to ethnicity, religion, or other traits.



**InfoQuest:** Explore the Internet to identify potential sources of financial assistance: scholarships, grants, or loans. Start with professional nursing organizations. Explore federal programs that may provide assistance that requires a work commitment upon completion of your program, for example, the military, the U.S. Public Health Service, or Indian Health Services. Look at civic or religious groups that you belong to. Does your employer provide educational support?

## Social Supports

Although students can be successful on their own, the support of others can make things go more smoothly. The people who can contribute the most to the success of students include their families and friends, their classmates, their employers and work colleagues, and their faculty.

Family and friends may be considered the first level of support and may provide assistance in a variety of ways. This assistance may include providing financial help, providing child care, cooking meals, typing papers, proofreading papers, acting as a sounding board for ideas,



## CRITICAL THINKING EXERCISE

**Time Management**

Remember that there are only 168 hours in a week. You can't borrow any hours from someone else, and you can't give any of your hours to someone else. With that in mind, use the instructions below to complete the following week-long schedule to reflect how you use your time.

Your totals at the end of each daily column should not exceed 24 hours, and your total hours for the week cannot exceed 168 hours. Do you have enough time to fulfill all your obligations? If you don't, from which activity will you take time? In looking at your schedule, do you see ways in which you can better manage your time?

| Activity        | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|-----------------|--------|---------|-----------|----------|--------|----------|--------|
| Work            |        |         |           |          |        |          |        |
| School/study    |        |         |           |          |        |          |        |
| Sleep           |        |         |           |          |        |          |        |
| Family          |        |         |           |          |        |          |        |
| Meals           |        |         |           |          |        |          |        |
| Spiritual needs |        |         |           |          |        |          |        |
| Exercise        |        |         |           |          |        |          |        |
| Personal time   |        |         |           |          |        |          |        |
| Total Hours     |        |         |           |          |        |          |        |

**Work.** How many hours a day/week do you work? How many days a week do you work? Do you work 8-hour, 10-hour, or 12-hour shifts? Working different time shifts changes the way you can plan the other obligations in your life. Is it possible to reduce the number of hours you work while you are in school?

**School/study.** How many hours a week do you attend class/participate in an online course? Remember to plan a minimum of 1-hour study time for each hour in class. Most experts recommend between 1 and 3 hours of study for each hour spent in class.

**Sleep.** How many hours of sleep do you need to feel well rested? When do you sleep? Do you take naps? It is important to get adequate sleep so that your body and mind are at the optimum for learning.

**Family.** What family obligations do you have? Do you have young children who need assistance with their homework or with out-of-school activities such as sports or hobbies? On what days do you have family obligations that may prevent study? It is important to plan family time so that you can also plan study time. What supports do you have? Will your spouse or parents help with child care or doing household chores so that you can attend class and have time for study?

**Meals.** How many meals do you usually eat each day? Do you typically have one meal with family

members? It is important to maintain adequate nutrition. Many successful students combine meal-time with family time or time with friends.

**Spiritual Needs.** Are spiritual obligations an important part of your life? Do you meditate, pray, or read spiritual literature daily or several times a day? Do you attend worship or prayer services one or more times per week? Spiritual obligations can be a source of strength and hope. For many students, participation in their spiritual practices helps them manage stresses associated with returning to school.

**Exercise.** Do you exercise routinely? How many hours a day or a week do you exercise? Exercise also can relieve stress related to balancing many responsibilities.

**Personal time.** Are there activities you do just for yourself (e.g., quiet time, taking a relaxation bath, meditation, reading)?

Analyze the time you need for each of the above activities. Do you have the time you need for all your obligations? If not, from which activity will you take the time? What do you sacrifice by taking time from another obligation? Keeping a daily planner will help you manage your time.

and helping to study for exams. Even having a friend to socialize or exercise with can be part of the balanced support system. Some nurses are concerned about whether they can continue to meet the needs of their family, especially young children, when they are going to school. The change will require some adjustment on each family member's part, but often the result is positive in ways that were unexpected. For example, children may learn about the importance of study habits and lifelong learning, continuing one's education over a lifetime.

A benefit of pursuing education is the opportunity to network with colleagues from other areas of practice and other healthcare organizations. These opportunities can broaden perspectives on health care and nursing, as well as establish important networks. New colleagues may challenge thinking during discussions of ideas and may be viewed as experts to consult in their area of practice. This expanded network can provide new contacts for obtaining new jobs based on experience and new knowledge.

Employers and work colleagues may be helpful in scheduling work time so that employee-students can attend

classes. Work colleagues who are also going to school may be willing to swap work schedules so that students can attend class regularly. Employers may be able to provide work experiences that reinforce class learning and contribute not only to the employee-student's learning, but also to the function of the nursing unit or organization. Work colleagues who are also going to school or taking Internet-based courses may develop study groups to help reinforce each other's learning and to provide mutual support.

## Working With Faculty

The faculty is an important resource in increasing knowledge, expanding ways of thinking, and enhancing professional capabilities. The primary goal of faculty is to see students succeed, not simply by graduating, but by achieving success in their professional career and contributing to the profession as a whole. It is important to use faculty to the fullest extent while remembering that they are also people. Suggestions for working with faculty are shown in the accompanying box.

When having difficulties related to your course work or personal concerns affecting your course work, discuss

### Suggestions for Working With Faculty

- *Treat faculty with respect.* When you show faculty respect, they will respect you in turn. Respect and courtesy go hand in hand. Find out your faculty's office hours. Even when faculty have posted office hours, it is of benefit to the student to make an appointment. That way the faculty member knows you are coming, doesn't schedule someone else at the same time, and can focus on your needs without interruption. When you make an appointment, keep it; if you can't, then contact the faculty member to cancel, using the faculty member's preferred method of contact (e.g., telephone, email, texting). Don't be afraid to speak up and let your teacher know what you need to meet your goals.
- *Don't wait until the end of the semester to seek help.* Introduce yourself to your faculty early in the semester. If you experience difficulties in the course, meet with your faculty as early as possible so that you and the faculty can develop a plan of action for success. If you are experiencing personal difficulties that are interfering with your performance, inform your faculty members so that they can help you make prudent decisions.
- *Remember, your faculty are human beings just like you.* Faculty members experience the same life problems as students. Although most of the time faculty will be fully there for students, there may be times when other things, either work related or personal, may take precedence. Before dropping in for a visit, confirm that it is a convenient time for both you and the faculty member. This will ensure that the faculty member is fully there for you.
- *Respect your instructor's privacy.* Do not call your instructor at home unless she or he has given you permission to do so. Visit faculty during posted office hours. Faculty have many responsibilities related to teaching, including course preparation, committee work, and grading student assignments/exams. Recognize that faculty members often schedule office time during which they wish not to be disturbed in order to complete work-related activities.
- *Instructors have many different personalities.* Some will be very tough and demanding, whereas others will be very casual. Whatever the instructor's personality, the course standards and requirements remain the same. Students will need to learn from a variety of teachers with different teaching styles. Being exposed to a diversity of instructors prepares students for interacting with the various people they will meet in their professional life.
- *Faculty do not fail students; students fail to meet course requirements.* Read the course syllabus completely during the first week of class. Know the course requirements and when they are due. Review the course and program policies (become knowledgeable about the program policies and procedures for students). If you are unsure of course requirements or program policies and procedures, ask the instructor.



them with the faculty. They may be able to suggest solutions, recommend resources in the college/university, or assist with learning. Sometimes personal circumstances necessitate dropping out of a class before the end of the semester or term. There are usually procedures that must be followed so that there is no negative impact on the student's progression or grade.

## Technology Skills

Students participating in formal educational programs, whether undergraduate or graduate, must have proficiency in technology skills, usually related to computing hardware, software, and applications, for example, the use of word-processing programs such as Microsoft Word, electronic literature databases, statistical software, spreadsheet programs, and graphic presentation programs. Written assignments may be required to follow a specific writing style such as APA or MLA and may be submitted electronically via email or through a course-related website. Some educational programs require that students submit papers for *plagiarism* review (the illegal and unethical copying of another's work), through prevention programs such as Turnitin.com, prior to submitting the paper for instructor grading. University and college libraries have electronic databases that provide access to research and other professional literature. Electronic databases commonly used by nursing students are the Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, and PsychLit. Students in nursing research courses may be required to have a statistical program in order to analyze statistical data. The Statistical Package for the Social Sciences (SPSS) is commonly used to analyze data in nursing research. Computer spreadsheet programs such as Excel and Access help organize information so that it can be categorized in different ways. Spreadsheet programs also can be used to create diagrams, graphs, and flow sheets. Students may be required to make presentations in class or online using programs such as PowerPoint to create graphic slides integrating text, photos, and diagrams in an aesthetically visual production. Many universities and colleges provide tutorials to help students learn and use these various programs.

When searching the Internet to find information, it is important to evaluate websites for the accuracy, reliability, validity, currency, and objectivity of the information provided. Anyone can publish anything on the Internet; therefore, information found on the Internet is not always appropriate for use in a scholarly setting. Some suggestions for evaluating Internet sites can be found in the box titled "Suggestions for Validating Internet Sources."



**InfoQuest:** Search the Internet for sources of information on nursing. Identify five sources that provide information about nursing. Evaluate these sources according to the criteria presented in the box titled, Suggestions for Validating Internet Sources.

Many nursing programs expect students to bring a laptop or notebook computer to class for in-class activities. It is important that the computer is compatible with the programs required for student work. Students may be required to have a smartphone or other personal digital assistant (PDA) for clinical nursing courses in order to access clinical information. A commonly required software program is Epocrates, which provides ready access to frequently updated information on drugs. Many universities and colleges have a computer retail center on campus to assist students in purchasing electronic equipment (hardware and software), often with a student discount.

Students enrolled in online nursing programs need to have proficiency in accessing the course website, downloading course documents, uploading course assignments, and communicating with the instructor and other students in the course through email or discussion boards. All these processes are conducted through the course website. In most cases, university/college technology departments provide tutorials and technical resources for students enrolled in online courses.

## Study Skills

Study skills and habits need to be reviewed and updated, especially if the student has been away from the formal academic setting for some time. Unlike in many noncredit continuing education activities, there are graded assignments, exams, and final grades in college courses. Students need to plan well to balance the many obligations they have in order to be successful. Some suggestions to enhance study skills follow.

- **Decide where you will study.** Most people prefer to study in quiet, whereas others find that soft background noise is helpful. If you prefer to study in quiet, you may want to use noise-canceling headphones (or ear plugs) to reduce outside noise and distractions. Determine where you will study. Be sure that there is adequate lighting, comfortable seating, and the supplies you need so that you can study without interruption. While many students study at home, consider whether family activities at home will be conducive to study. Some students choose to study in

## Suggestions for Validating Internet Sources

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Remember: Anyone can publish anything on the Web. When validating Internet sources, one should consider the following:

### Purpose

- What is the purpose of the website? Is the site trying to inform the viewer, or is it trying to sell something?
- Who is the intended audience of the information? Is the content information for consumers or for health professionals?

### Author

- Is the author identified?
- What are the author's credentials? Do the author's credentials indicate that she or he is an expert/authority based on education, experience, or research on the topic?
- Do you recognize the author's name as an expert in the profession?
- Is there a link to information about the author? If not, conduct a literature search using the author's name to determine whether she or he has written on the subject in another refereed source.
- Who is the sponsor of the website? Look for a header or footer that shows the sponsor affiliation. Check the domain (i.e., .com [commercial], .edu [educational], .gov [governmental], .org [organization], .net [network communication]).
- Is the sponsor credible? View with caution any site that is sponsored by the author individually or is trying to sell something.

### Functionality

- Is it easy to navigate the site?
- Does the site include a site map or index?
- When using links within the site, is it easy to get back to Home or to other pages within the site?

### Accuracy

- Is the material scholarly?
- Is the information reliable and verifiable?
- Are there errors, either factual or grammatical, in the presentation of information? Multiple spelling and/or

grammatical errors suggest that the material has not been reviewed by an editor or review panel.

- Is a bibliography or reference list provided?
- Are there links to background documentation/bibliography/reference lists?
- Does the content reflect a particular point of view or bias on the part of the author?

### Currency

- How timely is the information? Unless you are looking for historical information, currency is essential, especially in nursing and health care.
- Can you determine the date the information was published on the Web? If not, you don't know how old the information is.
- Can you tell when the site was last updated? Does the document refer to dated information (e.g., 2000 U.S. Census data)?
- If there are links on the website, are they current? Or are they dead ends?

### Objectivity

- Is information presented in an objective and unbiased manner?
- What is the nature of the information—fact or opinion? If fact, are background information and links to other sources/references provided?
- Is the information presented on a site sponsored by an organization with a clear personal investment in the issue? Is there advertising by the site sponsor on the page?
- If the site presents "research," are the methodology and data analysis provided?

### Coverage

- What topics are covered?
- What is the depth of coverage?
- Who is the information for—the public or health professionals?
- Is the content sourced?
- Are there links to background information? Can you find another source for this information?
- Is there a reference list or bibliography?

the university library, a local library, or other quiet place outside the home.

- **Decide whether you will study alone or with other classmates.** Some students prefer to learn and study by themselves, while others prefer to study with classmates, or in a combination of both alone and group study. Determine which works best for you. An advantage to studying alone is that you don't need to negotiate when and where to study; a disadvantage is that you don't have the benefit of discussing or clarifying your understanding with other classmates. Advantages of studying

with others include reinforcement of your own learning through discussion with other students, the ability to quiz each other on assigned material, and the division of study tasks when studying as a group. For example, if you find it helpful to outline an assigned chapter, group members can divide the different parts of the chapter among themselves for outlining and then share copies of the outlined parts with each other. The disadvantages of group study could include loss of focus among some group members, distraction from studying, or failure to complete assigned contributions to the group.

- **Avoid marathon study sessions.** Plan ahead and keep up with readings and other assignments so that you need only to review for exams. It is more valuable to get a good night's sleep and a nutritious meal than to study all night prior to an exam.
- **Be prepared for classes.** Read the reading assignments before class, and make notes or outline the material. Use class time to clarify information, to ask questions, and to participate knowledgeably in discussion and classroom activities. Don't expect faculty to read the textbook to you. They assign readings as a foundation for the class and then add to the lecture from other resources to enhance the assigned readings. When the syllabus lists recommended readings in addition to assigned or required readings, clarify with the instructor how the recommended readings will be used. Try to read both required and recommended readings.
- **Know how to read a textbook.** Reading a textbook is not like reading a novel. Generally there is no plotline.
  - Faculty usually assign readings as they relate to the curriculum and course plan, and they may assign chapters out of order or skip chapters all together.
  - Be sure to read the chapter objectives and the chapter summary or highlights; they help you focus on what is important in the chapter.
  - Chapter objectives can be rephrased as questions for review of information. For example, an objective for this chapter is "Implement strategies to ensure academic, professional, and personal success." This objective can be rephrased into the question, "What are strategies to ensure success?" "Which strategies to ensure success will you implement?"
  - Use a highlighter sparingly, if at all. Only highlight the most important material, and better yet, write a chapter outline. The process of outlining the chapter will reinforce your learning.
- **Review notes as soon after class as possible.** Make sure you understand your notes. Check your notes against the textbook to determine whether there are any discrepancies. If there are inconsistencies, ask or email your instructor for clarification. Don't wait until the exam to clarify inconsistencies.
- **Learn how to use the library and how to use computers.** The library is not just a building; it is a collection that is available by computer as well as in hard copy. At any time of the day or night, it provides access to hundreds of databases where students can locate information related to the area of study. Information from governmental and private organizations is available 24 hours a day by simply going online and using a search engine. Librarians are an invaluable resource for any student: They are knowledgeable and

ready to assist students in searching for information as well as teaching students how to search independently.

## Pedagogic Features for Using This Text

There are several features within this text designed to enhance the student's learning experience:

- **Reflect On.** Throughout this text, you will be asked to contemplate your own experiences, beliefs, and values as they relate to and influence your nursing practice. In each chapter, the self-reflections will be related to the chapter content. For example, in this chapter, you have been asked to consider the factors in your life that may cause difficulties in achieving your goal and to plan ways to overcome those difficulties. Your instructor may use these reflections as points for class discussion or may use them as part of a class journaling assignment. It is possible that no formal assignment will be made. Self-reflection is important in understanding yourself in relation to your professional role as a nurse. Evidence-based nursing requires that students think reflectively.
- **Critical Thinking Exercises.** Critical Thinking Exercises provide an activity to encourage the student to use the information in the chapter in a focused way. Consider these as exercise for your brain. Your instructor may ask you to complete these activities individually or with a group of classmates. There may be multiple correct solutions to these exercises. Discussing your thoughts with your classmates can enhance and expand your understanding of the text.
- **Research Currents Boxes.** Research Currents boxes provide examples of selected current research findings appropriate to the content of the chapter. Readers are encouraged to read the abstract in the text and, for greater understanding, to read the full article in the journal or Internet citation. Many of these research reports are available in full text online through your college/university library. Check with your library about how to access current information and evidence-based research to enhance your understanding of the chapter content.
- **InfoQuest.** InfoQuest asks you to search the Internet or other electronic databases in search of information related to the chapter content, and to analyze the validity of the information as you consider applying it to your practice. When accessing information on the Internet, it is important to authenticate the source and information. Access to library electronic databases is usually provided through the university/college library; students can then access them through a personal computer. The box titled "Suggestions for

Validating Internet Sources” in this chapter’s section on “Technology Skills” provides criteria for validating Internet sources.

- **Chapter Highlights.** Chapter Highlights is a bulleted list found at the end of a chapter that provides an overview of key information provided within the chapter. Chapter Highlights provides an excellent review and study tool for exams.

The challenges of starting professional nursing studies or returning to school to achieve a higher degree in nursing, represented by changes in lifestyle and new demands on time and intellect, can be stimulating and satisfying. Many opportunities will be available for personal and professional growth. New career possibilities will be obtainable, and new perspectives on old views will be considered. The journey is an important one to each student and to nursing as a profession.

## Chapter Highlights

- The reciprocal relationship between nursing and society requires that nursing must change in response to societal changes. As society in general and health care specifically become more complex, nurses need to increase their knowledge and skills to provide quality nursing care.
- Demographic changes in society that influence health care include the increase in the number of elderly who have more complex health problems and the increasing diversity of the population in culture, ethnicity, spirituality, and religion.
- In recent decades, there has been an increasing focus on health promotion and illness/injury prevention, with more care being provided in the community, which requires a nurse to be more autonomous in her/his role.
- Since the mid-20th century, there have been significant changes in the education of nurses, the numbers of men and minorities entering the profession, the average age of nurses and their career life expectancy, the ratio of full-time to part-time nurses, the types of nurse practice settings, and the credentialing of nurses.
- Bridges (2004) and Spencer and Adams (1990) provide models of transition that can assist nurses in understanding and managing the stresses they experience as they return to school for advanced nursing education.
- Strategies to ensure personal, academic, and professional success include developing skills in time management and financial management, developing a social support system, learning how to work with faculty, developing skills in the use of academic and healthcare technology, and enhancing study skills.

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# 2

## UNIT I

### Foundations of Professional Nursing Practice

# Socialization to Professional Nursing Roles

## Chapter Outline

### Challenges and Opportunities

#### Professionalism

Nursing as a Discipline and Profession  
Pavalko's Occupation-Profession Continuum Model  
Scope and Standards of Nursing Practice

#### Professional Socialization

Critical Values of Professional Nursing  
The Initial Process of Professional Socialization

#### Ongoing Professional Socialization and Resocialization

Kramer's Postgraduate Resocialization Model  
Dalton's Career Stages Model  
Benner's Stages From Novice to Expert

#### Role Theory

Elements of Roles  
Boundaries of Nursing Roles

#### Role Stress and Role Strain

Reducing Role Stress and Strain  
Stress Reduction Strategies  
Managing Role Stress and Role Strain

#### Chapter Highlights

## Objectives

1. Discuss professionalism and nursing.
2. Identify characteristics of a profession and describe how nursing meets or fails to meet those characteristics.
3. Describe Pavalko's eight categories in the occupation-profession model applied to nursing.
4. Describe socialization to professional nursing.
5. Compare socialization models.
6. Analyze elements of and boundaries for nursing roles.
7. Describe how stress and compassion fatigue can affect nurse satisfaction and quality of care.
8. Discuss ways to manage role stress and strain while enhancing professional identity.

Professional socialization transmits values, norms, and ways of viewing a situation that are unique to the profession and provide a common ground that shapes the ways in which work is conducted. It facilitates effective communication among members of the profession. The outcome is the formation of an individual's professional identity, the self-view as a member of a profession with the requisite knowledge, skills, responsibilities, and obligations.

A profession is generally distinguished from other kinds of occupations by (1) its requirement of prolonged, specialized training to acquire the body of knowledge and related skills pertinent to the role to be performed and (2) an orientation of the individual toward service, either to a community or to an organization. The standards of education and practice for the profession are determined by the members of the profession rather than by outsiders. The education of the professional involves a complete socialization process, more far-reaching in its social and attitudinal aspects and its technical features than usually required in other kinds of occupations.

There has been debate about whether nursing is a profession or has yet to reach that status. Traditionally, only medicine, law, and theology were considered professions, but nursing has been called a profession for many years. Some of the debate about professionalism for nurses centers on the models and definitions of a profession that stress rationalism, scientific standards, and objectivity and

represent masculine approaches. Feminist writers argue that these patriarchal values have failed to bring power and prestige to nursing because they do not embody the nature of nursing, with its emphasis on caring and human phenomena (Wuest, 1994). In *A Nursing Manifesto* (2000/2009), Cowling, Chinn, and Hagedorn suggest that “as nurses, we reach for meaningful expressions of our values, too often finding overwhelming constraint and resistance, sometimes within ourselves and sometimes imposed from without” and call for nurses to join in “envisioning, shaping, and manifesting a future that reflects the deepest passions, beliefs, and values that come from our roots in nursing—a future that is deliberately and consciously formed.”

## Challenges and Opportunities

**Level of Entry** There are both challenges and opportunities in the continuing discussion about level of entry to professional nursing. Professional role socialization has been impeded by nursing’s multiple levels of entry into the field and by the lack of agreement about role differences at these different levels. Nursing is the only major discipline that does not require its members to hold at least a baccalaureate degree to be licensed. Associate degree programs continue to maintain high enrollment and graduate large numbers of individuals. Role socialization depends on the way the role is conceptualized, and nurses prepared at multiple levels may not have a common language, common values, or a common understanding of the multiple roles of the professional nurse as care provider, interprofessional team member, educator, leader, advocate, and consumer of research. Thus, nurses may not be in accord with regard to professional practice and may have different perspectives relative to what constitutes professional practice. Consequently, there have been increasing calls for baccalaureate entry to practice, with the associate degree being a step on the path to professional growth.

**Gaps Between Education and Practice** New graduate RNs are coming into the workplace with greater loyalty to the profession than to the employing institution. New nurses are likely to experience value conflicts when moving into the workplace from the academic environment in which they first learned professional values. This conflict is related to the lack of agreement between educators and employers of nurses regarding competency expectations of graduates entering the field. Educators in the professional curriculum provide initial socialization, and they make decisions based on their conception of a beginning-level professional. Employers are looking for graduates who can function independently, are proficient in clinical skills, require little retraining or orientation, and can supervise a variety of less educated and unlicensed employees. Graduate nurses often experience role incongruity related

to having met the standards for graduation and licensure but not feeling confident in their nursing abilities for the new graduate nurse work role. New opportunities are being provided by both educators and employers through senior nursing student and new graduate residency programs, mentorship, and preceptorship programs to ease the transition from student/novice nurse to advanced beginner nurse. New nurses must be encouraged to take advantage of these transitional programs.

**Professional Identity: Job Versus Career** There is little commitment to a job other than going to work, doing what is expected, and collecting a paycheck. On the other hand, a career is viewed as a person’s life work, and it develops over time. A career requires commitment to planning for the future: what are one’s practice goals and what education and experiences are needed to achieve those goals. For many, both nurses and nonnurses, the practice of nursing is not viewed as a career. And yet, increasingly, as nurses pursue baccalaureate and advanced nursing education, the values of nursing as a career/profession are instilled.

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### Reflect On . . .

- what planning brought you to this phase of your career development.
  - your thoughts about nursing as an occupation (job) or as a profession. How would you describe your own practice as a nurse?
  - what motivates your commitment. What specific factors are important to you as you view your own role as a nurse? As you view the nursing profession as a whole?
- 

## Professionalism

### Nursing as a Discipline and Profession

Unlike other professions, nursing, starting in the 1950s, had three educational routes leading to eligibility for licensure as a registered nurse. This created controversy within the profession and confusion for the public. The earliest type of nursing education in the United States took place within hospital-based training schools and awarded a diploma in nursing at the conclusion. Baccalaureate nursing education started at the University of Minnesota in 1909 and today occurs in 4-year institutions of higher education. Associate degree nursing (ADN) programs began in 1952 in response to a nursing shortage and developed within community colleges. As nursing education began moving into institutions of higher education, some diploma programs closed while others affiliated with nearby colleges or universities in order to offer the associate degree or the baccalaureate



degree. By 2008, only 4% of prelicensure nursing programs were of the diploma type, while 58% were of the associate degree type and 38% were baccalaureate-granting programs (National League for Nursing, 2010).

Associate degree programs were developed as a temporary measure to address a nursing shortage following World War II. They focused on preparing bedside nurses and drew large numbers of students. ADNs helped to solve subsequent nursing shortages in the 1960s and 1980s. Baccalaureate degree programs provide a broader background of knowledge from the sciences and liberal arts than the other two programs and prepare the graduates for a greater variety of roles. These roles include community nursing and leadership.

In the period between 1980 and 2013, there was a shift in the preferred type of program for preparation for licensure as a registered nurse. The percentage of nurses prepared in diploma programs decreased from 60% to 14.2%, while preparation at the associate degree level increased from 19% to 40.2%. The percentage of nurses prepared at the baccalaureate level increased from 17% to 37.3%. Interestingly, 3% of nurses completed their initial nursing education in master's entry programs. That is, their initial prelicensure nursing program was at the master's level. These individuals had baccalaureate degrees in other fields, usually psychology, sociology, or one of the biological sciences, and used that knowledge to pursue a career in nursing. In 2013, 28.6% of nurses reported the associate degree as their highest level of education; 43.2% of nurses reported the baccalaureate degree as their highest level; and 18.9% reported a master's degree or doctoral degree as their highest level (U.S. Department of Health and Human Services, 2008; Budden, Zhong, Moulton, & Cimiotti, 2013).

In 1965, the American Nurses Association (ANA) published a position paper on educational preparation of nurses that identified nurses with baccalaureate degrees as professional nurses, differentiated from nurses with associate degrees, who were considered technical nurses. This issue has been a source of great controversy between those who believe professionals should have a minimum of a bachelor's degree and those who see all nurses as professionals. Many changes have occurred since the inception of these programs, allowing for articulation of the programs and making it easier for the ADN graduate to continue for a BSN. RN-to-BSN transition programs are common today, and many students enter an associate degree program with the intent of continuing for a BSN degree. Some nurse leaders now propose a master's degree as the minimum education for entry into professional practice. At the national level, nursing leaders have recommended that nurses who enter nursing at the diploma or associate degree levels be required to attain the baccalaureate degree in nursing within a certain period of time (e.g., 5–10 years) after their initial

licensure in order to retain their license. As it stands now, nurses have the lowest educational requirement among professional healthcare providers.

At the core of the controversy over level of entry into professional nursing is the definition of profession. For example, online dictionaries provide a simplistic definition of *profession*, as a type of job or paid occupation or vocation, one that may involve specialized education, prolonged training, and/or a formal qualification. In 1915, Abraham Flexner described a profession as an activity that is basically intellectual; its activities are practical and not theoretical. The work can be learned because it is based on a body of knowledge; its techniques can be taught. There is a strong organization in place, and the work is motivated by altruism, not by personal reward.

Others who have written about professions generally (Barber, 1963; Pavalko, 1971) and nursing specifically (Bixler & Bixler, 1945; Miller, Adams, & Beck, 1993; Joel & Kelly, 2002) have added the following characteristics:

- Education that begins in institutions of higher learning and continues throughout the professional career (lifelong learning)
- An increasing body of knowledge based on theory that is well defined and is strengthened through evidence
- A socialization process that inculcates the norms and values of the professional culture
- Autonomy or the ability to govern itself and its practice
- Work that has social value and provides a service to the public
- Adherence to a code of ethics
- Commitment to the work over personal gain



**InfoQuest:** Search the Internet for information about characteristics of a profession identified by Flexner; Bixler and Bixler; Barber; Miller, Adams, and Beck; and Joel and Kelly. What is the progression of thinking about the characteristics of a profession? What new characteristics were added over time? Were earlier characteristics dropped? How does the progression of thinking about the characteristics of a profession relate to the progression of nursing as a profession?

### Pavalko's Occupation-Profession Continuum Model

In his occupation-profession model, R. M. Pavalko (1971) identifies eight categories that serve as criteria to determine whether an occupation is a profession. Using Pavalko's framework, the following section describes how nursing may fulfill each criterion.

### Theory

The work group is judged on the extent to which its work is based on a systematic body of knowledge that is developed through research. As a profession, nursing continues to develop a well defined body of knowledge and expertise. A number of nursing conceptual frameworks contribute to the knowledge base of nursing and give direction to nursing practice, education, advocacy, and leadership.

Nursing scholars conducting research in nursing contribute to this body of knowledge. In the 1940s, nursing research was at a very early stage of development. In the 1950s, increased federal funding and professional support helped establish centers for nursing research. Most early research was directed to the study of nursing education. In the 1960s, studies focused chiefly on the nature of the knowledge base underlying nursing practice. Since the 1970s, nursing research has focused largely on developing the evidence to improve and support quality practice, to develop educational methodologies to prepare nurses who can meet the needs of today's healthcare consumers, and to develop nursing leaders and scholars.

### Relevance to Social Values

This category suggests that a profession justifies its existence by close association with values that society as a whole embraces, such as human rights and social justice. Since its inception, nursing has been truly altruistic in that it has existed to serve others. In the early history of nursing, nurses were expected to devote most of their lives to nursing, often joining religious orders or foregoing having their own families. Contemporary nursing still emphasizes service to others, but today's nurses expect fair compensation and a life separate from nursing.

Nursing's Social Policy Statement (American Nurses Association, 2010c) reflects nursing's relevance to social values in describing the goals of nursing actions to "protect, promote, and optimize health; to prevent illness and injury; to alleviate suffering; and to advocate for individuals, families, communities, and populations" (p. 11).

### Training (Education) Period

Training or education is the third characteristic in Pavalko's occupation-profession model. This category has four subdivisions: the educational content, length of education, the use of symbolic and ideational processes, and degree of specialization that is related to practice.

Nursing education involves theory and practice. However, the length of study required for entry to practice is still an issue of controversy because of the multiple educational paths to achieve nursing licensure. Historically, nurses were educated in hospitals. Now most nurses are educated in colleges or universities with nursing education based on a foundation of liberal arts or humanities, bio-

logic and social sciences. Certification for specialization generally requires a minimum of a baccalaureate degree along with a period of instruction and experience within the specialty. Specialization in advanced nursing practice requires master's or doctoral preparation.

### Motivation

Motivation to work is Pavalko's fourth category. In this instance, Pavalko refers not to the motivation of the individual but to the group or collective of nurses as a whole. Motivation means the extent to which the nursing group emphasizes service to others rather than service to self as its primary goal. In other words, why does a person choose to become a nurse? For the most part, nurses choose nursing in order to improve the health and well-being of their clients and their families, and the society as a whole.

### Autonomy

Pavalko's fifth category is autonomy, the freedom of the group to regulate and control its own work behavior. A profession is autonomous if it regulates itself and sets standards for its members. Providing autonomy is one of the purposes of a professional association. For nursing to have professional status, it must function autonomously in the formation of policy and in the control of its activity. International, national and state/provincial nursing associations have developed standards of practice (American Nurses Association, 2010b) and codes of ethics (International Council of Nurses, 2012; American Nurses Association, 2010a) that prescribe the roles and functions of nurses for which they are held accountable. To be autonomous, a professional group must be granted legal authority to define the scope of its practice, describe its particular functions and roles, and determine its goals and responsibilities in delivery of its services. The legal authority for nursing is generally held by state/provincial boards of nursing or nursing registries that determine the qualifications to become licensed as a nurse and the requirements to maintain that licensure. The amount of autonomy a professional group possesses depends on its effectiveness at self-governance. Governance is the establishment and maintenance of social, political, and economic arrangements by which practitioners control their practice, their self-discipline, their working conditions and their professional affairs. In nursing, self-governance is managed through professional organizations and state/provincial boards of nursing.

### Commitment

Pavalko's sixth category is commitment toward the work. In this context, people who are committed to their work view it as more than a stepping stone to another type of work or as intermittent work. For people who view their work as simply

a job, commitment tends to be lacking; professionals, in contrast tend to view their work as a career, a lifelong vocation, and commit to the work for a lifetime or a significant length of time. Career oriented nurses value commitment to people and continued education to broaden their own and nursing's power base; job-oriented nurses, in contrast, chiefly value the income they earn from the job.

### Sense of Community

A sense of community means that members of a group share a common identity and destiny and possess a distinctive subculture. In the past, nurses have worn many symbols of their profession, such as a cap, white uniform and nursing school pin. Although many of these symbols have disappeared, nurses do have a strong sense of professional identity. One way nurses can develop a sense of community is to participate in professional organizations.

### Code of Ethics

The existence of a code of ethics is the final category in Pavalko's model. Occupations are not likely to have a written code of ethics that sets forth standards of behavior and relationships between its members and the public they serve. Established professions, in contrast, do have formal codes of ethics. Nurses have traditionally placed a high value on the worth and dignity of others. The nursing profession requires integrity of its members, that is, a nurse is expected to do what is considered right regardless of the personal cost. The International Council of Nurses (2012), the American Nurses Association (2010a), the Canadian Nurses Association (2008), and other national nursing associations have codes of ethics.

### Reflect On . . .

- Pavalko's occupation-profession continuum model. Do you believe that nursing is a profession? What specific reasons can you give to support your answer?
- your own practice as a registered nurse. In what ways does your practice reflect the characteristics of a profession?



**InfoQuest:** Search the Internet for copies of the ICN, ANA, and CNA codes of ethics. In what ways are they similar? In what ways are they different?

### Scope and Standards of Nursing Practice

Professions have a responsibility to society. This responsibility can be operationalized through standards of practice. Establishing and implementing standards of practice are

major functions of a professional organization, and the purpose is to describe what nurses are accountable for. The standards (1) reflect the values and priorities of the nursing profession, (2) provide direction for professional nursing practice, (3) provide a framework for the evaluation of nursing practice, and (4) define the profession's accountability to the public and the client outcomes for which nurses are responsible (ANA, 2010, p. 99). In 1991, the ANA developed standards of clinical nursing practice that are generic in nature and provide for the practice of nursing regardless of area of specialization. They were revised in 1998, in 2004, and again in 2010. The ANA and various specialty nursing organizations have further developed specific standards of nursing practice related to the practice of nursing in a specialty area.

Nursing standards clearly reflect the specific functions and activities of nurses, as opposed to the functions of other health workers. The ANA's *Nursing Scope and Standards of Practice* consists of both standards of care and standards of professional performance. Standards of professional performance describe "a competent level of behavior in the professional role, including activities related to ethics, education, evidence-based practice and research, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health" (p. 10) for all registered nurses. The six standards of practice reflect the critical thinking model known as the nursing process and form the foundation for the nurse's decision making. The 10 standards of professional performance describe competent behaviors in performing the multiple roles of nursing. When standards are implemented, they serve as yardsticks for the measurements used in licensure, certification, accreditation, quality assurance, peer review, and public policy. These standards are shown in the accompanying box.

### Reflect On . . .

- the ANA *Nursing Scope and Standards of Practice*. In what ways are the ANA *Standards of Practice* reflected in your work setting? In what ways are the ANA *Standards of Professional Performance* reflected in your work setting? In what ways are the ANA *Standards of Practice* reflected in your own practice? In what ways are the ANA *Nursing Standards of Professional Performance* reflected in your own practice? What additional knowledge and experience do you need to effectively comply with the ANA *Nursing Scope and Standards of Practice*, specifically the *Standards of Professional Performance*?

## ANA Standards of Practice and Professional Performance

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### ANA Standards of Practice

#### **Standard 1. Assessment**

The registered nurse collects comprehensive data pertinent to the healthcare consumer's health and/or situation.

#### **Standard 2. Diagnosis**

The registered nurse analyzes the assessment data to determine the diagnoses or the issues.

#### **Standard 3. Outcomes Identification**

The registered nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.

#### **Standard 4. Planning**

The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

#### **Standard 5. Implementation**

The registered nurse implements the identified plan.

#### **Standard 5A. Coordination of Care**

The registered nurse coordinates care delivery.

#### **Standard 5B. Health Teaching and Health Promotion**

The registered nurse employs strategies to promote health and a safe environment.

#### **Standard 5C. Consultation**

The graduate-level prepared specialty nurse or advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect change.

#### **Standard 5D. Prescriptive Authority and Treatment**

The advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

#### **Standard 6. Evaluation**

The registered nurse evaluates progress toward attainment of outcomes.

### ANA Standards of Professional Performance

#### **Standard 7. Ethics**

The registered nurse practices ethically.

#### **Standard 8. Education**

The registered nurse attains knowledge and competency that reflects current nursing practice.

#### **Standard 9. Evidence-Based Practice and Research**

The registered nurse integrates evidence and research findings into practice.

#### **Standard 10. Quality of Practice**

The registered nurse contributes to quality nursing practice.

#### **Standard 11. Communication**

The registered nurse communicates effectively in all areas of practice.

#### **Standard 12. Leadership**

The registered nurse demonstrates leadership in the professional practice setting and the profession.

#### **Standard 13. Collaboration**

The registered nurse collaborates with healthcare consumer, family, and others in the conduct of nursing practice.

#### **Standard 14. Professional Practice Evaluation**

The registered nurse evaluates her or his own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.

#### **Standard 15. Resource Utilization**

The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible.

#### **Standard 16. Environmental Health**

The registered nurse practices in an environmentally safe and healthy manner.

*Source: Nursing Scope and Standards of Practice (2nd ed.), by the American Nurses Association, Silver Spring, MD, nursebooks.org. Reprinted with permission © 2010 American Nurses Association. All rights reserved.*

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## Professional Socialization

Socialization is the process by which people learn social rules and become members of groups. It involves learning to behave in a way that is consistent with the behavior of other persons occupying the same role. The goal of professional socialization is to internalize a professional identity

that includes the norms, values, attitudes, and behaviors of the profession.

An intrinsic aspect of the socialization process is social control, that is, the capacity of a social group to regulate itself through conformity and adherence to group norms to maintain the group's social order and



organization. Sanctions are used to enforce norms. Positive sanctions reward conformity to norms; negative sanctions punish nonconformity. Sanctions may be either externally employed by a source outside the individual (e.g., disciplinary action by a supervisor or a regulatory agency) or internally employed from within the individual (e.g., self-congratulations for a job well done, choosing a remedial program to improve practice). Socialization implies that the individual is induced to conform willingly to the ways of the group. Norms therefore become internalized standards. Professions require both a relatively long period of formal schooling and an informal, internalized system of ethics that guides practice of the professional role.

Professional socialization involves exposure to multiple agents of socialization. Agents of socialization are the people who initiate the socialization process; for children, the primary agents of socialization are the family, teachers, peers, and the mass media. For adults, the influence of these early agents continues, but other agents arise, such as superiors and subordinates in the workplace, peers, and people in various other kinds of social groups. Socialization agents that nursing students encounter include health-care consumers, nursing faculty, professional colleagues, other healthcare professionals, family (e.g., a nurse relative), and friends both in and outside the formal institutional structure. Professional socialization in nursing occurs formally through the educational experience in the nursing curriculum (i.e., classroom, laboratory, clinical settings, National Student Nurses Association) and later through preceptors, mentors, and staff development in the practice setting. The degree of congruence between the expectations of these multiple agents may either facilitate

or hinder socialization. Factors that facilitate the professional socialization process for nurses are listed in the accompanying box.

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### Reflect On . . .

- the agents of professional socialization in your own experience. Who have been your agents of socialization to nursing? In what ways have they influenced your development as a nurse?
  - your role as an agent of socialization to nursing students. How have you assisted others in their socialization to the role of the professional nurse?
- 

### Critical Values of Professional Nursing

Values guide interactions with patients, families, colleagues, and the public. Regardless of practice setting, the values identified greatly affect decisions concerning the provision of nursing service. For example, the organization that embraces the value of autonomy for nursing practice will create opportunities for nurses to make decisions governing practice policies and procedures. An organization that does not value autonomy for nurses will hand down decisions from the top. Some of nursing's values are accountability, reliability, autonomy, caring, and professionalism.

It is within the nursing educational program that the nurse develops, clarifies, and internalizes professional values. Professional values are preferred standards that guide behavior and are used for evaluating behavior. Specific professional nursing values are stated in three documents

### Factors That Facilitate the Professional Socialization Process for Nurses

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- Experiences that have occurred prior to entering the role (e.g., membership in a future nurse club, volunteer or paid work as an aide in a healthcare setting, personal experience as a patient or the family member of a patient)
  - Accurate and positive portrayals of the expected role in media
  - Positive understanding and support from teachers, counselors, friends, and family
  - Consistency and congruence in understanding and performance of the expected roles among those who are already in the role (registered nurses) and those who aspire to the role (students)
  - Positive understanding and support from others in the healthcare professions, including healthcare administrators, physicians, and other health professionals
  - Capacity of socialization agents (e.g., faculty, other nurses, professional organizations) to manage the socialization process
  - Role models and mentors who exhibit the desired professional characteristics and influence the internalization of those characteristics
  - Organized programs of orientation, preceptorship, internship, and residency models that provide ongoing support throughout the socialization process
  - Participation in group professional activities such as the National Student Nurses Association and the ANA that provide support and programming for those new to the profession
-



published by the ANA: the *Code of Ethics* (2010a), *Nursing Scope and Standards of Practice* (2010b), and *Nursing’s Social Policy Statement* (2010c).



**InfoQuest:** How does the nurse obtain copies of the three ANA documents that frame the values of nursing? How do these documents portray nursing to the healthcare consumer? To the general public?

Reflect On . . .

- *Nursing’s Code of Ethics*, *Nursing Scope and Standards of Practice*, and *Nursing’s Social Policy Statement*. What do you believe to be the critical values of nursing? How do you manifest those values in your practice?
- symbols of nursing past and present. How do clients, their families, and other healthcare professionals know who is the professional nurse? Are there characteristics of appearance that indicate a person is a professional nurse? Are there characteristics of behavior that indicate a person is a professional nurse?

The Initial Process of Professional Socialization

Professional socialization is the means of developing a professional identity incorporating values, skills, behaviors,

and norms for nursing practice. It is a lifelong process, beginning with the curriculum and faculty of the nursing program. Registered nurses who return to school for a baccalaureate degree in nursing experience professional resocialization. Their individual characteristics are diverse and affect resocialization in complex ways. Often, they need to overcome prejudices about and resistance to an educational program that may require them to shed previous ways of thinking. Although professional organizations adhere to the belief that baccalaureate education is the minimum education for professional nursing, there is an absence of agreement within the ranks of practicing nurses. Furthermore, there are others who promote the idea that the graduate level should be the professional level of entry.

Initial socialization prepares the student for the work setting. Several models have been developed to explain the initial process of socialization into professional roles. The models described here include those of Simpson, Hinshaw, and Davis. Each model outlines a sequential set of phases or chain of events beginning with the role of a layperson and ending with the role of a professional. Table 2–1 summarizes each model.

Simpson Model

Ida Harper Simpson (1967, 1979) outlined three distinct stages of professional socialization. In the first stage, the person concentrates on becoming proficient in specific work tasks. In the second stage, the person becomes attached to significant others in the work or reference group. In the third and final stage, the person internalizes the values of the professional group and adopts the prescribed behaviors.

TABLE 2–1 Models of Initial Socialization into Professional Roles

| Simpson (1967) Model                                                                                               | Hinshaw (1986) Model                                                                                  | Davis (1966) Doctrinal Conversion Model                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Stage 1</i> Proficiency in specific tasks                                                                       | <i>Phase I</i> Transition of anticipated role expectations to the role expectations of societal group | <i>Stage 1</i> Initial innocence work<br><i>Stage 2</i> Labeled recognition of incongruity                                                   |
| <i>Stage 2</i> Attachment to significant others in the work environment                                            | <i>Phase II</i> Attachment to significant others/labeling incongruities                               | <i>Stage 3</i> “Psyching out” and role simulation<br><i>Stage 4</i> Increasing role simulation<br><i>Stage 5</i> Provisional internalization |
| <i>Stage 3</i> Internalization of the values of the professional group and adoption of the behaviors it prescribes | <i>Phase III</i> Internalization of role values/behaviors                                             | <i>Stage 6</i> Stable internalization                                                                                                        |

Sources: Adapted from “Patterns of Socialization Into Professions: The Case of Student Nurses,” by I. H. Simpson, Winter 1967, *Sociological Inquiry*, 37, pp. 47–54; “Socialization and Resocialization of Nurses for Professional Nursing Practice,” by A. S. Hinshaw, 1986, in *Contemporary Leadership Behavior: Selected Readings* (2nd ed.), edited by E. C. Hein and M. J. Nicholson, Boston, MA: Little, Brown; and *Professional Socialization as Subjective Experiences: The Process of Doctrinal Conversion Among Student Nurses*, by F. Davis, September 1966, *Evian*, France: Sixth World Congress of Sociology.

### Hinshaw Model

Ada Sue Hinshaw (1986) provides a three-phase general model of socialization that is an adaptation of Simpson's model. During the first phase, individuals change their images of the role from anticipated concepts to the expectations of the persons who are setting the standards for them. Hinshaw states that (1) adults entering a profession have already learned a number of roles and values that help them to evaluate new roles, and (2) these individuals are actively involved in the socialization process, having chosen to learn the new role expectations and enter the socialization process.

The second phase has two components: (1) Learners attach themselves to significant others in the system, and at the same time, (2) they label situations that are incongruent between their anticipated roles and those presented by the significant others. In the initial professional socialization, significant others are usually a group of faculty; in the work setting, they are selected colleagues or immediate supervisors. Hinshaw emphasizes the importance of appropriate role models in both educational programs and work settings. At this stage, individuals are able to verbalize that the expected role behaviors are not what they anticipated. It is a stage that often involves strong emotional reactions to conflicting sets of expectations. Successful resolution of conflicts depends on the existence of role models who demonstrate appropriate behaviors and who show how conflicting systems of standards and values can be integrated.

In the third phase, the student internalizes the values and standards of the new role. The degree to which values and standards are internalized and the extent of incongruence in role expectations vary.

### Davis Model

Fred Davis (1966) describes a six-stage doctrinal conversion process among nursing students.

**Stage 1: Initial Innocence** As students enter a professional program, they have an image of what they expect to become and how they should act or behave. Nursing students usually enter a nursing program with a service orientation and expect to care for sick people. However, educational experiences often differ from what the students expect. During this phase, students may express disappointment and frustration at the experiences they undergo and may question their value.

**Stage 2: Labeled Recognition of Incongruity** In this phase, students begin to identify, articulate, and share their concerns. They learn that they are not alone in their values incongruity; their peers share the same concerns.

**Stages 3 and 4: "Psyching Out" and Role Simulation** At this point, the basic cognitive framework for the internalization of professional nursing values begins to take

shape. Students start to identify the behaviors they are expected to demonstrate and, through role modeling, begin to practice the behaviors. In Davis' terms, this process becomes a matter of "psyching out," or trying to figure out how the faculty will behave in a given situation. The more effectively the role simulation is done, the more authentic the person believes the behavior to be, and it becomes part of the person. However, students may think they are "playing a game" and are being "untrue to themselves," and the result is feelings of guilt and estrangement.

**Stage 5: Provisional Internalization** In stage 5, students vacillate between commitment to their former image of nursing and the performance of new behaviors attached to the professional image. Factors that enhance the students' new image are an increasing ability to use professional language and an increasing identification with professional role models, such as nursing faculty.

**Stage 6: Stable Internalization** During stage 6, the student's behavior reflects the educationally and professionally approved model. However, preparation of the student for the work setting is only the initial process in socialization. New values and behaviors continue to be formed in the work setting.

## Ongoing Professional Socialization and Resocialization

The process of socialization does not end with graduation from a program of study. It continues as the graduate begins a professional career and, in fact, continues throughout life. In school, the nursing student assimilates a central core of values emphasized by the faculty and the profession. In the work setting, the nurse faces the need to put the values of the profession into operation. The transition of the graduate to a full-fledged professional is facilitated if there is congruence between the norms, values, and expectations of the educational program and the realities of the work setting. However, practice settings are often bureaucratic and may not be supportive of professional career development. Three models of career stages of development—those of Kramer; Dalton, Thompson, and Price; and Benner—follow.

### Kramer's Postgraduate Resocialization Model

Marlene Kramer (1974) introduced the concept of *reality shock* to explain discrepancies that arise between the behavioral expectations and values of the educational setting and those of the work setting. Reality shock occurs when the new graduate is unprepared (ineffectively

TABLE 2–2 Dalton, Thompson, and Price Career Stages

| Stages    | Central Activity                                                                                                                           | Primary Relationship        | Major Psychological Issue          |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------------|
| Stage I   | Helping and learning: performs fairly routine duties under the direction of a mentor                                                       | Apprentice, subordinate     | Dependence                         |
| Stage II  | Works independently as a competent peer                                                                                                    | Colleague                   | Independence                       |
| Stage III | Influences, guides, directs, and helps others to develop                                                                                   | Informal mentor, role model | Assuming responsibility for others |
| Stage IV  | Influences the direction of the organization or a segment of it; has one of three roles: manager, internal entrepreneur, or idea innovator | Sponsor                     | Exercising power                   |

Source: Adapted from “The Four Stages of Professional Careers—A New Look at Performance by Professionals,” by G. W. Dalton, P. H. Thompson, and R. L. Price, Summer 1977, *Organizational Dynamics*, pp. 19–42.

socialized) to function effectively in the workplace. Kramer describes a four-stage postgraduate resocialization model for the transition of graduates from educational setting to work setting.

- Stage I: Skill and Routine Mastery. The nurse focuses on developing and mastering specific technical skills and may not focus on other important aspects of care.
- Stage II: Social Integration. The nurse is concerned with being accepted and having her/his competence recognized.
- Stage III: Moral Outrage. The nurse recognizes incongruities between understandings of the bureaucratic role, which is associated with rules and regulations and loyalty to the organization; the professional role, which is committed to continued learning and loyalty to the profession; and the service role, which is concerned with loyalty to and compassionate caring for the client as a person.
- Stage IV: Conflict Resolution. The nurse resolves conflicts of stage III by relinquishing values and/or behaviors or by learning to use both the values and behaviors of the profession and the values and behaviors of the organization in a politically astute manner. As nurses become more involved in organizational governance through membership on standing and ad hoc committees, conflict is often resolved through discussion and negotiation.

Dalton’s Career Stages Model

Dalton, Thompson, and Price (1977) describe a four-stage model that emphasizes the development of competence derived from experience. As the individual’s career progresses throughout each stage, activities, relationships, and psychological issues change in focus. For example, the individual’s major activities progress from helping, learning, and following directions (stage I) to shaping the direction of

the organization (stage IV). The primary relationships progress from that of an apprentice (stage I) to that of sponsor (stage IV). The major psychological issues progress from a feeling of dependence (stage I) to a feeling of comfort in exercising power (stage IV). These four stages are summarized in Table 2–2. Only a small percentage of nurses achieve the final stage because few stage IV positions are available.

Benner’s Stages From Novice to Expert

Patricia Benner (2001) describes five levels of proficiency in nursing based on the Dreyfus model of skill acquisition derived from a study of chess players and airline pilots. The five stages, which have implications for teaching and learning, are novice, advanced beginner, competent, proficient, and expert. Benner believes that experience is essential for the development of professional expertise. See box on page 27.

Reflect On . . .

- the range of Benner’s stages, from novice to expert. Where are you on Benner’s continuum in relation to your current area of practice? During your nursing career, what have you experienced as you have moved along Benner’s continuum? How might you assist a novice nurse to progress successfully to higher levels of practice?

Role Theory

Professional socialization has been based upon role theory, which emerged from the field of sociology. It involves preparation for particular job expectations or roles. A role is a set of expectations associated with a position in society. To understand socialization to a professional role, it is

## Benner's Stages of Nursing Expertise

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### Stage I: Novice

No experience (e.g., nursing student). Performance is limited, inflexible, and governed by context-free rules and regulations rather than experience.

### Stage II: Advanced Beginner

Demonstrates marginally accepted performance. Recognizes the meaningful “aspects” of a real situation. Has experienced enough real situations to make judgments about them.

### Stage III: Competent Practitioner

Has 2 or 3 years of experience. Demonstrates organizational and planning abilities. Differentiates important factors from less important aspects of care. Coordinates multiple complex care demands.

### Stage IV: Proficient Practitioner

Has 3–5 years of experience. Perceives situations as wholes rather than in terms of parts, as in stage II. Uses maxims as guides for what to consider in a situation. Has holistic understanding of the client, which improves decision making. Focuses on long-term goals.

### Stage V: Expert Practitioner

Performance is fluid, flexible, and highly proficient; no longer requires rules, guidelines, or maxims to connect an understanding of the situation to appropriate action. Demonstrates highly skilled intuitive and analytic ability in new situations. Is inclined to take a certain action because “it felt right.”

*Source: From Novice to Expert (Commemorative ed., pp. 20–34), by P. Benner, 2001, Upper Saddle River, NJ, Prentice Hall. Reprinted with permission.*

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necessary to have an understanding of role theory. What is it that defines a role and how does one make a transition into that role?

## Elements of Roles

Any role has three elements: the ideal role, the perceived role, and the performed role. The ideal role refers to the socially prescribed or agreed-upon rights and responsibilities associated with the role. Persons who assume a certain role are provided with sets of expectations and obligations or norms that can be identified and used as criteria to judge the adequacy of their performance in the role. The ideal role concept provides a relatively stable view of roles and role requirements, because the society at large is assumed to have the same or similar expectations about the pattern of behaviors that a person in a particular role should carry out. Although changes may occur in the prescribed rights and responsibilities associated with the ideal role, this ideal role tends to support a static view of role behaviors. Role expectations are the norms specific to a position that identify the attitudes, cognitions, and behaviors required and anticipated of a person in a particular role. Ideal role expectations may also be determined by culture and education. For example, the ideal role expectation of the nurse may include providing physical care and psychological support to the client who has difficulty caring for self, providing support for a frightened patient awaiting the results of a diagnostic test, or providing instruction in self-care to a client with newly diagnosed diabetes mellitus.

The perceived role refers to how a role incumbent (a person who assumes the role) believes she or he should

behave in the role. A role incumbent's perceptions of the expected patterns of behavior may differ from the conventional ideal role expectations. The nurse may perceive that she or he should include families in decision making and in planning care for the patient.

The performed role refers to what the role incumbent actually does. Role performance is defined as the behaviors of or actions taken by a person in relation to the expected behaviors of a particular position. With regard to the perceived role of including families in decisions about care, the nurse schedules a time for discussion with the family. *Role mastery* is the term used to indicate that a person demonstrates behaviors that meet the societal or cultural expectations associated with the specific role.

The person's perceptions and beliefs about what ought to be done are not the only factor influencing role performance. Other factors include health status, personal and professional values, needs of the client and their support persons, and politics of the employing agency. A healthy nurse, for example, may provide care associated with prescribed and perceived roles more effectively than an unhealthy nurse. A nurse who values the client's right to participate in care planning will elicit the client's thoughts and feelings before planning care. A nurse who must work in a situation in which several of the staff are absent may be required to defer basic aspects of care (e.g., bath, changing bed linen) for some clients in order to meet more critical needs of other clients.

Role transition is a process by which a person assumes or develops a new role. There are two components associated with role behaviors: norms and values.

Norms are the general expectations or standards of behaviors of a particular group; norms are a level to be achieved. Values justify and support the behaviors and help the nurse conform to the norms. In the new role, the person moves to a new set of responsibilities and, often, to new values as well. Role transition is influenced by many factors, such as individual factors, interpersonal factors, and organizational factors. A model of role transition is shown in Figure 2–1.

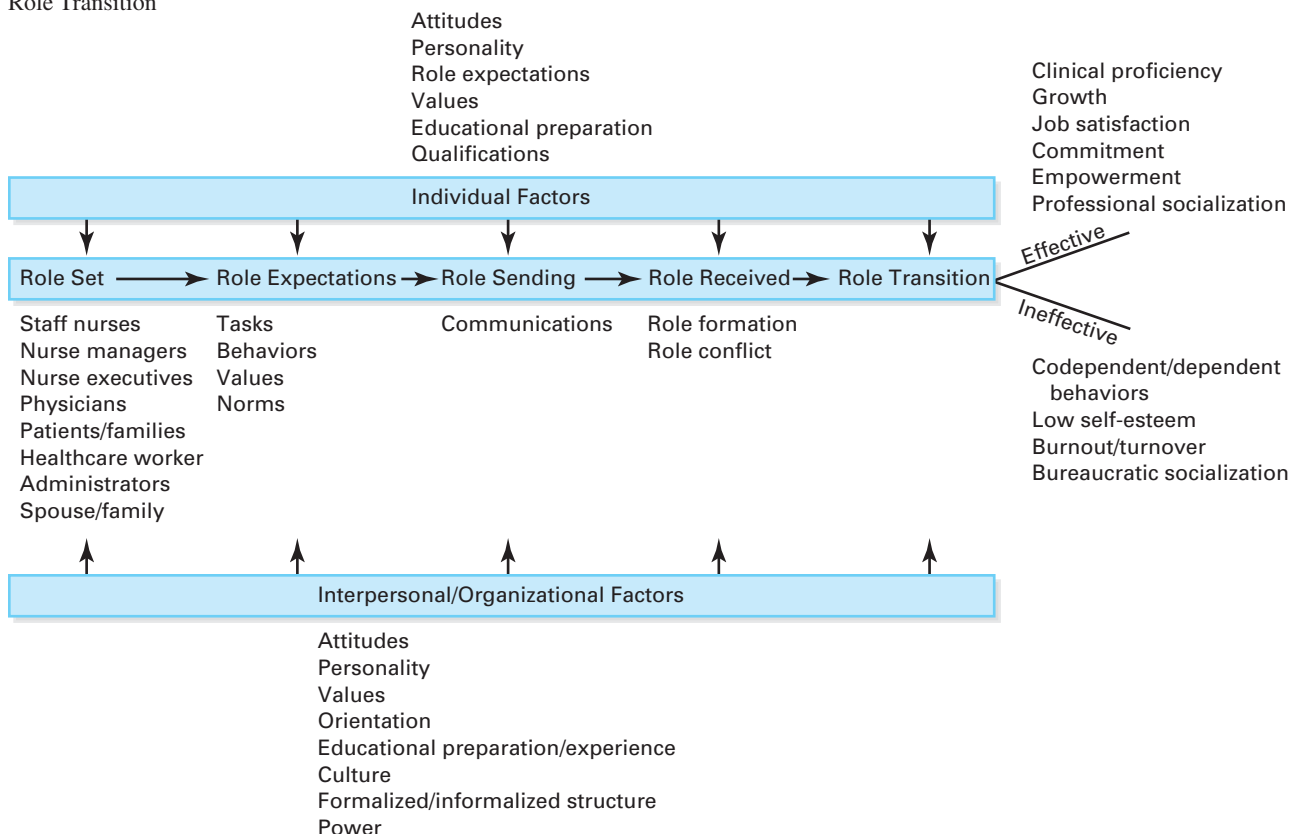
According to this model, the process begins by determining the role set, composed of individuals involved who hold beliefs and attitudes about what should or should not be done in that role, that is, role expectations. In role sending, the members of the role set communicate and model the role expectations, and this is the step where problems may develop. After the role expectations are sent, the next phase is role received, but what is sent may not be received without misunderstanding or distortion. Role formation is affected by such factors as personality, attitudes, qualifications, educational preparation, values, and clarity of communication. Role

conflict may develop when the role expectations of the various people involved are incompatible. The actual role transition occurs as the nurse learns role behaviors based on the role received, resulting in two possible outcomes: effective or ineffective. Effective role transitions have associated behaviors within the norms; these can lead to clinical proficiency, personal growth, job satisfaction, organizational commitment, empowerment, and professional socialization. When there is a great deal of role conflict, ineffective role transition is likely to be the outcome, resulting in low self-esteem, a low level of confidence, and burnout.

Transition shock or reality shock may happen when the perceived role comes into conflict with the performed role. Many new graduates experience this as cognitive dissonance; that is, they know what they should do and how they should do it, but circumstances do not allow them to perform the role in that way. The result is increased anxiety, which, if not resolved, can result in burnout. Preceptorships, internships, and externships are often found to be helpful in a successful role transition.

**FIGURE 2–1**

Role Transition



Source: *Role Transition to Patient Care Management*, by M. K. Strader and P. J. Decker, 1995, Norwalk, CT: Appleton and Lange.



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### Reflect On . . .

- the multiple roles you assume and the satisfactions you experience in relation to each. How does your role as a nurse relate to your other roles? In what ways does your choice of nursing as a career enhance or interfere with your other life roles?
- 

### Boundaries of Nursing Roles

The following five determinants currently form the boundaries for nursing roles:

1. Theoretical and conceptual frameworks that identify the concepts of nursing and specify the relationships among them. The major concepts in nursing theoretical and conceptual frameworks are person, health, environment, and nursing. Conceptual frameworks provide the nurse with an understanding of the person (as the recipient of nursing care); what constitutes health from an individual, professional, and societal perspective; what are the internal and external environments involved; and how these factors influence nursing goals and actions.
2. The nursing process, or standard scientific problem-solving method, that nurses use in the clinical setting. The nursing process determines nursing actions appropriate for each client. The nursing process consists of assessment, diagnosis (nursing), outcomes identification or goals, planning, implementation, and evaluation.
3. Standards of nursing practice established by the nursing profession. Standards of practice outline nursing functions and the level of excellence required of the nurse. These standards also define the nurse's ethical and legal obligations to clients and their support persons, to colleagues, to employers, and to society. The ANA has developed standards of practice and standards of professional performance that describe the competencies of all practicing nurses. Specialty nursing organizations have developed additional standards for nurses practicing within those specialty environments.
4. Nurse practice acts or nursing licensure laws of the specific jurisdiction that legally define the scope of nursing practice. Although nurse practice acts differ in various jurisdictions, they all have a common purpose: to protect the public.
5. National and international codes of ethics for nurses. These are fundamental to the practice of nursing. Codes of ethics describe the nurse's relationship to clients and their support persons, to colleagues, to employers, and to the public.

### Role Stress and Role Strain

Role stress in the form of work overload is considered one of the major reasons nurses leave nursing. Role stress is the discrepancy between the person's perception of what a particular role should be and the reality of what it is. Abendroth (2011) described as compassion fatigue the stress experienced by those who care for others, whether professional caregivers (e.g., nurses and other health professionals) or informal caregivers (e.g., family, significant others). Joinson (1992) defined **compassion fatigue** as a "unique form of burnout that affects people in caregiving professions" (p. 116), and Figley (1995) described it as a form of secondary traumatic stress reaction that occurs when caregivers strive to help people who are suffering from traumatic events. Factors found to be associated with role stress for nurses include having little control in the job, high demands or overload, and low supportive relationships. The high demands or overload often results from increases in the complexity of care along with shorter hospital stays, requiring the nurse to meet goals in a shorter period of time. Low morale, job dissatisfaction, burnout, and intention to leave the current job are frequent outcomes. For new graduates, additional stressors are lack of confidence, unrealistic expectations from their skill level and from employers and coworkers, values conflicts, and role ambiguity. The transition to new nurse is often associated with lack of clear and consistent information about expectations. Transitions are not limited to new nurses, the same stressors can come into play when a more experienced nurse changes roles.

People often assume multiple roles, and as the number of roles increases so does role stress. The result is role strain. Role stress may create *role strain*, an emotional reaction accompanied by psychological responses, such as anxiety, tension, irritability, anger, and depression, as well as social responses, such as job dissatisfaction and decreased involvement with friends, colleagues, and organizations. Common role stress problems and descriptions are shown in the box on page 30.

**Role ambiguity** refers to the lack of certainty or unclearness about role expectations. Often nurses experience role ambiguity because of the diversity of their roles (e.g., care provider, educator, advocate, leader/manager). Ambiguity can significantly affect a person's role performance, level of satisfaction, and commitment.

**Role conflict** occurs when competing demands are placed on the nurse who is trying to fulfill multiple roles. The primary consequence of role conflict is role stress. If not reconciled, role stress and role strain lead to burnout, a syndrome of mental and physical exhaustion involving negative self-concept, negative job attitude, and decreased concern for clients and others.

**RESEARCH CURRENT****Group Cohesion and Organization Commitment: Protective Factors for Nurse Residents' Job Satisfaction, Compassion Fatigue, Compassion Satisfaction, and Burnout**

The purpose of this study was to determine “whether factors such as group cohesion and organization commitment would be protective and moderate the association between stress exposure and posttraumatic stress symptoms and other negative nurse outcomes” (p. 89). The study sample consisted of 251 nurses (231 female, 20 male) who participated in a nurse residency program in a large pediatric hospital. To participate in the program, the participants had to be new graduates with less than 1 year of nursing experience. The residency program included theory specific to pediatric nursing, a skills lab, and clinical experiences under the guidance of a preceptor. Study participants completed the Life Events Checklist (LEC) during the first month of the residency program, and those who reported having experienced one or more stressful life events were asked to complete the PTSD Checklist Civilian Version (PCL-C). Upon completion of 3 months of bedside experience, the residents were asked to repeat the LEC and PCL-C instruments to “determine their exposure to stressful events and to determine the presence of PTSD symptoms during the initial 3 months of bedside nursing” (p. 92). Additionally, they completed the Compassion Satisfaction and Fatigue Test

(CSF) to determine “their levels of compassion satisfaction CFR/secondary traumatic stress symptoms (STS) and burnout.” The authors found that 89.2% of the participants had “directly experienced, witnessed, or learned about a stressful event” (p. 94) prior to starting the nurse residency program. Of those, 89% had directly experienced a stressful event. Group cohesion—that is, cohesiveness between members of each residency group—was “effective in moderating the negative effects of current stress exposure and posttraumatic stress symptoms, . . . specifically on increased compassion fatigue and burnout, and reduced compassion satisfaction” (p. 89). Commitment to the organization promoted job satisfaction and compassion satisfaction. The authors recommend that organizations be aware of the important influence of group cohesion and organizational commitment on job satisfaction, compassion satisfaction, and, therefore, nurse retention.

*Source:* From “Group Cohesion and Organizational Commitment: Protective Factors for Nurse Residents' Job Satisfaction, Compassion Fatigue, Compassion Satisfaction, and Burnout,” by A. Li, S. F. Early, N. E. Mahrer, J. L. Klaristenfeld, and J. I. Gold, 2014, *Journal of Professional Nursing*, 30(1), pp. 89–99.

A second cause of role conflict is different views concerning what nursing is and should be. Role value orientations vary considerably among practitioners; some nurses have a more traditional view of the nurse's role than new managers or new professionals. The role of the professional nurse continues to change; nurses are becoming increasingly involved in planning and organizing health-care activities and are becoming more responsible for delivering total client care services. The nurse's role is

becoming one of managing client care activities in general. In this new role, nurses have greater responsibility and accountability and may experience increased stress as a result.

A third cause of conflict is a discrepancy between the nursing and medical views of what the nurse's role should be. Physicians may view the caring ideology of nurses as secondary in importance to their own idealized curing aspects of care and may view the nurse as a subordinate

**Role Stress Problems****Role Ambiguity**

Role ambiguity results from unclear role expectations.

**Role Conflict**

Role conflict is an outcome of incompatible, competing role expectations within a single role or multiple roles.

**Role Incongruity**

Values are incompatible with role expectations.

**Role Overload or Underload**

Too much is expected in the time available, or the role is too complex (overload); minimal role expectations do not use the abilities of the role incumbent (underload).

**Role Overqualification or Underqualification**

The nurse's abilities and motivation exceed those required (overqualification); the nurse lacks the necessary resources (underqualification).

rather than a colleague. Nurses use behavioral science and communication skills to develop their professional relationship with clients; physicians have traditionally employed a clinical, biological approach. This variance can create role strain if (1) the physician expects the nurse to handle the client as the physician does, or (2) the physician does not listen to the nurse's concerns and suggestions about the client.

A fourth source of conflict is the public image of nursing. Personal expectations and self-image may conflict with perceived public expectations. The public may regard the ideal nurse as a dedicated angel of mercy. In fact, a survey of the public rated nurses as highest in honesty and ethical standards, above pharmacists, teachers, medical doctors, and the clergy, among others (Gallup, 2013). The broadcast media (e.g., television, movies), however, often portray the nurse as a sex symbol, a subordinate to the physician, or with another negative stereotype.

### Reducing Role Stress and Strain

Role stress and strain may be alleviated with appropriate strategies. Priority setting often makes role overload more manageable. When there is role ambiguity, rewriting the job description can provide more clarity about

expectations. Integrating multiple roles into a larger whole may be possible in order to reduce role conflict, but when this is not possible, it may be necessary to reduce the number of roles and subroles by eliminating some. A full-time student who is a mother and has a part-time job may need to give up her role as PTA chairperson. It is sometimes possible to avoid situations that produce role conflict by changing the setting or the context. A nurse who believes in providing holistic care may look for an employer whose philosophy is more closely aligned with her or his own. More often employment is accepted without an evaluation of the employer's philosophy and employment policies.

### Stress Reduction Strategies

Nurses need to first understand themselves as individuals, that is, in their personal self-concept, and next as nurses, that is, in their professional self-concept; combining these perspectives is an important step in identifying and managing potential conflicts, thereby reducing stress in the performance of the professional role. Nurses who seek to maintain or improve both their personal and professional selves are more effective in caring for their clients. They are also more effective in communicating with other health

## RESEARCH CURRENT

### Occupational Stress in the Australian Nursing Workforce: A Comparison Between Hospital-based Nurses and Nurses Working in Very Remote Communities

The purpose of this study was to compare workplace conditions and levels of occupational stress in two samples of Australian nurses: one group of nurses working in very remote Australia ( $n = 349$ ) and a second group of nurses working in three major hospitals in two Australian states/territories ( $n = 277$ ). The Nursing Stress Scale (NSS) was used to examine job demands. The NSS is a 34-item instrument that examines seven major sources of job related stress: (1) workload, (2) conflict with physicians, (3) conflict with other nurses and supervisor, (4) death and dying, (5) inadequate preparation to deal with the emotional needs of patients and their families, (6) lack of staff support, and (7) uncertainty concerning treatment. Job resources were measured using the Supervision and Social Support subscales from the Job Content Questionnaire (JCQ), the Possibilities for Development and Job Control subscales from the Copenhagen Psychosocial Questionnaire (COPSOQ), and a purpose-designed scale to measure Opportunity for Professional Development. Psychological distress and emotional exhaustion were measured using the General Health Questionnaire-12 (GHQ-12) and the Maslach

Burnout Inventory (MBI). Work engagement and job satisfaction were measured using the Utrecht Work Engagement Scale-9. The researchers found that for both groups, nurses working in major hospitals and nurses working in remote areas, all job demands were significantly positively correlated with psychological distress and emotional exhaustion; however, hospital nurses reported higher levels of psychological distress and significantly higher levels of emotional exhaustion than nurses working in remote areas. Nurses working in remote areas "reported higher levels of work engagement and job satisfaction than nurses working in major hospitals" (p. 41). This was attributed to the "relatively autonomous, extended generalist role of remote nurses" (p. 41). The researchers recommended further research to identify "workplace interventions that address job demands and increase job resources" (p. 41).

*Source:* From "Occupational Stress in the Australian Nursing Workforce: A Comparison Between Hospital-Based Nurses and Nurses Working in Very Remote Communities," by T. Opie, S. Lenthall, J. Wakerman, M. Dollard, S. Knight, G. Rickard, and S. Dunn, 2011, *Australian Journal of Advanced Nursing*, 28(4), pp. 26–43.

## RESEARCH CURRENT

## Organisational Intervention to Reduce Occupational Stress and Turnover in Hospital Nurses in the Northern Territory, Australia

In this follow-up interventional study, the researchers evaluated the effect of an organizational intervention designed to reduce organizational stress and turnover rates in hospital nurses. In the two hospitals where the study was conducted, the turnover rate was reported as 55%. The authors describe three types of workplace stress interventions; (1) primary, or stress reduction interventions to reduce stressful working conditions; (2) secondary, or stress management interventions to help employees develop and use skills to cope with workplace stress; and (3) tertiary interventions that treat those who have been negatively affected by workplace stress. The study used a survey with a pretest prior to implementation of interventions and post-test after implementation of the interventions. Interventions included (1) implementation of a nursing workload tool, (2) development of a scheduling tool with an associated educational program in its use for nurse managers and directors, (3) assessment of nursing workloads in all units, (4) addition of nursing positions where work overload was identified, (5) increased recruitment strategies to increase nurse employment, (6) an increase in nurse staffing by approximately one third, (7) an expansion of the new graduate program, (8) increased professional development programs, and (9) a recruitment campaign for new graduates and continuing employees. The pre- and postintervention questionnaire was developed using questions from the General Health Questionnaire-12

(GHQ-12), the Utrecht Work Engagement Scale-9, NSS, and the JCQ. Questions used in the intervention questionnaire addressed specific areas of occupational stress, work outcomes, job demands, and job resources. An additional instrument examined system capacity, including “flexible/adaptable culture, consultation and preparation, psychosocial safety climate, and communication” (p. 215). Preintervention data was collected as part of a previous study (reported above). Postintervention data was collected 1 year after implementation of interventions; 1 year after implementation of interventions, the authors reported reduced psychological distress among nurses, reduced emotional exhaustion, a slight reduction in job demands, improved supervisor and coworker support and job control, increased flexibility/adaptability in the workplace culture, increased communication, an increase in the psychosocial safety climate, an increase in total system capacity, and a decrease in nursing workforce turnover rate. There were no significant changes in work engagement; however, there was an increase in levels of job satisfaction. The results of the study suggest the need for hospital nursing administrators to attend to the multiple factors that contribute to increased workplace stress and high nursing turnover.

*Source:* From “Organisational Intervention to Reduce Occupational Stress and Turnover in Hospital Nurses in the Northern Territory, Australia,” by G. Rickard, S. Lenthall, M. Dollard, T. Opie, S. Knight, S. Dunn, J. Wakeman, M. Macleod, J. Seiler, and D. Brewster-Webb, 2012, *Collegian*, 19(4), pp. 211–221.

professionals and in promoting a positive image of nursing in the community. Berman and Snyder (2012) define **self-concept** as involving “all of the self-perceptions—appearance, values, and beliefs—that influence behavior and are referred to when using the words *I* or *me*” (p. 1022). **Professional self-concept** is how one views oneself in the chosen profession; it is the set of beliefs and images held to be true as a result of professional socialization. The development of one’s professional self-concept is based on one’s personal self-concept. An individual’s personal self-concept and professional self-concept affect each other. Berman and Snyder (2012) state that self-concept influences:

- how one thinks, talks, and acts
- how one sees and treats another
- choices one makes
- the ability to give and receive love
- the ability to take action and to change things (p. 1022)

Professional self-concept influences how one thinks, talks, and acts in the professional role; how the person interacts with clients, with family and significant others, and with colleagues, subordinates, and other healthcare professionals. It also influences decisions made in the professional role and the ability to react/respond to or initiate change. Professional self-concept is developed through nursing education, interactions with nurses and other health professionals, and interactions with clients and their families and significant others. Professional self-concept for nurses is guided by nursing’s social policy statement (Nurses Association, 2010c), code of ethics (American Nurses Association, 2010a), and standards of practice (American Nurses Association, 2010b).

Because a person’s subconscious mind acts positively or negatively on the information it receives, nurses can change their self-concept by controlling what goes into the subconscious mind. Nurses who perceive themselves as

**CRITICAL THINKING EXERCISE**

A nurse retires from her last nursing position after 48 years of being licensed as a registered nurse. During her career, she has practiced as a staff nurse, a nurse manager, a clinical nursing instructor, and an advanced nurse practitioner. At her retirement celebration, a young nurse whom the retiree precepted when the young nurse was a new graduate says to the retiree, “Now that you are retired and leaving nursing, you can sit back and relax.” The retiree responds, “I am not

leaving nursing; a nurse is an important part of who and what I am. I will go to my grave as a nurse.” How does this statement reflect the retiree’s socialization to nursing? How does this statement reflect the integration of the retiree’s personal and professional self-concepts? As you view your nursing career and your professional goals, do you anticipate that you will see yourself in the same way as the retiree does? Explain your answer.

successful will use their energy and creativity to explore ways to become even more successful. Positive thoughts help them to succeed.

To develop a positive professional self-concept:

- Develop a career plan enlisting the help of a mentor.
- Set career goals that are high but attainable.
- Develop expertise in some area to increase your value to yourself and to your employing agency. This may involve continuing education, obtaining certification in a specialized area of practice, or obtaining an advanced degree in nursing.

**Reflect On . . .**

- your image of yourself as a professional nurse. Are you satisfied with that image? If not, what would you need to do to improve that image?
- The challenges/conflicts you experience between your personal self-concept and your professional self-concept. How would you go about reconciling those challenges/conflicts?

**Managing Role Stress and Role Strain**

Prevention of burnout (i.e., the feeling of physical and/or mental exhaustion resulting from severe stress and high professional ideals) in professional nursing can be approached by stress reduction. A number of approaches can be applied, but common threads among them are personal goal setting, problem identification, and problem-solving strategies. Personal goals should include both long-term and short-term goals. Being goal directed reduces the erratic activity that frequently keeps the person busy and working hard without accomplishing much, which can lead to frustration. These goals can be applied to personal life choices as well as professional career development. An important step in implementing a plan to

pursue goals is identification of the problems that produce stress. Correctly identifying a problem allows the development of a plan to create an appropriate and positive solution. Problem solving is applied to the development of solutions that will result in stress reduction.

Time-management skills can be a valuable tool in stress reduction and may result in improvement in the nurse’s personal life, as well as in the practice setting. Assuming multiple roles creates heavy demands on time, and multitasking tends to fragment attention and concentration. Delegation is one tool the nurse can use in time management. Overcoming procrastination is another time-management strategy. Simply starting a task is one of the best ways to overcome procrastination. Once begun, a task is usually completed. Prioritization may be needed when the number or scope of tasks seems insurmountable.

Taking care of oneself is important in stress management. Nurses must care for themselves before they can care for others effectively. Eating a nutritious diet, getting enough sleep, and participating in regular exercise are all strategies to reduce stress. Decompression is an important component, and the nurse can reduce tension by taking time for those things that meet personal needs and are pleasurable and restorative. Nursing support groups are also helpful. Using these techniques prevents stress and keeps problems from becoming overwhelming.

A summary of stress reduction activities for the working nurse is shown in the table titled “Strategies for Stress Reduction and Time Management” (Table 2–3). It is divided into personal stress reduction strategies and strategies to employ in the work setting.

**Reflect On . . .**

- your own strategies for dealing with role stress. Which strategies have been effective? Which have not? What new strategies would you consider to reduce stress in your personal and professional



TABLE 2–3 Strategies for Stress Reduction and Time Management

| Personal                                                                                                                                                                                                                                                | Professional                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Care for yourself</b><br>Exercise regularly.<br>Eat a healthy diet.<br>Get adequate sleep and rest.                                                                                                                                                  | <b>Select employment thoughtfully</b><br>Compare your values to the agency’s mission.<br>Know your competencies and make a match.                                                                                                                                  |
| <b>Examine your lifestyle</b><br>Build time for relaxation activities such as meditation and yoga.<br>Reflect on what has been helpful in the past.<br>Budget time according to priorities.                                                             | <b>Participate in policy development opportunities</b><br>Join committees that contribute to governance.<br>Participate in organizational structure to target problematic job and role design.<br>Use negotiation skills.<br>Seek win-win resolutions to conflict. |
| <b>Develop new coping skills</b><br>Let go of perfectionism.<br>Let go of the need to do it all.<br>Attend time-management workshop.<br>Attend an assertiveness program.<br>Continue education to develop expertise in areas that give you satisfaction | <b>Manage your role positively</b><br>Network with colleagues.<br>Communicate clearly.<br>Support excellence in practice.<br>Be a self-advocate; use positive self-talk.<br>Develop good delegation skills.<br>Participate in support groups.                      |

- lives? How would you implement the new strategies you choose?
- the resources needed for healthcare organizations to provide a work environment that minimizes role stress and strain. What resources are available in your work environment? How effectively are the available resources utilized?



**InfoQuest:** Search the Internet for information about Magnet status for hospitals and other healthcare organizations. What criteria for Magnet hospital status help to create a more positive work environment for nurses and thereby improve work satisfaction, increase retention, and reduce work-related stress?

CRITICAL THINKING EXERCISE

Marcia is an RN who recently finished the RN-BSN transition program at Sierra University. In the cafeteria, she runs into Brenda, a former classmate from her ADN program, and Marcia tells Brenda about completing her BSN. Brenda then says to her, “I’ve thought about doing that, but it just doesn’t seem worth it. We all do the same things anyway, and I have so many other things to do in the evenings. What difference does it make?”

Using the information in this chapter on criteria of a profession, socialization, and role theory, develop a response to Brenda that Marcia could use to answer her friend’s question.

CRITICAL THINKING EXERCISE

Examine your own life. What are the stressors in your life (e.g., work, school, family)? How do you establish priorities in your life? What strategies work for you to reduce or manage stress in your life? What behaviors have not worked in managing the stress in your life? Are there new strategies that you are willing to learn (e.g., meditation, establishing an exercise program). Develop a personal plan for managing stress. Discuss your plan with a colleague(s). Considering the discussion with your colleague(s), will you revise your plan? Implement your plan for this course period, and evaluate your ability to manage the stress in your life at the end of the course. Has your plan worked? If not, how would you revise it?

## Chapter Highlights

- Professional socialization transmits values, norms, and ways of viewing a situation that are unique to the profession and provides a common understanding among members of a professional group.
- The multiple levels of education to enter practice as a registered nurse continue to be a challenge.
- Flexner, Barber, and Pavalko are early authors who have written about general characteristics of a profession.
- Pavalko's Occupation-Profession Continuum Model (1971) can serve as a framework to examine the status of nursing as a profession.
- Bixler and Bixler (1945), Miller, Adams, and Beck (1993), and Joel and Kelly (2002) provide a progression of thinking about the characteristics of a profession as they relate specifically to nursing.
- Professional organizations establish standards of practice that operationalize the work of a profession. The ANA has established the scope and standards of practice for nursing in the United States. The ANA standards include standards of practice and standards of professional performance.
- Professional socialization is the process by which people learn the norms, values, attitudes, and behaviors of the professional group. There are several agents of socialization to the nursing profession: nursing educators, nurses in practice, life experiences with nurses, nursing clients and their families, and other healthcare professionals.
- Critical values of nursing are delineated in ANA documents such as the *Code of Ethics for Nurses* (2010), *Nursing: Scope and Standards of Practice* (2010), and *Nursing's Social Policy Statement* (2010).
- Models of initial socialization to nursing include those of Simpson (1967), Hinshaw (1986), and Davis (1966). Each model outlines a sequential set of phases beginning with the role of a layperson and ending with the role of a professional nurse.
- Benner (2001) describes five levels of proficiency beginning with the novice nurse and progressing through the expert nurse. Nursing experience is essential for the development of professional expertise.
- Professional socialization is based upon role theory. A role has three elements: the ideal role, the perceived role, and the performed role. Role transition is the process by which a person assumes or develops a new role.
- Boundaries for nursing roles include theoretical and conceptual frameworks; the nursing process; standards of practice; nurse practice acts and nurse licensure laws and regulations; and national and international codes of ethics.
- Role stress in the form of work overload is considered one of the major reasons nurses leave nursing. Compassion fatigue, a response to role stress, has been described as a unique form of burnout that affects people in the caregiving professions. Symptoms of compassion fatigue are similar to those seen in persons with secondary traumatic stress reaction.
- Role stress problems include role ambiguity, role conflict, role incongruity, role overload or underload, and role overqualification or underqualification.
- An important step in reducing role stress is for nurses to understand themselves first as individuals in their personal self-concept, and next as nurses in their professional self-concept. Nurses who seek to maintain or improve both their personal and professional selves are more effective in caring for their clients.
- It is important for nurses to develop personal strategies to cope with role stress and role strain. Some strategies that are helpful are developing time-management skills and taking care of oneself through proper nutrition, getting adequate sleep, and participating in routine exercise.

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# 3

## Historical Foundations of Professional Nursing

### Chapter Outline

#### Challenges and Opportunities

##### Nursing in History

- Nursing in Primitive Societies
- Nursing in Ancient Civilizations
- The Role of Religion in the Development of Nursing
- The Development of Modern Nursing
- The Development of Nursing in the Americas

##### Historical Leaders in Nursing

- The Founders
- Men in Nursing
- The Risk Takers
- The Social Reformers

##### Nursing: A History of Caring

##### The Development of Professional Nursing Organizations

- American Nurses Association
- National Student Nurses' Association
- National League for Nursing
- American Association of Colleges of Nursing
- Canadian Nurses Association
- International Council of Nurses
- Sigma Theta Tau International
- Specialty Nursing Organizations
- Special-Interest Organizations

##### Chapter Highlights

### Objectives

1. Discuss the historical development of nursing from ancient times to the present.
2. Discuss the role of religion in the development of nursing.
3. Discuss the influence of war on the development of nursing.
4. Describe contributions of selected nurses to nursing and society.
5. Analyze the contributions of selected nurses and the nursing profession to society from a historical perspective.
6. Compare and contrast the history of nursing and the history of caring.
7. Discuss the development of professional nursing organizations and their role in advocating for nurses and health care.

One of the irrefutable laws of nature is dynamism, or change. Individual and group elements of society respond and adapt to historical events that may alter the behaviors, values, laws, beliefs, and even the daily living habits of society. Influencing events may be related to natural disasters, such as floods, earthquakes, famine, or epidemic disease, or they may be new discoveries or inventions, such as the discovery of fire, or the invention of the wheel, the printing press, the microscope, and penicillin. War, political upheaval, religious intolerance, and economic instability are systemic events that can alter the lives of individuals, their families, and their communities as well as the progress of society.

As a subgroup of society, nursing must also respond and adapt to the influences of society. Nursing has been a continuous thread linking the past with the present, from tribal groups of early societies to modern societies linked by jet-powered transportation and instant telecommunications. Just as human history has shown tremendous adaptation over the centuries, so has nursing evolved from the art and science of comforting, caring for, and nurturing the sick to a synthesis of this art and science with the science and technology of contemporary understanding.



## Challenges and Opportunities

The history of nursing was a major component of nursing curricula in the early 1900s, but as curricula expanded with new scientific knowledge that nurses required, these subjects supplanted the study of nursing history (Toman & Thifault, 2012). (See the accompanying Research Currents box.) How can we know where nursing is if we don't understand where nursing has been? An understanding of the history of nursing can lead to an appreciation of the development of the discipline and profession that challenges nurses to honor the leaders of the past and present and to carry forward the best of the values and traditions of the profession. The perspective provided by knowing the roots of nursing can contribute to professional identity. Although nursing is facing a time of change and challenge, the depth and breadth of nursing's historical foundations provide a broad base of experience to draw on as the profession evolves. One challenge is to continue the leadership within the profession in furthering the traditional values by understanding where nursing has been, how it got there, and where it needs to go in the future. It is important to convey to new nurses a knowledge and value of the past. In a profession that can be intensely involved in immediate decision making, knowing the past may seem to be of low priority.

Knowing the past and understanding the roles of nursing leaders throughout history provide an opportunity to use the experience and lessons learned to create the future. The mistakes and successes of the past provide examples and can help guide decisions of today. Appreciation of what has been contributed by nursing leaders within the

context of the social influences of the past provides the opportunity to celebrate the accomplishments, take pride in what has been done, and carry the best of the past into the future.

## Nursing in History

### Nursing in Primitive Societies

It is impossible to describe nursing practice or the role of the nurse before recorded history. It is also difficult to differentiate between the role of the physician and that of the nurse or even to determine whether there were two distinctly different roles. It is possible that any differentiation that existed was based on male-female role proscriptions, such as the person who compounded medicines or performed magical healing was referred to as a medicine man, whereas the herb or root woman gathered plants (roots, leaves, flowers, stems, herbs, etc.) and created medicinal remedies from them. It may be postulated that individuals provided care or cure based on experience and oral transmission of available knowledge about health and illness. Traditional female roles of wife, mother, daughter, and sister always included the care and nurturing of other family members. Women cared for the children, and for those family members who were unable to care for themselves because of illness, injury, or age. The term *nurse* derives from the care mothers gave to their helpless infant children. Donahue (2011) states, "From the dawn of civilization, evidence supports the premise that nurturing has been essential to the preservation of life. Survival of the human race, therefore, is inextricably intertwined with the development of nursing" (p. 4).

## RESEARCH CURRENT

### Historical Thinking and the Shaping of Nursing Identity

The purpose of Toman and Thifault's study was to examine the "concept of historical thinking—what it is, how it develops, and what it contributes to practice-based professions" (p. 184). In two online nursing history courses (one in English, one in French), the investigators used both primary sources (diaries, interviews, pictures) and secondary sources, some in their original language, to present course content. Students participated in online discussions, posting comments to course content at least weekly. They were also required to submit two written assignments in which they had to find and critically appraise one specific primary source and describe what they learned from the source. Finally, each student submitted a final paper synthesizing their course learning. Each course was taught four times with a total of 164 student participants.

Analysis of the student postings "suggests that primary sources and critical appraisal skills are keys to the formation of historical thinking" (p. 184). Participation in the online nursing history courses "fostered a strong sense of professional identity" (p. 190) in the students, who often indicated that they had not had much previous exposure to content on nursing history. One student commented, "I am so surprised how much I learned about nursing from this course. Not only am I now more knowledgeable about where the profession came from, but I am able to see how decisions made in certain time periods profoundly affected how nursing is presently viewed and how it has developed" (p. 200).

Source: "Historical Thinking and the Shaping of Nursing Identity," by C. Toman and M. C. Thifault, 2012, *Nursing History Review*, 20, pp. 184–204.



## Nursing in Ancient Civilizations

In the recordings of early history, there is little information about those who cared for the sick. It is known that midwives provided care for the mother and infant during birthing and that wet nurses frequently suckled and cared for infant children of wealthy families. Often, these roles were filled by female slaves. This fact contributes to the lack of recorded information about nursing, because slaves had no status, and thus their work was not thought worthy of documentation. The slave-nurse depended on the master, healer, or priest for instruction or direction in the care of her charge. Often, the care provided for the sick was related to physical maintenance and comfort.

During this time, beliefs about the cause of disease were imbedded in superstition and magic, so treatment often required magical cures. The priest or witch doctor enjoyed great status in ancient societies. But as these societies evolved, practical theories of medical care emerged as nonmagical causes of disease were observed. The earliest recording of healing practices is a 4,000-year-old clay tablet attributed to the Sumerian civilization. It contains healing prescriptions but, unfortunately, neglects to describe the illnesses for which they were prescribed.

The earliest documentation of law governing the practice of medicine is the Code of Hammurabi, attributed to the Babylonians and dating to 1900 B.C. The code recorded regulations related to sanitation and public health, the practice of surgery, the differentiation between the practice of human medicine and veterinary medicine, a table of fees for operations, and penalties for violators of the code. There is no specific record of nursing in the Babylonian civilization; however, there are references to tasks and practices traditionally provided by nurses. Medical illustrations from that period often include a nurselike figure, who may be female or male, assisting the physician/healer or providing patient support or comfort.

Important historical findings related to the Egyptian culture include the Smith and Ebers papyri and the practice of mummification. The Smith papyrus, which dates to approximately 1600 B.C. contains information about the practice of surgery in ancient Egypt. The Ebers papyrus dates to approximately 1550 B.C. and is believed to be the oldest medical text in the world. It describes many diseases known today (e.g., asthma, diabetes) and identifies specific symptomatology. The Ebers papyrus also lists more than 700 substances that were used as drugs and describes their preparation and medicinal use. Indicative of the importance of magic and religion in healing, the Ebers papyrus includes incantations and verbal charms used in healing.

Mummification, or embalming, derived from the belief in life after death. The development of effective solutions to

preserve the body from decay and the consequent ability of modern-day anthropologists to examine the mummified body indicate a high level of knowledge of human anatomy, physiology, and pathophysiology.

The ancient Hebrew culture contributed the Mosaic Health Code to the history of health care. This code is considered the first sanitary legislation and contains the first record of requirements to improve public health. The code, which covered every aspect of individual, family, and community health, differentiated between clean and unclean. Principles of personal health that were related to rest, sleep, and cleanliness were also provided. There were rules for women related to menstruation and childbearing. Dietary laws were a significant part of the Mosaic Code and provided for the *kosher* slaughter of animals, as well as the preparation and preservation of animal and plant foods. Many of these ancient laws are still followed today by Jews around the world.

The use of quarantine as a method to prevent the transmission of communicable diseases, such as leprosy and diphtheria, is recorded in the Bible. Nurses are mentioned occasionally in the Old Testament as women who provided care for infants, children, the sick, and the dying, and as midwives who assisted during pregnancy and at delivery. In Genesis, Chapter 24, Verse 59, Deborah is described as a nurse to Rebekah. Deborah may have provided care to Rebekah as a child, served as a companion, and, after Rebekah married Isaac, assisted her during childbirth and in the care of her children.

In ancient African cultures, the nurturing functions of the nurse included roles as midwives, herbalists, wet nurses, and caregivers for children and the elderly (Dolan, Fitzpatrick, & Herrmann, 1983, p. 19). In ancient India, early hospitals were staffed by male nurses, who were required to meet four qualifications: (1) knowledge of how drugs should be prepared or compounded for administration, (2) cleverness, (3) devotedness to the patient waited upon, and (4) purity (of both mind and body). (N. D. Kaviratna, as cited in Donahue, 2011, p. 24). Donahue (2011) states that the “world’s first nursing school was founded in India in 250 B.C. but only men were considered ‘pure’ enough to become nurses” (p. 3). Indian women served as midwives and nursed ill family members. There is no mention of the nurse role in ancient China; however, the contribution of ancient China to healthcare knowledge includes the effects of some 365 herbal remedies in the Pen Tsao (ca. 2799 B.C.), the use of acupuncture as a treatment method, and the publication of the Nei Ching (Canon of Medicine), which detailed the four steps of examination (look, listen, ask, and feel) and the “five methods of treatment; cure the spirit, nourish the body, give medications, treat the whole body, and use acupuncture and moxibustion” (p. 26).

In the histories of ancient Greece and Rome, care of the sick and injured was advanced in mythology and reality. The Greek mythic God Asklepios was the chief healer; his wife, Epigone, was the soother. Hygeia, the daughter of Asklepios, was the goddess of health and was revered by some as the embodiment of the nurse, and Meditrina, the preserver of health, was considered the forerunner of the public health nurse. Temples built to honor Asklepios became centers of healing, and the priests of Asklepios provided healing through natural and supernatural remedies (Donahue, 2011, p. 30). The ancient Greek physician Hippocrates is honored today as the father of medicine. He believed that disease had a natural cause, in contrast to the magical and mystical causes pronounced by the priest healers of the temples.

After they conquered Greece in 200 B.C., the Romans borrowed gods from the Greeks, including Aesculapius (Asklepios) and Hygeia. Greek physician-slaves brought medical practices to the Roman Empire. The Romans' contribution to health care was in public sanitation, the draining of marshes, and the building of aqueducts, public and private baths, drainage systems, and central heating.

## The Role of Religion in the Development of Nursing

Many of the world's religions encourage benevolence, but it was the Christian value of "love thy neighbor as thyself" that significantly influenced the development of Western nursing. The principle of caring was established with Christ's parable of the Good Samaritan providing care for an injured stranger. Converts to Christianity who were considered an embodiment of early nursing during the third and fourth centuries A.D. included several wealthy women of the Roman Empire (see the accompanying box).

Women were not the sole providers of nursing services; in 3rd-century Rome, there was an organization of men called the Parabolani Brotherhood. This group of men

provided care to the sick and dying during the great plague in Alexandria. During the Crusades, the knighthood orders, such as the Knights Hospitallers of St. John of Jerusalem, the Teutonic Knights, and the Knights of Lazarus, often comprised brothers in arms who provided nursing care to their sick and injured comrades. These orders were responsible for building great hospitals, the organization and management of which set a standard for the administration of hospitals throughout Europe at that time.

As the Christian church grew, more hospitals were built, as were specialized institutions providing care for orphans, widows, the elderly, the poor, and the sick. Unfortunately, the religious beliefs of the church were in conflict with scientific thought and education during this period. The church encouraged care and comfort of the sick and poor but did not allow for the advancement of knowledge in preventing illness or curing disease. This attitude pervaded the period known as the Dark Ages, also referred to as the *Middle Ages*, which lasted for approximately 1000 years.

During the Dark or Middle Ages (A.D. 500–1500), male and female religious, military, and secular orders were formed with the primary purpose of caring for the sick. Conspicuous among them were the Knights Hospitallers of St. John, the Alexian Brotherhood (organized in 1431), and the Augustinian Sisters, which was the first purely nursing order.

In the Islamic world, Rufaidah is considered the first professional nurse (Kasule, 2010). Rufaidah bint Sa'ad learned medical care from her father, who was a physician and trained a group of women as nurses. These women prepared food, established tent hospitals, and attended the sick and wounded during the time of the Prophet Muhammad in battles during the late sixth and early seventh centuries. She is believed to have started the first nursing school in Islam when she taught women and girls the art of nursing the sick and wounded. She is described as having set down the first code of nursing rules and ethics in the

## Dedicated Women of the Roman Empire

- Marcella converted her palace into a monastery and encouraged other Roman matrons to join her in caring for the sick poor. She is considered by some to be the first nurse educator, because she taught her followers how to care for the sick. She was also literate in Latin, Greek, and Hebrew and encouraged the education of women.
- Fabiola, a follower of Marcella, also contributed her great wealth to the care of the poor and sick. She is credited with establishing the first public hospital in

Rome in A.D. 390. She is said to have personally nursed patients whose wounds and sores were ugly and repugnant. She was considered the patron of nursing.

- Paula was a wealthy and learned friend of Fabiola. Upon the death of her husband, she converted to Christianity. She, too, studied with Marcella. In A.D. 385, she moved with her daughter to Palestine, where she built hospitals for the sick and hospices for the pilgrims who followed the road to Bethlehem. She also provided direct care to the sick.

## RESEARCH CURRENT

## Influence of Religion on Nursing

The Catholic faith has focused on providing care for the less fortunate through religious vocation. Villa's historical research describes the contributions of Catholic orders of nuns to nursing education and clinical practice. The significant influence of Catholic nuns on nursing was in the

introduction of spirituality and its importance in providing quality patient care.

Source: "Catholic Orders' Influence on Nursing: 1900–1920," by J. Villa, 2012, *Journal of Christian Nursing*, 29(2), pp. 90–95.

world and is still considered a symbol of noble deeds and self denial in the modern Islamic world. Rufaidah was also involved in social work, providing assistance to the poor, the orphans, and the handicapped. The need for women care providers in the Islamic world is dictated by the custom of purdah, which makes it difficult for women to receive care from men and for men to receive care from women other than their family members.

In 1633, the order of the Sisters of Charity was founded by St. Vincent de Paul in France. It was the first of many such orders organized under various Roman Catholic church auspices and largely devoted to caring for the sick. Today, nursing services at many Catholic hospitals around the world are provided under the direction of Roman Catholic nursing orders.

The deaconess groups, which had their origins in the Roman Empire of the third and fourth centuries under Marcella, Fabiola, and Paula, were suppressed during the Middle Ages by western European churches. However, these groups of nursing providers recurred occasionally throughout the centuries, most notably in 1836, when Theodor Fliedner reinstituted the Order of Deaconesses and opened a small hospital and training school in Kaiserswerth, Germany. Florence Nightingale received her nurse's training at the Kaiserswerth school.

### The Development of Modern Nursing

From the 16th to the 19th centuries, new discoveries such as those of Nicolaus Copernicus, Galileo Galilei, Isaac Newton, Johannes Kepler, Henry Briggs, and René Descartes precipitated an intellectual revolution. Andreas Vesalius, William Harvey, Robert Hooke, and Anton van Leeuwenhoek contributed to the scientific revolution in medicine. With the discovery and exploration of new continents, an economic revolution evolved, after which nations became more interdependent through trade and mercantilism. New illnesses, transmitted in the holds of ships by sailors and stowaway rodents, jumped national boundaries and continents. The Industrial Revolution displaced workers from being cottage craftspeople to factory laborers. With these changes came stressors to health. The

closeness of factory work, the long hours, and the unhealthy working conditions led to the rapid transmission of communicable diseases such as cholera and other infectious diseases. Lack of prenatal care, inadequate nutrition, and poor delivery techniques resulted in a high rate of maternal and infant mortality. Orphaned children died in workhouses of neglect or cruelty. These conditions have been effectively portrayed in the writings of Charles Dickens, including *Oliver Twist* and *David Copperfield*.

During the early 19th century, women's roles were dictated by their gender and included daughter, wife, and mother. Howell (2001) states, "As men gave in to 'selfish passions' [work] outside the home, women came to be seen as the most responsible for the common good—for caring" (p. 80). The appropriate role for an affluent young woman of that time was to maintain a gracious and elegant home for her family. A common woman worked as a servant in a private home or was dependent on her husband's wages. Nursing care was provided by a female family member or a servant. The provision of care for the sick in hospitals or private homes fell to the uncommon women, often prisoners or prostitutes, who had little or no training in nursing and even less enthusiasm for the job. As a result, nursing had little acceptance and no prestige. The only acceptable nursing role was within a religious order, which provided services to the hospital for little or no cost.

The development of the Deaconess Institute at Kaiserswerth, Germany, changed all this. Associated with a religious organization, the Order of Deaconesses ignited recognition of the need for the services of women in the care of the sick, the poor, children, and female prisoners. The training school for nurses at Kaiserswerth included care of the sick in hospitals, instruction in visiting nursing, instruction in religious doctrine and ethics, and pharmacy. The Deaconess movement eventually spread to four continents: North America, North Africa, Asia, and Australia.

Florence Nightingale, the most famous Kaiserswerth pupil, was born to a wealthy and intellectual family. Her education included the mastery of several ancient and modern languages, literature, philosophy, history, science, mathematics, religion, art, and music. It was expected that

she would follow the usual path of a wealthy and intelligent woman of the day: marry, bear children, and maintain an elegant home. She was determined, however, to become a nurse in order to diminish the suffering of the helpless. As a well-traveled young woman of the day, in 1847 she arranged to visit Kaiserswerth, where she received 3 months' training in nursing. In 1853 she studied in Paris with the Sisters of Charity, after which she returned to England to assume the position of superintendent of a charity hospital for ill governesses. In 1859, Nightingale's *Notes on Nursing: What It Is and What It Is Not* was published. Though very different from modern textbooks, it was considered the first textbook of nursing in the modern era. In it, Nightingale exhorted those who provide care to the sick and injured to provide "the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient" and also discussed the "elements of what constitutes good nursing . . . for the well as for the sick" (p. 6).

During the Crimean War (1853–1856), there was public outcry about the inadequacy of care for the soldiers. The death rate, estimated at 43%, was attributed to wounds, infection, cholera, inadequate nutrition, lack of drugs, and lack of care. Florence Nightingale was asked by Sir Sidney Herbert of the British War Department to recruit a contingent of female nurses to provide care to the sick and injured in the Crimea. In spite of opposition from the army medical officers, she and her nurses transformed the environment by organizing classes and setting up diet kitchens, a laundry, recreation centers, and reading rooms. She trained the orderlies to scrub the wards and empty wastes. In the course of 6 months, the mortality rate decreased to 2% (Donahue, 2011, p. 118). Interestingly, on the Russian side of the Crimean, a group of women sponsored by Grand Duchess Elena Pavlovna and under the direct supervision of Aleksandra Petrovna Stakhovich, Directress of the Order of the Exaltation of the Cross (a religious order), went to the Crimea to provide nursing care to Russian soldiers who were wounded or sick. They also faced opposition from the military officials, but their work also resulted in better outcomes for the soldiers (Curtiss, 1966).

When Nightingale returned to England, she was given an honorarium of 4,500 pounds in gratitude. She later used this money to develop the Nightingale Training School for Nurses, which opened in London in 1860. The school served as a model for other nurse training schools. Its graduates traveled to other countries to manage hospitals and to institute nurse-training programs. The efforts of Florence Nightingale and her nurses changed the status of nursing to a respectable occupation for women. Today, people can

visit the Florence Nightingale Museum on the grounds of St. Thomas Hospital in London to better understand the life and work of this nursing exemplar.

## The Development of Nursing in the Americas

In early America, native tribes used traditional medicine, which viewed health as a balance of life between the person, nature, and the supernatural. Healing remedies were based on cultural norms, were passed between generations, and included a belief in the healing properties of living plants (Sitzman & Judd, 2014). In the 1600s and 1700s, healthcare practices and perceptions of nursing were similar to those in Great Britain (Kalisch & Kalisch, 2004). Between the American Revolution and the Civil War, nursing in America probably paralleled nursing in Europe. Early public hospitals that developed in the colonies included Bellevue Hospital in New York (founded 1658) and the Philadelphia Almshouse (founded 1731). These early hospitals provided care for the sick, indigent, insane, infirm, prisoners, and orphans. Caregivers or attendants were described as paupers or prisoners, who were often drunk.

In 1639, the Augustinian Sisters migrated to Canada and eventually established the first hospital, the Hôtel-Dieu, in Quebec City. In 1809, in the United States, Mother Elizabeth Seton established the first American Order of the Sisters of Charity of St. Joseph in Maryland. Eventually, other orders or branches of orders in the Roman Catholic church evolved under the name of Sisters of Charity throughout the eastern United States and Canada. These religious orders developed programs of nursing education and provided nursing service. Following the westward expansion of the United States, Roman Catholic religious orders established hospitals in New Orleans, Chicago, and San Francisco. Religious sisterhoods of Protestant churches, including the Episcopal Sisterhood of the Holy Communion and the English Lutheran Church, also established hospitals and provided nursing care.

Much of nursing's development is related to the need to provide care to sick and injured soldiers during times of war. This fact is true in the development of nursing in the United States. According to Donahue (1996), in the American Revolution, George Washington ordered that women be recruited to nurse wounded and sick soldiers. Women often followed their husbands to the battlefield and cared for and nursed them. During the Civil War, Dorothea Dix was appointed superintendent of the first nurse corps of the U.S. Army. She recruited only women who were over 30 and plain looking. She was able to recruit 2,000 women to care for the armed forces. These nurses dressed wounds, gave medicines, and attended to diets. In addition to war



## Nurses in the U.S. Congress, 2014

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Congresswoman Karen Bass of California  
Congresswoman Diane Black of Tennessee  
Congresswoman Lois Capps of California

Congresswoman Renee Ellmers of North Carolina  
Congresswoman Eddie Bernice Johnson of Texas  
Congresswoman Carolyn McCarthy of New York

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wounds, the soldiers suffered from dysentery and smallpox, and many nurses died as a result of disease contracted in the line of duty.

Like Nightingale in the Crimea, the nurses in the Civil War met with opposition from the male physicians. Hospital ships were used to transport the wounded to hospitals, and nurses provided care along with medical orderlies. Many assertive women, known not only for their ability to nurse but also for their influence in other arenas, provided nursing service during the Civil War. Some of the most influential were Louisa May Alcott, who eventually became an important literary figure; Harriet Tubman, who as a nurse and abolitionist provided care and comfort to her fellow African Americans on the Underground Railroad; and Sojourner Truth, another African American nurse who provided care for the wounded soldiers of the Union Army and was active in the early roots of the women's movement.

During World War I, approximately 23,000 nurses were assigned to military service. After the war, many of these nurses continued to provide care with relief programs in Europe and Asia. The need for trained nurses placed a strain on the supply of nurses, resulting in a fear that the admission and graduation standards of nurse training would be lowered. Rather than sacrifice the quality of nurses, a committee composed of M. Adelaide Nutting, Annie Goodrich, and Lillian Wald met to develop an alternative training program combining university and hospital training. The first such program was the Vassar Training Camp, under the direction of Isabel Stewart. In 1918, in response to the need for trained nurses, the Secretary of War authorized the Army School of Nursing, with Annie Goodrich as its first dean.

World War II had a tremendous influence on the evolution of nursing into the profession we know today. Nurses served at the war front in field hospitals, on hospital ships, and in air ambulances. Again the need for nurses influenced nursing education, resulting in the development of the U.S. Cadet Nurse Corps, a training program for nurses funded by federal funds under the Bolton Act of 1943. This was a forerunner of the federal funding programs aiding nursing education. Provisions

of this act forbade discrimination on the basis of race and marital status, required minimum educational standards, and forced nursing schools to review and revise their curricula (Joel, 2011; Judd & Sitzman, 2014; Kelly & Joel, 2003).

As nursing developed its practice and training schools proliferated, nurse leaders considered the need to establish minimum standards for educational programs and for safe practice. In 1903, North Carolina, New Jersey, New York, and Virginia enacted voluntary licensure laws. These laws did not require licensure but regulated the use of the title Registered Nurse (RN). In 1915, the American Nurses Association (ANA) drafted a model nurse practice act. By 1923, all 48 states had passed laws to regulate nursing licensure or registration. Licensure was still voluntary or permissive. It was not until 1935 that the first mandatory licensure act was passed in New York, but it did not go into effect until 1949. Now, licensure is mandatory throughout the United States and Canada. In 1971, Idaho became the first state to recognize advanced nursing practice in its Nurse Practice Act (Ellis & Hartley, 2012).

Social change has continued to influence change within the profession at the same time nurses change society through their education and practice. In 1992, Eddie Bernice Johnson was the first nurse elected to the U.S. House of Representatives. Today, many nurses have been elected to local, state, and national office. At present, there are six nurses representing their constituents in the U.S. Congress (see the accompanying box). These nurses effect change in the policies that in turn affect the social systems in which nurses work and live. Nurses are involved in professional and civic organizations to effect change in society.

## Historical Leaders in Nursing

Throughout the history of nursing, individuals have come forward to influence the profession and society. Many of the names are familiar. The people discussed are not the only leaders in nursing but are presented to provide a perspective of nurses as women and men, founders, risk takers, and social reformers.



## The Founders

It is usually difficult to identify who was the first nurse in a specific country. Often, the first person to provide nursing care or to try a new nursing innovation was an unnamed slave, convict, soldier, pilgrim, rebel, mother, daughter, wife, or other unknown. Nurses as founders have established schools of nursing, hospitals, and organizations to

promote the good health of the public. The accompanying box describes some of nursing's founders.

## Men in Nursing

Although nursing is frequently thought of as a woman's profession, men have been influential in nursing's history. In fact, the first school of nursing in the world was founded in

### Nurses as Founders

- Rufaidah bint Sa'ad (6th century) considered the "first nurse in Islam," started the first nursing school in Islam to teach women and girls the art of nursing the sick and wounded.
- Jeanne Mance (1606–1673), founder of the Hôtel-Dieu hospital in Quebec, Canada, is credited with being the first lay nurse in North America.
- Florence Nightingale (1820–1910) is considered the founder of modern nursing and the first nurse researcher. Her achievements in improving standards for the care of war casualties in the Crimea earned her the title "The Lady with the Lamp." She was the first nurse to exert political pressure on government to improve health conditions. Through her contributions to nursing education, she is also recognized as nursing's first scientist/theorist for her work *Notes on—Nursing: What It Is, and What It Is Not*.
- Mary Seacole (1805–1881) learned about nursing from her mother in Jamaica, British West Indies. When she learned about the war in the Crimea, she offered to go to the Crimea to tend the soldiers. Her request was denied, so she traveled at her own expense to the Crimea, where she opened a lodging house in which she cared for wounded and sick officers.
- Clara Barton (1821–1912) nursed in federal hospitals during the Civil War. Following the war she went to Europe, where she learned about the International Red Cross. She served with the Red Cross during the Franco-Prussian War. She returned to the United States, where she was instrumental in founding the American Red Cross in 1882.
- Lucy Osborne (1835–1891) was a Nightingale-trained nurse who arrived in Australia in 1868 as superintendent of nurses, along with five head nurses, to provide nursing care to patients at the Sydney Hospital. She is credited with founding the Sydney training school, the first training school for nurses in Australia using the Nightingale model (Burchill, 1992).
- Linda (Melinda) Richards (1841–1930) is considered the first trained nurse in the United States. She received her nursing certificate October 1, 1873, from the New England Hospital for Women and Children. She went to England in 1877 to study nursing with Florence Nightingale. She then went to Japan, where she organized the first nurse-training school in Japan.
- Mary Mahoney (1845–1926) is considered America's first African American professional nurse, receiving her nursing certificate from the New England Hospital for Women and Children in 1879. Along with Martha Franklin, she founded the National Association of Colored Graduate Nurses (NACGN) in 1908. In recognition of her contributions to nursing, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Cecilia Makiwane (1880–1919) became South Africa's first Black African professional nurse in 1908. She was a pioneer for nurses in Africa (Carnegie, 1995).
- Lillian Wald (1867–1940) is considered the founder of public health nursing. She and Mary Brewster were the first to offer services by trained nurses to the poor in the New York City slums. Their home among the poor on the upper floor of a tenement, called the Henry Street Settlement and the Visiting Nursing Service, provided nursing services, social services, and organized educational and cultural activities. In recognition of her contributions to nursing, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Mary Breckinridge (1881–1965) established the Frontier Nursing Service in 1925 to provide health care to the people of rural America. Within this organization, Breckinridge started one of the first midwifery training schools in the United States. In recognition of her contributions to nursing, she was inducted into the ANA Hall of Fame posthumously in 1982.
- Martha Minerva Franklin (1870–1968) advocated for racial equality in nursing and was instrumental in founding the National Association of Colored Graduate Nurses in 1908, serving as its first president. In 1951, this organization merged with the ANA. In recognition of her contribution, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Loretta C. Ford (1920–) is credited with founding the first nurse practitioner program in 1965, in collaboration with Dr. Henry K. Silver, a pediatrician. Together, they developed the Public Health Nurse Pediatric Nurse Practitioner program to educate nurses in advanced nursing practice to provide care for children in rural Colorado.
- Faye G. Abdellah (1919–), the first nurse and woman to serve as the Deputy Surgeon General of the United States, is credited with developing the first nurse scientist program. In recognition of her leadership, she was inducted into the ANA Hall of Fame in 2012.

## Men in Nursing

- John Ciudad (1495–1550) founded the order of the Brothers of St. John of God, or the Brothers of Mercy, in 1538. He opened a hospital in Granada, Spain, and asked a group of friends to assist in providing nursing care to the mentally ill, homeless vagrants, the crippled, derelicts, and abandoned children.
- St. Camillus de Lellis (1550–1614) founded the Nursing Order of Ministers of the Sick. Men of this order cared for the dying, people stricken with the plague, and alcoholics. St. Camillus opened a hospital for alcoholics in Germany.
- James Derham (1762–1802?) was an African American who worked as a nurse in New Orleans in 1793. He was able to save enough money to buy his freedom from slavery. He went on to become the first African American physician in the United States (Carnegie, 1995).
- Walt Whitman (1819–1892), poet and writer, served as a volunteer hospital nurse in Washington, DC, during the Civil War. He recorded his experiences in a collection of poems called *Drumtaps* and in his diary, *Specimen Days and Collect*.
- Luther Christman (1915–2011) founded the American Assembly for Men in Nursing and the National Student

Nurses' Association. Dr. Christman was an advocate for patient-centered nursing care, and for advanced education of nurses and science-based nursing education. He fought to end discrimination against men and other minorities in the nursing profession. In recognition of his leadership, he was inducted into the ANA Hall of Fame posthumously in 2004.

- Russell E. Tranbarger (1937–), a role model for men in nursing, encouraged the profession to accept men. He demonstrated leadership in the American Assembly for Men in Nursing and as co-editor of the book, *Men in Nursing: History, Opportunities and Challenges*. In recognition of his contributions to nursing, he was inducted into the ANA Hall of Fame in 2012.
- Richard Henry Carmona (1949–), a nurse who became a physician, was Surgeon General of the United States from 2002 to 2006 and in that role was responsible for the health and well-being of U.S. citizens and residents. Dr. Carmona states that he became a very good doctor because he was a very good nurse.

250 B.C. in India, when only men were considered “pure” enough to become nurses (Donahue, 2011, p. 3). Cultural and religious values related to gender roles often required that sick or injured adult men be cared for only by other men (O’Lynn, 2007). Male caregivers were not always called nurses; however, their activities of caring for and nurturing the sick and injured reflect the values and activities of nursing. For example, knighthood orders of the Middle Ages combined religion, chivalry, militarism, and charity. Their original purpose was to carry the wounded from the battlefield to the hospitals and to provide care. During the Crusades, the organization and management of their battlefield hospitals became the standard for

the development of hospitals throughout Europe. The American Assembly for Men in Nursing was established in 1974. Some specific men who have been identified with their nursing roles are described in the accompanying box.

### The Risk Takers

Many nurses have taken personal risks to uphold the values of nursing. Caring for those who are ill exposes nurses to the obvious risks of contagious illnesses and work-related injuries. Some nurses have risked loss of status, danger to family and friends, and even death. Some of the risk takers are described in the accompanying box.

## Nurses as Risk Takers

- Clara Maass (1876–1901) volunteered to go to Havana, Cuba, where experiments on yellow fever were being conducted. She provided nursing care for victims of yellow fever through the spring of 1901. She allowed herself to be bitten by a mosquito to prove a theory that yellow fever was caused by mosquitoes. She experienced a mild attack of the fever in June but offered to be bitten again. She died in August 1901, following the second bite, demonstrating that mosquitoes were indeed the cause of yellow fever. In recognition of her commitment, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Edith Cavell (1865–1915) was an English nurse during World War I who had founded a training school for nurses in Belgium. During the war, her hospital cared for

both Allied and German soldiers. She also assisted Allied soldiers who were prisoners of the Germans to escape. She was charged by the Germans with harboring British and French soldiers and aiding them in escape. She was shot on October 12, 1915.

- Sharon Lane (1943–1969), a U.S. Army nurse during the Vietnam conflict, was the only nurse to die as a result of enemy fire. She died on June 8, 1969, of wounds received while on duty.
- Barbara Fassbinder (1951–1994) was an advocate for mandatory HIV testing of healthcare workers. She was infected with HIV in 1986 while caring for a patient with AIDS. She is recognized as the first healthcare provider to acquire AIDS on the job. She died in 1994 of AIDS.

## Nurses as Social Reformers

- Sojourner Truth (1797–1883) was an early feminist and abolitionist who identified the similarity between the problems of African Americans and women. She was significant in helping African American women overcome the oppression caused by their race and sex.
- Dorothea Lynde Dix (1802–1887) was an early crusader for humane care for the mentally ill in the United States. She also advocated for humane care for criminals in prison after finding that many of them suffered from mental illness. Before her efforts, it was not uncommon to find mentally ill people imprisoned in jails along with criminals. Through her efforts, standards of care for the mentally ill were improved, and more than 30 psychiatric hospitals were established in the United States. In recognition of her contributions, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Harriet Tubman (1820–1913) was called the “Moses of her people.” She made numerous trips between the South and the North to assist slaves in their quest for freedom. She was an abolitionist who became active with the Underground Railroad. She provided nursing care to sick and suffering slaves and former slaves.
- Lavinia Dock (1858–1956) was a feminist, prolific writer, political activist, and suffragist. She actively participated in protest movements for women’s rights that resulted in the passage of the 19th Amendment to the U.S. Constitution in 1920, which granted women the right to vote. She also campaigned for legislation to allow nurses rather than physicians to control the nursing profession. In 1893, she founded, with the assistance of Mary Adelaide Nutting and Isabel Hampton Robb, the American Society of Superintendents of Training Schools for Nurses of the United States and Canada, a forerunner of the National League for Nursing. In recognition of her contributions, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Margaret Sanger (1883–1966) worked as a public health nurse in New York City. In 1912, she was called to care for a woman who had attempted to abort her pregnancy and later died. It was illegal at the time to provide information about contraception and family planning. However, Sanger learned everything she could about contraception and family planning and published information about it in a journal. She was arrested, convicted, and sentenced to 30 days in a workhouse. She continued to provide information about family planning and lobbied to change the laws. She founded the National Committee on Federal Legislation for Birth Control, the forerunner of the Planned Parenthood Federation. In recognition of her contributions, she was inducted into the ANA Hall of Fame posthumously in 1976.
- Mabel Staupers (1890–1989) was an advocate for racial equality in both nursing and the provision of health care, authoring *No Time for Prejudice*. In recognition of her contributions, she was inducted into the ANA Hall of Fame posthumously in 1996.
- Susie Walking Bear Yellowtail (1903–1981) helped to bring modern health care to Native Americans. She advocated to end abuses in the American Indian healthcare system. She was an effective communicator of Native American culture and perspectives to non-Native Americans. She was the founder of the Native American Nurses Association. In recognition of her contributions, she was inducted into the ANA Hall of Fame posthumously in 2002.
- Mary Elizabeth Carnegie (1916–2008) was active in fighting segregation and discrimination in the nursing profession. She was the first Black nurse elected to the board of the Florida Nurses Association. In recognition of her contributions, she was inducted into the ANA Hall of Fame in 2000.

## The Social Reformers

Nurses have assumed roles in social reform throughout recorded history. Many of their efforts have been to improve the plight of the poor, the sick, the abandoned, or the hopeless. Often, the focus has been on the particular difficulties experienced by women and children who did not have the support of male family members. It must be remembered that it was not until the 20th century that women and minorities achieved the right to vote or to own property in many Western nations. The accompanying box describes the work of some of these social reformers.

### Reflect On . . .

- how the history of nursing has affected your own nursing practice.
- who the nursing leaders in your community or your area of practice are. What have they done to enhance the profession or the society in which we live?
- issues in health care today that ask nurses to become risk takers to uphold the values of nursing. What risks are you willing to take to uphold the values of nursing?

## RESEARCH CURRENT

## An Exploration of the Nature of Caring Relationships in the Writings of Florence Nightingale

The purpose of Wagner and Whaite's study was to discover the nature and attributes of caring relationships as shown in the writings of Florence Nightingale. The method used was a qualitative, historical field study. Primary sources analyzed focused on 18 documents written by Nightingale that related to caring for patients, nursing education, and the relationships between the nurse and the patient. The investigators describe and define five themes that represented a caring relationship: (1) "attend to" (p. 230) ("the behaviors and actions of a nurse in response to her patients and/or environmental needs," p. 230); (2) "attention to" (p. 230) ("the nurse's ability to consider and maintain focused concentration of thought

and observant care of the patients and their environmental needs," p. 230); (3) nurturing ("the nurse conducts herself in a manner that cherishes, strengthens, encourages, supports, and promotes growth, and protects her patients," (p. 230)); (4) competence ("has the required abilities and/or qualities to provide excellent care to her patients," (p. 230)); and (5) genuineness ("possessing the character attributes of truthfulness, sincerity, free from hypocrisy or pretense, and the ability to express real concern for the patient," (p. 230)).

Source: "An Exploration of the Nature of Caring Relationships in the Writings of Florence Nightingale," by D. J. Wagner and B. Whaite, 2010, *Journal of Holistic Nursing*, 28(4), pp. 225–234.

## Nursing: A History of Caring

When studying nursing history, most students focus on the most recent history, starting with Nightingale because of her influences on today's nursing care and nursing education. However, the notion of caring has spanned not only centuries but also millennia, going back to prerecorded history. Nursing has created a history starting in ancient times before the word *nurse* had the meaning it has today. Rather, the basis for this more modern history is the idea of caring: caring for and caring about. What did it mean to care for family or those who were not family? What were the issues that nurses focused on: care for the poor, care for wounded soldiers, care for the sick, care for children, care for women, care for the aged, care for the disenfranchised, care for individuals with mental illness, care for society in times of increased urbanization that led to disease, care for those with diseases that were associated with loose moral integrity?

More contemporary thinking about the history of nursing suggests that rather than looking at history in the context of specific individuals and their influences on nursing at a specific time, one should look at the reasons why individuals did what they did in the past and why people do what they do in the present. In analyzing the reasons for actions, one can better understand the symbiotic relationship between the history of nursing, the history of caring, and the history of women. For example, every student nurse in the Western world knows who Florence Nightingale was and her influence on nursing. But if one looks at the actions of Nightingale in the context of what was actually expected of a wealthy young British woman of the mid-19th century, one sees the influence of Nightingale on society as a whole, as an early feminist, as a nurse, and as

a hospital administrator. She aspired to make a difference as a nurse and was willing to take risks to do so. She connected meaning to the needs of poor women and children and to suffering soldiers in the Crimea, and she "cared" in such a way as to improve their plight. Much of Nightingale's work is not only the foundation for nursing but also the foundation for hospital administration, social services, and public health, all the so-called *caring professions*. See the accompanying box.

When we look at other nursing leaders, we see that the connection between them is not that they were nurses, but that they cared deeply about the society in which they lived and wanted to make changes. Most of these individuals have other descriptors attached to their names besides *nurse*, descriptors such as *suffragist* (Lillian Wald), *abolitionist* (Sojourner Truth), or *mental health advocate* (Dorothea Dix). Maggs (1996) suggests that analysis of nurses' memoirs provides information about nurses' choices to do what they do, and about the decisions they made about practice and caring. Memoirs also give the context of the time in which the decisions were made.

### Reflect On . . .

- your own thoughts about the meaning of caring. Within the context of nursing, what does it mean to care?
- your own nursing history. What were the reasons that you chose nursing as a career? What are the factors that influence you as a nurse? How do your beliefs about caring and nursing influence your practice? How do you see your own influence as a nurse?





**InfoQuest:** search the Internet and electronic library databases for reliable sources of information on nursing's history. What sources did you find? Select a specific leader from the history of nursing. Search the Internet and electronic library databases for information about this nursing leader. How does the nursing leader's work influence nursing today?

## The Development of Professional Nursing Organizations

As nursing has evolved as a profession, an increasing number of nursing organizations have formed. These organizations serve the profession at the local, regional, national, and international levels. When nurses participate in the activities of nursing organizations, they enhance their own professional growth and help all nurses collectively as they influence policies affecting nursing, nursing practice, and the health of the community. Nursing organizations can be divided into three types: organizations that represent all nurses (e.g., the ANA and the National League for Nursing), organizations that meet the needs of nurses within specific nursing specialties (e.g., the American Association of Critical-Care Nurses, the Gerontologic Nursing Association, the Association of periOperative Registered Nurses), and organizations that represent special interests (e.g., the National Black Nurses Association, the American Assembly of Men in Nursing). Some of these organizations are discussed on the following pages.

### American Nurses Association

The ANA, with its headquarters in Washington, D.C., is the national professional organization representing all registered nurses in the United States. It was founded in 1896

as the Nurses Associated Alumnae of the United States and Canada (2013b). In 1908, the Canadian National Association of Trained Nurses was formed as a separate entity. In 1911, the name Nurses Associated Alumnae of the United States and Canada was changed to American Nurses Association. It was a charter member of the International Council of Nurses in 1899, along with nursing organizations in Great Britain and Germany.

Nurses participate in the ANA by joining as individual members or through their state nurses' associations (American Nurses Association, 2013c). Official publications of the ANA are the *American Nurse*, *American Nurse Today*, and *OJIN: The Online Journal of Issues in Nursing*.

Since its beginning, the ANA has increased its membership; expanded its services; published the *Code of Ethics for Nurses*, *Nursing's Social Policy Statement*, *Nursing: Scope and Standards of Practice*, and other resource material on the nursing profession and nursing practice; developed and instituted a mechanism for registered nurses to be credentialed in areas of specialization; and become actively involved in state and national legislative activity to advance the nursing profession so that the roles, duties, and practice areas of nursing are respected in the world today. The mission statement of the ANA is "Nurses advancing our profession to improve health for all" (American Nurses Association, 2013d). Affiliate groups of the ANA are the American Nurses Credentialing Center (ANCC), which conducts the certification process at the nurse generalist and the advanced practice levels in many nursing specialties; the American Nurses Foundation (ANF), which supports nursing research and scholarship; and the American Academy of Nursing (AAN), which recognizes nursing leaders. The ANA honors nurses whose dedication and achievements have significantly affected the nursing profession. Nursing leaders inducted into the ANA Hall of Fame in 2012 can be seen in the accompanying box.

### CRITICAL THINKING EXERCISE

Interview nurses who have varying career lengths: 5, 10, 15, 20, and 25 years in the profession. What are the reasons they chose nursing for their career? What nursing situations or experiences have provided the most gratification for them? How do they relate their personal life experiences to their professional life experiences? Compare the experiences of the nurse(s) you interviewed with the experiences of the historical nursing leaders described in this chapter. How are the experiences similar? How are they different?

Interview nurses from various nursing specialties: critical care, community health, home health, pediatrics, oncology, hospice/palliative care, anesthesia, midwife, education. What are the reasons they chose their specialties? What nursing situations or experiences have provided the most gratification for them? How do they relate their personal life experiences to their professional life experiences? How do the descriptions of their experiences demonstrate caring?



## ANA Hall of Fame 2014 Inductees

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- Barbara Thoman Curtis, RN
- Pearl McIver, MS, RN
- Mary Ellen Patton, RN
- Robert V. Piemonte, EdD, RN, CAE, FAAN
- Jessie M. Scott, DSc, RN, FAAN, RADM

Source: ANA Hall of Fame, news release, by American Nurses Association, 2014. Retrieved from <http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2014-PR/ANA-Announces-National-Award-Recipients.pdf>

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## National Student Nurses' Association

The National Student Nurses' Association (NSNA) was established in 1952 for students enrolled in associate, baccalaureate, diploma, and generic graduate nursing programs. The mission of the NSNA is to “mentor students preparing for initial licensure as registered nurses, and to convey the standards, ethics and skills that students will need as responsible and accountable leaders and members of the profession” (National Student Nurses' Association, 2013). The official journal of the NSNA is *Imprint*.

## National League for Nursing

The National League for Nursing (NLN) is an organization whose mission is to promote “excellence in nursing education to build a strong and diverse workforce to advance the nation's health” (National League for Nursing, 2013). Its core values are Caring, Integrity, Diversity, and Excellence. The NLN began in 1893 as part of the American Society of Superintendents of Training Schools for Nurses. The NLN provides professional development for nursing faculty, offers support for research related to nursing education, and provides information, services, and products to support nursing education. The official journal of the NLN is *Nursing Education Perspectives*, and the newsletter is the *NLN Report*.

The National League for Nursing Accrediting Commission (NLNAC), an affiliate of the NLN, serves as a national accreditation body for schools of nursing at the vocational, associate degree, baccalaureate, master's, and clinical doctorate levels. In 1997, the NLNAC became the sole authority and accountability for the responsibilities related to nursing program accreditation. In 2013, the NLNAC changed its name to the Accreditation Commission for Education in Nursing (ACEN), an independent organization for the accreditation of nursing programs (National League for Nursing Accrediting Commission, 2013).

## American Association of Colleges of Nursing

The American Association of Colleges of Nursing (AACN) is the national voice for baccalaureate and higher-degree nursing education programs in the United States. The mission of the AACN is to serve “the public interest by setting

standards, providing resources, and developing the leadership capacity of member schools to advance nursing education, research, and practice” (American Association of Colleges of Nursing, 2013). The official publication of the AACN is the *Journal of Professional Nursing*.

The Commission on Collegiate Nursing Education (CCNE), created in 1996, is a nongovernmental peer review organization that evolved from the AACN and now serves as “an autonomous accrediting agency . . . ensuring the quality and integrity of baccalaureate, graduate, and residency programs in nursing” (Commission on Collegiate Nursing Education, 2013).

## Canadian Nurses Association

The Canadian National Association of Trained Nurses (CNATN) was formed in 1908. In 1924, the organization changes its name to the Canadian Nurses Association (CNA), representing nurses from the nine provinces that had a provincial nurses' organization. The CNA is now a federation of 11 provincial and territorial registered nurses associations and colleges. The mission of the CNA is to serve as the national professional voice of approximately 149,000 registered nurses in Canada, “advancing the practice of nursing and the profession to improve health outcomes in a publicly funded, not-for-profit health system” (Canadian Nurses Association, 2013). On May 19, 2013, the CNA announced that Judith Shamian, past president of the CNA, had been elected president of the International Council of Nurses.

## International Council of Nurses

The International Council of Nurses (ICN) was formed in 1899 as the world's first and widest international organization for health professionals. The ICN is a federation of more than 130 national nurses' associations, representing more than 13 million nurses worldwide. The mission of the ICN is “to represent nursing worldwide, advancing the profession and influencing health policy” (International Council of Nurses, 2013). The goals are “to bring nursing together worldwide, to advance nurses and nursing worldwide, and to influence health policy” (International Council of Nurses, 2013). The five core values of ICN are “visionary leadership, inclusiveness, innovativeness, partnership, and transparency” (International Council of Nurses, 2013). The ICN

Code for nurses is the “foundation for ethical nursing practice throughout the world. ICN standards, guidelines, and policies for nursing practice, education, management, research and socio-economic welfare are accepted globally as the basis of nursing policy” (International Council of Nurses, 2013). The ICN has published 59 position statements addressing global issues related to nursing roles in healthcare services, the nursing profession, socioeconomic welfare of nurses, healthcare systems, and social issues. The official journal of the ICN is *International Nursing Review*.

### Sigma Theta Tau International

Sigma Theta Tau International (STTI) is the international honor society for nursing. It was founded in 1922 at the University of Indiana in Indianapolis. The Greek letters stand for the Greek words *storga*, *tharos*, and *tima*, meaning “love,” “courage,” and “honor.” The society is a member of the Association of College Honor Societies. The mission of the society is to “support the learning, knowledge, and professional development of nurses committed to make a difference in health worldwide” (Sigma Theta Tau International, 2013). The society’s vision is “to create a global community of nurses who lead in using knowledge, scholarship, service and learning to improve the health of the world’s people” (Sigma Theta Tau International, 2013). The official publication of STTI is the *Journal of Nursing Scholarship*.

### Specialty Nursing Organizations

There are more than 60 nursing organizations that represent the special interests of nurses in clinical specialty areas. Examples of such organizations are the Association of peri-Operative Registered Nurses (AORN); the American Association of Critical-Care Nurses (AACN); the Emergency Nurses Association (ENA); Academy of Medical-Surgical Nurses (AMSN); Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN); Society of Pediatric Nurses; Association of Rehabilitation Nurses (ARN); and Association of Nurses in AIDS Care (ANAC). A listing of national and international nursing organizations with contact links can be found at [nurse.org](http://nurse.org). Specialty nursing organizations usually offer educational opportunities to their members specific to the specialty, including national or international conferences that provide information related to current research findings in the specialty, information about new equipment used in the specialty, and general information about professional topics and issues in healthcare policy related to the specialty or to the nursing profession as a whole.

### Special-Interest Organizations

There are also organizations that represent nurses of specific ethnic groups or other special interests. Some of these organizations address the special needs of nurses from minority

groups such as the Aboriginal Nurses Association of Canada, the National Alaska Native American Indian Nurses Association (NANAINA), the National Black Nurses Association (NBNA), the National Association of Hispanic Nurses (NAHN), and the Philippine Nurses Association (PNA). These organizations represent the issues and concerns of these nurses and the populations they serve. For example, the mission of the National Black Nurses Association is “to provide a forum for collective action by African American nurses to investigate, define and determine what the health care needs of African Americans are and to implement change to make available to African Americans and other minorities health care commensurate with that of the larger society” (National Black Nurses Association, 2013).

Another example of a special-interest group is the American Assembly for Men in Nursing (AAMN) whose objectives include supporting “men who are nurses to grow professionally and demonstrate to each other and to society the increasing contributions being made by men within the nursing profession.” Additionally, AAMN advocates “for continued research, education and dissemination of information about men’s health issues” (American Assembly for Men in Nursing, 2013).

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### Reflect On . . .

- your involvement in professional nursing organizations. Which organizations are you a member of? If you do not belong to any professional organizations, why not? How might being a member of a professional organization help you become more connected with the profession?
  - why many nurses choose not to be involved in nursing organizations.
  - how involvement in professional nursing organizations can assist nurses in managing the stresses of the changing and challenging healthcare system.
  - the nursing organizations you are involved in. What benefits do you obtain from membership in these organizations?
- 



**InfoQuest:** Select a professional nursing organization. Search the Internet to locate its website. What information can you find out about this organization? What is the purpose of the organization? What are the criteria for membership? What benefits are provided to members of the organization?

## Chapter Highlights

- Nursing, as a part of human history, has existed since before recorded history. Evidence of the nurturing role of nursing can be found in cave drawings, cultural artifacts, art, and literature. Much of the history of nursing is part of the history of women, as women provided most of the nursing care for their families within the home.
- Care of the sick and injured has been influenced by many factors, including cultural and religious beliefs, war, gender role proscriptions, political events, legislation, and societal upheaval.
- Some of the earliest historical writings that describe health and medicinal practices are the Ebers papyrus, the Code of Hammurabi, the Smith papyrus, and the Mosaic Health Code.
- Religious beliefs and values influenced early health practices and the development of nursing. Early Christian matrons of the Roman Empire, including Marcella, Fabiola, and Paula provided care for the sick and poor, building hospitals and hospices.
- During the Middle Ages, male and female religious, military, and secular orders were established with the primary purpose of caring for the sick and injured. Examples of these orders are the Knights Hospitallers of St. John, the Alexian Brotherhood, the Augustinian Sisters, and the Sisters of Charity.
- In the Islamic world, Rufaidah bint Sa'ad is considered the first professional nurse. She learned medical care from her father, who was a physician and trained other women as nurses.
- Modern nursing begins with Florence Nightingale, who studied nursing at Kaiserswerth Hospital in Germany. She also studied with the Sisters of Charity in Paris. She is revered for her work during the Crimean War, where she and her nurses are credited with lowering the mortality rate related to infection, cholera, inadequate nutrition, lack of drugs, and lack of care from 43% to approximately 2%.
- In the Americas, the earliest hospital is the Hôtel-Dieu founded in Quebec City, Canada, in 1639 by the Augustinian Sisters. In the United States, Mother Elizabeth Seton established the first American order of the Sisters of Charity of St. Joseph in Maryland.
- The influence of war on nursing and nursing's concurrent influence on military medical care is exemplified by Florence Nightingale in the Crimean War; Clara Barton, Dorothea Dix, Sojourner Truth, and Harriet Tubman in the American Civil War; and Isabel Stewart, M. Adelaide Nutting, Annie Goodrich, and Lillian Wald in World War I.
- As nursing developed in the United States, the need to establish minimum standards for nursing care was identified. Voluntary licensure laws were enacted in 1903 in North Carolina, New Jersey, New York, and Virginia. The first mandatory licensure act was passed in 1935 in New York and went into effect in 1949.
- Social change has continued to influence change within the profession, and at the same time, nurses change society through their education and practice. In 1992, Eddie Bernice Johnson was the first nurse elected to the U.S. House of Representatives. Nurses who acted as social reformers include Sojourner Truth, Dorothea Lynde Dix, Margaret Sanger, Lavinia Dock, Mabel Staupers, Susie Walking Bear Yellowtail, and Mary Elizabeth Carnegie.
- Throughout history, men have functioned in nursing roles. In ancient India "only men were considered 'pure' enough to become nurses" (Donahue, 2011, p. 3). Knighthood orders such as the Knights Hospitallers and the Knights of St. John provided care to the sick and injured on the battlefield and built hospitals for care of the sick. The American Assembly for Men in Nursing was established in 1974. Some significant men in the history of nursing are John Cuidad, St. Camillus de Lellis, James Derham, Luther Christman, and Russell E. Tranbarger.
- Nurses have also taken personal risks to uphold the values of nursing. Some of these risk takers are Clara Maass, Edith Cavell, Sharon Lane, and Barbara Fassbinder.
- The history of nursing parallels the history of caring. The issues that nurses cared about throughout the millennia include care for wounded soldiers, care for the sick, care for the vulnerable, care for the disenfranchised, care for the mentally ill, and care for society in times of increased urbanization that led to disease.
- Professional nursing organizations enhance nurses professional growth and help all nurses collectively as they influence policies affecting nursing, nursing practice, and the health of society. Professional organizations may be local, state, regional, national, or international and can be categorized into organizations that represent all nurses (e.g., the ANA, the ICN), organizations that meet the needs of nurses within specific nursing specialties (e.g., the American Association of Critical-Care Nurses, the Emergency Nurses Association), and organizations that represent special interests (e.g., the American Assembly of Men in Nursing, the National Black Nurses Association).



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# 4

## Ethical Foundations of Professional Nursing

### Chapter Outline

#### Challenges and Opportunities

##### Values

- Values Transmission
- Values Clarification
- Identifying Personal Values
- Helping Clients Identify Values

##### Moral and Ethical Behavior

- Moral Development
- Lawrence Kohlberg
- Carol Gilligan
- Moral and Ethical Theories or Frameworks
- Moral and Ethical Principles

##### Ethics in Nursing

- Nursing Codes of Ethics
- Types of Ethical Problems
- Making Ethical Decisions
- Specific Ethical Issues
- Strategies to Enhance Ethical Decision Making

##### Advocacy

- The Advocacy Role
- Professional/Public Advocacy

##### Chapter Highlights

### Objectives

1. Discuss how cognitive development, values, moral frameworks, and codes of ethics affect decision making.
2. Explain how nurses can help clients clarify their values to facilitate ethical decision making.
3. Analyze ways in which nurses can enhance their ethical decision-making abilities.
4. Identify the moral principles involved in ethical decision making.
5. Explain the uses and limitations of professional codes of ethics.
6. Discuss common bioethical issues currently facing healthcare professionals.
7. Describe the advocacy role of the nurse.

**P**rofessional nurses must attend to the ethical responsibilities and conflicts they may experience as a result of their unique relationships in professional practice. Advances in medical and reproductive technology, clients' rights, social and legal changes, and the allocation of scarce resources are among the things that have contributed to an increase in ethical concerns. Standards of conduct for nurses are set forth in codes of ethics developed by international, national, and state or provincial nursing associations. Nurses need to be able to apply ethical principles in decision making and consider their own values and beliefs and the values and beliefs of clients, of the profession, and of all other concerned parties. Nurses have a responsibility to protect the rights of clients by acting as client advocates. Advocacy derives from the ethical principles of beneficence (the duty to do good) and nonmaleficence (the duty to do no harm).

### Challenges and Opportunities

Nursing has long advocated a nonjudgmental approach to care. However, nurses come into the profession with established values and beliefs, which may conflict with the values and beliefs of clients. Nurses sometimes feel compromised when they must provide care in such a situation. Beliefs may be so strong that it is difficult not to judge the other person and act or react in a way that might compromise care. The nursing profession must be able to



identify ways and means of assisting members of the profession so that values are not compromised by either party.

*Ethical* and *legal* are not synonymous. There are times in professional practice when the legal requirement does not appear compatible with the ethical approach. The result is referred to as *moral distress*. Nurses may place themselves in legal jeopardy when they opt for what they see as the ethical, or right, thing to do in spite of what is mandated in the laws that apply. A similar conflict may occur with institutional policy and may place the nurse in a similar position of risk at the workplace. Advocacy for the profession is needed when such a conflict arises, so that laws and/or policies may better serve the public.

Values

Values are highly personal, freely chosen, enduring beliefs or attitudes about the worth of a person, object, idea, or action. Values frequently derive from a person’s cultural, ethnic, and religious background; from societal traditions; and from the values held by peer group and family. Values exist within a person and affect the person’s relationships with others; they motivate behavior and guide choices and decisions. These values may be of a moral or a nonmoral nature: Values of a nonmoral nature may simply reflect

personal preferences, such as neatness or achievement. Values of a moral nature may be exemplified by honesty and doing good. A value system is the organization of a person’s values along a continuum, that is, from most important to least important. Values form the basis of purposive behavior, that is, actions that a person performs on purpose, with the intention of reaching some goal or bringing about a certain result. Thus, purposive behavior is based on a person’s decisions or choices, and these decisions or choices are based on the person’s underlying values.

Values of both a moral and a nonmoral nature can come into conflict, and this conflict may occur between nurses and other professionals or between nurses and patients. A value of promptness on the part of the nurse that is not shared by the patient may cause conflict. When values come into conflict, it is important to understand the importance of the value to the people involved in the conflict before it can be resolved, but people are not always aware of their values. Becoming aware of one’s values is necessary in order to make ethical decisions.

Values Transmission

Values are learned within the context of a person’s socio-cultural environment through observation and experience. Early influences come from the family and gradually

Examples of Societal and Personal Values

| SOCIETAL VALUES                                                                                                                                                                                                                                                                                                                                                                                                                                                    | PERSONAL VALUES                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Human life</li><li>• Individual rights</li><li>• Individual autonomy</li><li>• Liberty</li><li>• Democracy</li><li>• Equal opportunity</li><li>• Power</li><li>• Health</li><li>• Wealth</li><li>• Youth</li><li>• Vigor</li><li>• Intelligence</li><li>• Imagination</li><li>• Education</li><li>• Technology</li><li>• Conformity</li><li>• Friendship</li><li>• Courage</li><li>• Compassion</li><li>• Family</li></ul> | <ul style="list-style-type: none"><li>• Family unity</li><li>• Worth of others</li><li>• Independence</li><li>• Religion</li><li>• Honesty</li><li>• Fairness</li><li>• Love</li><li>• Sense of humor</li><li>• Safety</li><li>• Peace</li><li>• Beauty</li><li>• Harmony</li><li>• Financial security</li><li>• Material things</li><li>• Property of others</li><li>• Leisure time</li><li>• Work</li><li>• Travel</li><li>• Physical activity</li><li>• Intellectual activity</li></ul> |

widen to include extended groups in the community. For example, if a parent consistently demonstrates honesty in dealing with others, the child will probably begin to value honesty. Cultural influences can be particularly influential. For example, some cultures value the treatment of a folk healer over that of a physician. Acquiring values is a gradual process, usually occurring at an unconscious level.

Although people derive some values from the society or subgroup of society in which they live, they may internalize some or all of these values and perceive them as personal values. People need societal values to feel accepted, and they need personal values to produce a sense of individuality. See the accompanying box for examples of personal and societal values.

Professional values often reflect and expand on personal values. Nurses acquire professional values during socialization into nursing from nursing experiences, teachers, and peers. As members of a caring profession, nurses hold values that relate to both competence and compassion.

Nurses often need to behave in a value-neutral way, which means being nonjudgmental. This outlook permits nurses to establish effective relationships with clients who have diverse values. Although nurses cannot and should not ignore or deny their own and the profession's values, they need to be able to accept a client's values and beliefs rather than assume their own are the right ones. This acceptance and nonjudgmental approach requires nurses to be aware of their own values and how they influence behavior.

### Reflect On . . .

- what values you hold about life, health, illness, and death. How might your values influence the nursing care you provide?
- whether a nurse who smokes can effectively help a client stop smoking or whether a nurse who is overweight can effectively help a client who needs to lose weight.
- whether a nurse whose religious beliefs oppose the use of contraceptives can effectively teach a client about family planning.

## Values Clarification

Values clarification is a process by which people identify, examine, and develop their own individual values. This may come about through the conscious examination of experience or scenarios. A principle of values clarification is that no one set of values is right for everyone. When people are able to identify their values, they can retain or change them and thus act on the basis of freely chosen rather than unconscious values. Values clarification promotes personal growth by fostering awareness, empathy, and insight.

A widely used theory of values clarification, which identifies a valuing process, was developed by Raths, Harmin, and Simon (1966). It includes cognitive, affective, and behavioral components, referred to as choosing, prizing, and acting. See Table 4–1.

## Identifying Personal Values

Nurses need to know specifically what values they hold about life, health, illness, and death. Beginning as students, nurses should explore their own values and beliefs regarding such situations as the following:

- An individual's right to make decisions for himself or herself when those decisions conflict with medical advice
- Abortion
- End-of-life care
- Domestic violence, child discipline
- Cloning and genetic engineering
- Having a child to provide a bone marrow transplant for another family member

Identification of personal values helps nurses understand why certain situations bother them. This knowledge helps nurses decide whether they can accept differences in values when providing care.

Because nurses are called upon to provide care to individuals who may have made decisions that conflict with the nurse's values, self-awareness is important. Nurses must be aware of their own values and attitudes in order to recognize when a situation might affect the care they are able to provide. Often, the awareness of the conflict of values allows nurses to hold their personal values in check and provide effective care. In those instances when nurses feel

**TABLE 4–1 Values Clarification**

| Processes | Domains    | Actions                                                                                               |
|-----------|------------|-------------------------------------------------------------------------------------------------------|
| Choosing  | Cognitive  | Reflection and consideration of alternatives result in freely choosing beliefs.                       |
| Prizing   | Affective  | Chosen beliefs are cherished.                                                                         |
| Acting    | Behavioral | Chosen beliefs are incorporated into behaviors that are affirmed to others and repeated consistently. |

TABLE 4–2    Behaviors That May Indicate Unclear Values

| Behavior                                                      | Example                                                                                                                          |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Ignoring a health professional’s advice                       | A client with heart disease who values hard work ignores advice to exercise regularly.                                           |
| Inconsistent communication or behavior                        | A pregnant woman says she wants a healthy baby but continues to drink alcohol and smoke tobacco.                                 |
| Numerous admissions to a health agency for the same problem   | A middle-aged, obese woman repeatedly seeks help for back pain but does not lose weight.                                         |
| Confusion or uncertainty about which course of action to take | A woman wants to obtain a job to meet family financial obligations but also wants to stay at home to care for an ailing husband. |

they cannot be effective because of their conflicting values, they need to be able to discuss the situation with colleagues who may be able to assist with providing care.

Helping Clients Identify Values

Nurses need to help clients identify values as they influence and relate to a particular health problem. Examples of behaviors that may indicate the need for values clarification are listed in Table 4–2.

The following steps may help clients clarify their values:

1. **List alternatives.** Make sure that the client is aware of all alternative actions and has thought about the consequences of each. Ask, “Are you considering other courses of action?”
2. **Examine possible consequences of choices.** Ask, “What do you think you will gain by doing that? What benefits do you foresee from doing that? What might you lose by doing that? What are the risks of doing that?”
3. **Choose freely.** To determine whether the client chose freely, ask, “Did you have any say in that decision? Did you have a choice?”
4. **Feel good about the choice.** To determine how the client feels, ask, “How do you feel about that decision (or action)?” Because some clients may not feel satisfied with their decision, a more sensitive question may be “Some people feel good after a decision is made; others feel bad. How do you feel?”
5. **Affirm the choice.** Ask, “What will you say to others (family, friends) about this?”
6. **Act on the choice.** To determine whether the client is prepared to act on the decision, ask, for example, “Will it be difficult to tell your wife about this?”
7. **Act with a pattern.** To determine whether the client consistently behaves in a pattern, ask, “How many times have you done that before?” or “Would you act that way again?”

When implementing these seven steps, the nurse assists the client to think each question through, never imposing personal values. When clarifying values, the nurse never offers an opinion (e.g., “It would be better to do it this way”) or offers a judgment (e.g., “That’s not the right thing to do”). Nor should the nurse suggest how she or he would act if in a similar situation (e.g., “If it were me, I would . . .”). The nurse might offer an opinion only when the client asks the nurse for it, and then only with careful consideration. The nurse may provide information in a nonjudgmental way that would assist a client to make an informed decision even if it differs from the one the nurse would make.

Moral and Ethical Behavior

The terms *morals* and *ethics* are used interchangeably, but the nursing literature often differentiates between the two by describing morals as personal ethics guiding the individual’s behavior and choices. Ethics are described as referring to the beliefs of a particular group, such as a religion or a profession, as members of the group consider what is right or wrong, good or bad. For instance, professions have codes of ethics.

Moral Development

Moral development is a complex process that is not fully understood. It is more than the imprinting of parents’ rules and virtues or values upon children; rather, moral development is the process of learning what ought to be done and what ought not to be done. The terms *morality*, *moral behavior*, and *moral development* need to be distinguished. **Morality** refers to the requirements necessary for people to live together in society; **moral behavior** is the way a person perceives those requirements and responds to them; **moral development** is the pattern of change in moral behavior over time. Lawrence Kohlberg and Carol Gilligan

are two researchers who have studied and developed theories about moral development.

### Lawrence Kohlberg

The research of Lawrence Kohlberg has provided one of the most well-known approaches to moral development. He was directly affected by Jean Piaget's theory of cognitive development. Kohlberg's theory focuses on the structure of thought about moral issues rather than the specific content of moral values (Kohlberg, 1972). It applies ways of thinking about issues that depend upon the specific issue and whether the person is very familiar with the topic. According to Kohlberg, moral development progresses through three levels and six stages, and they are not always linked to a specific age or growth-and-development phase; rather, they progress from concrete to abstract. Some people progress to a higher level of moral development than others. The levels and stages range from egocentric actions to behaviors that show concern for society and rightness.

At Kohlberg's first level, called the *premoral* or *pre-conventional level*, children are responsive to cultural rules and labels of good and bad, right and wrong. However, children interpret these in terms of the physical consequences of their actions, that is, punishment or reward. At the second level, the *conventional level*, the individual is concerned about maintaining the expectations of the family, group, or nation and sees this concern as right. The emphasis at this level is on conformity and loyalty to one's own expectations as well as society's. The third level is called the *postconventional*, *autonomous*, or *principled*

*level*. At this level, people make an effort to define valid values and principles without regard to outside authority or to the expectations of others. For additional information about Kohlberg's levels, see Table 4–3.

With reference to Kohlberg's six stages, Munhall (1982, p. 14) writes that stage 4, the "law-and-order" orientation, is the dominant stage of most adults. It is recognized that there is a difference in action between nurses who act at the conventional level (the second level) and those who act at the postconventional or principled level (the third level).

Progression through the stages is determined by one's exposure to social complexity and the opportunity to question and discuss ethical decisions (Baril & Wright, 2012). Theoretically, formal operations (Piaget) are associated with stage 4; the ability to think abstractly is necessary to consider such things as social order. It is rare for an adult to reach stage 6. In his later writings, Kohlberg questioned the validity of including it as a stage.

Some have questioned whether Kohlberg's stages, particularly 5 and 6, are universal across cultures. There is research supporting the sequence and achievement of these stages among various groups, such as South African Blacks and Whites, Chinese, Buddhists, British, Hong Kong Chinese, Mexicans, and Norwegians (Commons, Galaz-Fontes, & Morse, 2006; Lei, 1994; Skisland, Bjornestad, & Soderhamn, 2011; Tudin, Straker, & Mendolsohn, 1994). Others question whether the universal ethical principle at stage 6 might reflect Western ways of thinking (Heubner & Garrod, 1993; Larin, Geddes, & Eva, 2009; Miller, 1994).

**TABLE 4–3 Kohlberg's Stages of Moral Development**

| Preconventional Level                                                                                                                                                                                                                 | Conventional Level                                                                                                                                                                                                                     | Postconventional Level                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><i>Stage 1. Obedience and Punishment</i><br/>Actions are chosen to avoid punishment.</p> <p>Example:<br/>The nurse carefully adheres to strict visitation policies to avoid criticism by her or his manager.</p>                   | <p><i>Stage 3. Good Boy/Good Girl</i><br/>Actions are chosen to gain the approval of others.</p> <p>Example:<br/>The nurse enforces her or his manager's preferred approach to visitation in order to gain the manager's approval.</p> | <p><i>Stage 5. Social Contract</i><br/>Actions are selected to protect the rights of others.</p> <p>Example:<br/>The nurse advocates for exceptions to the visitation policies when family wishes or needs are expressed that are contrary to the policy.</p>           |
| <p><i>Stage 2. Instrumentalism/Self-Interest</i><br/>Actions are chosen to satisfy one's own needs.</p> <p>Example:<br/>The nurse enforces the visitation policy in order to have the quieter environment that she or he prefers.</p> | <p><i>Stage 4. Law and Order</i><br/>Actions are chosen to follow the rules and maintain order.</p> <p>Example:<br/>Visitation policies are enforced regardless of family preference or need.</p>                                      | <p><i>Stage 6. Universal Moral Principle</i><br/>Actions are guided by respect for others.</p> <p>Example:<br/>The nurse makes an accommodation for family visits that violate existing policy because the accommodation meets the needs of the patient and family.</p> |

Kohlberg developed his theory by conducting interviews using hypothetical dilemmas. Each dilemma described a character who finds himself or herself in a difficult situation and has to choose from conflicting values. The participant is asked how the character should resolve the problem in the right way. Analysis of the responses resulted in the formulation of Kohlberg’s levels and stages (Colby & Kohlberg, 1987). All the subjects in the study were male, which has led to serious criticism of the theory.

Carol Gilligan

Carol Gilligan (1982) has been one of the major critics of Kohlberg’s theory, particularly in its application to females. She contends that Kohlberg’s stage sequence places the qualities most often stressed in the socialization of females in stage 3; these qualities are compassion, responsibility, and obligation. Men, who are taught to organize social relationships in a hierarchical order and subscribe to a morality of right, will be included in Kohlberg’s higher stages of moral judgment.

After more than 10 years of research with women subjects, Gilligan found that women often considered the situations that Kohlberg used in his research to be irrelevant. Women scored consistently lower on his scale of moral development, even though they approached moral situations with considerable sophistication. Gilligan maintains that most frameworks do not include the concepts of caring and responsibility.

In contrast to Kohlberg’s theory of moral development, which emphasizes fairness, rights, and autonomy in a *justice framework*, Gilligan focuses on a *care perspective*, which is organized around the notions of responsibility, compassion (care), and relationships. Gilligan contends that for women, moral maturity is less a matter of abstract, impersonal justice and more an ethic of caring relationships.

The ethic of *justice*, or fairness, is based on the idea of equality: that everyone should receive the same treatment. This is the development path usually followed by men. By contrast, the ethic of *care* is based on a premise

of nonviolence: that no one should be harmed or abandoned. This is the path typically followed by women. Distinctions between a justice orientation and a care orientation are shown in Table 4–4.

A blend of justice and care perspectives is considered necessary for a person to reach maturity. The blending of these two perspectives could give rise to a new view of human development and a better understanding of human relations. To Gilligan, two intersecting dimensions characterize human relationships: equality and attachment. All relationships can be described as unequal or equal and as attached or detached. Most people have been vulnerable both to oppression and to abandonment. Thus, two moral visions—one of justice and one of care—recur in human experience (Jorgensen, 2006).

Gilligan (1982) describes three stages in the process of developing an “ethic of care” (p. 74). Each stage ends with a transitional period. A *transitional period* is a time when the individual recognizes a conflict or discomfort with some present behavior and considers new approaches.

- **Stage 1. Caring for oneself.** In this first stage of development, the person is concerned only with caring for the self. The individual feels isolated, alone, and unconnected to others. There is no concern or conflict with the needs of others because the self is the most important. The focus of this stage is survival. The end of this stage occurs when the individual begins to view this approach as selfish. At this time, the person also begins to see a need for relationships and connections with other people.
- **Stage 2. Caring for others.** During this stage, the individual recognizes the selfishness of earlier behavior and begins to understand the need for caring relationships with others. Caring relationships bring with them responsibility. The definition of responsibility includes self-sacrifice, in which “good” is considered to be “caring for others.” The individual now approaches relationships with a focus of not hurting others. This approach causes the individual to be more

TABLE 4–4    Comparison of Moral Justice and Care Orientations

| Justice Orientation                                                       | Care Orientation                                                        |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Focuses on the moral vision of “not to treat others unfairly.”            | Focuses on the moral vision of “not to turn away from someone in need.” |
| Requires understanding of what “fairness” means.                          | Requires understanding of what constitutes “care.”                      |
| Draws attention to problems of inequality and oppression.                 | Draws attention to problems of detachment or abandonment.               |
| Holds up an ideal of reciprocal rights and equal respect for individuals. | Holds up an ideal of attention and response to need.                    |



### CRITICAL THINKING EXERCISE

Situations may arise in health care in which the cultural practices of a family conflict with the values of the dominant culture. For instance, child discipline practices that are accepted as appropriate by some may be interpreted

as severe or abusive by others. How might the nurse respond to the dilemma of mandatory reporting to a child protection agency at each stage or level of Kohlberg's and Gilligan's theories?

responsive and submissive to others' needs, excluding any thoughts of meeting his or her own needs. A transition occurs when the individual recognizes that this approach can cause difficulties with relationships because of the lack of balance between caring for oneself and caring for others.

- **Stage 3. Caring for oneself and others.** During this last stage, a person sees that there is a need for a balance between caring for others and caring for the self. One's conception of responsibility is now defined as including responsibility for both the self and other people. In this final stage, care still remains the focus on which decisions are made. However, the person now recognizes the interconnections between the self and others and thus realizes that it is important to take care of one's own needs, because if those needs are not met, other people may also suffer.

### Moral and Ethical Theories or Frameworks

There are many theories of ethics, and one way to classify them is as consequential or nonconsequential. Consequential theories look at outcomes: An action that produces good outcomes is right, and an action that produces bad outcomes is wrong. These theories are referred to as *teleological*. In **teleology**, the ends justify the means, and applying this rule requires that the person be able to predict outcomes of actions when making decisions. One application is triage in a disaster, when the greatest good for the greatest number guides decisions about who should receive care and what care is provided.

Nonconsequential theories claim that certain acts are right or wrong based upon rules or laws or ideas. These theories are referred to as *deontological*. **Deontology** focuses on adherence to the right action regardless of consequences. For instance, a nurse might believe it is necessary to tell the truth no matter who is hurt. There are many deontological theories; each justifies the rules of acceptable behavior differently. For example, some state that the rules are known by divine revelation; others refer to a natural law or social contract; still others propose both of these as sources.

The difference between teleology and deontology can be seen when each approach is applied to the issue of

abortion. A person taking a teleological approach might consider that saving the mother's life (the end, or consequence) justifies the abortion (the means, or act). A person taking a deontological approach might consider any termination of life as a violation of the rule "Do not kill" and therefore would not abort the fetus, regardless of the consequences to the mother. It is important to note that the approach, or framework, guides the making of the moral decision; it does not determine the outcome (e.g., the person taking a teleological approach might have considered that saving the life of the fetus justifies the death of the mother).

A third framework, **virtue ethics**, focuses on developing and maintaining good character traits, so the decision is not what to do but how to be. The belief is that the good character traits, such as kindness or generosity, will lead to good decision making. If the intent is good, the act is moral regardless of the outcome.

Benner and Wrubel (1989) proposed **caring** as the central goal of nursing as well as a basis for nursing ethics. Unlike the preceding theories, which are based on the concept of fairness (justice), an ethic of caring is based on relationships. Caring theories stress courage, generosity, commitment, and responsibility. Caring is a force for protecting and enhancing client dignity. Caring is of central importance in the client-nurse relationship. For example, guided by this ethic, nurses use touch and truth telling to affirm clients as persons rather than as objects and to assist them to make choices and find meaning in their illness experiences. While it is generally accepted that a nurse cannot make good ethical decisions without being caring, good ethical decision making requires more than caring. Caring may be important, but it is not all-important.

### Moral and Ethical Principles

**Moral and ethical principles** are at the center of theories of ethics and guide ethical decision making. They generally assert that certain actions should or should not be performed and are often applied in professional ethics. Some ethical principles that have been identified as important to nursing practice are sanctity of life, utility, autonomy, respect for person, beneficence and nonmaleficence,

justice, veracity, and fidelity (Benjamin & Curtis, 2010; Fry & Johnstone, 2008; Johnstone, 2009). Principles are useful in ethical discussions because even people who do not agree on which action to take may be able to agree on the principles that apply. That agreement can serve as the basis for an acceptable solution. For example, most people would agree that nurses are obligated to respect their clients (a principle), even if they disagree about whether a nurse should keep information from a client about the client's prognosis (action).

**Sanctity of life** directs us to preserve and protect life. Some believe that life is an absolute moral value and no cost or effort should be spared to preserve or prolong it. However, this principle may conflict with other principles, such as autonomy.

**Utility** directs us to perform those actions likely to have the best consequences for all who are affected. It considers the greatest good for the greatest number of people.

**Autonomy** refers to self-determination and the right to make one's own decisions. Respect for person is incorporated and means that nurses recognize the individual's uniqueness, the right to be who the person is, and the right to choose personal goals. Nurses who follow the principle of autonomy respect a client's right to make decisions even when those choices seem to the nurse not to be in the client's best interest.

**Respect for person** also means treating others with consideration. In a healthcare setting, this principle is violated when a nurse disregards clients' subjective accounts of their symptoms (e.g., pain). The application of this principle requires that clients give informed consent before tests and procedures are carried out.

**Nonmaleficence** means the duty to do no harm. This principle is the basis of most codes of nursing ethics. Although this would seem to be a simple principle to follow in nursing practice, in reality it is complex. Harm can mean deliberate harm, risk of harm, and unintentional harm. In nursing, intentional harm is always unacceptable. However, the risk of harm is not always clear. A client may be at risk of harm during a nursing intervention that is intended to be helpful. For example, a client may react adversely to a medication. Sometimes, the degree to which

a risk is morally permissible can be in dispute. There may be situations in which a new but highly risky procedure holds promise of producing a good outcome.

**Beneficence** refers to doing good. Nurses are obligated to act in the best interest of the clients and their support persons. However, in an increasingly technological healthcare system, doing good can also pose a risk of doing harm. For example, a nurse may advise a client about an intensive exercise program to improve general health but should not do so if the client is at risk of cardiovascular compromise.

**Justice** is often referred to as fairness and treating people equally. Nurses frequently face decisions in which a sense of justice should prevail. For example, a nurse is alone on a hospital unit, and one client arrives to be admitted at the same time another client requires a medication for pain. Instead of running from one client to the other, the nurse weighs the situation and then acts based on the principle of justice. It also means that the nurse provides the same level of care regardless of a person's socioeconomic background.

**Fidelity** means to be faithful to agreements and responsibilities one has undertaken. If a nurse tells a client she will return in an hour to check on the effectiveness of the pain medication, she should be faithful to that promise. Nurses have responsibilities to clients, employers, government, society, the profession, and themselves. Fidelity also refers to maintaining confidentiality.

**Veracity** refers to telling the truth. Most children are taught always to tell the truth, but for adults, the choice is often less clear. Does a nurse tell the truth when it is known that doing so will cause harm? Does a nurse tell a lie when it is known that the lie will relieve anxiety and fear? The loss of trust in the nurse and the anxiety caused by not knowing the truth, for example, usually outweigh any benefits derived from lying.

## Ethics in Nursing

The term **ethics** derives from the Greek *ethos*, meaning "custom" or "character." It has several meanings in common usage. First, it refers to a method of inquiry that

### CRITICAL THINKING EXERCISE

You are caring for a client who is contemplating an abortion but has moral distress about doing so. She tells you her boyfriend is strongly opposed to an abortion. She, however, feels she is too young to be a mother but feels

guilty about having an abortion. Applying the moral principles of beneficence, nonmaleficence, veracity, autonomy, justice, fidelity, and veracity, decide how you would care for her. Give your rationale.

assists people to understand the morality of human behavior; that is, ethics is the study of morality. When used in this sense, ethics is an activity; it is a way of looking at or investigating certain issues about human behavior. Second, ethics refers to the practices, beliefs, and standards of behavior of a certain group (e.g., physicians' ethics, nursing ethics). These standards are described in the group's code of professional conduct. **Bioethics** is a relatively new field that applies ethics to life sciences and health care in an interdisciplinary setting (Johnstone, 2009). Because of technological advances, bioethics is receiving increased attention in literature and discussions. *Nursing ethics* refers to ethical issues involved in nursing practice.

Nurses are accountable for their ethical conduct. In 2010, the American Nurses Association (ANA) published the second edition of *Nursing: Scope and Standards of Practice*. Standard 7 relates to ethics. See the accompanying box.

Nurses need to understand their own values related to moral matters and to use ethical reasoning to determine and explain their moral positions. Sometimes it is not enough for nurses to be aware of an ethical issue; they also need moral principles and reasoning skills to explain their position. Otherwise, they may give emotional responses, which often are not helpful.

## Nursing Codes of Ethics

A **code of ethics** is a formal statement of a group's ideals and values. It is a set of ethical principles that is shared by members of the group, reflects their moral judgments over time, and serves as a standard for their professional actions. Codes of ethics are usually higher than legal standards, but they can never be less than the legal standards of the profession.

International, national, state, and provincial nursing associations have established codes of ethics. The International Council of Nurses (ICN) developed and adopted their first code of ethics in 1953. The ICN Code was revised in 2012. The ICN Code of Ethics for Nurses has four principle elements that outline the standards of ethical conduct; these are nurses and people, nurses and practice, nurses and the profession, and nurses and coworkers. The code asserts that nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health, and to alleviate suffering. These responsibilities are believed to be universal (International Council of Nurses, 2012, pp. 2–5).

The ANA first adopted a code of ethics in 1950; it was revised in 1968, 1976, 1985, and 2001 and is simply referred to as the Code for Nurses. It is published in booklet form called *Code of Ethics for Nurses with Interpretive Statements* (2001). The code has nine provisions, and they are shown in the accompanying box.

### ANA Standard of Professional Performance 7: Ethics

The registered nurse practices ethically.

#### Competencies

The registered nurse:

- Uses the *Code of Ethics for Nurses With Interpretive Statements* (American Nurses Association, 2001) to guide practice.
- Delivers care in a manner that preserves and protects healthcare consumer autonomy, dignity, rights, values, and beliefs.
- Recognizes the centrality of the healthcare consumer and his or her family as core members of any healthcare team.
- Upholds healthcare consumer confidentiality within legal and regulatory parameters.
- Assists healthcare consumers in self-determination and informed decision making.
- Maintains a therapeutic and professional healthcare consumer-nurse relationship within appropriate professional role boundaries.
- Contributes to resolving ethical issues involving healthcare consumers, colleagues, community groups, systems, and other stakeholders.

- Takes appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interests of the healthcare consumer or situation.
- Speaks up when appropriate to question healthcare practice when necessary for safety and quality improvement.
- Advocates for equitable healthcare consumer care.

#### Additional Competencies for the Graduate-Level Prepared Specialty Nurse and the APRN

The graduate-level prepared specialty nurse or the advanced practice registered nurse (APRN):

- Participates in interprofessional teams that address ethical risks, benefits, and outcomes.
- Provides information on the risks, benefits, and outcomes of healthcare regimens to allow informed decision making by the healthcare consumer, including informed consent and informed refusal.

Source: *Nursing: Scope and Standards of Practice* (2nd ed.), by the American Nurses Association, 2010, Silver Spring, MD: nursesbooks.org (pp. 47–48).

The code serves the following purposes (American Nurses Association, 2001, p. 5):

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

The first three provisions describe the most fundamental values and commitments, the next three address boundaries of duties and loyalty, and the remaining three address duty beyond individual nurse-patient encounters. The code provides a basis for ethical analysis and decision making and establishes the ethical standard for the profession in the United States.

In 1980, the Canadian Nurses Association (CNA) adopted a code of ethics based on eight primary values central to ethical nursing practice; it was revised in 2008. The *Code of Ethics for Nurses in Australia* was first published in 1993 and revised in 2008 (Nursing and Midwifery Board of Australia, the Australian College of Nursing, and the Australian Nursing Federation, 2008). Increasingly, professional nursing associations are taking an active part in improving and enforcing standards. Nurses are responsible for being familiar with the code that governs their practice.

Nursing codes of ethics have the following purposes:

1. To inform the public about the minimum standards of the profession and to help them understand professional nursing conduct

2. To provide a sign of the profession's commitment to the public it serves
3. To outline the major ethical considerations of the profession
4. To provide general guidelines for professional behavior
5. To guide the profession in self-regulation
6. To remind nurses of the special responsibility they assume when caring for clients

Because the wording in a code of ethics is intentionally vague, such codes can serve as general guides. They do not give direction for actions to take in specific cases. For example, the first item in the ANA Code of Ethics for Nurses (2001) refers to respect for human dignity and states that in caring for clients, nurses should be "unrestricted by considerations of the nature of health problems" (p. 11). Does that mean that it is wrong for a pregnant nurse to refuse to care for a client with active herpes? Or that it is wrong to refuse to care for a client who uses rude language? When making ethical decisions, nurses should consider their code of ethics together with a more unified ethical theory, ethical principles, and the relevant data about each situation.



**InfoQuest:** Identify nursing codes of ethics for at least three nursing organizations worldwide. How are the codes similar? How are they different?

## ANA Code of Ethics for Nurses

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining integrity of the profession and its practice, and for shaping social policy.

Source: Used by permission of the American Nurses Association from the *Code of Ethics for Nurses With Interpretive Statements*, American Nurses Association, 2001, Washington, DC: Author.



## Types of Ethical Problems

Nurses encounter two broad types of problems: decision-focused problems and action-focused problems; each requires a different approach (Wilkinson, 1993, p. 4).

In decision-focused problems, the difficulty lies in deciding what to do, and the question to be asked is “What should I do?” For example:

Because Leon is committed to the sanctity of life, he wishes his client to have artificial nutrition and hydration. As a nurse, Leon also believes in relieving suffering, so when he sees that the tube feedings are prolonging the client’s pain and even contributing to her discomfort, he wishes to have the feedings discontinued. He is not comfortable with either choice.

In this case, two principles clearly apply, so no matter what the nurse does, an important value must be sacrificed. This is the typical **ethical dilemma** that people commonly refer to as “being between a rock and a hard place.” The nature of a dilemma dictates that there are no easy solutions. However, because the difficulty is personal and internal, nurses can address decision-focused problems by engaging in activities developed to enhance decision-making skills, for example, by reviewing their own personal value systems, taking advantage of continuing education offerings, and attending ethics rounds.

In **action-focused problems**, the difficulty lies not in making the decision, but in implementing it. In these situations, nurses usually feel secure in their judgment about what is right but act on their judgment only at personal risk. The central question is “What can I do?” or “What risks am I willing to take to do what is right?” **Moral distress**, one type of action-focused problem, occurs when the nurse knows the right course of action but cannot carry it out because of institutional policies or other constraints (Jameton, 1984, p. 6). The result is feelings of anger, guilt, and loss of integrity on the part of the nurse, which can affect client care. For example:

A resident physician has told the nurses to order a complete blood count (CBC) and urinalysis on all clients and to get the results before calling him to the emergency room to examine the clients. The nurses believe this procedure is unethical because it is wasteful and poses unnecessary discomfort and possible risks for clients. However, they do not have the authority or the access to decision-making channels needed to change the situation. So they order the tests, but they feel guilty and upset because they believe what they are doing is wrong.

Unlike decision-focused problems, one cannot resolve action-focused problems by improving one’s decision-making skills. Even after a nurse decides what is right to do, the issue becomes what the nurse actually can do given the conditions of practice. Nurses’ actions are influenced by such constraints as lack of support from both peers and administrators and consequently fear of losing their jobs or their nursing licenses and fear of legal action. Action-focused problems require knowledge, experience, communication, and the ability to make integrity-preserving compromises. To deal successfully with these problems, nurses must shift their attention away from making the right decision to focusing on the factors that are preventing the right action (Wilkinson, 1993, p. 5). The professional code of ethics provides support for doing the right thing in many situations.

Ethical conflicts also arise from nurses’ unresolved questions about the nature and scope of their practice. High-technology and specialty roles (intensive care nurses, advanced practice nurses) have expanded the scope of nursing practice, often causing nursing and medical activities to overlap and creating value conflicts for nurses. For example:

- Although nurses value health promotion and wellness, many still work in hospitals and many are involved in high-tech treatment of illness.
- Although the profession values a humanistic, caring approach and emphasizes nurse-client relationships, many nurses spend much of their time attending to the client’s machines.

Because of their unique position in the healthcare system, nurses experience conflicting loyalties and obligations to clients, families, physicians, employing institutions, and licensing bodies. The client’s needs may conflict with institutional policies, physician preferences, needs of the client’s family, or even laws of the state. According to the nursing code of ethics, the nurse’s first allegiance is to the client. However, it is not always easy to determine which action best serves the client’s needs. For instance, a nurse may believe that the client’s interests require telling the client a truth that others have been withholding. But this action might damage the client-physician relationship, in the long run causing harm to the client rather than the intended good.

## Making Ethical Decisions

Responsible ethical reasoning involves rational thinking. It is also systematic and based on ethical principles and civil law. It should not be based on emotions, intuition, fixed policies, or precedent. (A *precedent* is an earlier similar occurrence. For example, “We have always done it this way” is a statement reflecting a decision based on precedent.)



## RESEARCH CURRENT

## Consequences of Clinical Situations That Cause Critical Care Nurses to Experience Moral Distress

Wiegand and Funk's open-ended survey identified clinical situations that caused critical care nurses to experience moral distress and its consequences. Three questions were asked: (1) What situations caused moral distress for critical care nurses? (2) What were the consequences of each of the situations? (3) What would the critical care nurses do differently if faced with a similar situation in the future? Handwritten responses were obtained from 49 nurses and were then subjected to an inductive thematic analysis. A random sample of 10 of the participants was analyzed by a second researcher to ensure consistency in the themes. Of the 49 nurses in the original sample, 79% said that they had experienced moral distress. The majority of the situations that caused the moral distress were related to end-of-life care, including medical futility, organ donation, and over- or underadministration of analgesic medications. Situations other than end-of-life care included disclosure or

nondisclosure of patient information, lack of respect for the patient, maintaining safe care, safety of the nurse, and lack of a work ethic on the part of others. Negative consequences for the patient and for the nurse resulted. Patients experienced more suffering and prolonged death, undignified death, quantity versus quality of life, disrespect, and false hope. For nurses, the consequences included frustration, anger, and psychological and physical exhaustion. Some felt they had to administer a lower standard of care. Of the nurses in the study, 60% said they would intervene in a similar clinical situation in the future, while 40% said they would not. Moral distress occurs frequently in nursing practice and has detrimental effects on nurses. However, it can strengthen resolve to do better in the future.

*Source:* "Consequences of Clinical Situations That Cause Critical Care Nurses to Experience Moral Distress," by D. L. Wiegand and M. Funk, 2012, *Nursing Ethics*, 19(4), pp. 479–487.

Catalano (2009) has developed an ethical decision-making algorithm for the nurse. It involves five steps, beginning with the identification of a potential ethical dilemma and resulting in either a resolution or a decision to take no action. Many components enter into the decision-making process, including:

- Facts of the specific situation
- Ethical theories and principles
- Nursing codes of ethics
- The client's rights
- Personal values
- Factors that contribute to or hinder one's ability to make or enact a choice, such as cultural values, societal expectations, degree of commitment, lack of time, lack of experience, ignorance or fear of the law, and conflicting loyalties

Ethical decision making that entails a person's choices, values, and actions begins in desire: People are inspired by a desire to pursue the good as each of them sees it. However,

to know that what they are pursuing truly is good, people must rely on reason. Ethical choices, values, and actions then become a reasoned desire (Husted & Husted, 2008, pp. 178–183).

Nurses are responsible for deciding on their own actions and for supporting clients who are making ethical decisions or coping with the results of decisions that other people have made. A good decision is one that is in the client's best interest and at the same time preserves the integrity of all involved. Nurses have multiple obligations when making ethical decisions (see the accompanying box).

Ethical decision making requires that the nurse understand the differences among problems, dilemmas, and quandaries. A problem may be hard to understand and to deal with, but it is solvable in principle. A **quandary** is a perplexed state with uncertainty over alternatives. A **dilemma** is a specific situation involving a choice between undesirable alternatives, where there are no precedents or rules to follow (Thompson, Melia, Boyd, &

## Examples of Nurses' Obligations in Ethical Decisions

- Maximizing the client's well-being
- Balancing the client's need for autonomy with family members' responsibilities for the client's well-being
- Supporting each family member and enhancing the family support system
- Carrying out hospital policies
- Protecting other clients' well-being
- Protecting the nurse's own standards of care

Horsburgh, 2006, p. 47). Moral dilemmas bring into sharper focus the moral values and principles that matter. Ethical decision making applies problem solving and involves reflecting on alternatives and justification of actions chosen.

In some cases, the most important question is who should make the decision. When the decision maker is the client, the nurse functions in a supportive role. Clients need knowledge about the probability and nature of the consequences attending various courses of action, and nurses share their special knowledge and expertise with clients to enable them to make informed decisions.

The following questions may help the nurse determine ownership of the decision:

- For whom is the decision being made?
- Who should be involved in making the decision, and why?
- What criteria (social, economic, psychological, physiological, or legal) should be used in deciding who makes the decision?
- What degree of consent is needed by the subject of the decision?

Table 4–5 shows an example using a bioethical decision-making model.

Because they have ethical obligations to their clients, to the agency that employs them, and to the other members of the health-care team, nurses weigh competing factors when making ethical decisions. In many health-care settings, nurses are not given the autonomy to act on their own moral or ethical choices.

The goal of settling moral conflict is to ensure that the conflicting values of all parties are respected, and sometimes concessions are made. When compromises are necessary, the most desirable outcome is the preservation of each person's integrity, with no one forced to give up values, principles, or moral integrity. In the process, all parties are encouraged to discuss personal values, their assessment of the situation, and the perceived best decision for the client. For example, a nurse who is opposed to abortion provides physical care and emotional support for a woman having an elective abortion because there was no one else available to provide adequate care. The outcome of moral compromise strives to preserve each party's integrity with a decision that respects the values held by all the decision makers; the outcome does not necessarily

**TABLE 4–5 Clinical Application of Bioethical Decision-Making Model**

| <b>Situation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mrs. LaVesque, a 67-year-old woman, is hospitalized with multiple fractures and lacerations caused by an automobile crash. Her husband, who was killed in the crash, was taken to the same hospital. Mrs. LaVesque, who had been driving the automobile, constantly questions Kate Murillo, her primary nurse, about her husband. The surgeon, Dr. Mario Gonzales, has told the nurse not to tell Mrs. LaVesque about the death of her husband; however, he does not give the nurse any reason for these instructions. Ms. Murillo expresses concern to the charge nurse, who says the surgeon's orders must be followed. Ms. Murillo is not comfortable with this ruling and wonders what she should do. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Nursing Actions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Considerations</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1. The moral aspects.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | In this situation, the ethical dilemma is either to tell the truth or to withhold it. There is conflict between the values of honesty and loyalty. The primary nurse wants to be honest with Mrs. LaVesque without being disloyal to the surgeon and the charge nurse. Her choice will probably be affected by her concern for Mrs. LaVesque and perhaps by the surgeon's incomplete communication with her.                                                                                                                                                                                                            |
| 2. Gather relevant facts related to the issue.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Data should include information about the client's health problems. Also a determination should be made about who is involved, the nature of their involvement, and their motives for acting. In this case, the people involved are the client (who is concerned about her husband), the husband (who is deceased), the surgeon, the charge nurse, and the primary nurse. Motives are not known. Perhaps, the nurse wishes to protect her therapeutic relationship with Mrs. LaVesque; possibly, the physician believes he is protecting Mrs. LaVesque from psychological trauma and consequent physical deterioration. |
| 3. Determine ownership of the decision.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | In this case, the decision is being made for Mrs. LaVesque. The surgeon obviously believes that he should be the one to decide, and the charge nurse agrees. It would be helpful if caregivers agreed on criteria for deciding who the decision maker should be.                                                                                                                                                                                                                                                                                                                                                        |

(Continued)

**TABLE 4–5 Clinical Application of Bioethical Decision-Making Model (Cont.)**

| Nursing Actions                                                                                                                                                                                                                                                                                                                                                                    | Considerations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4. Clarify and apply personal values.                                                                                                                                                                                                                                                                                                                                              | We can infer from this situation that Mrs. LaVesque values her husband's welfare, that the charge nurse values policy and procedure, and that Ms. Murillo seems to value a client's right to have information. Ms. Murillo needs to clarify her own and the surgeon's values, as well as confirm the values of Mrs. LaVesque and the charge nurse.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 5. Identify ethical theories and principles.                                                                                                                                                                                                                                                                                                                                       | For example, failing to tell Mrs. LaVesque the truth can negate her autonomy. The nurse would uphold the principle of honesty by telling Mrs. LaVesque. The principles of beneficence and nonmaleficence are also involved because of the possible effects of the alternative actions on Mrs. LaVesque's physical and psychological well-being.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 6. Identify applicable laws or agency policies.                                                                                                                                                                                                                                                                                                                                    | Because Dr. Gonzales simply "gave instructions" rather than an actual order, agency policies might not require Ms. Murillo to do as he says. She should clarify this question with the charge nurse. She should also be familiar with the nurse practice act in her state or province.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 7. Use competent interdisciplinary resources.                                                                                                                                                                                                                                                                                                                                      | In this case, Ms. Murillo might consult literature to find out whether clients are harmed by receiving bad news when they are injured. She might also consult with the hospital chaplain.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 8. Develop alternative actions and project their outcomes for the client and family. Possibly because of the limited time available for ethical deliberations in the clinical setting, nurses tend to identify two opposing, either-or, alternatives (e.g., to tell or not to tell) instead of generating multiple options. This approach creates a dilemma even when none exists. | Two alternative actions, with possible outcomes, follow:<br>1. Follow the charge nurse's advice and do as the surgeon says. Possible outcomes: (a) Mrs. LaVesque might become increasingly anxious and angry when she finds out that information has been withheld from her; or (b) by waiting until Mrs. LaVesque is stronger to give her the bad news, the healthcare team avoids harming Mrs. LaVesque's health.<br>2. Discuss the situation further with the charge nurse and the surgeon, pointing out Mrs. LaVesque's right to autonomy and information. Possible outcomes: (a) The surgeon acknowledges Mrs. LaVesque's right to be informed, or (b) he states that Mrs. LaVesque's health is at risk and insists that she not be informed until a later time. Regardless of whether the action is congruent with Ms. Murillo's personal value system, Mrs. LaVesque's best interests take precedence. |
| 9. Apply nursing codes of ethics to help guide actions. Codes of nursing usually support autonomy and nursing advocacy.                                                                                                                                                                                                                                                            | If Ms. Murillo believes strongly that Mrs. LaVesque should hear the truth, then, as a client advocate, she should choose to confer again with the charge nurse and the surgeon.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 10. For each alternative action, identify the risk and seriousness of consequences for the nurse.                                                                                                                                                                                                                                                                                  | If Ms. Murillo tells Mrs. LaVesque the truth without the agreement of the charge nurse and the surgeon, she risks the surgeon's anger and a reprimand from the charge nurse. If Ms. Murillo follows the charge nurse's advice, she will receive approval from the charge nurse and the surgeon; however, she risks being seen as unassertive, and she violates her personal value of truthfulness. If Ms. Murillo requests a conference, she may gain respect for her assertiveness and professionalism, but she risks the surgeon's annoyance at having his instructions questioned.                                                                                                                                                                                                                                                                                                                         |
| 11. Participate actively in resolving the issue.                                                                                                                                                                                                                                                                                                                                   | The appropriate degree of nursing input varies with the situation. Sometimes, nurses participate in choosing what will be done; sometimes, they merely support a client who is making the decision. In this situation, if an action cannot be agreed upon, Ms. Murillo must decide whether this issue is important enough to merit the personal risks involved.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 12. Implement the action.                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 13. Evaluate the action taken.                                                                                                                                                                                                                                                                                                                                                     | Ms. Murillo can begin by asking, "Did I do the right thing?" Involve the client, family, and other members of the healthcare team in the evaluation, if possible. Ms. Murillo can ask herself whether she would make the same decision again if the situation were repeated. If she is not satisfied, she can review other alternatives and work through the process again.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

Source: "Preparing Students to Be Moral Agents in Clinical Nursing Practice," by J. Cassells and B. Redman, June 1989, *Nursing Clinics of North America*, 24(2), pp. 463–473.

fall in line with what any one person thinks should be done. Each participant needs to recognize reasonable differences of opinion, see things from others' points of view, and reach an agreement that is mutual and peaceful for all concerned.

According to Winslow and Winslow (1991, pp. 309, 315–320), an **integrity-preserving moral compromise** is one in which the following elements are present:

1. **Some basic moral language must be shared.** Currently, moral and ethical issues are expressed in the language of client care, client rights, autonomy, and client advocacy. One task of institutional ethics committees is to provide a setting in which a mutual moral language can be built.
2. **A context of mutual respect must exist.** All parties must listen with respect to those with whom they differ. Coercive measures are not used. Without mutual respect, compromise becomes capitulation or persuasion. Everyone's views must be considered.
3. **The moral perplexity of the situation must be honestly acknowledged.** Each person should retain a sense of humility, remembering that there are elements of uncertainty and that he or she could be wrong.
4. **Legitimate limits to compromise must be admitted.** There are times when one cannot compromise. Compromise is more likely when there is factual uncertainty, ambiguity, and an extremely complex situation. The more certain a person is of the facts and the more clearly convinced he or she is about the morality of a course of action, the less room there is for compromise. The limits of compromise are reached when a person is so certain about a particular course of action that to compromise on that point would be to compromise the sense of self as a moral agent.

## Specific Ethical Issues

The changing scope of nursing practice has led to an increasing incidence of conflicts between clients' needs and expectations and nurses' professional values. Some of these conflicts involve end-of-life care, elective abortion, genetic engineering, and the allocation of healthcare resources. With the development of sophisticated technology that affects the course and outcome of illness, nurses and clients face more complex ethical decisions. Because today's public is better informed about medical advances and issues, it is important that nurses become comfortable in dealing with clients, families, and peers facing ethical decisions. Nurses are ethically obligated to maintain a non-judgmental attitude, to be honest, and to protect the client's right to privacy and confidentiality.

### Elective Abortion

Abortion is a highly publicized issue about which many people, including nurses, feel very strongly. Debate continues, pitting the principle of the sanctity of life against the principle of autonomy and the woman's right to control her own body. This is an especially volatile issue because no public consensus has yet been reached.

Most state and provincial laws have provisions known as *conscience clauses*, which permit individual physicians and nurses, as well as institutions, to refuse to assist with an abortion if doing so violates their religious or moral principles. However, nurses have no right to impose their values on a client, and nursing codes of ethics support clients' rights to information and counseling regarding abortion.

### End-of-Life Care

Advances in health-care technology have made it possible to sustain life much longer than previously possible. Some people want everything possible done to maintain life, and others do not. Competent adults have a legal right to refuse any medical treatment or to have it withdrawn. Often, family members of the dying patient cannot make end-of-life decisions or have conflicting desires about the care that should be provided. *Advance directives* and *living wills* allow people to indicate their desires about end-of-life care. A *durable power of attorney* designates a decision maker in the event that the patient is unable to make the choice. Information about advance directives are mandated for individuals admitted to health-care facilities. Nurses are often called upon to present information and provide explanations.

Active and passive euthanasia are also end-of-life issues. *Active euthanasia* involves the administration of a lethal agent to end life and alleviate suffering; this approach can result in criminal charges. *Passive euthanasia* involves the withdrawal of extraordinary means of life support, such as removing ventilator support and withholding resuscitation (do-not-resuscitate [DNR] orders). The concept of death with dignity and concerns about quality of life have brought about right-to-die legislative actions. These statutes absolve healthcare personnel from possible liability when they support a client's wishes not to prolong life. However, these statutes are complex and varied. Nurses are advised to familiarize themselves with the statutes in their particular state or province.

Withdrawing or withholding food and fluids, as well as terminating or withholding treatment, presents difficult decisions. It is generally accepted that providing food and fluids is part of nursing practice and is therefore a moral duty. A nurse is morally obligated, however, to withhold food and fluids when it is more harmful to administer them than to withhold them.

Clients may specify that they wish to have life-sustaining measures withdrawn, they may have advance directives on this matter, or they may have specified a surrogate decision maker. When these decisions are made, the nurse, as the primary caregiver, must ensure that sensitive care and comfort measures are given as the client's illness progresses. A decision to withdraw treatment is not a decision to withdraw care.

### Organ Donation

Organs for transplantation may come from living donors or from donors who have just died. Ethical issues related to organ transplantation include the allocation of organs, the selling of body parts, the involvement of children as potential donors and recipients, and cloning for the manufacture of organs. Ethical decision making related to these issues is complex. In some situations, religious beliefs may be a source of conflict; for example, the mutilation of the body even for the benefit of another person may be forbidden.

Many people are choosing to become donors by giving consent under the Uniform Anatomical Gift Act. Making these decisions in advance can be helpful. When there is a death resulting from injury and organs are healthy enough to be harvested, it often falls upon the nurse and other members of the healthcare team to approach the grieving family about the possibility of organ donation. Many nurses feel uncomfortable about discussing this topic with the family. Some nurses have strong feelings about organ donation that make it difficult to remain neutral when a family faces that decision.

### Allocation of Health Resources

Allocation of healthcare goods and services, including such things as organ transplants, the services of medical specialists, and care involving expensive technology, has become an especially urgent issue as medical costs continue to rise and more stringent cost-containment measures are implemented. For example, decisions about the number of office visits and the length of hospital stays are increasingly being influenced not by medical considerations but by administrative policies of healthcare facilities and funding entities, such as insurance companies, HMOs, and Medicare. Third-party coverage of some expensive and/or experimental treatments is being denied.

Critics dispute that health care is a scarce resource in North America; instead, they contend that access to health care is limited for segments of the population. Increasing people's access to health care is costly, however, and makes decisions about providing and financing health care difficult. An ethical argument arises as to whether health care is a right or a privilege.

### Reflect On . . .

- whether there should be a level of essential care that is provided for all individuals and a higher level that must be financed privately.
- whether preventive care services should receive the same financing as illness services.
- your views about organ donation from someone under the age of 18 years.

## RESEARCH CURRENT

### Moral Obligations of Nurses and Physicians in Neonatal End-of-Life Care

Epstein's study of perceived moral obligations during end-of-life care in the neonatal intensive care unit (NICU) interviewed 19 nurses and 11 physicians, identified through purposive sampling. These nurses and physicians provided care in a level III NICU, where 21 neonatal deaths occurred during the study. A demographic survey and a semistructured interview were used for data collection as the participants were asked to describe their overall experience with a particular infant and family around the time of death. They were then asked, "What were your obligations to the infant and family?" A phenomenological approach was used to analyze the content and identify common threads. The central obligation of both nurses and physicians was to create the best possible experience

for the infants and their parents. While there was significant overlap in the responses, there were also differences. Physicians said that their obligations occurred around decision making, while the nurses said that their obligations were based on the end-of-life period. The specific obligations that they identified were (1) providing options, (2) preparing parents, and (3) *being with* the parents and the infant. In addition, the nurses identified an obligation to act as a liaison with the physician and to create peace and normalcy. These findings inform about how nurses and physicians view their moral duties in providing end-of-life care to neonates and their parents.

Source: "Moral Obligations of Nurses and Physicians in Neonatal End-of-Life Care," by E. G. Epstein, 2010, *Nursing Ethics*, 17(5), pp. 577–589.



Jameton (1984) distinguishes among three categories of ethical issues: moral uncertainty, moral dilemma, and moral distress. *Moral uncertainty* may be the earliest response of the nurse when there is a feeling that “something is not right” or there is uncertainty about what is right. It results in discomfort and tension. A *moral dilemma* poses two opposing courses of action, both of which can be justified, but the nurse is uncertain about the best alternative. *Moral distress* occurs when the nurse knows the right action to take but feels powerless due to some restriction such as institutional policy or lack of resources. Feelings of moral distress may eventually lead to negativity and burnout (Cohen & Erickson, 2006).

### Strategies to Enhance Ethical Decision Making

Rodney and Starzomski (1993, p. 24) and Davis and Aroskar (2010, p. 65) describe several strategies to help nurses overcome possible organizational and social constraints that may hinder the ethical practice of nursing and create moral distress for nurses. These strategies encompass the areas of education, administration, practice, and research.

**Become aware of one’s own values and the ethical aspects of nursing situations** Much of this chapter has been devoted to discussions of nursing values and ethical situations. Most nursing programs include information about these topics at the undergraduate and graduate levels. Continuing education, in the form of in-service programs or other activities, also helps practicing professionals learn more about ethics.

**Be familiar with nursing codes of ethics** The content and intent of these codes focus on supporting nursing practice based on ethical principles.

**Understand the values of other healthcare professionals** An understanding of the values that other healthcare professionals hold enables nurses to appreciate and respect values, opinions, and responsibilities similar to and different from their own. For example, nurses may find it helpful to know that the American Medical Association considers it morally permissible to refrain from exercising or to discontinue extraordinary efforts to prolong life. In this context, the choice of action is decided on the basis of doing good and avoiding harm.

Some educational institutions now include interdisciplinary ethics education at both undergraduate and graduate levels to enhance the understanding of beliefs, responsibilities, and values among various members of the healthcare team. For example, nursing students and medical students

take classes together on bioethics, professional ethics, and business ethics. The goal of this type of interdisciplinary education is to bring about better team communication in the practice setting.

**Participate on ethics committees** Because nurses have more contact with the client and the family than other members of the healthcare team, they know the client better and have access to special kinds of information not available to other healthcare professionals. Nurses offer unique perspectives that can greatly improve the quality of the ethical decisions made in healthcare settings. One important way for nurses to provide input is to serve on institutional ethics committees. Standards established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (now The Joint Commission) support this involvement.

Ethics committees typically review cases, write guidelines and policies, and provide education and counseling. They ensure that relevant facts are brought out; provide a forum in which diverse views, such as views on resource allocation, can be expressed; and reduce stress for caregivers, and they can reduce legal risks. These factors tend to produce better decisions than would otherwise be made.

Institutional policies and guidelines about such issues as informed consent, the withdrawal or withholding of life-sustaining treatment, and do-not-resuscitate (DNR) orders provide direction for all healthcare practitioners to resolve ethical conflicts. To encourage the most effective functioning, ethics committees need to include representatives of all parties involved: consumers, hospital administrators, nurses, physicians, attorneys, hospital chaplains, social workers, and bioethicists.

**Participate in or establish a nursing ethics group** A nursing ethics group can address the specific ethical issues of nursing practice and explore ethical choices nurses consider on a daily basis. Nurses are most commonly involved in issues of client refusal of treatment, informed consent, discontinuation of life-saving treatment, withholding of information from clients, confidentiality, client competence, and allocation of resources.

Nursing ethics committees also can provide an opportunity for nurse-to-nurse collaboration, facilitating effective cooperation among nurses and increasing nurses’ power or capacity to produce change and to implement the care they believe to be most beneficial to their clients. For nurses to act freely as moral agents within any institution, collaboration among and support of peers are essential. Discussions with peers during difficult ethical situations help to reduce nurses’ moral distress.

**Participate in or establish educational ethics rounds**

Ethics rounds using hypothetical or real cases can be used to explore ethical principles and discuss ethical dilemmas. Ethics rounds incorporate the traditional teaching approach for clinical rounds, but the focus is on the ethical dimensions of client care rather than the client's clinical diagnosis and treatment. Discussions may be held at the bedside, where healthcare professionals can speak directly to the client. Consent from the client must first be obtained.

Ethics rounds help all those involved to articulate their own views, encourage discussion of value conflicts, and help individuals apply decision-making skills. There are various formats. The situations to be discussed may be presented by staff nurses, advanced nursing students, clinical nurse specialists, or ethics consultants, among others. Rounds serve as examples for future situations the nurse may confront. Each healthcare facility establishes the format and procedure of ethics rounds to fit its particular situation.

## Advocacy

Advocacy is an ethical concept for nursing practice and refers to providing support for a patient's rights or best interests. The word *advocate* derives from the Latin *advocatus*, meaning, "one summoned to give evidence." The focus of the client advocacy role is to respect client decisions and enhance client autonomy. Values basic to client advocacy are shown in the accompanying box.

Three models can be used to describe nurse advocacy for patients. One is the **rights protection model**, which places the nurse as defender of the patient's rights within the healthcare system. The nurse informs patients of their rights, makes certain that rights are understood, and protects patients from infringement of those rights. The second model is the **values-based model**, which positions the nurse as the one who discusses patients' needs and choices with them and helps them reach decisions consistent with their values and lifestyles,

without the nurse imposing her or his personal values and beliefs on the patient's decision making. A third model is the **respect-for-persons model** which sees the patient as a fellow human entitled to respect. The nurse acts to protect dignity, privacy, and choices. It is consistent with the various codes of ethics for nurses to protect patients from harm (Fry & Johnstone, 2008).

## The Advocacy Role

The nurse needs self-knowledge as well as professional knowledge about nursing and health care or needs to know where to obtain such knowledge to assist clients in their decision making. Nurses as knowledgeable professionals share their unique knowledge with the community when needed. Today's healthcare crises of homelessness, teenage pregnancy, child and spouse abuse, drug and alcohol abuse, and increasing healthcare costs all demand that the nurse fulfill the role of advocate in the community.

## Professional/Public Advocacy

Gates (1995, p. 32) states that advocacy encompasses a range of approaches, including legal, self, collective (class), and citizen advocacy. Citizen advocacy may be likened to client advocacy. See Table 4–6.

The defining attributes of patient advocacy include the following (Baldwin, 2003):

- Securing patients' freedom and self-determination by means of a therapeutic nurse-patient relationship
- Promoting and protecting patients' rights to be involved in decision making and informed consent
- Acting as an intermediary between patients and their families or significant others, and between them and healthcare providers

These attributes involve valuing patients as unique individuals and informing, advising, and educating them to help in their reasoning and deliberations. The nurse may need to intercede and help patients overcome barriers to meeting their needs in a context of vulnerability, in which

## Nursing Values Basic to Client Advocacy

- 
- The client is a holistic, autonomous being who has the right to make choices and decisions.
  - Clients have the right to expect a nurse-client relationship that is based on shared respect, trust, collaboration in solving problems related to health and healthcare needs, and consideration of their thoughts and feelings.
  - Clients are responsible for their health.
  - Nurses are responsible for helping clients use their strengths to achieve the highest level of health possible.
  - It is the nurse's responsibility to ensure the client has access to healthcare services that meet his or her health needs.
  - The nurse and client are equally accountable and responsible for the outcomes of care.
-

**TABLE 4–6 Types of Advocacy**

| Type                                | Description                                                                                                                                                                                                                                                            | Example                                                                                                                                                                                                                 |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Legal advocacy</i>               | Related to various tribunals and other court case work                                                                                                                                                                                                                 | Limited to the work of attorneys or other court-appointed agents                                                                                                                                                        |
| <i>Self-advocacy</i>                | Individual people or groups speaking or acting on behalf of other people on issues that are of mutual interest, which includes encouraging individuals to speak for themselves to establish self-empowerment                                                           | Individual clients or family members telling the physician their own requirements related to treatment<br>Nurses behaving assertively in describing their own needs to administrators                                   |
| <i>Collective or class advocacy</i> | Relatively large organizations that pursue the interests of a category of people and that usually have a national resource that provides full-time officers, as well as volunteers who are able to act as advocates                                                    | American Association for Retired Persons (AARP), National Association for the Advancement of Colored People (NAACP)<br>Professional organizations: American Nurses Association (ANA), Canadian Nurses Association (CNA) |
| <i>Citizen or client advocacy</i>   | Concerned primarily with empowering people through an individual relationship in which one person represents, as if they were his or her own, the interests of another person who has needs that are unmet and are likely to remain unmet without special intervention | Nurse, social worker, court-appointed temporary guardian, guardian ad litem                                                                                                                                             |

the nurse is needed for assistance in facing a conflict or making a decision.

An advocate supports clients in their decisions. Support can involve action or nonaction. An advocate must know how to provide support in an objective manner, being careful not to convey approval or disapproval of the client's choices. Advocacy involves accepting and respecting the client's right to decide, even if the nurse believes the decision is wrong. As advocates, nurses do not make decisions for clients; clients must make their own decisions freely. For example, after being fully informed about the chemotherapy treatment, the alternative treatments, and the possible consequences of the available choices, Mr. Rae decides against further chemotherapy for his cancer. The client advocate supports Mr. Rae in his decision. Underlying client advocacy are the beliefs that individuals have the following rights (Donahue, 1985, p. 1037):

- The right to select values they deem necessary to sustain their lives
- The right to decide which course of action will best achieve the chosen values
- The right to dispose of values in a way they choose without coercion by others

There are many occasions when the nurse may speak up for clients. Examples include issues of resuscitation

status, inadequate pain control, lack of information, or the client's desire to refuse a treatment. It is often stated that nurses are in a unique position to be client advocates because they spend more time with clients and their families than any other healthcare professionals. However, a number of challenges face nurses who wish to act as client advocates. To be a client advocate involves the following:

- Being assertive
- Recognizing that the rights and values of clients and their families must take precedence when they conflict with those of healthcare providers
- Ensuring that clients and families are adequately informed to make decisions about their own health and health care
- Being aware that potential conflicts may arise over issues that require consultation, confrontation, or negotiation between the nurses and the administrative personnel or between the nurse and the physician
- Working with unfamiliar community agencies or lay practitioners

Advocacy may also require political action, such as communicating a client's healthcare needs to government and other officials who have the authority to do something about these needs.

**Reflect On . . .**

- risks the nurse takes when assuming an advocacy role. What benefits might the nurse realize when acting as an advocate?
- factors that would make the nurse an appropriate or inappropriate advocate for a client. In what situations might you feel personally compromised as the client's advocate?
- what client advocacy needs may be required as a result of changes in technology.

- what societal situations require professional nursing advocacy.



**InfoQuest:** The National Center for Ethics in Health Care has a website with information about integrated ethics. It has a number of educational tools and informative articles related to clinical practice. The center is operated by the Veterans Administration. Visit the website at [www.ethics.va.gov](http://www.ethics.va.gov) and note the information on integrated ethics.

**Chapter Highlights**

- Values give direction and meaning to life and guide a person's behavior.
- Values are freely chosen, prized and cherished, affirmed to others, and consistently incorporated into one's behavior.
- A person may internalize some or all of these values and perceive them as *personal values*.
- *Professional values* often reflect and expand on personal values.
- *Values clarification* is a process in which people identify, examine, and develop their own values.
- *Morality* refers to what is right and wrong in conduct, character, or attitude, that is, the requirements necessary for people to live together in society.
- *Moral behavior* is the way a person perceives those requirements and responds to them.
- *Moral development* is the pattern of change in moral behavior that occurs with age.
- According to Lawrence Kohlberg, moral development progresses through three levels: the premoral or pre-conventional level; the conventional level; and the postconventional, autonomous, or principled level. Each level has two stages.
- Carol Gilligan describes three stages in the process of developing an "ethic of care": caring for oneself, caring for others, and caring for self and others.
- The general moral frameworks are teleology, deontology, virtue ethics, and caring.
- Moral principles, such as autonomy, beneficence, non-maleficence, justice, fidelity, and veracity, are broad, general philosophical concepts.
- Nursing codes of ethics are formal statements of the profession's ideals and values that serve as a standard for professional actions and inform the public of the profession's commitment.
- Nurses' ethical decisions are influenced by their role perceptions, moral theories and principles, nursing codes of ethics, level of cognitive development, and personal and professional values.
- In all situations, nurses are ethically obligated to maintain a nonjudgmental attitude, to be honest, and to protect the client's right of privacy and confidentiality.
- To enhance their ethical decision making, nurses can gain a better understanding of their own values and those of other healthcare professionals; participate on ethics committees, nursing ethics groups, and educational rounds; and help establish an ethical research base.
- The focus of client advocacy is to respect client decisions and enhance client autonomy. Its goal is to protect the rights of clients.
- Various levels and types of client advocacy include advocacy for self, advocacy for the client, and advocacy for the community of which the nurse is a part.



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# 5

## Legal Foundations of Professional Nursing

### Chapter Outline

#### Challenges and Opportunities

#### The Legal System

- Constitutions
- Statutory Law
- Administrative Law
- Judicial or Decisional Law
- Types of Legal Actions

#### Safeguarding the Public

#### Credentialing

- Licensure
- Registration
- Certification
- Accreditation
- Standards of Care

#### Potential Liability Areas

- Negligence and Malpractice
- Documentation
- Delegation
- Restraints
- Informed Consent
- Advance Healthcare Directives
- Do-Not-Resuscitate Orders
- Adverse Events and Risk Management
- Death and Related Issues

#### The Impaired Nurse

#### Sexual Harassment

#### Nurses as Witnesses

#### Collective Bargaining

#### Chapter Highlights

### Objectives

1. Identify primary sources of law and types of legal actions.
2. Describe the nurse practice act as the legal boundary of nursing.
3. Discuss essential legal aspects of malpractice, informed consent, adverse event reports, DNR orders, euthanasia, and death-related issues.
4. Examine the nurse's role in identifying and assisting the impaired nurse.
5. Examine the problem of sexual harassment in nursing.
6. Consider how the collective bargaining process is used to improve nursing practice.

**K**nowledge of legal rights and responsibilities related to nursing practice is essential for the nurse. In the past, nurses were not considered responsible for their actions. In fact, the hospital, physician, clinic, or employing agency assumed responsibility for a nurse's actions. In the 19th century, life was fairly simple, and questions were uncomplicated. Medical advances were few. The roles of physicians and nurses were to support patients through times of illness, helping them toward recovery or providing comfort measures until death. The nurse acted as a caregiver and physician helper. However, as nursing practice became more autonomous, nurses have increasingly been held responsible for their actions as well as the actions of those they supervise. Understanding one's own rights and responsibilities as a registered nurse, as well as those of others, is essential for competent and safe nursing practice. Standards of practice, codes of ethics, and established laws serve as both guides and boundaries for nursing practice.

In 1938, New York State passed the first nurse practice act, which was implemented in 1949. By 1952, all states had nurse practice acts. Nurse practice acts control the practice of nursing through licensure. They legally define the practice of nursing within the specific state, thereby describing the scope of nursing and protecting the public. Nurse practice acts also set the requirements for licensure, including educational requirements, and they describe the legal titles and abbreviations that a nurse may use.

## Challenges and Opportunities

The latter part of the 20th century introduced lifesaving technology. The creation of critical care units, new surgical techniques for organ transplantation and the development of medications to prevent rejection, the ability to keep individuals alive on life support, and the ability to manipulate genes to mediate genetically carried diseases presented new legal and ethical challenges for nurses. These advances led to the development of advance healthcare directives, such as living wills, and the creation of healthcare surrogates. In many situations, nurses needed to act as client advocates to articulate the wishes of their clients.

Scientific development and new technological advances will continue to create situations and questions that may be resolved only in courts of law. Genetic engineering and the identification of disease-carrying genes present problems regarding confidentiality and possible discrimination. As client advocates, nurses find themselves on the front line in many of these situations. Analysis, discussion, and debate among nurses, other healthcare providers, ethicists, and attorneys will take place to develop an understanding and agreement on public policy and laws regarding these scientific advances.

Changes in the healthcare system have provided new opportunities for nursing. The roles of the advanced practice nurse (APN), clinical specialist, and clinical nurse leader (CNL) have taken on new dimensions. APNs act as primary care providers in areas such as emergency care, critical care, and prison health, and in community health settings such as schools and free-standing clinics. Many work as first surgical assistants. Additionally, APNs work as nurse midwives and nurse anesthetists. With these expanded roles come added responsibilities and legal issues.

Nurses will need to understand the legalities involved with these new technologies to practice safely and effectively. Dock (1907) emphasized, “It is essential that nurses as trained workers exercise social awareness” (p. 896). Scientific achievements have opened up new ground for nursing exploration. In response to the need for nursing input into social and legal issues, nurses now find career opportunities as forensic nurses, legal nurse consultants, and nurse attorneys.

## The Legal System

Law is defined by Sheppard (2011) as “a system of rules followed by officials and by those subject to law in their daily lives, which are fair and just” (p. 619). The legal systems in both the United States and Canada have their origins in the English common law system. The four primary sources of law are constitutions, statutes, administrative

laws, and decisions of courts (also referred to as *common law* or *judicial law*).

### Constitutions

Constitutions “establish the basis of the governing system” (Guido, 2014, p. 2). Examples of constitutions are the Constitution of the United States, the Bill of Rights, and amendments to the U.S. Constitution. The Constitution of the United States, which was ratified in 1787, establishes the general organization of the federal government into the executive, legislative, and judicial branches; grants certain powers to each branch; and places limits on what federal and state governments may do. Constitutions create legal rights and responsibilities and are the foundation for a system of justice. The individual states also have constitutions, but state statutes and regulations must be consistent with the principles contained in the Constitution of the United States.

### Statutory Law

Laws enacted by any legislative body are called *statutes* or *statutory laws*. When federal and state laws (or, in Canada, provincial laws) conflict, federal law supersedes. Likewise, state or provincial laws supersede local laws.

An example of a federal statutory law is the Patient Self-Determination Act of 1990, which enables clients to participate in decisions about their care, including the right to refuse treatment, even if such treatment is necessary to preserve life. This act requires that hospitals and other healthcare organizations receiving payment through Medicare and Medicaid do the following:

- Tell clients that they have the right to declare their personal wishes regarding treatment decisions, including the right to refuse medical treatment.
- Inform the client regarding the hospital’s policy on how advance healthcare directives are honored.
- Provide a written statement on the client’s medical record indicating whether the client has an advance healthcare directive. A copy of the advance healthcare directive should be included on the client’s medical record.
- Provide staff and community education on advance healthcare directives.

An additional example of federal statutory law is the Patient Protection and Affordable Care Act of 2010, which is a comprehensive federal regulation of health care and health insurance. Rights and protections under this act can be found at [healthcare.gov](http://healthcare.gov) and include:

- Creation of the Health Insurance Marketplace, a new way for individuals, families, and small businesses to obtain health coverage

- Requirements for insurance companies to cover people with preexisting health conditions
- Helping individuals understand the coverage they are getting
- Holding insurance companies accountable for rate increases
- Making it illegal for health insurance companies to arbitrarily cancel health insurance just because the person gets sick
- Protecting the individual’s choice of doctors
- Allowing parents to keep their children under age 26 on their family policies
- Providing free preventive care
- Ending lifetime and yearly dollar limits on coverage of essential health benefits
- Guaranteeing the right to appeal

At the state level, nurse practice acts, Good Samaritan laws, and laws regarding elder or child abuse are other examples of statutes that affect nursing and health care.

Administrative Law

Administrative laws are enacted by the specific governing bodies charged with implementing particular legislation. The regulation of nursing is a function of state or provincial law and is an example of administrative law. The members of the governing bodies usually have knowledge and expertise in the area of the enacted law; for example, the board of nursing, which enforces the nurse practice act, should be made up of all or a majority of registered nurses. State or provincial legislatures enact nurse practice acts; the boards of nursing are then charged to implement and enforce nurse practice acts by writing rules and regulations for enforcement.

Judicial or Decisional Law

The body of principles that evolves from court decisions is referred to as *judicial law*, or *decisional law*. Judicial law is continually being adapted and expanded. To arrive at a ruling in a particular case, the court examines the law as it applies to the case being heard and applies the same rules and principles applied in previous, similar cases; this practice is known as following precedent. Courts may depart from precedent when differences are noted between cases. See Table 5–1 for types of laws that affect nurses.

Types of Legal Actions

There are two kinds of legal actions: civil (private) actions and criminal actions. Civil actions deal with conflicts between individuals; for example, a man may file a suit against another person he believes cheated him. Criminal actions deal with disputes between an individual and the

TABLE 5–1 Types of Laws Affecting Nurses

|                           |                                                                                                                                                                                                |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Constitutional            | Due process<br>Equal protection                                                                                                                                                                |
| Statutory (legislative)   | Good Samaritan acts<br>Child and elder abuse laws<br>Patient Self-Determination Act<br>Sexual harassment laws<br>Americans With Disabilities Act<br>Patient Protection and Affordable Care Act |
| Administrative            | Nurse practice acts<br>Regulatory boards (e.g., boards of nursing)                                                                                                                             |
| Criminal (public)         | Homicide, manslaughter<br>Theft<br>Arson<br>Active euthanasia<br>Sexual assault<br>Illegal possession of controlled substances                                                                 |
| Contracts (private/civil) | Nurse and client<br>Nurse and employer<br>Nurse and insurance<br>Client and agency                                                                                                             |
| Torts (private/civil)     | Negligence<br>Libel and slander<br>Invasion of privacy<br>Assault and battery<br>False imprisonment<br>Abandonment                                                                             |

society as a whole; for example, if a person kills another person, society, through the actions of the court, brings the alleged offender to trial.

Safeguarding the Public

The first laws applicable to nursing in the United States were passed in the 1890s. These were considered permissive laws because they placed no restrictions on nursing practice, stating that the registered nurse (RN) title could be used by individuals who were registered and paid the required fee. By 1923, all states had nurse registration laws.

In 1981, the American Nurses Association (ANA) published a document titled *The Nursing Practice Act: Suggested State Legislation*, to serve as a guide for states in developing their nurse practice acts. This document described nursing practice as including but not limited to “administration, teaching, counseling, supervision,

delegation, and evaluation of practice and execution of the medical regimen, including the administration of medications and treatments prescribed by any person authorized by state law to prescribe” (American Nurses Association, 1981, p. 6). In 1990, the ANA published *Suggested State Legislation: Nursing Practice Act, Nursing Disciplinary Diversion Act, Prescriptive Authority Act*, to help state nurses’ associations revise their nurse practice acts to incorporate issues related to impaired nurses and advanced nursing practice.

The governing body that has the authority for the regulation of nursing practice within a state is the state board of nursing. The boards of nursing are authorized to develop administrative rules, regulations, and responsibilities related to the nurse practice act, and to enforce the rules to obtain and maintain licensure. The boards are appointed by the governor and usually consist of registered nurses (RNs), advanced practice registered nurses (APRNs), licensed practical/vocational nurses (LPNs/LVNs), and consumers of nursing. State boards may be independent agencies of the state government or part of a bureau or department, such as the department of health or the department of professional licensure and regulation.

The National Council of State Boards of Nursing (NCSBN) comprises all the state boards of nursing. The mission of the NCSBN is to “provide education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection” (National Council of State Boards of Nursing, 2010). State boards of nursing and state nurses’ associations usually collaborate on the development or revision of the state’s nurse practice act. According to Russell (2012, p. 37), all nurse practice acts include:

- Definitions
- Authority, power, and composition of the board of nursing
- Educational program standards
- Standards and scope of nursing practice
- Type of titles and licenses
- Protection of titles
- Grounds for disciplinary action, other violations, and possible remedies.

Because RNs not only provide care to patients and clients directly but also supervise the care given by others, state nurse practice acts permit professional nurses to delegate, but they do not permit delegation by licensed vocational/practical nurses. An important aspect of the delegation process is the ethical responsibility of delegates, those to whom responsibility has been delegated, to refuse any responsibilities for activities that they do not have the expertise to carry out safely and competently. This applies

even if hospital policies, physicians, and other nurses request these activities be carried out.

## Credentialing

**Credentialing** is the process of determining and maintaining competence in nursing practice. The credentialing process is one way in which the nursing profession maintains standards of practice and accountability for the educational preparation of its members. Credentialing includes licensure, registration, certification, and accreditation.

## Licensure

**Licensure** is defined by the National Council of State Boards of Nursing (2013b) as “the process by which boards of nursing grant permission to an individual to engage in nursing practice after determining that the applicant has attained the competency necessary to perform a unique scope of practice.” Licenses are legal permits a government agency grants to individuals to engage in the practice of a profession and to use a particular title. A particular jurisdiction or area is covered by the license. Licensure may be obtained as an initial licensure after completing an accredited educational program, as a renewal after expiration of the initial term of licensure, or by endorsement by an RN seeking to practice as an RN in another state/jurisdiction.

Under the 2011 Uniform Licensure Requirements published by the NCSBN (National Council of State Boards of Nursing, 2011), an applicant for initial licensure must graduate or be eligible to graduate from an approved RN prelicensure program; successfully complete the NCLEX-RN (National Council Licensure Examination); self-disclose all misdemeanors, felonies, and plea agreements up to the time of application; submit to state and federal fingerprint checks; and self-disclose any substance use disorder in the previous 5 years. For licensure renewal or reinstatement, an applicant must self-disclose all misdemeanors, felonies, and plea agreements not previously reported to the board of nursing; self-disclose any substance use disorder since the last renewal; self-disclose current participation in any alternative-to-discipline program in any jurisdiction; self-disclose any current or pending investigation or any action taken on a license by any board of nursing; and self-disclose any actions taken or initiated against a professional or occupational license, registration, or certification not previously reported.

Nurses applying for licensure by endorsement must meet all the requirements for initial licensure, including verification of educational preparation; successful completion of the NCLEX-RN examination; verification of an active licensure in another state; criminal background check; and self-disclosures related to any crime, including



felonies and misdemeanors, substance abuse, or actions taken or initiated against their professional or occupational license.

In each state, there is a mechanism by which licenses (or registration in Canada) can be revoked for just cause, for example, incompetent nursing practice, professional misconduct, or conviction for a crime, such as use or sale of illegal substances. In 2006, the National Council of State Boards of Nursing (2009) revised the Model Nursing Practice Act to include new sections that require criminal background checks on all applicants for licensure and current licensees as determined by the state board. Included in the revision are specific crimes for which a license may be refused or revoked. In each situation, all the facts are generally reviewed by a committee at a hearing. Nurses are entitled to be represented by legal counsel at such a hearing. If the nurse's license is revoked as a result of the hearing, the nurse can appeal the decision to a court of law; in some states, an agency is designated to review the decision before any court action is initiated. In 2012, the NCSBN Model Act and Rules were updated and approved.

In recent years, changes in the delivery of nursing and health care and increasing use of communication technology—for example, telehealth—have led to questions about one-state licensure. Nurses who are licensed in one state may be providing direct care or patient education to clients in another state. Additionally, emergency situations such as tornados, hurricanes, or human-caused disasters have resulted in states having unexpected and abrupt needs for increased numbers of professional staff from outside the state to assist victims. In response to these changes, in 1998 the NCSBN developed Nurse Licensure Compact Model Legislation (National Council of State Boards of Nursing, 2013c). Under the Nurse Licensure Compact (NLC), nurses can practice physically and/or electronically across state lines. The nurses must be licensed in an NLC state in order to practice in another state within the same NLC. APRNs are not included in the NLC. Additional information can be obtained at the website for the NCSBN). For advanced nursing practice, many states require a different license or have an additional clause in the Nurse Practice Act that pertains to actions that may be performed only by nurses with advanced education and, in many cases, advanced certification within the area of advanced practice. For example, an additional license may be required to practice as a nurse midwife, nurse anesthetist, or nurse practitioner. The advanced practice nurse also requires a license to be able to prescribe medication or order treatment from physical therapists or other health professionals. In 2008, the NCSBN Board of Directors endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, and Certification and Education

to promote uniformity of advanced practice licensure across the United States (National Council of State Boards of Nursing, 2013a). Nurses interested in becoming advanced-practice nurses must review legislation within their practice state.



**InfoQuest:** Go to the Internet and find the nurse practice act for your state or province. How is nursing defined? What is the composition of the state board of nursing in your state/province? What types of nursing licenses are granted under the nurse practice act? What grounds for disciplinary action are identified? What are the potential penalties for disciplinary action?



**InfoQuest:** Go to the National Council of State Boards of Nursing website and review the materials related to Nurse Licensure. How do they differ related to initial licensure, licensure by endorsement, licensure of international nurses who wish to practice in the United States, and renewal of license? Is your state part of a Nurse Licensure Compact? If yes, what other states are members of the same compact?

### Reflect On . . .

- the nurse practice act in your state or province. What are the actions of the nurse that are permitted under your nurse practice act? What actions are prohibited? What actions of nurse colleagues are you responsible for reporting? What are the requirements for initial licensure? Renewal of licensure? How do you feel about the regulation of nursing practice in your state? What changes would you suggest? Why?
- the nurse practice act in your state as it regulates advanced nursing practice. Is there separate licensure or certification required for advanced practice? What are the criteria to practice in an advanced practice role in your state? Are advanced practice nurses permitted to prescribe medications? How do you feel about the regulation of advanced nursing practice in your state? What changes would you suggest? Why?



## Registration

Prior to mandatory nurse licensure, nurses listed, or registered, their names and information on the official roster of a governmental or nongovernmental agency. This listing was usually called the nurse registry. This is the origin of the title *registered nurse*. Today, in the United States, all RNs must be licensed by the board of nursing of the state where they practice; in Canada they are licensed or registered by the provincial nursing association or college of nursing.

## Certification

**Certification** is the voluntary practice of validating that an individual nurse has met minimum standards of nursing competence in specialty or advanced practice areas, such as maternal-child health, pediatrics, mental health, and gerontology. Certification programs are conducted by the American Nurse Credentialing Center (an affiliate organization of the American Nurses Association) and by specialty nursing organizations. In Canada, the Canadian Nurses Association (CNA) certifies nurses in a number of specialized fields of nursing.



**InfoQuest:** Search the Internet for the criteria for certification in your area of nursing specialization. What organization provides certification in your specialty? What are the requirements to obtain and maintain certification?

## Reflect On . . .

- specialty certification in your practice setting. Are you certified in a specialty area of practice? What are the personal and professional benefits of certification in your practice setting?

## Accreditation

**Accreditation** is a process by which an organization such as the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE) or governmental agencies such as state boards of nursing, appraises and grants accredited status to institutions and/or programs or services that meet predetermined standards and measurement criteria. According to the CCNE, accreditation “serves the public

interest by assessing and identifying programs that engage in effective educational practices” (Commission on Collegiate Nursing Education, 2015). Minimum standards for basic nursing education programs are established in each state of the United States and in each province in Canada. State accreditation or provincial approval is granted to nursing educational programs meeting the minimum criteria. Accreditation by ACEN or CCNE is at the national level and indicates that a nursing education program has met not only state standards but also national standards.

An organization that accredits healthcare organizations and programs is The Joint Commission. The mission of The Joint Commission is “to continuously improve health care for the public”; Joint Commission accreditation is “recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards” (The Joint Commission, 2015).

Achievement of accreditation indicates to the general public that an organization has clear and appropriate objectives and is providing the conditions and environment in which its objectives can be fulfilled. While accreditation is voluntary, many governmental and nongovernmental organizations will provide educational grants, research grants, or governmental reimbursement of fees for care only to accredited organizations.

## Standards of Care

Another way the nursing profession attempts to ensure that its practitioners are competent and safe to practice is through the establishment of standards of practice. The ANA published *Nursing: Scope and Standards of Practice* that identifies standards of practice and standards of professional performance that apply to all nurses regardless of practice setting. These standards are often used to evaluate the quality of care nurses provide. In addition to this basic set of standards, the ANA has developed standards of nursing practice for specific areas, such as maternal-child health, medical-surgical, geriatric, psychiatric, and community health nursing. Some nursing specialty organizations have also developed standards of practice for nurses in the specific specialty.

Standards have also been developed for Medicare and Medicaid providers. The Joint Commission has developed accreditation standards that help ensure specific levels of care in hospitals and other healthcare organizations. In addition, individual healthcare agencies have developed standard care plans intended to reflect a standard of care. Specific nursing measures that promote safe nursing practice are shown in the box on page 80.

## Nursing Measures That Protect Nurses and Clients

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- Know your job description.
  - Maintain your clinical competence.
  - Know and follow the policies and procedures of the agency in which you are employed.
  - Always identify clients before implementing nursing activities.
  - Report all incidents or accidents involving clients.
  - Know your own strengths and weaknesses.
  - Question any order that a client questions.
  - Question any order that seems inappropriate.
  - Question any order if a client's condition has changed since it was written.
  - Question and record verbal orders to avoid miscommunication.
  - Question standing orders if you are inexperienced in the particular area.
- 

## Potential Liability Areas

### Negligence and Malpractice

**Negligence** means “conduct lacking in due care” (Guido, 2014, p. 69) or “failing to perform a legal duty which causes a distinct injury to another person” (Sheppard, 2011, p. 727). **Malpractice**, which may be referred to as professional negligence, is “harm caused by a professional’s wrongful or unskillful act or omission” (Sheppard, 2011, p. 673). The alleged misconduct may be intentional or unintentional. The elements of proof for nursing malpractice are:

- A duty of the nurse to the client to provide care and follow an acceptable standard
- A breach, or failure of the nurse to perform the duty
- Foreseeability, or the knowledge that if the nurse fails in the duty an injury may occur
- An injury to the client
- A causal relationship between the breach of the duty and the client’s subsequent injury

A nurse could be liable for malpractice if the nurse injures a client while performing a procedure differently from the way other nurses would have done it. Malpractice may be charged whether the injury resulted from an act of commission or an act of omission, or a failure in execution. An act of commission would occur when the nurse did something incorrectly or in violation of the standard of care. An example of an act of commission is giving the medication to the wrong client or giving the wrong dose of the medication. An act of omission would occur when the nurse failed to do something that should have been done according to the standard of care. An example of an act of omission is when the nurse forgets to give the client a medication or fails to monitor the client’s response to treatment. An error of commission is “an error which occurs as a result of an action taken” (National Patient Safety Foundation, 2015). An error in execution would occur when the nurse does the right thing but does not do it correctly, for example, the nurse

administers the right dose of the right medication to the right patient but does not administer it according to the prescribed route.

Malpractice suits may result from untoward client outcomes or injury related to client falls, operating room errors, medication errors, or other negligent acts on the part of the healthcare provider. In 2000, the Institute of Medicine (IOM) reported that “44,000 to 98,000 deaths occur from medical errors each year” (Kohn, Corrigan, & Donaldson, 2000, p. 1). According to the Office of the Inspector General of the U.S. Department of Health and Human Services (Levinson, 2010), one in seven Medicare patients is injured during hospital stays, and adverse events occurring during the course of care result in the deaths of 180,000 patients per year. The IOM report recommended a mandatory medical-error reporting system, including a national patient safety center. The reporting system and safety center would work together to decrease system errors. The IOM defined error “as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (Kohn et al., 2000, p. 4). Healthcare errors can result from problems in the practice, inappropriate use of or unsafe products, and inadequate procedures and/or systems. In court, error is not necessarily equated with legal liability. Therefore, an error in judgment may not necessarily have the elements necessary to constitute professional negligence.

Nurses are responsible for their own actions, whether they are independent practitioners or employees of a healthcare agency. The descriptions of malpractice do not mention good intentions; it is not pertinent that the nurse did not intend to be negligent. If a nurse administers an incorrect medication, even in good faith, the fact that the nurse failed to read the label correctly indicates malpractice if all other elements of malpractice are met.

To avoid charges of malpractice, nurses need to recognize nursing situations in which unsafe practice is most likely to occur and take measures to prevent such situations. Healthcare organizations are implementing programs to improve quality of client care and ensure a safe

care environment. The Agency for Healthcare Research and Quality (AHRQ) publishes resources related to quality and safety of health care. Nurses can sign up for email notices of new clinical guidelines and recommendations as well as other resources at the AHRQ website.

Medication errors account for a large number of deaths each year. Many individuals receive either the wrong medication or the right medication but the wrong dosage. Elderly patients who are prescribed several medications may experience a drug interaction that results in harm. Some patients may not receive their ordered medication. In addition to medication errors, other causes of medical errors include misdiagnosis; equipment malfunction; infections, such as nosocomial and postsurgical wound infections; blood transfusion-related injuries; failure to monitor patient status adequately; and communication failure, such as not reporting changes in client status in a timely manner or misinterpretation of medical orders. The accompanying box lists categories and examples of negligence resulting in malpractice lawsuits.

Because of the increase in the number of malpractice lawsuits against health professionals, nurses are advised to carry their own liability insurance. Most hospitals have liability insurance that covers all employees (including all nurses) who provide care consistent with safe practice and the policies and procedures of the organization. The nurse should always check with the employer at the time of hiring to determine what coverage the facility provides. A physician or a hospital can be sued because of the negligent conduct of a nurse, and the nurse can also be sued and held liable for negligence or malpractice. Because health-care organizations have been known to countersue nurses when they have been found negligent and the injury was the result of the nurse not following the organization's established policies/procedures, nurses are advised to obtain their own insurance coverage and not rely on hospital-provided liability insurance. Additionally, attorneys hired by the healthcare organization are primarily hired to represent the organization, while an attorney hired by the nurse is representing the interests of the nurse. According

### Categories of Negligence That Result in Malpractice Lawsuits

#### **Failure to follow standards of care**, including failure to

- Perform a complete admission assessment or design a plan of care.
- Institute a fall protocol.
- Adhere to standardized protocols or institutional policies and procedures (e.g., using an improper injection site).
- Follow a primary care provider's verbal or written orders.

#### **Failure to use equipment in a responsible manner**, including failure to

- Follow the manufacturer's recommendations for operating the equipment.
- Check equipment for safety prior to use.
- Place equipment properly during treatment.
- Learn how equipment functions.

#### **Failure to communicate**, including failure to

- Notify a primary care provider in a timely manner when conditions warrant it.
- Listen to a client's complaints and act on them.
- Communicate effectively with a client (e.g., inadequate or ineffective communication of discharge instructions).
- Communicate important assessment findings to the nurse for the oncoming shift.
- Seek higher medical authorization for a treatment.

#### **Failure to document**, including failure to follow the facility's documentation policies and procedures and/or failure to note in the client's medical record

- A client's progress and response to treatment.
- A client's injuries.
- Pertinent nursing assessment information (e.g., drug allergies).
- A primary care provider's medical orders.
- Information on telephone conversations with primary care providers, including time, content of communication between nurse and primary care provider, and actions taken.

#### **Failure to assess and monitor**, including failure to

- Complete a shift assessment.
- Implement a plan of care.
- Observe a client's ongoing progress.
- Interpret a client's signs and symptoms.
- Recognize significant changes in a client's condition and communicate them promptly.

#### **Failure to act as a client advocate**, including failure to

- Question discharge orders when a client's condition warrants it.
- Question incomplete or illegible medical orders.
- Provide a safe environment.

*Source:* From "Legal Aspects of Nursing," by A. Berman and S. Snyder, 2012, in *Kozier and Erb's Fundamentals of Nursing: Concepts, Process, and Practice* (p. 69, 9th ed.), Upper Saddle River, NJ: Pearson.

to Guido (2014, p. 188) the benefits of professional liability insurance include:

- Payment for the cost of expert legal advice and representation
- Payment for the costs associated with representation in a court
- Payment for the costs associated with representation before a state board of nursing
- Payment for court costs and settlements made out of court, including appeals
- Reimbursement for the nurse, to a limited extent, for lost wages incurred while defending the lawsuit

Nurses can obtain professional liability insurance through some professional nursing organizations and through private insurance companies. Nursing students can also obtain liability insurance through the National Student Nurses' Association. Some schools of nursing require that students have professional liability insurance while in their educational program.



**InfoQuest** Search the Internet for information and resources related to medical errors, patient safety, quality improvement, and quality of care. Find information that addresses nurses' roles in preventing errors and providing safe and quality care. Review the nursing and medical literature related to medical errors, patient safety, quality improvement, and quality care through electronic library databases.

## Documentation

The medical record is the legal source of information about the client. The primary use of the medical record is to communicate information about the client's care among health-care providers. It includes data about the client's status, such as demographic information, allergies, vital signs, laboratory data, results of diagnostic studies, diagnoses, medication and treatment orders, and assessments and actions of the various healthcare providers providing care to the client, including physicians, nurses, therapists, and social workers. The medical record is a dynamic document that provides information about changes in the client's status so that care providers can determine the effectiveness of treatment and make appropriate changes. The medical record may also be used for the following purposes:

- Financial and business operations to identify efficient equipment, materials, and personnel flow management, and to ensure accurate billing

- Data collection, statistical analysis and research to identify health problems and improve health care of the public as a whole
- Education of health professionals at all levels
- Litigation and risk-management activities to protect the client and ensure quality care

Prior to the 21st century, most client documentation was handwritten and located in various places: in a paper chart maintained in the physician's office for office visits, a paper chart on the nursing unit when the client was hospitalized, or in the medical records file room when the client was not hospitalized. One client's medical information could be stored in multiple locations, depending on the number of physicians the client was seeing, or on major changes in the client's residence. Beginning in 1991, the IOM started calling for widespread implementation of an **electronic health record (EHR)** system. Proposed benefits of an electronic health record are improved patient safety through the reduction of medical errors, decreased health costs through improved safety, and increased communication of client health information between the client's healthcare providers. The U.S. Department of Health and Human Services (USDHHS) established a goal within *Healthy People 2020* to use health communication strategies and health information technology (IT) to improve population health outcomes and healthcare quality, and to achieve health equity (U.S. Department of Health and Human Services, 2013). The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the development of a centralized electronic database containing all health records for every patient in the United States. The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, promotes the widespread adoption of EHR and authorizes Medicare incentive payments to doctors and hospitals using a certified EHR and eventually imposing financial penalties for physicians and hospitals that do not implement EHR. Issues of concern in using an electronic health record system are related to privacy and confidentiality. Legal liability could apply if someone is inappropriately accessing an individual's EHR.

The old adage "not documented, not done" holds true in nursing. According to the law, if something is not documented, then the responsible party may not have done whatever needed to be done. If the nurse did not carry out or complete an activity or documented it incorrectly, she or he is open to a charge of malpractice. Nursing documentation needs to be legally credible; that is, it must give an accurate accounting of the care the client received. Whitehead,

## Guidelines for Documentation

- What to Chart
  - All client assessments.
  - Changes in client's condition and follow-up interventions.
  - Client's stated concerns (e.g., pain, discomfort, anxiety) and nursing response.
  - Scheduled medications (time, dose, route, response); if scheduled medication is missed, provision of a reason and an indication of what was done.
  - PRN medications and client response.
  - Treatments done and client's response.
  - Client/family education and response.
  - Calls to physicians, time of call, purpose of call, physicians' response.
  - Client/family refusals of medications or treatments and the client's/family's stated reason.
- When to Chart
  - At the time assessment/observation is done or care is given (e.g., medications, treatments, assessments).
  - If late entry, write "late entry" and record the date and time of the late entry. Actual time of occurrence can be included in the late entry note.
  - Do not chart prior to or in anticipation of care to be provided.
- How to Chart
  - Ensure that you are writing in the correct record.
  - Use organization flow sheets and checklists per agency policy.
  - Handwritten documentation must be legible.
  - Information must be specific, objective, accurate, and factual.
  - Information should be organized logically.
  - Identify yourself after each entry according to agency policy.
  - Errors should be corrected according to agency policy.
  - Chart only care that you have provided; do not chart for another; do not ask another to chart for you.
  - When charting electronically, chart under your log-in only; do not give your log-in to another.
- Why to Chart
  - Charting communicates client care and response to care to all healthcare providers involved in care.
  - It is a source of client information for all future healthcare interactions (e.g., follow-up visits, rehospitalization)
  - It is a source of data for reimbursement for services provided.
  - It is a source of data for healthcare research.
  - It provides case-based information (case study) for healthcare students.
  - It is a legal requirement.

Weiss, and Tappen (2010, p. 29) assert that documentation is credible when it is:

- **Contemporaneous.** Care is documented at the time it is provided.
- **Accurate.** A factual account is given of what the nurse did and how the client responded.
- **Truthful.** Documentation includes an honest account of what was actually done or observed.
- **Appropriate.** Only what one would be comfortable discussing in a public setting is documented.

The client's medical record is a legal document and can be produced in court as evidence. Often, the record is used to remind a witness of events surrounding a lawsuit, because several months or years usually elapse before the suit goes to trial. The effectiveness of a witness's testimony can depend on the accuracy of such records. Therefore, nurses need to keep accurate and complete records of nursing care provided to clients. Failure to maintain proper records can constitute negligence and be the basis for tort liability. Insufficient or inaccurate assessments and documentation can hinder proper diagnosis and treatment and

result in injury to the client. The accompanying box provides guidelines for appropriate documentation.

## Delegation

The American Nurses Association *Guide to the Code of Ethics for Nurses: Interpretation and Application* (2010) states that the nurse is "responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care" (p. 41). The nurse is responsible and accountable for the care given to her or his clients even if that care has been delegated to a subordinate. The National Council of State Boards of Nursing and the American Nurses Association (2005) published a position statement defining delegation as "the process for a nurse to direct another person to perform nursing tasks and activities." To delegate tasks safely, nurses must delegate appropriately and supervise adequately. The five *rights* of delegation include the *right* task being performed, in the *right* circumstances, by the *right* person (delegate) (RN, licensed practical/vocational nurse, nursing assistant), who has received the *right* directions and communication (from



## Components of the Decision Tree for Delegation to Nursing Assistive Personnel

1. **Assessment and planning.** All the following questions must be answered in the affirmative for the nurse to delegate the specific tasks to nursing assistive personnel:
  - a. Are there laws and rules in place that support the delegation?
  - b. Is the task within the scope of the delegating nurse?
  - c. Has there been an assessment of the client's needs?
  - d. Is the delegating nurse competent to make this delegation decision?
  - e. Is the task consistent with the recommended criteria for the delegation to nursing assistive personnel?
  - f. Do the nursing assistive personnel have the appropriate knowledge, skills, and abilities to accept the delegation?
  - g. Does the ability of the nursing assistive personnel match the care needs of the client?
  - h. Are there agency policies, procedures, and/or protocols in place for this task/activity?
  - i. Is appropriate supervision available?
2. **Communication.** This is a two-way process between the nurse and the assistive personnel and consists of both verbal and written communication. Verbal communication ensures understanding of the task to be completed. Written communication ensures appropriate documentation of the care provided and the response to care.
3. **Surveillance and supervision.** These address the nurse's overall responsibility for monitoring and supervising the client's care, including those clients whose care is delegated to assistive personnel.
4. **Evaluation and feedback.** The nurse considers the appropriate feedback to the assistive personnel, determines whether it was the best way to meet the client's need, and decides whether to adjust the plan of care.

Source: Adapted from "Decision Tree for Delegation to Nursing Assistive Personnel," by the American Nurses Association and National Council of State Boards of Nursing Joint Statement on Delegation, (2005). Retrieved from [www.ncsbn.org/Delegation\\_joint\\_statement\\_NCSBN-ANA.pdf](http://www.ncsbn.org/Delegation_joint_statement_NCSBN-ANA.pdf)

the RN or delegator), and who has the *right* supervision and evaluation (by the RN or delegator).

In 2005, the National Council of State Boards of Nursing and the American Nurses Association developed the "Decision Tree for Delegation to Nursing Assistive Personnel" to help nurses delegate appropriately. The four steps of the decision tree are outlined in the accompanying box.

Nurses who delegate tasks to nursing assistive personnel should evaluate the activities being considered for delegation. Guido (2014, p. 379) recommends consideration of the following before making a decision to delegate:

- What is the potential for harm to the patient/client? There should be a low potential for harm.
- What is the complexity of the task to be done? The task to be delegated should not entail complex nursing activity or problem solving.
- What is the predictability for the outcome of the task? The outcome for the task should be highly predictable.
- Is there adequate and available RN supervision of the delegatee? There should be adequate RN supervision of the individual performing the task.
- Is there opportunity for interaction with the delegate and patient/client? There should be opportunity for interaction with the individual performing the task as well as the patient/client for whom the task is to be done.

It is the responsibility of the nurse to be well acquainted with the state nurse practice act and regulations

issued by the state board of nursing regarding licensed and unlicensed nursing assistive personnel. State laws and regulations supersede organizational policies and any publications or opinions set forth by professional organizations.

### Reflect On . . .

- the responsibilities for delegation in your practice setting. What policies exist in your practice setting to ensure responsible delegation of nursing care? What are the qualifications of your colleagues to whom you delegate aspects of nursing care?



**InfoQuest:** Access your state nurse practice act online and review your state's requirements regarding delegation of nursing activities. Are your institutional policies regarding delegation consistent with the state nurse practice act?

### Restraints

**Restraints** are protective devices used to limit physical activity of the client or a part of the client's body. Restraints may be of two types, physical or chemical. **Physical restraints** include manual methods or physical or mechanical devices that attach to the client's body or body part that restrict movement. **Chemical restraints** are medications

**TABLE 5–2 Potential Harmful Effects of Restraints**

| Physical Restraints                                                                                                                                                                                                                                                                                                                                                                                                                    | Chemical Restraints                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Impaired skin integrity: abrasions, decubiti</li> <li>• Impaired circulation</li> <li>• Impaired respiratory function: pneumonia</li> <li>• Strangulation</li> <li>• Impaired neurologic function: nerve damage</li> <li>• Musculoskeletal impairment: contractures, muscle weakness</li> <li>• Urinary and fecal incontinence</li> <li>• Urinary tract infection</li> <li>• Death</li> </ul> | <ul style="list-style-type: none"> <li>• Impaired respiration</li> <li>• Decreased mental capacity: confusion</li> <li>• Impaired judgment</li> <li>• Increased drowsiness</li> <li>• Death</li> </ul> |

that are used to control socially disruptive behavior. Medications can include sedatives, anxiolytics, or psychotropic agents. Because there is a risk of harm when using restraints (see Table 5–2), especially in the care of elderly clients, restraints should be used with extreme caution and only according to institutional policy.

In 2006, the Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services, 2006) affirmed the right of patients to “be free of inappropriate use of restraint and seclusion with requirements that protect the patient when use of either intervention is necessary” (p. 71379). Further, “all patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff” (p. 71427). In this document, the federal government set out the policies shown in the box on page 86. These policies, which were developed with the input of healthcare providers, healthcare provider organizations, consumers, and healthcare accrediting organizations, continue to be implemented through Joint Commission accreditation standards and healthcare provider organizational policies.

The Board of Directors of the American Nurses Association (2012b) adopted the position statement on Reduction of Patient Restraint and Seclusion in Health Care Settings. This position statement “strongly supports registered nurse participation in reducing patient restraint and seclusion in health care settings. Restraining or secluding patients/residents either directly or indirectly is viewed as contrary to the fundamental goals and ethical traditions of the nursing profession, which upholds the autonomy and inherent dignity of each patient or resident.”

In order to minimize the use of physical and chemical restraints, nurses should consider alternative measures to promote patient safety and the safety of healthcare providers and others. Such measures include frequent orientation

of clients to their surroundings, the use of “sitters,” placing patients in an area where they can be closely monitored, and placing the call bell and frequently used items (e.g., bedside table/overbed tray, tissue box, water pitcher, drinking glass, TV remote) within easy reach. The nurse can also anticipate patients’ needs for assistance with toileting, or bed/chair transfers, or eating and assign appropriate personnel to provide assistance. It is important that the nurse educate the client and family members about the need to limit mobility related to treatment devices such as IVs, oxygen tubing, or gastric tubes and to call for assistance when needed. Devices such as bed occupancy monitors are helpful in alerting the nurse if a client is attempting to get out of bed. Creating a calming environment with the use of color, reduction of noise, and other calming measures can also be helpful. Nurses can participate in research to identify specific situations that place clients at risk and develop interventional strategies that promote a safe environment while respecting the client’s right to freedom and autonomy.

## Informed Consent

**Informed consent** is an agreement by a client, or the client’s legal representative in the case where the client is unable to give consent, to accept a course of treatment or a procedure after complete information, including the risks of treatment and facts relating to it, has been provided by the physician or independent practitioner in a manner that the client or representative understands. In the information intended to obtain informed consent, the client should also be made aware of the alternatives to the proposed treatment and the risks and dangers involved in each alternative (Guido, 2014). Informed consent, then, is an exchange between a client, or the client’s legal representative, and a physician or independent practitioner. Usually, the client signs a form provided by the agency. Consent forms usually contain (1) the signature of the patient, or legal representative

## Patients' Rights Related to Restraint or Seclusion

1. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
2. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
3. The use of restraint or seclusion must be
  - a. In accordance with a written modification to the patient's plan of care
  - b. Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with state law.
4. The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient.
5. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
6. The attending physician must be consulted as soon as possible if the attending physician did not order restraint or seclusion.
7. Unless superseded by State law that is more restrictive:
  - a. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:
    - i. 4 hours for adults 18 years of age or older
    - ii. 2 hours for children and adolescents 9 to 17 years of age
    - iii. 1 hour for children under 9 years of age
  - d. After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient must see and assess the patient.
8. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
9. The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner, or trained staff that have completed specified training.
10. Physician and other licensed independent practitioner training requirements must be specified in hospital policy.
11. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention
  - a. By a physician or other licensed independent practitioner, or registered nurse or physician assistant who has been trained
  - b. To evaluate the patient's immediate situation, the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.
12. When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:
  - a. The 1-hour face-to-face medical and behavioral evaluation
  - b. A description of the patient's behavior and the intervention used
  - c. Alternatives or other less restrictive interventions attempted (as applicable)
  - d. The patient's condition or symptom(s) that warranted the use of the restraint or seclusion
  - e. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

Source: "Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights," by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, 2006, *Federal Register*, 71(236), pp. 71378–71428. Retrieved from [www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf)

if the client is unable to provide consent; (2) the name and full description of the procedure to be done; (3) the name(s) of the person(s) to perform the procedure; (4) a description of the risks of the procedure; (5) a description of the expected outcomes of the proposed procedure; (6) a description of alternative treatments and their risks; and (7) the signature(s) of witness(es) as required by state law or institutional policy.

Obtaining informed consent for specific medical and surgical treatments is the responsibility of the physician

or the independent practitioner who will perform the treatment or procedure. Some organizations allow nursing staff to obtain consent for surgery; however, in such cases, the nurse and the organization assume accountability for the information given. It is appropriate for the nurse to provide information about the required preparations for surgery (e.g., enemas, skin preparation, food/fluid intake) and the nursing care that the patient will receive after the procedure (e.g., pain medication, IVs, mobility limitations, diet). Often, it is the nurse's responsibility to

## RESEARCH CURRENT

## Use of Physical Restraints in Nursing Homes and Hospitals and Related Factors: A Cross-sectional Study

Heinze, Dassen, and Grittner had two purposes of their study: to examine what factors were related to the use of restraints and whether the number of nurses (or patient/resident/nurse ratio) was an influencing factor in using restraints. The study was conducted in 76 nursing homes and 15 hospitals located in Germany. Consent was obtained from the patient, resident, or his or her legal representative. Trained nursing staff collected the data using standardized questionnaires. Physical restraint was defined as the use of any bed rails and/or belt fixation of the trunk or extremities to a bed or chair at the time of data collection. A fall was defined as “a rapid descent of the body from a higher to lower level due to disturbed balance or reduced capacity to bear weight of body in different positions” (International Classification of Nursing Practice, 2005). The Care Dependency Scale was used to measure the care dependency of patients/residents. Data about staffing were collected, including the number of staff and their educational qualifications. The investigators found that there was no significant relationship between the number of nurses and the use of restraints in hospitals or

nursing homes. Restraints were more likely to be used on geriatric units than other hospital units. In hospitals, restraints were more likely to be used with older patients, female patients, patients with high care dependency, patients who had had a fall incident in the previous 2 weeks, patients with polypharmacy, and those who had a higher perceived risk of falling. In nursing homes, there was a higher use of restraints for residents who were more care dependent. In both institutions, patients/residents who had urinary incontinence, were disoriented, or were confined to bed were more likely to be restrained. The investigators recommend that, “more efforts should be undertaken in staff training and changing staff attitudes against restraint use” (p. 1033).

*Author's note:* Many organizations have instituted voluntary or mandatory restraint protocols that may vary in different countries. Nurses must be familiar with and follow the restraint protocols within their organization.

*Source:* “Use of Physical Restraints in Nursing Homes and Hospitals and Related Factors: A Cross-sectional Study, by C. Heinze, T. Dassen, and U. Grittner, 2011, *Journal of Clinical Nursing*, 21, pp. 1033–1040.

witness the giving of informed consent. This involves the following:

- Witnessing the exchange between the client and the physician
- Establishing that the client really did understand, that is, was really informed
- Witnessing the client's signature

If a nurse witnesses only the client's signature and not the exchange between the client and the physician, the nurse should write “witnessing signature only” on the form. If the nurse finds that the client really does not understand the physician's explanation, the physician must be notified.

There are three major elements of informed consent:

1. The consent must be given voluntarily.
2. The consent must be given by an individual with the capacity and competence to understand.
3. The client must be given enough information to be able to make an informed decision.

To give informed consent voluntarily, the client must not feel coerced. Sometimes fear of disapproval by a health professional can be the motivation for giving consent; such consent is not considered voluntary.

To give informed consent, the client must receive sufficient information to make a decision; otherwise, the client's right to decide has been usurped. Information must include the purpose and expected outcomes of the treatment, benefits, risks, and alternative treatment methods. It is also important that the client understand. Technical words and language barriers can inhibit understanding. If a client cannot read, the consent form must be read to the client before it is signed. If the client does not speak the same language as the health professional providing the information, an appropriate interpreter must be used.

If given sufficient information, a client can make decisions regarding health. To do so, the client must be competent and an adult. A competent adult is a person 18 years of age and older who is conscious and oriented. A person under 18 years of age may give consent if he or she is considered “an emancipated minor” (e.g., lawfully married, the holder of a court adjudicated petition) or the law recognizes the minor as having the ability to consent to therapy or if there is a court order allowing the treatment. A client who is confused, disoriented, or sedated is not considered functionally competent at that time.

There are three groups of people who cannot provide consent. The first is *minors*. In most jurisdictions, a parent or guardian must give consent before minors can obtain

treatment. In some states, however, minors are allowed to give consent for such procedures as blood donations, treatment for drug dependence and sexually transmitted disease, and procedures for obstetrical care. The second group is *persons who are unconscious or injured* in such a way that they are unable to give consent. In these situations, consent is usually obtained from the closest adult relative if existing statutes permit. In a life-threatening emergency, if consent cannot be obtained from the client or a relative, then the law generally agrees that consent is assumed. This is referred to as *implied consent*. The third group is *mentally ill persons* who have been judged to be incompetent. State and provincial mental health acts or similar statutes generally provide definitions of mental illness and specify the rights of the mentally ill under the law as well as the rights of the staff caring for such clients.



**InfoQuest:** Search the Internet to determine the regulations in your state related to informed consent. What is the definition of a minor? How is a minor emancipated? What are the requirements for consent to treatment for those who are mentally incompetent? What are the requirements for consent in an emergency situation when the client is unable to provide consent?

## Advance Healthcare Directives

An **advance directive** is a statement the client makes specifying his or her wishes regarding healthcare decisions: “a written declaration of health care decisions made in advance of incapacity” (Sheppard, 2011, p. 306). There are several types of advance healthcare directives: the living will; natural death acts; the durable power of attorney for health care or medical durable power of attorney; and the medical or physician directive. Each offers an individual the right to make certain decisions in relation to his or her health care in advance of the need for such decisions to be made. Each can be rescinded at the individual’s direction at any time; in other words, the individual can change his or her mind at the time a health incident occurs.

A **living will** is a legal document that an individual creates to make his or her wishes known regarding life-prolonging treatments in the event that he or she becomes terminally ill or permanently unconscious or is in a vegetative state and unable to make decisions. The individual can itemize what treatments he or she wants and what treatments he or she does not want. For example, the individual can indicate a wish not to be kept alive by artificial means

such as cardiopulmonary resuscitation (CPR) and pulmonary ventilation but may wish to maintain nutritional support such as intravenous or tube feeding.

**Natural death acts** enact into law the function of the living will. They provide protection to healthcare providers from potential lawsuits when the providers are following the directive of the client’s living will. Natural death acts are enacted at the state level and so may vary from state to state. The **durable power of attorney for health care** (DPAHC), also called the **medical durable power of attorney** (MDPA), allows competent individuals to appoint a surrogate or proxy, usually a relative or trusted friend, to make medical decisions on the client’s behalf in the event that the client is unable to do so. The DPAHC or MDPA is not limited to terminal situations but can apply to any illness or injury in which the client is incapacitated. The DPAHC/MDPA is a witnessed notarized statement appointing someone else to manage healthcare treatment decisions when the client is unable to do so. **Medical or physician directives** “list a variety of treatments and let patients decide what they would want, depending on the patient’s condition at the time” (Guido, 2014, p. 140). This kind of directive has legal value similar to a living will.

The specific requirements of advance healthcare directives are directed by individual state legislation. In most states, advance healthcare directives must be witnessed by two people but do not require review by an attorney. Some states do not permit relatives, heirs, or physicians to witness advance healthcare directives.

The ANA (1991) supports the client’s right to self-determination and believes that nurses must play a primary role in implementation of the law. The nurse is often the facilitator of discussions between clients and their families about health care and end-of-life decisions. The ANA recommends that the following questions be part of the nursing admission assessment regarding advance healthcare directives:

- Does the client have basic information about advance healthcare directives, including living wills and the durable power of attorney for health care?
- Does the client wish to initiate an advance healthcare directive?
- If the client has prepared an advance healthcare directive, did the client bring it to the healthcare agency?
- Has the client discussed end-of-life choices with the family and/or designated surrogate, physician, or other healthcare team member?

Nurses should learn the law regarding client self-determination for the state in which they practice, as well as the policy and procedures for implementation in the institution where they work.



## RESEARCH CURRENT

## Disconnect Between Emergency Contacts and Surrogate Decision-Makers in the Absence of Advance Directives

The purpose of Song and Ward's study was to determine if the surrogate identified by seriously ill patients during study enrollment were the same as the emergency contact noted on the medical record. Ninety-four patients participated in the study. Participants were dyads of dialysis patients and their chosen surrogate decision makers recruited from outpatient dialysis centers in North Carolina. The average age of participants was 62.1 years; the majority were Black and female and had completed at least a high school education. All patients had been receiving dialysis for an average of 4.6 years. Common comorbid conditions experienced by the patient participants were diabetes (89.4%), congestive heart failure (55.3%), peripheral vascular disease (41.9%), cerebrovascular disease (35%), and chronic pulmonary disease (29.8%). At the time of study enrollment, only 3 of the 94 patients had a surrogate documented in an advance directive. The remaining 91 patients decided to choose a surrogate after

working with the study recruiter. Of the patients studied, 34% named a spouse as their surrogate, 30.9% named a child, 18.1% named a friend, and 8.5% named some other person. Of the 94 surrogates named, only 60 (63.8%) were also listed as the emergency contact. The investigators describe the importance of patients with serious chronic illness naming surrogate decision makers should they be unable to make their own healthcare decision. Further, they point out the importance of congruence between the named healthcare surrogate and the named emergency contact person to prevent confusion in patient healthcare decisions, and they recommend that instead of "the routine procedure of asking patients to name an emergency contact . . . helping the patient to identify a surrogate decision maker" be done (p. 792).

"Disconnect Between Emergency Contacts and Surrogate Decision-Makers in the Absence of Advance Directives," by M. D. Song and S. E. Ward, 2013, *Palliative Medicine*, 27(8), pp. 789–792.

## Do-Not-Resuscitate Orders

Physicians may order "no-code" or do-not-resuscitate (DNR) for clients who are in a stage of terminal, irreversible illness or expected death. DNR orders require that no effort be made to resuscitate the client in the event of a respiratory or cardiac arrest and must be documented in the client's medical record. In 2012, the ANA published a position statement on Nursing Care and Do Not Resuscitate (DNR) and Allow Natural Death (AND) Decisions that states, "The ANA supports the rights of patients for self-determination. This right includes the right to a natural death without resuscitative efforts" (American Nurses Association, 2012a, p. 11). The ANA states that nurses have a duty to:

- Educate patients and their families about the use of biotechnologies at the end of life, termination of treatment decisions, and advance directives.
- Encourage patients to think about end-of-life preferences in illness or a health crisis.
- Support patients, their families, and their surrogates to have end-of-life discussions with their physicians.
- Ensure advance directives are implemented.
- Communicate known information that is relevant to end-of-life decisions to appropriate healthcare personnel.
- Advocate for a patient's end-of-life preferences regardless of surrogate decision maker's or the physician's desire not to honor them if, indeed, the preferences reflect beneficent care.



**InfoQuest:** Search the Internet to find living will forms for your state. Compare such forms with advance directive documents developed by your own healthcare organization. How are they similar/different?

## Adverse Events and Risk Management

An adverse event report, also called an unusual occurrence or incident report, is an agency record of an adverse event or unusual occurrence that is required by The Joint Commission. Adverse events include medication errors, patient or visitor falls, equipment malfunction, surgical errors, and other incidents that may have been preventable. Adverse event reports are used to make all the facts about an unusual occurrence available to agency personnel, to contribute to statistical data about adverse events, and to help healthcare personnel prevent future incidents. Adverse events are usually filed with the agency's risk-management department. The box on page 90 lists information to be included in an adverse event report. The report should be completed as soon as possible after the event (and always within 24 hours of the event) and filed according to agency policy. Because adverse event reports are not part of the client's medical record, the facts of the incident should also be noted in the client's medical record. Adverse event reports are used not

## Information to Include in an Adverse Event Report

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- Identify the client by name, initials, and hospital or agency identification number.
  - Record the date, time, and place of the incident.
  - Describe the facts of the incident. Avoid any conclusions or blame. Describe the incident as you saw it even if your impressions differ from those of others.
  - Identify all witnesses to the incident, including agency employees and visitors.
  - Identify any equipment by identifying number and any medication by name, identifying number, and brand name.
  - Document any circumstances surrounding the incident, for example, that another client was experiencing cardiac arrest.
- 

only to report incidents related to direct client care but also to report occupational injuries of employees, such as needlestick or back injuries, and injuries to visitors to the agency, such as falls.

The risk-management department reviews all adverse event reports. The purpose of risk management is to identify, analyze, treat, and evaluate real and potential hazards (Whitehead et al., 2010). The risk-management department decides whether to investigate the incident further. Such investigations are referred to as *root cause analysis* or *error analysis*. It is important to conduct investigations of adverse events in a nonpunitive atmosphere so that all facts of an incident can be identified. If healthcare providers feel that they will be punished because an error occurred, they might not reveal facts that might be self-incriminating. When this occurs, ways in which the event could have been prevented may not be realized, and corrective action does not occur. The nurse may be asked to answer questions about the circumstances of the incident, for example, what the nurse believes precipitated the incident, how it could have been prevented, and whether any equipment or policies should be adjusted to prevent recurrence of the event.

Nurses who believe they may be dismissed or that a suit may be brought against them should obtain legal advice. Even if the risk-management department clears the nurse of responsibility, the client or the client's family may file suit. The plaintiff, however, bears the burden of proving that the incident occurred because reasonable care was not taken. Even if the accepted standard of care was not met, the plaintiff must prove that the incident was the direct result of failure to meet the acceptable standards of care and that the incident caused physical, emotional, or financial injury.

When an adverse event occurs, the nurse should first assess the client and intervene to prevent injury. If the client is injured, nurses must take care to protect the client from further injury and to protect themselves and their employer. Most agencies have policies regarding incidents. It is important to follow these policies and not to assume

someone is negligent. Although negligence may be involved, incidents can and do happen even when every precaution has been taken to prevent them.

## Death and Related Issues

Legal issues surrounding death include issuing the death certificate, labeling the deceased, performing an autopsy, and arranging for organ donation and an inquest. By law, a death certificate must be completed when a person dies. It is usually signed by the attending physician and filed with a local health or other government office. The family typically is given a copy to use for legal matters, such as insurance claims.

Nurses have a duty to handle the deceased with dignity and label the body appropriately. Mishandling can cause emotional distress to survivors. Mislabeling can create legal problems if the body is inappropriately identified and prepared incorrectly for burial or a funeral. Usually, the deceased's wrist identification tag is left on, and another tag is tied to the deceased's ankles, in case one of the tags becomes detached. Tags tied to the ankles are preferred because any tissue damage they cause will be concealed by bed linen or clothing. A third tag is attached to the shroud. All identification tags should include the client's name, the agency identification number, and the physician's name.

## Organ Donation

Under the Uniform Anatomical Gift Act in the United States or the Human Tissue Act in Canada, any person 18 years of age or older and of sound mind may make a gift of all or any part of the body for the following purposes: for medical or dental education, research, advancement of medical or dental science, therapy, or transplantation. The donation can be made by registering with the state's donor registry, or by completing a wallet-size organ donation card when getting or renewing a driver's license. This card is usually carried at all times by the person who signed it. Organ donation can also be included in the individual's living will. In some states, organ donation permission is recorded on the driver's license. In most states and provinces, organ donation can be

revoked either by destroying the form or by oral revocation in the presence of two witnesses. In the absence of an organ donation card, and in the case of an individual under 18 years of age, the closest relative can give permission for organ donation. Nurses may serve as witnesses for persons consenting to donate organs. In some states, healthcare workers are required to ask survivors for consent to donate the deceased's organs.

### Wills

A will is a declaration by a person about how the person's property is to be disposed of after death. For a will to be valid the following conditions must be met:

- The person making the will must be of sound mind, that is, able to understand and retain mentally the general nature and extent of the person's own property, the relationship of the beneficiaries and of relatives to whom portions of the estate will be left, and the disposition being made of the property. Therefore, a person who is seriously ill and unable to carry out usual roles but who is mentally competent may still be able to direct preparation of a will.
- The person must not be unduly influenced by anyone else. Sometimes a client may be persuaded by someone who is close at that particular time to make that person a beneficiary. Clients sometimes are persuaded to leave their estates to persons looking after them rather than to their relatives. Frequently, the relatives contest the will in such situations and take the matter to court, claiming undue influence.

Nurses may be requested from time to time to witness a will, although most agencies have policies that nurses not do so. In most states and provinces, a will must be signed in the presence of two witnesses. In some situations, a mark can suffice if the person making the will cannot write a signature. When witnessing a will, the nurse (1) attests that the client signed the will and (2) attests that the client appears to be mentally sound and appreciates the significance of his or her actions.

If a nurse witnesses a will, the nurse should note on the client's chart the fact that a will was made and the nurse's perception of the physical and mental condition of the client. This record provides the nurse with accurate information if she or he is called as a witness later. The record may also be helpful if the will is contested. If a nurse does not wish to act as a witness, she or he has the right to refuse to act in this capacity.

### Euthanasia

**Euthanasia** is the "deliberate ending of a person's life for medical reasons" (Sheppard, 2011, p. 395). Medical reasons cited when a client considers euthanasia are usually

related to unbearable suffering from incurable or distressing disease. Euthanasia is often referred to as *mercy killing*. *Assisted dying* (the term used by the countries involved) is within legal provisions in the Netherlands, Belgium, Switzerland, and Luxembourg (Hendry et al., 2012). Regardless of compassion and good intentions or moral convictions, euthanasia or assisted dying is legally wrong in Canada and most of the United States and can lead to criminal charges of homicide or to a civil lawsuit for withholding treatment or providing an unacceptable standard of care. Because advanced technology has enabled the medical profession to sustain life almost indefinitely, people are increasingly considering the meaning of quality of life. For some people, the withholding of artificial life support measures or even the withdrawal of life support is a desired and acceptable practice for clients who are terminally ill or who are incurably disabled and are believed to be unable to live their lives with some happiness and meaning.

Voluntary euthanasia, or assisted suicide, refers to situations in which the dying individual desires some control over the time and manner of death. **Physician-assisted suicide** is when death is accomplished by a physician intentionally providing an overdose of a prescription medication. Currently, Oregon, Washington, and Montana have passed legislation allowing physician-assisted suicide. Other states have rejected legislation to legalize physician-assisted suicide.

The ANA issued a position statement in 2013 that "prohibits nurses' participation in assisted suicide and euthanasia as being in violation of the Code of Ethics for Nurses With Interpretive Statements, the ethical traditions and goals of the profession, and its covenant with society" (p. 1). When patients ask nurses about euthanasia or assisted suicide, it is the nurses' responsibility to explain the laws that currently exist within the state where they practice. Further, nurses should discuss options with the patient and his or her family about symptom management and provide information about services that the patient may need. The nurse should also discuss with the physician strategies to manage symptoms, including effective pain management.

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### Reflect On . . .

- your own beliefs about death and dying. How do you feel about terminating ventilator support, intravenous or tube feedings, or other life-maintaining strategies used for terminally ill clients? What are the policies in place in your practice setting that cover the termination of life support?
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## RESEARCH CURRENT

### Why Do We Want the Right to Die? A Systematic Review of the International Literature on the Views of Patients, Carers and the Public on Assisted Dying

The purpose of Hendry et al.'s study was to synthesize the international research related to the views and attitudes of patients, caregivers, and the general public regarding assisted dying. Research on the views and attitudes of doctors, nurses, and other health professionals were excluded from this study. This meta-analysis reviews the literature identified in 11 electronic databases from inception to October 2011, based on search terms related to assisted dying (e.g., euthanasia, assisted suicide, right to die, assisted or aided dying). Articles reviewed included 18 qualitative studies and 94 quantitative (surveys) studies. While the literature review included international studies reported in English, the majority (64 studies) were set in North America. Study populations included those with terminal illness, disability, and dementia; relatives of people who had received assistance in dying; vulnerable groups; people with specific religious beliefs; and the general public. Qualitative synthesis identified four themes: concerns about poor quality of life, desire for good quality of death, concerns about abuse if assisted dying were legalized, and the importance of individual stance related to assisted dying. Within each theme were categories as follows: Concerns about poor quality of life

included unbearable suffering, dependency, burden, and loss of self; desire for good quality of death included choice, autonomy, and control; concerns about abuse if assisted dying were legalized included the need for safeguards, financial pressure, vulnerable groups and the potential for discrimination, and the role of others in decision making; the importance of individual stance relating to assisted dying included moral or religious views, personal experience of death, and whether they were for or against allowing assisted dying. Study sample sizes were small so it is difficult to generalize the findings from either individual studies or all study data compiled together. However, in studies that reported both patient and relative views, a greater percentage of relatives (54% to 77%) were in favor of assisted dying than were patients (46% to 54%). There is much debate about assisted suicide, and nurses and other health professionals must stay informed about the legal and ethical implications related to this controversial issue.

*Source:* "Why Do We Want the Right to Die? A Systematic Review of the International Literature on the Views of Patients, Carers and the Public on Assisted Dying" by M. Hendry, D. Pasterfield, R. Lewis, B. Carter, D. Hodgson, and C. Wilkinson, 2012, *Palliative Medicine*, 27(1), pp. 13–26.



**InfoQuest:** Search the Internet to determine the status of legislation related to assisted suicide or death with dignity in your state.

## The Impaired Nurse

According to Thomas and Siela (2011), approximately 10% to 15% of all nurses may be impaired or participating in alcohol or drug addiction recovery programs. An **impaired nurse** is one whose practice is negatively affected because of substance abuse, specifically the use of alcohol and/or drugs. Chemical dependence in health-care workers has become a problem because of the high levels of stress involved in many healthcare settings and the easy access to addictive drugs. In addition to substance abuse, emotional disturbances or mental illnesses such as depression or secondary posttraumatic stress disorder may also affect a nurse's ability to deliver safe and competent care. The ANA *Guide to the Code of Ethics for Nurses*:

*Interpretation and Application* says that "nurses must be vigilant to protect the patient, the public, and the profession from potential harm when a colleague's practice, in any setting, appears to be impaired" (American Nurses Association, 2010, p. 155). Some state nurse practice acts require that a nurse report a colleague suspected of practicing impaired to the state board of nursing.

There are three victims of the nurse who is impaired: the client, whose care may be compromised by the nurse whose judgment and skills are impaired; the nurse's colleagues, who must pick up after the impaired worker; and the impaired nurse, whose illness may go undetected and untreated. The primary concern is for the protection of clients, but it is also critically important that the nurse's problem be identified quickly so that appropriate treatment can be instituted. In 1981, the ANA appointed a task force on addiction and psychological disturbance to develop guidelines for identifying, treating, and assisting nurses impaired by alcohol or drug abuse or psychological disturbance. Table 5–3 lists behaviors that may be seen in the impaired nurse.



**TABLE 5–3 Behaviors Suggesting Impaired Nursing Practice**

| Signs and Symptoms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Physical Signs                                                                                                                                                                                                                                                                                                                                                                                                                               | Behavioral Changes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Brief, unexplained absences from the nursing unit</li> <li>• Rounding at odd hours</li> <li>• Medication errors</li> <li>• Isolation from peers</li> <li>• Mood changes after meals or breaks</li> <li>• Frequent reports of lack of pain relief from assigned patients</li> <li>• Narcotic or Pyxis obsession, offering to medicate coworkers' patients</li> <li>• Wasted narcotics attributed to a single nurse</li> <li>• Increased narcotic sign-outs</li> <li>• Discrepancies with the narcotic record and or the patient record</li> <li>• Altered verbal or telephone medication orders</li> <li>• Decreased quality of care, documentation</li> <li>• Arriving late to work and requesting to leave early</li> </ul> | <ul style="list-style-type: none"> <li>• Shakiness and or tremors</li> <li>• Fatigue</li> <li>• Slurred speech</li> <li>• Frequent use of mouthwash or breath mints</li> <li>• Watery eyes</li> <li>• Constricted or dilated pupils</li> <li>• Diaphoresis</li> <li>• Unsteady gait</li> <li>• Frequent runny nose</li> <li>• Frequent nausea, vomiting and diarrhea</li> <li>• Weight gain or loss</li> <li>• Change in grooming</li> </ul> | <ul style="list-style-type: none"> <li>• Frequent mood changes</li> <li>• Outbursts of anger</li> <li>• Defensiveness</li> <li>• Inappropriate laughter</li> <li>• Hyperactivity or hypoactivity</li> <li>• Lack of concentration</li> <li>• Blackout periods</li> <li>• Justifying the addiction to “relax,” “need to escape reality”</li> <li>• Cold weather clothing in warm weather to hide track marks</li> <li>• Frequent accidents or emergencies</li> <li>• Personal relationship issues</li> <li>• Insomnia</li> <li>• Frequent complaints of pain</li> <li>• Denial of problem; frequent lying</li> <li>• Decreased judgment in their own performance</li> </ul> |

Source: “The Impaired Nurse: Would You Know What to Do If You Suspected Substance Abuse?” by C. M. Thomas and D. Siela, 2011, *American Nurse Today*, 6(8). Retrieved from [www.americanursetoday.com/article.aspx?id=8114&fid=8078](http://www.americanursetoday.com/article.aspx?id=8114&fid=8078). Used with permission.

The nurse should take the following actions when she or he suspects a colleague of being chemically impaired:

- Do not permit a visibly impaired coworker to care for clients. The safety of clients, staff, and other individuals in the care environment must be protected.
- Report physical signs, symptoms, and behavioral changes associated with unsafe practice or impaired behavior immediately to the appropriate supervisor (see Table 5–3).
- Document accurately and completely any suspicious behaviors or incidents suggestive of impairment.
- The nurse suspected of substance abuse should be confronted by a supervisor or manager in the presence of at least one other witness.
- The nurse’s right to confidentiality and privacy must be respected during the investigative process.
- Avoid being judgmental. Be supportive and recognize that substance abuse is an illness that can be treated.

Several programs have been developed to assist impaired nurses to recovery. In many states, impaired nurses who enter an intervention program for treatment do not have their nursing license revoked, but their practice is closely supervised within the limitations placed by the intervention program. Progress in the intervention program is also monitored by the state board of nursing. The NSCBN lists all state boards of nursing on its website.

Information on support programs for impaired nurses can be obtained from each state board.

### Reflect On . . .

- the factors in nursing that may lead to nurses being impaired. Have you worked with a nurse you suspected of being impaired? How did you feel about that situation? Under your state nurse practice act and your agency policies, what is your responsibility if you suspect a nursing colleague is impaired? How do you feel about this responsibility?

There are many situations in nursing practice that may have legal implications for nurses. It is important to be knowledgeable about the employing agency’s policies and procedures that provide direction in managing such situations. It is also vital for nurses to be knowledgeable about their state nurse practice act, as it may provide guidance for dealing with situations related to their practice.

## Sexual Harassment

Sexual harassment is a violation of an individual’s rights and a form of discrimination. The Equal Employment Opportunity Commission (EEOC) defines sexual harassment as “unwelcome sexual advances, requests for sexual



favors and other verbal or physical conduct of a sexual nature” occurring in the following circumstances (U.S. Equal Employment Opportunity Commission, 2014):

- When submission to such conduct is considered, either explicitly or implicitly, a condition of an individual’s employment.
- When submission to or rejection of such conduct is used as the basis for employment decisions affecting the individual.
- When such conduct interferes with an individual’s work performance or creates an “intimidating, hostile, or offensive working environment.”

In health care, both clients and healthcare professionals may experience sexual harassment. Because sexual harassment is often related to a power imbalance, female nurses are more likely to experience sexual harassment from male colleagues. Nurses may report having been “sexually propositioned,” “suggestively touched,” or “sexually insulted” by physicians or male healthcare administrators during their career. Such behavior is considered sexual harassment and can negatively affect client care. For example, to avoid uncomfortable sexual harassment situations, the nurse may refuse to care for the clients of a particular offensive physician, or to work on a unit with an offensive administrator, or the nurse may avoid calling a physician to report changes in client status or to suggest changes to improve client care.

The victim of the harasser may be male or female. The victim does not have to be of the opposite gender. Moreover, the victim does not have to be the person harassed; anyone who is affected by the offensive conduct may be considered a victim (U.S. Equal Employment Opportunity

Commission, 2014). Nurses must be familiar with the sexual harassment policies and procedures in their employing agency. Many organizations offer and some require employees to take educational programs that provide information about sexual harassment, including what incidents are considered sexual harassment and how to prevent them. They also review sexual harassment policies and procedures, including grievance procedures; determine to whom incidents should be reported; and provide the process for resolution. See the accompanying box for strategies to deter sexual harassment.

## Nurses as Witnesses

A nurse may be called to testify in a legal action for a variety of reasons. The nurse may be a defendant in a malpractice or negligence action or may have been a health professional that provided care to the plaintiff. It is advisable that any nurse who is asked to testify in such a situation obtain the advice of an attorney before providing testimony. In most cases, the attorney for the institution will provide support and counsel during the legal case. If the nurse is the defendant, however, it is advisable for the nurse to retain an attorney to protect her or his own interests.

A nurse may also be asked to provide testimony as an expert witness. An **expert witness** is “one who can explain highly specialized technology or skilled nursing care to jurors” (Guido, 2014, p. 65). Such a witness is usually called to help a judge or jury understand evidence pertaining to the standard of care or the extent of damage. The nurse, as an expert witness, will review the medical record and other appropriate documents (e.g., the state nurse

## Strategies to Deter Sexual Harassment

- 
- Educate yourself about sexual harassment. What constitutes sexual harassment?
  - Examine your own feelings and attitudes regarding sexual harassment.
  - Act with confidence; individuals who are seen as weak are more likely to be targeted for sexual harassment or bullying.
  - Dress and act appropriately. Inappropriate dress (e.g., provocative attire) or behavior (e.g., teasing, flirting) may be interpreted as welcoming sexual advances.
  - Know your organization’s policies and procedures regarding sexual harassment.
  - Examine your own behaviors that may be considered sexual harassment by others (e.g., telling lewd or sexually oriented jokes).
  - When harassed, confront the harasser immediately, and ask that the behavior stop. Be very clear that the behavior is unwanted and unacceptable.
  - Distance yourself from individuals who make unwelcome sexual comments or advances.
  - Document the harassment, recording in detail the who, what, where, and when of the situation and how you responded. Include witnesses if any.
  - Report the harassment to the appropriate personnel (e.g., supervisor, human resources) following agency policies and procedures.
  - Seek support from others, such as workplace human resources departments, friends, colleagues, relatives, or an organized support group.
-

### CRITICAL THINKING EXERCISE

You are called as a witness in a malpractice case. The incident occurred more than 3 years ago. The case is against the healthcare institution where you were employed at the time the incident occurred, and a nurse whom you know was overtly negligent. This negligence resulted in harm to the client, who has filed a lawsuit against the healthcare institution. On several previous occasions, you observed the nurse violating standards of care. You reported these incidents to the administration.

At the time of the incident in question, you kept personal anecdotal notes because you were concerned about a possible lawsuit in the future. You are still an employee of the healthcare institution being sued. You are asked if you have ever witnessed other incidents of negligence performed by this nurse and, if so, what you did. What is your responsibility to your employer, the nurse being sued, the client in question, and the institution's clients? What do you do? To whom are you obligated?

practice act, institutional policies and procedures related to the incident, scope and standards of nursing practice) and provide an expert opinion based on her or his knowledge, skill, and professional expertise.

When called into court as a witness, the nurse has a duty to assist justice as far as possible. The nurse should always respond directly and truthfully to the questions asked. The nurse is not expected to volunteer additional information nor to remember completely all the details of a situation that may have occurred months or even years before the legal action. The nurse may ask to refer to the client record or to personal notes related to the incident. If the nurse does not remember the details of the incident, it is advisable to say so rather than to report inaccurately. In any case, it is the nurse's professional responsibility to provide accurate testimony during both the pretrial discovery phase and the trial phase of a legal action.

## Collective Bargaining

**Collective bargaining**, also referred to as *labor relations*, is the “joining together of employees for the purpose of increasing their ability to influence the employer and improve working conditions” (Guido, 2014, p. 328). It is also the formalized decision-making process between representatives of management and representatives of labor to negotiate wages and conditions of employment, including work hours, working environment, and fringe benefits of employment (e.g., vacation time, sick leave, and personal leave). Through a written agreement, both employer and employees legally commit themselves to observe the terms and conditions of employment.

Collective bargaining is a controversial issue among nurses. Some nurses consider collective bargaining unprofessional and unethical especially when faced with a decision about striking. Others argue that collective bargaining

is necessary to obtain control of nursing practice and economic security and to prevent unfair or arbitrary treatment related to scheduling, staffing, rotating shifts, and on-call assignments.

The collective bargaining process involves the recognition of a certified bargaining agent for the employees. This agent can be a union, a trade association, or a professional organization. However, the organization that represents labor for purposes of collective bargaining cannot include persons considered management. For this reason, the ANA, which represents all RNs in the United States cannot function as a collective bargaining agent; however, the ANA supports the right of nurses to collective bargaining. There are several organizations that represent nurses for collective bargaining purposes, including United American Nurses and National Nurses United. The agent represents the employees in the negotiation of a contract with management.

In the 1930s, the National Labor Relations Act (NLRA) established the regulation of collective bargaining. In nursing, the NLRA provides guidelines for the resolution of conflicts between nurse employees and their employers. Nurses who are supervisors are not covered by the NLRA.

When collective bargaining breaks down because an agreement cannot be reached, the employees may call a strike. A **strike** is an organized work stoppage by a group of employees to express a grievance, enforce a demand for changes in conditions of employment, or solve a dispute with management.

Because nursing practice is a service to people (often people who are ill and vulnerable), striking presents a moral dilemma to many nurses. Actions taken by nurses can affect people's safety. When faced with a strike, each nurse must make an individual decision to cross or not to cross a picket line. Nursing students may also be faced with decisions about crossing picket lines in the event of a

strike at a clinical agency used for learning experiences. In such a case, the educational institution usually makes the decision regarding nursing student activities in a striking organization.

Collective bargaining is more than the negotiating of salary terms and hours of work; it is a continuous process in which day-to-day difficulties or grievances are handled through the grievance procedure, a formal plan established in the contract that outlines the channels for handling and settling grievances through progressively higher levels of administration. A grievance is any dispute, difference, controversy, or disagreement arising out of the terms and conditions of employment.

### Reflect On . . .

- your own opinions about collective bargaining. Do you believe nurses should be able to strike or have a work stoppage?
- what would happen if your workplace downsized and closed several units. The administration is requesting nurses to take leave days without pay when the census drops. At the same time, the administration is asking nurses to work 4–6 hours overtime to cover units when staffing is inadequate. Nurses are also being floated to areas where they have no expertise. The nurses want to organize for collective bargaining. What is your position? What can be gained by organizing? Are there disadvantages to organizing in a union?
- healthcare settings where nurses choose not to organize for collective bargaining. What are the characteristics of these employment settings?
- healthcare settings where nurses choose to organize for collective bargaining. What are the characteristics of these employment settings?

## Chapter Highlights

- Understanding one's own rights and responsibilities as an RN, as well as those of others, is essential for competent and safe nursing practice.
- Nurses need to understand laws that regulate and affect practice to ensure that their actions are consistent with current legal principles and to protect themselves from liability.
- Nurse practice acts legally define and describe the scope of nursing practice.
- Competence in nursing practice is determined and maintained by various credentialing methods, including licensure, registration, certification, and accreditation. The purpose of credentialing is to protect the interests and safety of the public.
- Standards of practice are published by national and state or provincial nursing associations, and agency policies, procedures, and job descriptions further delineate the scope of a nurse's practice.
- Negligence or malpractice can be established when (1) the nurse (defendant) owed a duty to the client, (2) the nurse failed to carry out that duty, (3) the client (plaintiff) was injured, and (4) the client's injury was caused by the nurse's failure to carry out that duty.
- The medical record is the legal source of information about the client. It is the vehicle for communication about the patient's care and status among all healthcare providers. The medical record may also be used for education, research, risk-management activities, and financial and business operations. Documentation should be contemporaneous, accurate, truthful, and appropriate.
- When the nurse delegates care to a subordinate, the nurse is responsible and accountable for the care given. Components of the decision tree for delegation include assessment and planning, communication, surveillance and supervision, and evaluation and feedback.
- Restraints are protective devices used to limit the physical activity of a client or a part of a client's body. Restraints may be physical or chemical. Restraints or seclusion should only be used when less restrictive interventions have been determined to be ineffective to protect the client, staff members, or others from harm. Nurses must be knowledgeable about the restraint policies within their organization.
- The nurse is responsible for ensuring that informed consent from clients (or from the closest relative or

surrogate in emergencies, or from parents or guardians if the client is a minor) is in the medical record before treatment regimens and procedures begin. Informed consent requires that (1) the consent was given voluntarily, (2) the client was of age and had the capacity and competence to understand, and (3) the client was given sufficient information on which to make an informed consent.

- Advance healthcare directives are statements that clients make specifying their wishes regarding healthcare decisions. The principle of autonomy supports the right to self-determination in relation to health care. Documents associated with advance healthcare directives include the living will, the durable power of attorney for health care (DPAHC), the medical durable power of attorney (MDPA), and medical or physician directives.
- Do-not-resuscitate orders may be ordered for clients who are in a stage of terminal, irreversible illness or expected death and require that no effort be made to resuscitate them in the event of a respiratory or cardiac arrest. Such orders must be documented in the client's medical record.
- When a client is injured or involved in an unusual incident, the nurse's first responsibility is to take steps to protect the client, then to document the incident and to notify appropriate agency personnel.
- Other legal issues related to death and dying that nurses may encounter in their practice are organ donation, wills, and euthanasia. The nurse is responsible for being informed about such issues as they relate to nursing practice and for practicing in accordance with legal boundaries and organizational policies and procedures.
- An impaired nurse is one whose practice is negatively affected because of substance abuse. Nurses must be aware of their responsibility in ensuring the safe practice of their colleagues in the care of their patients/clients.
- Sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature." Nurses should be knowledgeable about the sexual harassment policies of their organization and ensure that patients, colleagues, and other staff are protected from such behavior.
- Nurses may be called to testify in a legal action as a defendant, a witness, or an expert witness in a malpractice lawsuit. A nurse who is a defendant is advised to retain an attorney to protect her or his own interests.
- Collective bargaining is a formalized decision-making process between representatives of management and representatives of labor to negotiate wages and conditions of employment.

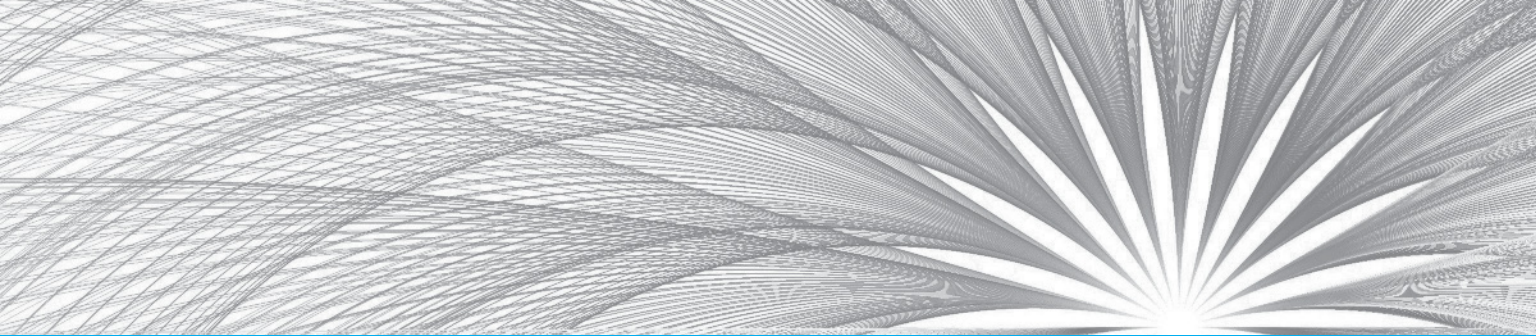
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# 6

## Knowledge Development in Nursing

### Chapter Outline

#### Challenges and Opportunities

#### Worldviews and Knowledge Development

#### Defining Terms

#### Theory Development in Nursing

Early Knowledge Development in Nursing

#### Selected Nursing Theories

Rogers's Science of Unitary Human Beings

Orem's Self-Care Deficit Theory of Nursing

King's Goal-Attainment Theory

Neuman's Systems Model

Roy's Adaptation Model

Benner's Novice to Expert

The Caring Theorists

Middle-Range Theories

#### Relationship of Theories to the Nursing Process and Research

#### Chapter Highlights

### Objectives

1. Describe the nature of knowledge development.
2. Differentiate among the terms *concept*, *conceptual framework*, and *conceptual model*.
3. Analyze the development of knowledge in nursing.
4. Compare the theoretical approaches of selected nurse theorists.
5. Identify the relationship between nursing process and nursing theory.

**K**nowledge development in nursing has proliferated since the 1960s. To be meaningful, this knowledge must be organized, and information must be linked in a way that can be understood and used to continue to generate new knowledge. Theory and conceptual frameworks allow that organization and linking of data in the building of a body of knowledge for nursing as a foundation for practice (see box on the following page). This chapter presents the development of theoretical foundations for professional nursing practice.

### Challenges and Opportunities

Knowledge development in nursing began with theories developed and articulated by academicians who proposed those theories to guide practice in nursing. The practicing nurse often regarded them as ethereal and unrelated to the real world of nursing. Nursing theories must be seen as supporting and guiding practice and must be communicated in ways that are compelling to nurses, who must apply them in a clinical setting.

The development of nursing theory has been the foundation for knowledge development in the discipline. Theories have been drawn from a number of other disciplines and have been developed at varying levels of abstraction. This approach has the advantage of allowing nurses to match their own thinking and reasoning styles with the theory that they deem the best fit. But is this diverse approach the one that best serves the profession in an age of evidence-based practice?

## Purposes of Nursing Theories and Conceptual Frameworks

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These purposes are to provide direction and guidance for (1) structuring professional nursing practice, education, and research and (2) differentiating the focus of nursing from that of other professions.

### In Practice

- Assist nurses to describe, explain, and predict everyday experiences.
- Serve to guide assessment, intervention, and evaluation of nursing care.
- Provide a rationale for collecting reliable and valid data about the health status of clients, which is essential for effective decision making and implementation.
- Help establish criteria to measure the quality of nursing care.
- Help build a common nursing terminology to use in communicating with other health professionals. Ideas are developed and words defined.

- Enhance the autonomy (independence and self-governance) of nursing through defining its independent functions.

### In Education

- Provide a general focus for curriculum design.
- Guide curricular decision making.

### In Research

- Offer a framework for generating knowledge and new ideas.
  - Assist in discovering knowledge gaps in the specific field of study.
  - Offer a systematic approach to identifying questions for study; select variables, interpret findings, and validate nursing interventions.
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## Worldviews and Knowledge Development

Einstein is credited with saying that there is nothing so practical as a good theory. A theory is defined as a system of ideas proposed to explain something. Theory helps to improve practice by describing, explaining, predicting, and controlling phenomena. It guides practice, education, and research and provides professional autonomy as knowledge is systematically developed, producing practices that are more likely to be successful. The study of theory helps nurses develop analytical skills and critical thinking ability. Each nurse uses concepts and theories daily to guide nursing actions, although they may not be articulated or perceived as theories. Each time a decision is made based on ideas that explain the situation or event, theory is used, even though it may not be formalized as such. In the 1960s, theory was developed by nurses who were pursuing graduate degrees in nursing and related fields. Few other nurses knew or cared about such matters; theory was not part of nursing education at that time. Until the 1950s nursing practice was based on principles and traditions passed on through an apprenticeship form of education and common sense that came from years of experience. In the mid-1800s, Florence Nightingale proposed that nursing knowledge was based on knowledge of persons and their environment and was different and distinct from medical knowledge. It was nearly a century later that nursing theory began to emerge and be valued by the profession.

Different theories represent different worldviews, which are different ways of conceiving of knowledge.

Theories are not discovered; individuals who think and see the world in different ways create them. These worldviews provide contrasting **paradigms** (structures for organizing theory) and provide different traditions in and approaches to science and knowledge development.

One paradigm is derived from the positivist approach, which comes from the 19th-century Age of Enlightenment and represents what many people regard as hard science. It deals with natural law and assumes that there is a body of facts and principles to be discovered and understood independent of the context. This approach is linear and attempts to look at cause and effect by using experimental research methods. The theories generated by quantitative methods are normative, and they suggest propositions to explain relationships. They start with a generalization and bring it to a more specific level. Hypotheses are deduced from the theory to be tested in research.

The second paradigm began as a countermovement to positivism and sees science as necessarily embedded in time because truth is dynamic. That is, reality as an entity is not fixed but is relative. Truth is found in one's experiences, and research uses naturalistic settings and observational methods to describe phenomena. This approach is sometimes referred to as *constructivist*. These theories are inductively constructed and give insights into social contexts and personal meanings; they start with a specific observation or relationship and make generalizations from it.

Theories differ in their scope and have been categorized in different ways. One of those categorization schemes, which divides them according to scope, uses

**TABLE 6–1 Nursing Theorists and Their Theoretical Scope**

| Philosophies                                   | Nursing Models                           | Nursing Theories                                                        | Middle-Range Theories                        |
|------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------|
| Jean Watson's philosophy and science of caring | Martha Rogers's unitary human beings     | Madeleine Leininger's culture care theory of diversity and universality | Merle Mishel's uncertainty in illness theory |
| Marilyn Ray's theory of bureaucratic caring    | Dorothea Orem's self-care deficit theory | Margaret Newman's health as expanding consciousness                     | Katherine Kolcaba's theory of comfort        |
| Patricia Benner's novice to expert             | Betty Neuman's systems model             | Rosemarie Parse's human becoming theory                                 | Cheryl Beck's postpartum depression theory   |
|                                                | Sister Callista Roy's adaptation model   | Afaf Meleis's transition theory                                         | Kristen Swanson's theory of caring           |
|                                                | Imogene King's theory of goal attainment | Anne Boykin and Savina Schoenhofer's theory of nursing as caring        | Ramona Mercer's maternal role attainment     |

Source: Based on *Nursing Theorists and Their Work* (7th ed.), by A. M. Tomey and M. R. Alligood, 2010, St. Louis, MO: Mosby.

philosophies, models, grand theories, and middle-range theories.

A *philosophy* looks at the nature of things and aims to provide the meaning of nursing phenomena. Philosophies are the broadest in scope and provide a broad understanding. *Nursing models* begin to form interrelationships among concepts and definitions to provide a more organized perspective. A *grand theory*, referred to as nursing theories in the above table, is broad and complex and tends to be very general; grand theories are abstract but may provide insights useful for practice. They are conceptual and have concepts, definitions, and propositions. *Middle-range theory* has a narrower focus and is derived from earlier works, such as philosophies and grand theories, or from works in other disciplines that are refined through a series of studies, each providing increased focus. Middle-range theory may be said to have more direct practice application when describing, explaining, predicting, and controlling some phenomenon. Table 6–1 lists theorists whose work falls into the categories just discussed.

## Defining Terms

Before specific theories and conceptual frameworks can be understood, the terms *concept*, *conceptual framework*, *conceptual model*, and *theory* must be clarified. **Concepts**, the building blocks of theory, are abstract ideas or mental images of phenomena. Concepts are words that bring forth mental pictures of the properties and meanings of objects, events, or things. Concepts may be (1) readily observable, or concrete, ideas such as thermometer, rash, and lesion; (2) indirectly observable, or inferential, ideas such as pain and temperature; or (3) nonobservable, or abstract, ideas such as equilibrium, adaptation, stress, and powerlessness.

Four concepts have been identified as the metaparadigm of nursing—the most global philosophical or conceptual framework of a profession. The term originates from two Greek words: *meta*, meaning “with”; and *paradigm*, meaning “pattern.” The four concepts are as follows:

1. *Person or client*, the recipient of nursing care (includes individuals, families, groups, and communities)
2. *Environment*, the internal and external surroundings that affect the client, including people in the physical environment, such as families, friends, and significant others
3. *Health*, the degree of wellness or well-being that the client experiences
4. *Nursing*, the attributes, characteristics, and actions of the nurse providing care on behalf of or in conjunction with the client

Each nurse theorist's definitions of these four concepts vary in accordance with the theorist's philosophy, scientific orientation, experience, and view of nursing. At the time the metaparadigm was conceived, it assisted nurse scholars and students of nursing to analyze, compare, and contrast theories within a nursing framework. Not all theorists embrace the four concepts as distinct concepts. The theories representing more holistic and phenomenological approaches do not necessarily separate person from environment or health.

## Theory Development in Nursing

The terms *theory* and *conceptual framework* are often used interchangeably in nursing literature. Strictly speaking, they differ in their levels of abstraction; a conceptual framework is more abstract than a theory. A

**conceptual framework**, viewed simply, is a group of related concepts. It provides an overall view or orientation to focus thoughts. A conceptual framework can be thought of as an umbrella under which many concepts can exist. A **conceptual model**, a term often used interchangeably with *conceptual framework*, is a graphic illustration or diagram of a conceptual framework. A **theory** is a supposition or system of ideas that is proposed to explain a given phenomenon. For example, Isaac Newton proposed his theory of gravity to explain why objects always fall from a tree to the ground. A theory goes one step beyond a conceptual framework; a theory relates concepts by using definitions that state significant relationships between concepts.

Knowledge development may use a deductive or an inductive approach. These two approaches represent theory testing or theory generation. Theory testing compares observed outcomes with the relationship predicted by the hypothesis that was drawn from the theory and linked the concepts. Theory generation comes from descriptive data that result in new concepts that may be related to other concepts. Generally speaking, theory testing uses a deductive approach and applies quantitative research methods. Theory generation uses an inductive approach and is a result of qualitative research.

Not all knowledge comes about as a result of research. Ways of knowing have been identified and described that include but are not limited to empirical methods. Kneller (1971) described the following five kinds of knowledge:

*Revealed knowledge*—that disclosed by God

*Intuitive knowledge*—that coming from a process of discovery nurtured by experience with the world

*Rational knowledge*—that using principles of formal logic

*Empirical knowledge*—information tested by observation or experiment

*Authoritative knowledge*—that vouched for by authorities in the field

Carper (1978) organized ways of knowing according to the following framework: empirical, aesthetic, personal, and ethical. *Empirical knowing* represents the science of nursing and emphasizes generation of theory that is systematic and controllable by factual evidence. *Aesthetic knowing* represents the art of nursing and emphasizes expressiveness, creativity, perceptions, subjectivity, and empathy. *Personal knowing* focuses on interpersonal processes and the therapeutic use of self. *Ethical knowing* represents a pattern of knowing related to what ought to be done and focuses on matters of obligation. Chinn and Kramer (2010) added a fifth pattern called *emancipatory knowing*; it

focuses on noticing social injustice, investigating the causes, and identifying changes that would correct the injustice or oppression.

Efforts to develop theory in nursing have resulted in discussion and debate about what is unique to nursing. Do nurses need basic scientific knowledge that they apply in practice, or is there a distinct body of knowledge for the discipline? Historically, nursing practice has been linked to the use of medical knowledge and has embraced the scientific bases of social and behavioral sciences as well as education.

Some have suggested that theories in nursing are borrowed and shared theories. Other disciplines have provided the foundation of a nursing theory unique to nursing. Nurse theorists have borrowed from others and applied their theories to nursing. Some theories are shared with other disciplines. For instance, Abraham Maslow's hierarchy of needs and Erik Erikson's psychosocial development are applied to nursing without modification of the theories. This application has resulted in a diversity of theories. An overview of some selected nursing theories representing a range of scope and worldviews is included in this chapter. For further examination of particular theories, the student is referred to one of the many books available on nursing theory.

## Early Knowledge Development in Nursing

Three pioneers in nursing knowledge development are Florence Nightingale, Hildegard Peplau, and Virginia Henderson. Florence Nightingale is proclaimed by many to be the first nurse theorist. Hildegard Peplau moved nursing toward human relationships and added a new dimension to the traditional biological and procedural aspects of care. Virginia Henderson formulated a definition of nursing that differentiated nursing from medicine and began to move nursing away from its reliance on the medical model.

### Nightingale's Environmental Theory

Florence Nightingale is often considered the first nurse theorist, and she defined nursing more than 100 years ago as utilizing the environment of the patient to assist in recovery (Nightingale, 1860/1957). She linked health with five environmental factors: (1) pure or fresh air, (2) pure water, (3) efficient drainage, (4) cleanliness, and (5) light, especially direct sunlight. Deficiencies in these five factors produced lack of health, or illness.

These factors are especially significant when one considers that sanitation conditions in hospitals of the mid-1800s were extremely poor and that women working in the hospitals were often unreliable, uneducated, and incompetent to care for the ill.



In addition to the preceding factors, Nightingale stressed the importance of keeping the client warm, maintaining a noise-free environment, and attending to the client's diet in terms of assessing intake, timeliness of the food, and its effect on the person.

Nightingale set the stage for further work in the development of nursing theories. Her general concepts about ventilation, cleanliness, quiet, warmth, and diet remain integral parts of nursing and health care today.

### Peplau's Interpersonal Relations Model

Hildegard Peplau, a psychiatric nurse, introduced her interpersonal concepts in 1952 (Peplau, 1952) and based them on theories available at the time: psychoanalytic theory, principles of social learning, and concepts of human motivation and personality development. *Psychodynamic nursing* is defined as the nurse understanding his or her own behavior in order to help others identify their own experience of difficulties. Principles of human relations are applied to problems arising during the nursing experience.

Peplau views nursing as a maturing force that is realized as the personality develops through educational, therapeutic, and interpersonal processes (Peplau, 1963, 1980). Nurses enter into a personal relationship with an individual when a felt need on the part of the client is present. This nurse-client relationship evolves in four phases:

1. **Orientation.** During this phase, the client seeks help, and the nurse assists the client to understand the problem and the extent of the need for help.
2. **Identification.** During this phase, the client assumes a posture of dependence, interdependence, or independence in relation to the nurse (relatedness). The nurse's focus is to assure the person that the nurse understands the interpersonal meaning of the client's situation.
3. **Exploitation.** In this phase, the client derives full value from what the nurse offers through the relationship. The client uses the available services on the basis of self-interest and needs. Power shifts from the nurse to the client.
4. **Resolution.** In this final phase, old needs and goals are put aside and new ones are adopted. Once older needs are resolved, newer and more mature ones emerge.

During the nurse-client relationship, nurses assume many roles: stranger, teacher, resource person, surrogate, leader, and counselor. Today, Peplau's model continues to be used by clinicians when working with individuals in psychiatric and mental health settings.

### Henderson's Definition of Nursing

Virginia Henderson is well known for her *Textbook on the Principles and Practices of Nursing*, coauthored with Canadian nurse Bertha Harmer (Harmer & Henderson, 1955); Henderson's subsequent publications include *The Nature of Nursing* (1966) and numerous scholarly papers. She was motivated to develop her ideas because she was dissatisfied with the emphasis that nursing education programs placed on technical competence and mastery of nursing procedures; her experiences in psychiatric, pediatric, and community health nursing were other major influences (Henderson, 1991).

In 1955, Henderson formulated a definition of the unique function of nursing. This definition was a major stepping-stone in the emergence of nursing as a discipline separate from medicine. She wrote, "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1966, p. 3). Like Nightingale, Henderson described nursing in relation to the client and the client's environment. Unlike Nightingale, Henderson saw the nurse as concerned with both well and ill individuals, acknowledged that nurses interact with clients even when recovery may not be feasible, and mentioned the teaching and advocacy roles of the nurse.

Basic to her definition are various assumptions about the individual, namely, that the individual (1) needs to maintain physiological and emotional balance, (2) requires assistance to achieve health and independence or a peaceful death, and (3) needs the necessary strength, will, and knowledge to achieve or maintain health. These needs give direction to the nurse's role.

Henderson conceptualized the nurse's role as assisting sick or well individuals in a supplementary or complementary way. The nurse needs to be a partner with the client, a helper to the client, and, when necessary, a substitute for the client. The nurse's focus is to help individuals and families (which Henderson viewed as a unit) to gain independence in meeting the following 14 fundamental needs (Henderson, 1966):

1. Breathing normally
2. Eating and drinking adequately
3. Eliminating body wastes
4. Moving and maintaining a desirable position
5. Sleeping and resting
6. Selecting suitable clothes
7. Maintaining body temperature within normal range by adjusting clothing and modifying the environment



8. Keeping the body clean and well groomed to protect the integument
9. Avoiding dangers in the environment and avoiding injuring others
10. Communicating with others in expressing emotions, needs, fears, or opinions
11. Worshipping according to one's faith
12. Working in such a way that one feels a sense of accomplishment
13. Playing or participating in various forms of recreation
14. Learning, discovering, or satisfying the curiosity that leads to normal development and health, and using the available health facilities

Henderson continues to be cited in current nursing literature. Her emphasis on the importance of nursing's independence from and interdependence with other healthcare disciplines is well recognized.

### Reflect On . . .

- the relationship between Henderson's 14 fundamental needs and Maslow's hierarchy of needs. How might one have built upon the other?

## Selected Nursing Theories

In the early 1970s, nursing knowledge continued to develop as the theorists provided new and more diverse views of the practice of nursing. This development moved the discipline farther from the medical model and provided a perspective that was more uniquely a nursing perspective.

### Rogers's Science of Unitary Human Beings

Martha Rogers first presented her theory of unitary human beings in 1970, providing a new view of nursing by focusing on the mutual process of human and environment rather than health and illness (Malinski, 2006; Sarter, 1988; Madrid & Barrett, 1994). The theory contains complex conceptualizations related to multiple scientific disciplines and was influenced by Einstein's theory of relativity, which introduced the four coordinates of space-time; Burr and Northrop's electrodynamics theory of life, which revealed the pattern and organization of the electrodynamics field; Ludwig Von Bertalanffy's general systems theory; and many other disciplines, such as anthropology, psychology, sociology, astronomy, religion, philosophy, history, biology, and literature. She was a pioneer in her focus on human beings and their environments as equally important, and she traced that

influence to Florence Nightingale (Fawcett, 2003; Rogers, 1989, 1994).

Rogers views the person as an irreducible whole, the whole being greater than the sum of its parts. *Whole* is differentiated from *holistic*, the latter often being used to mean only the sum of all the parts. She states that humans are dynamic energy fields in continuous exchange with environmental fields, both of which are infinite. Both human and environmental fields are characterized by pattern, a universe of open systems, and pandimensionality. According to Rogers, a *unitary human being*:

- Is an irreducible energy field identified by pattern
- Manifests characteristics different from the sum of the parts
- Interacts continuously and creatively with the environment
- Behaves as a totality
- As a sentient being, participates creatively in change

The key concepts Rogers uses to describe the individual and the environment are *energy fields*, *openness*, *pattern and organization*, and *pandimensionality*. Energy fields are the fundamental level of humans and the environment (all that is outside a given human field). Energy fields are dynamic, constantly exchanging energy with other energy fields. The concept of *openness* holds that the energy fields of humans and the environment are open systems, that is, infinite, integral with one another, and in continuous process. *Pattern* refers to the unique identifying behaviors, qualities, and characteristics of the energy fields, which change continuously and innovatively. *Pandimensionality* expresses the idea of a unitary whole; it provides for an infinite domain without limits.

To Rogers, the life process in humans is homeodynamic, involving continuous and creative change. She provides three principles of homeodynamics to offer a way of perceiving how unitary human beings develop: integrality (formerly complementarity), resonancy, and helicy. According to the principle of *integrality*, the human and environmental fields interact mutually and simultaneously. *Resonancy* means the wave patterns in the fields change continuously and from lower- to higher-frequency patterns. *Helicy* is spiral development, that is, continuous and nonrepeating.

Applied to nursing practice, Rogers's theory (1) focuses on the person's wholeness, (2) seeks to promote symphonic interaction between the two energy fields (human and environment) to strengthen the coherence and integrity of the person, (3) coordinates the human field with the rhythmicities of the environmental field, and (4) directs and patterns of interaction between the two energy fields to promote

maximum health potential. This theory guided nursing to a more holistic approach.

### Orem's Self-Care Deficit Theory of Nursing

Dorothea Orem's theory, the result of the work of her Nursing Development Conference Group and first published in 1971, has been widely accepted by the nursing community. This general theory of nursing is referred to as the *self-care deficit theory of nursing*, and it consists of the articulation of the theories of self-care, self-care deficit, and nursing systems. It provides a way of looking at and investigating what nurses do.

Self-care theory postulates that self-care and the self-care of dependents are learned behaviors that individuals initiate and perform on their own behalf to maintain life, health, and well-being. Self-care theory is based on four concepts: self-care, self-care agency, self-care requisites, and therapeutic self-care demand (Orem, 1980, 1985, 1991). *Self-care* refers to those activities an individual performs independently throughout life to promote and maintain personal well-being. *Self-care agency* is the individual's ability to perform self-care activities. It consists of two agents: a *self-care agent* (an individual who performs self-care independently) and a *dependent-care agent* (a person other than the individual who provides care). Adults care for themselves, whereas infants, the aged, the ill, and the disabled require assistance with self-care activities.

*Self-care requisites* are measures or actions taken to regulate functioning and development. They are the goals of self-care. There are three categories of self-care requisites:

1. *Universal requisites* are common to all people. They include maintaining intake and elimination of air, water, and food; balancing rest, solitude, and social interaction; preventing hazards to life and well-being; and promoting normal human functioning.
2. *Developmental requisites* result from maturation and are related to stage of development or are associated with conditions or events, such as adjusting to a change in body image or to the loss of a spouse.
3. *Health deviation requisites* result from illness, injury, or disease or its diagnosis and treatment. They include actions such as seeking healthcare assistance, carrying out prescribed therapies, and learning to live with the effects of illness or treatment.
4. *Therapeutic self-care demand* refers to all self-care activities required to meet the requisites for certain conditions and circumstances, such as an illness.

Self-care deficit theory asserts that people benefit from nursing because they have health-related limitations

in providing self-care. These limitations may result from illness, injury, or the effects of medical tests or treatments. Two variables affect these deficits: self-care agency (ability) and the therapeutic self-care demands (the measures of care required to meet the existing requisites). *Self-care deficit* results when the self-care agency is not adequate to meet the known self-care demand. Orem's self-care deficit theory explains not only when nursing is needed but also how people can be assisted through five methods of helping: acting or doing for, guiding, teaching, supporting, and providing an environment that promotes the individual's abilities to meet current and future demands.

### Nursing Systems

Nursing systems theory postulates that nursing systems form when nurses prescribe, design, and provide nursing that regulates the individual's self-care capabilities and meets therapeutic self-care requirements. Orem identifies three types of nursing systems:

1. *Wholly compensatory* systems are required for individuals who are unable to control and monitor their environment and process information.
2. *Partly compensatory* systems are designed for individuals who are unable to perform some (but not all) self-care activities.
3. *Supportive-educative* systems are designed for persons who need to learn to perform self-care measures and need assistance to do so.

Development of the theory continues with contributions from researchers, scholars, nursing faculty, nursing students, and practicing nurses (Orem, 1995).

### King's Goal-Attainment Theory

Imogene King's theory of goal attainment is based on systems theory, the behavioral sciences, and deductive and inductive reasoning. She first published *Toward a Theory of Nursing: General Concepts of Human Behavior* in 1971. Initially, King formulated her theory as a conceptual framework for nursing when, as an associate professor of nursing at Loyola University in Chicago, she developed a master's degree program in nursing. King refined her concepts in her 1981 publication, *A Theory for Nursing: Systems, Concepts, Process*. Important in King's theory is mutual goal setting based on the nurse's assessment, the nurse's and the patient's perceptions, and their information sharing in order to attain the identified mutual goals.

King's theory consists of three dynamic interacting systems: (1) personal systems (individuals), (2) interpersonal systems (groups), and (3) social systems (society).

Key concepts are identified for each system as follows (Frey, Sieloff, & Norris, 2002):

1. **Personal-system concepts:** coping, spirituality, perception, self, body image, growth and development, space, and time
2. **Interpersonal-system concepts:** interaction, communication, transaction, role, stress, and coping
3. **Social-system concepts:** organization, authority, power, status, and decision making

The client and nurse are personal systems or subsystems within interpersonal and social systems. To identify problems and to establish goals, the nurse and the client perceive one another, act and react, interact, and transact. *Transactions* are defined as purposeful interactions that lead to goal attainment. Transactions have the following characteristics:

- They are basic to goal attainment and include social exchange, bargaining and negotiating, and sharing a frame of reference toward mutual goal setting.
- They require perceptual accuracy in nurse-client interactions and congruence between role performance and role expectation for nurse and client.
- They lead to goal attainment, satisfaction, effective care, and enhanced growth and development.

King postulates seven hypotheses in goal-attainment theory:

1. Perceptual congruence in nurse-client interactions increases mutual goal setting.
2. Communication increases mutual goal setting between nurses and clients and leads to satisfaction.
3. Satisfaction in nurses and clients increases goal attainment.
4. Goal attainment decreases stress and anxiety in nursing situations.
5. Goal attainment increases client learning and coping ability in nursing situations.
6. Role conflict experienced by clients, nurses, or both decreases transactions in nurse-client interactions.
7. Congruence in role expectations and role performance increases transactions in nurse-client interactions.

King's theory highlights the importance of the participation of all individuals in decision making and deals with the choices, alternatives, and outcomes of nursing care. The theory offers insight into nurses' interactions with individuals and groups within the environment. Scholars who have been followers of King's theory have continued the work and developed middle-range theories related to care of families with children or adolescents with chronic mental illness, families of children with chronic illness,

and patients with chronic obstructive pulmonary disease (COPD) (Alligood, 2010).

## Neuman's Systems Model

Betty Neuman, a pioneer in mental health nursing, developed her model in response to the expressed needs of her students for content that would present a general picture of nursing before content on specific nursing problems. The model is based on numerous theories, including Gestalt theory, Hans Selye's stress theory, and general systems theory. It adapts the concept of levels of prevention from Caplan's conceptual model and relates these levels to nursing; they are primary, secondary, and tertiary prevention. Neuman's model was first published in 1972 in *Nursing Research* in an article coauthored with R. J. Young, "A Model for Teaching Total Person Approach to Patient Problems." Refinements were published as the "Neuman Systems Model" in 1974, 1982, 1989, and 1995.

The Neuman systems model focuses on the wellness of the client system in relation to environmental stressors and reactions to stressors (Fawcett, 2002a; Clarke & Lowry, 2012). It guides the nurse to consider five client system variables and four levels of environmental influence on the client system. The five client system variables are physiological, psychological, sociocultural, developmental, and spiritual. The four levels of environmental influence are internal, external interpersonal, external extrapersonal, and created.

Neuman views the client as an open system consisting of a basic structure or central core of energy resources (physiological, psychological, sociocultural, developmental, and spiritual) surrounded by two lines of resistance. These lines of resistance represent internal factors that help the client defend against a stressor; one example is an increase in the body's leukocyte count to combat an infection. Outside the lines of resistance are two lines of defense. The inner line of defense, or *normal line of defense* represents the person's state of equilibrium or the state of adaptation developed and maintained over time and considered normal for that person. The *flexible line of defense* is dynamic and can be rapidly altered over a short period of time. It is a protective buffer that prevents stressors from penetrating the normal line of defense. Certain variables (e.g., sleep deprivation) can create rapid changes in the flexible line of defense.

Neuman describes a stressor as any environmental force that alters the system's stability. Stressors are categorized as *internal stressors*, those that occur within the individual (e.g., an infection); *interpersonal stressors*, those that occur between individuals (e.g., unrealistic role expectations); *extrapersonal stressors*, those that occur outside the person (e.g., financial concerns); and *created stressors*,

those that are unconsciously mobilized toward system integration, stability, and integrity. The individual's reaction to stressors depends on the strength of the lines of defense. When the lines of defense fail, the resulting reaction depends on the strength of the lines of resistance. As part of the reaction, a person's system can adapt to a stressor, an effect known in this model as *reconstitution*.

Nursing interventions focus on retaining or maintaining system stability. These interventions are carried out on the following three preventive levels:

1. *Primary prevention* identifies risk factors, attempts to eliminate the stressor, and focuses on protecting the normal line of defense and strengthening the flexible line of defense. A reaction has not yet occurred, but the degree of risk is known.
2. *Secondary prevention* relates to interventions or active treatment initiated after symptoms have occurred. The focus is to strengthen internal lines of resistance, reduce the reaction, and increase resistance factors.
3. *Tertiary prevention* refers to intervention following that in the secondary stage. It focuses on readaptation and stability and protects reconstitution or return to wellness following treatment. The nurse emphasizes educating the client in strengthening resistance to stressors and ways to help prevent recurrence of reaction or regression.

Betty Neuman's model of nursing has been widely accepted by the nursing community, both nationally and internationally. It is applicable to a variety of nursing practice settings involving individuals, families, groups, and communities.

## Roy's Adaptation Model

Callista Roy, a nurse and sociologist, based her theory on Harry Helson's work in psychophysics and on her observations of the great resilience of children and their ability to adapt to major physical and psychological changes. Roy's adaptation model, widely used by nurse educators, researchers, and practitioners, was introduced in *Nursing Outlook* as "Adaptation: A Conceptual Framework in Nursing" (Roy, 1970). The model was published in book form in 1976 (the first edition) and 1984 as *Introduction to Nursing: An Adaptation Model* (Roy, 1976, 1984) and, with H. A. Andrews, in 1991 (first edition) and 1999 as *The Roy Adaptation Model* (Roy & Andrews, 1991, 1999).

Roy focuses on the individual as a biopsychosocial adaptive system that employs a feedback cycle of input, throughput, and output. Both the individual and the environment are sources of stimuli that require modification to promote adaptation, an ongoing purposive response.

Adaptive responses contribute to health, which Roy defines as the process of being and becoming integrated; ineffective or maladaptive responses do not contribute to health. Each person's adaptation level is unique and constantly changing.

As an open system, an individual receives input or stimuli from both the self and the environment. Roy identifies the following three classes of stimuli:

1. *Focal stimuli*: the internal or external stimuli most immediately confronting the person and contributing to his or her behavior
2. *Contextual stimuli*: all other internal or external stimuli present
3. *Residual stimuli*: beliefs, attitudes, or traits that have an indeterminate effect on the person's behavior and whose effects are not validated

*Throughput* makes use of a person's (1) *processes*, which are control mechanisms that a person uses as an adaptive system, and (2) *effectors*, which refer to the physiological function, self-concept, and role function involved in adaptation. *Output* of the system refers to the individual's behaviors, which can be either adaptive responses promoting the system's integrity or ineffective responses, such as not following a prescribed therapy. These outputs or responses provide feedback for the system.

Roy's adaptive system consists of two interrelated subsystems. The *primary subsystem* is a functional or internal control process that consists of the regulator and the cognator. The *regulator* processes input automatically through neural-chemical-endocrine channels. The *cognator* processes input through cognitive pathways, such as perception, information processing, learning, judgment, and emotion. Roy views the regulator and cognator as methods of coping.

The *secondary subsystem* is an effector system that manifests cognator and regulator activity. It consists of the following four adaptive modes:

1. The *physiological mode* involves the body's basic physiological needs and ways of adapting in regard to fluid and electrolytes, activity and rest, circulation and oxygen, nutrition and elimination, protection, the senses, and neurological and endocrine function.
2. The *self-concept mode* includes two components: the *physical self*, which involves sensation and body image, and the *personal self*, which involves self-ideal, self-consistency, and the moral-ethical self.
3. The *role-function mode* is determined by the need for social integrity and refers to the performance of duties based on given positions within society.



4. The *interdependence mode* involves the person’s relations with significant others and support systems that provide help, affection, and attention.

These adaptive modes include people as individuals or in groups.

Roy’s work has been shaped by the current influences in nursing of holism and spiritualism. She has proposed some changes to guide nursing through the 21st century. Adaptation has been redefined as “the process and outcome whereby the thinking and feeling person uses conscious awareness and choice to create human and environmental integration” (Roy, 1997, p. 42). Two sets of assumptions of the Roy model, scientific and philosophical, have been examined for applicability in the 21st century. These are listed in the accompanying box.

Benner’s Novice to Expert

Patricia Benner studied clinical nursing practice to examine knowledge embedded in nursing practice that accrues over time. She was interested in the difference between practical and theoretical knowledge and believed that knowledge development comes about through the extension of practical knowledge, or know-how, through theory-based scientific investigations. She emphasized the charting of practices and clinical observations. She described “knowing how” as skill acquisition that is different from “knowing that.”

Benner was a medical-surgical nurse who worked as a research assistant with Richard Lazarus and did

research on stress, coping, and health. Her thinking in nursing was influenced by Virginia Henderson. Hubert Dreyfus, a philosophy professor at the Berkeley campus of the University of California, introduced her to phenomenology and to the Dreyfus model of skill acquisition. Both of these were influential in her development of “Novice to Expert,” an adaptation of the Dreyfus and Dreyfus model of skill acquisition and skill development as it applies to clinical nursing practice (Benner, 1984; Benner, Hooper-Kyriakidis, & Stannard, 1999; Benner, Tanner, & Chesla, 2009). The model is situational and consists of five levels: (1) novice, (2) advanced beginner, (3) competent, (4) proficient, and (5) expert. As one moves through the levels, the following four aspects of performance change:

- Movement from a reliance on abstract principles and rules to use of past concrete experiences
- A shift from reliance on analytical, rule-based thinking to intuition
- Change in perception of the situation from a compilation of equally relevant bits to a view of it as a more complex whole, with some aspects being more or less relevant than other aspects
- Passage from a detached observer to someone fully engaged and involved in the situation

The concept of experience is important to the progression. As the nurse gains experience, clinical knowledge becomes a blend of practical and theoretical knowledge.

Roy’s Adaptation Model

| Scientific Assumptions for the 21st Century                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Philosophical Assumptions for the 21st Century                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Systems of matter and energy progress to higher levels of complex self-organization.</li><li>• Consciousness and meaning are constitutive of person and environment integration.</li><li>• Awareness of self and environment is rooted in thinking and feeling.</li><li>• Human decisions are accountable for the integration of creative processes.</li><li>• Thinking and feeling mediate human action.</li><li>• System relationships include acceptance, protection, and fostering interdependence.</li><li>• Persons and the earth have common patterns and integral relations.</li><li>• Person and environment transformations are created in human consciousness.</li><li>• Integration of human and environment meanings results in adaptation.</li></ul> | <ul style="list-style-type: none"><li>• Persons have mutual relationships with the world and with a god figure.</li><li>• Human meaning is rooted in what Roy refers to as an “omega point convergence of the universe.”</li><li>• God is intimately revealed in the diversity of creation and is the common destiny of creation.</li><li>• Persons use human creative abilities of awareness, enlightenment, and faith.</li><li>• Persons are accountable for the processes of deriving, sustaining, and transforming the universe.</li></ul> |

Source: From “Future of the Roy Model: Challenge to Redefine Adaptation,” by C. Roy, 1997, *Nursing Science Quarterly*, 10(1), pp. 42–48.



The model was based upon qualitative, hermeneutic research involving 1,200 nurses. Observations and narratives of nursing practice were interpreted as they described the following five levels of skill acquisition:

1. **Novice:** No background understanding of the situation is present. This level is represented by nursing students as they enter their programs of study.
2. **Advanced beginner:** At this level, there is enough experience to grasp aspects and meaningful components of the situation. An example is the new graduate nurse.
3. **Competent:** The nurse is beginning to be able to determine which aspects of a situation are important and which are not.
4. **Proficient:** The nurse is now able to perceive the situation as a whole and is guided by principles and rules of conduct. There is an intuitive grasp of the situation.
5. **Expert:** Judgment is based on understanding, and the nurse focuses on the salient part of the problem. The nurse is no longer reliant on rules, guidelines, and principles.

The model is situational, so a nurse who is expert in one set of circumstances may not perform at that level in a different situation. These levels are fluid and do not have set boundaries.

## The Caring Theorists

Several nursing theories are based on the concept of caring. This movement grew out of humanism and was given considerable impetus by the work of Mayeroff (1971), a philosopher who provided much of the foundational work on the concept of caring. The caring theories of nursing provide a link between generic caring and the uniqueness of caring in nursing. In 1998, the American Association of Colleges of Nursing (American Association of Colleges of Nursing, 1998) published *The Essentials of Baccalaureate Education for Professional Nursing Practice*, a document prepared to guide education for practice in the 21st century. It defines caring as a concept central to the practice of professional nursing and identifies it as a core value encompassing altruism, autonomy, human dignity, integrity, and social justice.

Caring as a central concept in nursing has its own substantive area of nursing science and has been a focus of scholarly inquiry. Jean Watson (1979, 1985, 1988, 1997, 1999b, 2010) may be the best known and most widely recognized caring theorist. However, Madeleine Leininger (1978, 1980, 1984) was a forerunner in the caring movement, although her work may be better known for its transcultural focus. Roach (1992) and Boykin and

Schoenhofer (1993) further developed the concepts of caring. Each of these theorists identifies caring as the essence of nursing and as a central and unifying feature. Table 6–2 shows a comparison of five caring theories.

Critics of caring theory question whether practitioners can use these theories with a limited understanding of the existential-phenomenological-spiritual philosophies that underpin and contribute to the language used in describing them. Nurses from mainstream nursing curricula often find the theories to be abstract and difficult to understand. However, few nurses will deny that caring is essential to professional practice.

The caring movement has produced an organization dedicated to the dissemination of research and scholarly activity in caring. The International Association for Human Caring was first convened by Madeleine Leininger in 1978, and it continues to meet on an annual basis.

Leininger's and Watson's theories are the best known of the caring theories and have had the most exposure in nursing literature and critical review. They are the least abstract and have been the basis of research and clinical applications. Both of these theories will be briefly described.

---

## Reflect On . . .

- whether caring is the essence of nursing. If so, should it be studied and have its own body of knowledge? How does this knowledge apply in situations where fast responses and highly technological care are critical to outcomes?
- 

## Watson's Human Caring Theory

Jean Watson was educated in psychiatric and mental health nursing and received her doctorate in educational psychology and counseling. Her theory of the science of caring was first published in *Nursing: The Philosophy and Science of Caring* (Watson, 1979). She refined her ideas in the three editions of *Nursing: Human Science and Human Care* (Watson, 1985, 1988, 1999a). Watson believes the practice of caring is central to nursing; it is the unifying focus for practice. Two major assumptions underlie human care values in nursing: (1) Care and love constitute the primal and universal psychic energy, and (2) care and love are requisite for our survival and the nourishment of humanity. Watson's major assumptions about caring are shown in the accompanying box.

The major conceptual elements of the theory are carative factors, transpersonal caring relationship, and caring moment/caring occasion. The *carative factors* provide a focus for nursing phenomena; these factors are evolving

**TABLE 6–2 Comparison of Caring Models and Theories**

|                       | Mayeroff                                                                                                             | Leininger                                   | Roach                                                                                                                                         | Watson                                                                                                                                                                                                     | Boykin and Schoenhofer                                                                                                                 |
|-----------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Perspective on caring | To care for another person is to help that person grow and actualize.                                                | Care is the essence of nursing.             | Caring is the human mode of being.                                                                                                            | Individual healing processes can be strengthened through authentic caring relationships.                                                                                                                   | Caring is an essential feature and expression of being human.                                                                          |
| Unique focus          | Major ingredients of caring are knowing, alternating rhythms, patience, honesty, trust, humility, hope, and courage. | Caring is inextricably linked with culture. | Caring is not unique to nursing but is unique in nursing.                                                                                     | Caritas processes are based on the carative factors. A transpersonal caring relationship is established through the processes of caring and healing and being in an authentic relationship, in the moment. | Nurturing involves persons living and growing in caring.                                                                               |
| Expression in nursing | It assists the nurse in developing a sense of self as a caring person.                                               | Provide culturally acceptable care.         | Professionalization of caring is expressed through the 5 C's of caring:<br>Compassion<br>Competence<br>Confidence<br>Conscience<br>Commitment | Watson's theory stresses the importance of the lived experience not only of the client but of the nurse. Both the nurse and the client come together in a caring moment.                                   | Caring is the intentional and authentic presence of the nurse with another who is recognized as a person living and growing in caring. |
| Discipline of origin  | Philosophy                                                                                                           | Anthropology                                | Philosophy                                                                                                                                    | Humanism and metaphysics                                                                                                                                                                                   | Philosophy, human science, and nursing                                                                                                 |

Source: Based on "Caring: Theoretical Perspectives of Relevance to Nursing," by T. V. McCance, H. P. McKenna, and J.R.P. Boore, 1999, *Journal of Advanced Nursing*, 30(6), pp. 1388–1395; *On Caring*, by M. Maycroff, 1971, New York, NY: Harper Perennial; *Nursing as Caring: A Model for Transforming Nursing Practice*, by A. Boykin and S. Schoenhofer, 1993, National League for Nursing Press. Boston, MA: Jones & Bartlett; *Theory of Human Caring*, by J. Watson, in *Nursing Theories and Nursing Practice* (pp. 351–369), by M. Parker (Ed.), 2010, Philadelphia, PA: F. A. Davis.

### Watson's Assumptions of Caring

- Human caring in nursing is not just an emotion, concern, attitude, or benevolent desire. Caring connotes a personal response.
- Caring is an intersubjective human process and is the moral ideal of nursing.
- Caring can be effectively demonstrated only interpersonally.
- Effective caring promotes health and individual or family growth.
- Caring promotes health more than does curing.
- Caring responses accept a person not only as he or she is now but also for what he or she may become.
- A caring environment offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
- Caring occasions involve action and choice by nurse and client. If the caring occasion is transpersonal, the limits of openness expand, as do human capacities.
- The most abstract characteristic of a caring person is that the person is somehow responsive to another person as a unique individual, perceives the other's feelings, and sets one person apart from another.
- Human caring involves values, a will and commitment to care, knowledge, caring actions, and consequences.
- The ideal and value of caring are a starting point, a stance, and an attitude that have to become a will, an intention, a commitment, and a conscious judgment that manifests itself in concrete acts.

into *caritas processes*. The word *caritas* comes from the Latin word meaning “esteem, affection.” This newer focus includes a greater spiritual dimension and allows for caring and love to transform the self and those being cared for. The original 10 caring factors and the evolution to *caritas* as part of her theory are shown in Table 6–3. *Transpersonal caring relationships* convey a concern for another, which reaches to the deeper connections of spirit with the broader universe; it calls one to be authentic. A *caring moment/caring occasion* occurs at the moment the nurse and another come together for human-to-human transaction. It involves action and choice by both the nurse and the other.

Watson considers her work to be a philosophical and moral/ethical foundation for professional nursing and part of the central focus for nursing at the disciplinary level. It includes a call for both art and science that embraces and intersects with art, science, the humanities, spirituality, and new dimensions of mind/body/spirit medicine and nursing.

### Leininger's Culture Care Diversity and Universality Theory

Madeleine Leininger, a well-known nurse anthropologist, has written extensively on transcultural nursing concepts and is a proponent of the science of human caring. She first published her cultural care diversity and universality theory in 1985 in the journal *Nursing and Health Care*, explained it further in 1988, and then again in 1991, in her book *Culture Care Diversity and Universality: A Theory of Nursing* (Leininger, 1984, 1988, 1991; Fawcett, 2002b). In this book, she produced the sunrise model to depict her theory.

Leininger postulates that caring and culture are inextricably linked. Educated in cultural and social anthropology, Leininger observed a marked number of differences between Western and non-Western cultures in caring and health practices. She defines transcultural nursing as a major area of nursing that focuses on the comparative study and analysis of different cultures and subcultures in the world, with respect to their caring

**TABLE 6–3 Watson's 10 Caring Factors and Caritas**

| Caring Factors                                                                                                      | Caritas                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Formation of a humanistic-altruistic system of values                                                               | Practice of loving-kindness and equanimity within a context of caring consciousness                                                                                                                                                                                                           |
| Instillation of faith-hope                                                                                          | Being authentically present and enabling and sustaining the deep belief system and subjective life world of the self and the one-being-cared-for                                                                                                                                              |
| Cultivation of sensitivity to oneself and to others                                                                 | Cultivation of one's own spiritual practices and transpersonal self, going beyond the ego self                                                                                                                                                                                                |
| Development of a helping-trusting, human caring relationship                                                        | Developing and sustaining a helping-trusting, authentic caring relationship                                                                                                                                                                                                                   |
| Promotion and acceptance of the expression of positive and negative feelings                                        | Being present to, and supportive of, the expression of positive and negative feelings as a connection with the deeper spirit of the self and the one-being cared-for                                                                                                                          |
| Systematic use of a creative problem-solving caring process                                                         | Creative use of the self and of all ways of knowing as part of the caring process; engaging in the artistry of caring-healing practices                                                                                                                                                       |
| Promotion of transpersonal teaching-learning                                                                        | Engaging in a genuine teaching-learning experience that attends to unity of being and meaning, attempting to stay within the other's frame of reference                                                                                                                                       |
| Provision of a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment | Creating a healing environment at all levels (physical as well as nonphysical), a subtle environment of energy and consciousness whereby wholeness, beauty, comfort, dignity, and peace are potentiated                                                                                       |
| Assistance with gratification of human needs                                                                        | Assisting with basic needs, with an intentionally caring consciousness, administering “human care essentials,” which potentiate alignment of mind/body/spirit, wholeness, and unity of being in all aspects of care; tending to both the embodied spirit and the evolving spiritual emergence |
| Allowance for existential-phenomenological-spiritual force                                                          | Opening and attending to spiritual-mysterious existential dimensions of one's own life-death; soul care and the one-being-cared-for                                                                                                                                                           |

## Leininger's Descriptions of Care and Caring

- Caring includes assistive, supportive, and facilitative acts toward or for another individual or group with evident or anticipated needs.
- Caring serves to ameliorate or to improve human conditions or lifeways. It emphasizes healthful, enabling activities of individuals and groups that are based on culturally defined, ascribed, or sanctioned helping modes.
- Caring is essential to human development, growth, and survival.
- Caring behaviors include comfort, compassion, concern, coping behavior, empathy, enabling, facilitating, interest, involvement, health consultative acts, health maintenance acts, helping behaviors, love, nurturance, presence, protective behaviors, restorative behaviors, sharing, stimulating behaviors, stress alleviation, succor, surveillance, tenderness, touching, and trust.

behavior, nursing care, health values, beliefs, and patterns. The goal of transcultural nursing is to develop a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing practices. Central to her theory is the belief that cultures have differences in their ways of perceiving, knowing, and practicing care but that there are also commonalities about care among cultures. Thus, her theory focuses on diversity and universality.

Leininger states that care is the essence of nursing and the dominant, distinctive, and unifying feature of nursing. She says that there can be no cure without caring, but that there may be caring without curing. She emphasizes that human caring, although a universal phenomenon, varies among cultures in its expressions, processes, and patterns; it is largely culturally derived. These differences in caring values and behaviors lead to differences in the expectations of those seeking care. For example, cultures that perceive illness primarily as a personal and internal body experience—caused by physical, genetic, and intrabody stresses—tend to use more medications and physical techniques than cultures that view illness as an extrapersonal experience.

Leininger identifies many caring constructs (see the accompanying box). Leininger believes that the goal of healthcare personnel should be to work toward an understanding of care and the values, health beliefs, and lifestyles of different cultures, which will form the basis for providing culture-specific care.

Leininger's work has generated much research and facilitated other work on models and tools for culture care and cultural competence.

A comparison of perspectives, focus, and expression of Leininger and other selected caring theorists can be found in Table 6–4.

## Middle-Range Theory

The development of middle-range theory answered a call for the development of nursing knowledge to have a more direct application to care and to provide less abstraction in theory. While the level of abstraction varies among the middle-range theories, they provide a more focused approach to nursing knowledge.

### Kolcaba's Theory of Comfort

Considered a middle-range theorist, Kolcaba began with a concept analysis of comfort. Three nursing theorists' ideas contributed to the development of the theory; *relief* came from the work of Ida Jean Orlando, *ease* was derived from the work of Virginia Henderson, and *transcendence* was contributed from the work of Josephine Paterson and Loretta Zderad. Katharine Kolcaba defines comfort as "the immediate and holistic experience of being strengthened through having the needs met for the three types of comfort (relief, ease, and transcendence) in four contexts of experience (physical, psycho-spiritual, social, and environmental)" (Dowd, 2006, p. 728). Relief is the state of having had a specific need met, ease is a

## CRITICAL THINKING EXERCISE

How does Leininger's description of caring compare to and contrast with Watson's description of caring? In providing care to an infant with diarrhea and dehydration,

would nursing practice based on each of these two theories of caring lead to differing or similar nursing interventions? Would they lead to different outcomes?



**TABLE 6–4 Transcultural Nursing Theory and Models**

|                                                                     |                                        |                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                              |
|---------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <b>Culture Care Universality and Diversity</b>                      | Madeleine Leininger                    | Assumptions: <ul style="list-style-type: none"> <li>• Care is the essence of nursing.</li> <li>• Universalities exist among and between cultures.</li> <li>• Every culture has some practices to be discovered and used for culturally congruent care.</li> </ul>                                                                                      | Action modes: <ul style="list-style-type: none"> <li>• Preservation and/or maintenance</li> <li>• Accommodation and/or negotiation</li> <li>• Repatterning and/or restructuring</li> </ul>                                                                                                                                                                                                                         | Ethnonursing research method                                                 |
| <b>Model for Cultural Competence</b>                                | Larry Purnell                          | Assumptions: <ul style="list-style-type: none"> <li>• Culture has a powerful influence on interpretation and response to health care.</li> <li>• Cultural-general and cultural-specific information is needed for culturally competent care.</li> <li>• Providing care in a culturally competent way will improve care.</li> </ul>                     | Cultural domains: <ul style="list-style-type: none"> <li>• Overview/heritage</li> <li>• Communication</li> <li>• Family roles and organization</li> <li>• Workforce issues</li> <li>• Biocultural ecology</li> <li>• High-risk behaviors</li> <li>• Nutrition</li> <li>• Pregnancy</li> <li>• Death rituals</li> <li>• Spirituality</li> <li>• Healthcare practices</li> <li>• Healthcare practitioners</li> </ul> | Framework for assessment                                                     |
| <b>Process of Cultural Competence in the Delivery of Healthcare</b> | Josepha Campinha-Bacote                | Four constructs: <ul style="list-style-type: none"> <li>• Cultural awareness</li> <li>• Cultural knowledge</li> <li>• Cultural skill</li> <li>• Cultural encounters</li> </ul>                                                                                                                                                                         | Assessing levels of competency: <ul style="list-style-type: none"> <li>• Awareness</li> <li>• Skill</li> <li>• Knowledge</li> <li>• Encounters</li> <li>• Desire</li> </ul>                                                                                                                                                                                                                                        | Tool to measure the level of cultural competence                             |
| <b>Transcultural Assessment Model</b>                               | Joyce Newman Giger and Ruth Davidhizar | Five metaparadigms: <ul style="list-style-type: none"> <li>• Transcultural nursing and culturally diverse nursing</li> <li>• Culturally competent care</li> <li>• Culturally unique individuals</li> <li>• Culturally sensitive environments</li> <li>• Health and health status based on culturally specific illness and wellness behavior</li> </ul> | Six cultural phenomena: <ul style="list-style-type: none"> <li>• Biological variations</li> <li>• Environmental control</li> <li>• Time</li> <li>• Social orientation</li> <li>• Space</li> <li>• Communication</li> </ul>                                                                                                                                                                                         | Clinical assessment tool                                                     |
| <b>Health Traditions Model</b>                                      | Rachel Spector                         | Incorporates Giger and Davidhizar's six cultural phenomena into the health traditions model. These surround religion, culture, and ethnicity in the personal health traditions of a unique cultural human being.                                                                                                                                       | Developed a heritage assessment tool to determine the depth of identification with one's own personal heritage a tool that can be used to assess the patient's or the nurse's own heritage                                                                                                                                                                                                                         | Holistic framework for assessment and provision of culturally competent care |

*(Continued)*

TABLE 6–4 Transcultural Nursing Theory and Models (Contd.)

|                                                                            |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                    |                                                                                                                                     |
|----------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Transcultural Nursing Assessment Guide for Individuals and Families</b> | Margaret Andrews and Joyceen Boyle | 12 categories of cultural knowledge: <ul style="list-style-type: none"><li>• Cultural affiliations</li><li>• Values orientation</li><li>• Communication</li><li>• Health-related beliefs and practices</li><li>• Nutrition</li><li>• Socioeconomic considerations</li><li>• Organizations providing cultural support</li><li>• Education</li><li>• Religion</li><li>• Cultural aspects of disease incidence</li><li>• Biocultural variations</li><li>• Developmental considerations across the life span</li></ul> | Involvement in nurse-patient interactions of communication in an environmental context of health-related values, attitudes, beliefs, and practices | Assessment tool that allows for community assessment and organizational cultural competence in addition to individuals and families |
|----------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|

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state of calm or contentment, and transcendence is a state in which the person rises above problems or pain.

Assumptions in the theory of comfort include the following:

- Human beings have holistic responses to complex stimuli.
- Comfort is a desirable holistic outcome important to the discipline of nursing.
- Human beings actively endeavor to meet their basic comfort needs or to have them met.
- Enhanced comfort gives patients strength to engage in health-seeking behaviors (HSBs) of their choice.

RESEARCH CURRENT

Patient-Centered Culturally Sensitive Health Care: Model Testing and Refinement

This study by Tucker, Marisiske, Rice, Nielson, and Herman tested a patient-centered culturally sensitive healthcare model that was developed to explain and improve health care for ethnically diverse patients in community-based primary-care clinics. The model was developed from an extensive literature review as well as ongoing research using focus groups and the Tucker Culturally Sensitive Health Care Inventory. Low-income African American and non-Hispanic White Americans were recruited and completed questionnaires about their perceptions of healthcare providers’ cultural sensitivity and adherence to the treatment regimen recommended to them by their provider. This survey included measures of trust in the provider, interpersonal control, satisfaction with the provider, physical stress, engagement in a health-promoting lifestyle, and dietary and medication adherence. A two-group

path analysis was used to test the model. Providers’ cultural sensitivity had significant positive effects on trust in the provider and satisfaction with the provider in both groups; however, the effect on trust was higher in the non-Hispanic White sample. There was a significant effect on dietary adherence for the African Americans. Trust in the provider had significant effects on provider care satisfaction in both groups, although it was significantly greater for the non-Hispanic Whites. Overall, the findings support patient-centered culturally sensitive health care and also support the model and help explain the linkages between culturally sensitive health care and health behaviors and outcomes of patients.

Source: “Patient-Centered Culturally Sensitive Health Care: Model Testing and Refinement, by C. Tucker, M. Marisiske, K. Rice, J. Nielson, and K. Herman, 2011, *Health Psychology*, 30(1), pp. 342–350.

- Patients empowered to actively engage in HSBs are satisfied with their health care.
- The institution's integrity is based on a value system focused on care recipients.

This theory asserts that nurses identify unmet comfort needs, design comfort measures to address those needs, and thus seek to enhance comfort in their patients. Enhanced comfort leads to engagement in HSBs, and when patients have the proper support to engage in HSBs, the institution's integrity is enhanced also (Kolcaba, 1994, 2003, 2010).

Comfort measures are nursing interventions designed to address specific comfort needs, including physiological, social, financial, psychological, spiritual, environmental, and physical needs. HSBs are defined by the person in consultation with the nurse and cover broad categories. Institutional integrity is possession of the qualities or states of being complete, whole, sound, upright, appealing, honest, and sincere. Institutions do not necessarily have walls and could include communities.

From the outset, this middle-range theory has provided focus on nursing intervention and is relevant for practice. It provides a framework for assessment and planning nursing care in any setting. It also provides a way to validate outcomes.

### **Mishel's Uncertainty in Illness Theory**

Uncertainty is the inability to determine the meaning of illness-related events and occurs when the decision maker is unable to assign definite value to objects or events or is unable to predict outcomes accurately (Mishel, 1988). First published in 1988, this theory was developed from an information-processing model used by psychology. It then incorporated information from the stress and coping theory of Richard Lazarus and Susan Folkman. Mishel placed uncertainty as a stressor within the context of illness as she developed a middle-range theory for nursing. A later addition incorporated chaos theory and allowed the inclusion of chronic illness and its disruption of equilibrium leading to the incorporation of continual uncertainty and finding new meaning in the illness.

Assumptions of this theory are:

- Uncertainty is a cognitive state whereby the existing schema is inadequate to support an interpretation of the illness-related events.

- Uncertainty is neutral until it is interpreted as desirable or aversive.
- Adaptation is the desired outcome of coping efforts to reduce uncertainty that has been interpreted as danger or opportunity.
- The relationships among the illness events, uncertainty, appraisal, coping, and adaptation are linear and unidirectional, moving from uncertainty to adaptation.
- As biopsychosocial systems, people typically function in far-from-equilibrium states.
- Major fluctuations in a far-from-equilibrium system enhance the system's receptivity to change.
- Fluctuations result in repatterning, which is repeated at each level of the system.

Mishel's theory asserts that uncertainty happens when a person cannot structure or categorize adequately an illness-related event. The uncertainty can take the form of ambiguity, complexity, lack of consistent information, or unpredictability. As the symptom pattern, familiarity with the event, and event congruence increase, the uncertainty decreases. Credible authority, social support, and education can decrease uncertainty. When the uncertainty is appraised as danger, coping efforts are directed at reducing it, and when it is appraised as opportunity, coping efforts are directed at maintaining it. The influence of the uncertainty on psychological outcomes is mediated by the appraisal outcomes. Coping strategies can be used to manage the emotional response to appraised danger. The longer the uncertainty persists within the illness, the more unstable are the previous modes of functioning in the individual, and when there is enduring uncertainty, it may come to be accepted as a natural part of life. Integrating this new view of life can be blocked or supported by credible authority, social support, or education. Prolonged exposure to uncertainty that is appraised as danger can lead to intrusive thoughts, avoidance, and severe emotional distress (Mishel, 1988, 1990).

This middle-range theory provides a framework for assessing the patient's experience of acute and chronic illness and a means to focus nursing interventions that will promote adaptation and adjustment. It helps to explain stressors associated with symptoms, diagnosis, and treatment, leading the nurse to a better understanding of how to teach and support individuals as they manage their uncertainty surrounding a new diagnosis or illness.

### **CRITICAL THINKING EXERCISE**

How is comfort different from pain management? Is comfort applicable to communities through nursing

interventions? How does it reflect institutional integrity?

## RESEARCH CURRENT

## Brain Tumor Symptoms as Antecedents to Uncertainty: An Integrative Review

Uncertainty is a common experience for cancer patients. According to Mishel's theory of uncertainty in illness, patients who are unable to infer symptom-based patterns have difficulty predicting outcomes, so a state of uncertainty is promoted. Cahill, LoBiondo-Wood, Bergstrom, and Armstrong's integrative literature review examined the published research that sought to identify the somatic symptom experience associated with primary and secondary brain tumors and the impact on illness-related uncertainty.

A search on MEDLINE and in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) yielded 21 studies on the somatic symptoms of patients with brain tumors who were at least 18 years of age. The majority of the studies were descriptive; sample sizes ranged from 54 to 490. The studies identified the following

symptoms: fatigue, headache and pain, nausea and vomiting, neurological and mental status symptoms, seizure, and symptom distress and interference. The theme that emerged was the prominence and severity of fatigue, altered mental status, and neurological symptoms for all brain tumor patients. In particular, fatigue was correlated with uncertainty. Greater symptom distress and an increased number of symptoms correlated with higher levels of uncertainty. The extent to which symptoms are familiar, predictable, and understandable can mitigate uncertainty. Nurse-led interventions may provide an avenue in helping patients understand and predict their symptom experience, thus reducing their uncertainty.

*Source:* "Brain Tumor Symptoms as Antecedents to Uncertainty: An Integrative Review," by J. Cahill, G. LoBiondo-Wood, N. Bergstrom, and T. Armstrong, 2012, *Journal of Nursing Scholarship*, 44(2), pp. 145–155.

## Relationship of Theories to the Nursing Process and Research

It is important to distinguish between theory and a set of concepts. Theories relate concepts in a logical, testable way and provide clarity. Theories create a foundation as they describe, predict, and explain phenomena, which helps distinguish the practice that is unique to nursing. It does this through research (Karnick, 2013).

Conceptual models for nursing are abstractions that are operationalized, or made real, by the use of the nursing process. Each step is guided by the selected theory.

- 1. Assessing.** The specific data collected about a client's health needs relate directly to the theorist's view of the client. These views will identify the focus of the assessment. For example, if the client is seen as having 14 fundamental needs, the nurse collects data about these 14 needs.
- 2. Diagnosing.** In this step, the nurse analyzes the assessment data to identify actual, potential, and possible nursing diagnoses. The nurse outlines or writes up the client's actual or potential health problems as a nursing diagnostic statement in accordance with the terminology and focus of the nursing model used. Some models would look at problems that are fairly specific, whereas others would look more holistically.
- 3. Planning.** Planning also relates directly to the conceptual nursing model. The nurse establishes goals

for the resolution of client problems, nursing interventions aimed at achieving those goals, and outcome criteria by which the nurse can evaluate whether or not the goals have been met. These goals, interventions, and criteria are established in accordance with the modes of intervention outlined in the conceptual model. Some models will direct the nurse to plan care in partnership with the client, for instance.

- 4. Implementing.** Implementing the planned interventions draws on scientific knowledge from many sources. The nursing model instructs the nurse what to do and directly influences what nursing interventions are planned, but it does not tell the nurse how to do them. Implementation in Orem's theory, for instance, would have the nurse work within a wholly compensatory, partially compensatory, or education-supportive system.
- 5. Evaluating.** Evaluating is a continuous nursing function. How is the client adjusting and reacting? What does the client see as his or her needs? How does the client see these needs changing? Has the client achieved the desired consequences? The answers to these questions help the nurse evaluate the effectiveness of the total nursing process and the nursing model. In Roy's model this evaluation would be part of the output and throughput.

Table 6–5 outlines how two selected nurse theorists have addressed the nursing process.

**TABLE 6–5 Selected Nursing Theories and the Nursing Process**

| Theory                                  | Nursing Process | Application                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Orem's general theory of nursing</b> | Assessing       | Involves collecting data about the client's capacities (knowledge, skills, and motivation) to perform universal, developmental, and health deviation self-care requisites; determines self-care deficits.                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                         | Diagnosing      | Is stated in terms of the client's limitations to maintain self-care (a deficit in self-care agency).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                         | Planning        | Involves considering and designing, with the client's participation, an appropriate nursing system (wholly compensatory, partially compensatory, and/or supportive-educative) that will help the client achieve an optimal level of self-care (i.e., enhance the client's self-care agency).                                                                                                                                                                                                                                                                                                                                                                       |
|                                         | Implementing    | Assists the client by acting for or doing for, guiding, supporting, providing a developmental environment, and teaching.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                         | Evaluating      | Determines the client's level of achievement in resolving self-care deficits and in performing self-care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Roy's adaptation model</b>           | Assessing       | Involves two levels: <i>First-level assessment</i> includes collecting data about output behaviors related to the four adaptive modes (physiological, self-concept, role function, and interdependence modes); <i>second-level assessment</i> includes collecting data about internal and external stimuli (focal, contextual, or residual) that are influencing the identified behaviors.                                                                                                                                                                                                                                                                         |
|                                         | Diagnosing      | Focuses on adaptation problems and uses one of three alternative methods: <ol style="list-style-type: none"> <li>1. Stating behaviors within one mode with their most relevant influencing stimuli.</li> <li>2. Clustering behavioral information and labeling it according to indicators of positive adaptation and a typology of common adaptation problems related to each mode. Roy provides a typology of indicators of positive adaptation and a typology of commonly recurring adaptation problems according to each of the four modes.</li> <li>3. Labeling a behavioral pattern when more than one mode is being affected by the same stimuli.</li> </ol> |
|                                         | Planning        | Sets goals in terms of behaviors the client is to achieve; plans nursing interventions to promote the effectiveness of the client's coping mechanisms and adaptive behaviors.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                         | Implementing    | Alters and manipulates the focal, contextual, and residual stimuli by increasing, decreasing, or maintaining them.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                         | Evaluating      | Determines the client's output behaviors with those identified in the goals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

The conceptual models for nursing drive nursing research and provide a way to organize findings of research in a meaningful way. Variables selected for study are selected according to the suggested relationships drawn from theories; research then validates theory and confirms the presence of the proposed relationships. Research can also generate theory by describing concepts and suggesting relationships between and among variables that have not previously been proposed.



**InfoQuest:** Many of the nursing theorists have websites with information about continuing work on the development of the theory and about current research being conducted with the theory. Explore some of the theories that interest you by searching the Internet. Which theories seem to have the most activity under way related to the development and application of that theory?



## Chapter Highlights

- Nursing has its own unique knowledge base, the body of knowledge needed for practice.
- Nursing knowledge comes from science generated by varying worldviews.
- Theories and conceptual frameworks help to unify the knowledge into a science of nursing and offer ways of conceptualizing the discipline in clear, explicit terms that can be easily communicated.
- Theories vary in level of abstraction, conceptualization, and ability to describe, explain, or predict.
- A conceptual framework is more abstract than a theory.
- A conceptual model is a system of related concepts or a conceptual diagram.
- Nursing knowledge directs the three areas of nursing: practice, education, and research.
- A theory generates knowledge in a field.
- Theory development in nursing had its origins with Florence Nightingale.
- Much of the early theory was inspired by related science in other fields.
- A current focus in nursing theory development is caring, which has been identified by the AACN as a core value for the profession.
- Challenges in the 21st century include making theory-based practice a reality.
- To be considered professionals, nurses must be able to communicate about the science of nursing.
- Theory can offer a way of communicating to others what is unique about nursing and direct practice in a meaningful way.
- Theory can be either generated by or tested by research.

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# 7

## UNIT II

### Professional Nursing Roles

# The Nurse as Health Promoter and Care Provider

## Chapter Outline

### Challenges and Opportunities

### Defining Health Promotion

#### Healthy People 2020

Leading Health Indicators

Four Foundation Health Measures

### Health Promotion Activities

Types of Health Promotion Programs

Sites for Health Promotion Activities

### Health Belief Models

Health Locus of Control Model

The Health Belief Model

### Health Promotion Models

Pender's Health Promotion Model

Neuman Systems Model

### Stages of Health Behavior Change

### The Nurse's Role in Health Promotion

### Chapter Highlights

## Objectives

1. Differentiate between health prevention or protective care and health promotion.
2. Discuss essential components of health promotion.
3. Discuss the overarching goals, foundation health measures, topics, and objectives of *Healthy People 2020*.
4. Identify various types of and sites for health promotion programs.
5. Compare and contrast the locus-of-control and health belief models as they relate to healthcare decision making.
6. Compare and contrast Pender's Health Promotion Model (HPM) and the Neuman Systems Model as they relate to health-promotion decision making.
7. Discuss Prochaska and DiClemente's five-stage model of behavior change.
8. Analyze the nurse's role in health promotion.

**H**ealth promotion is an important component of nursing practice. It is a way of thinking that revolves around a philosophy of wholeness, wellness, and well-being. Since the 1970s, the public has become increasingly aware of and interested in health promotion and illness/injury prevention. Our earliest nursing leaders championed concepts of health promotion. Florence Nightingale described the importance of pure or fresh air, pure water, efficient drainage, cleanliness, and light in promoting health. Nola Pender, who first described her Health Promotion Model (HPM) in 1982, states that “nurses must accept the challenge of designing and providing high-quality health promotion services in every health care setting” (Pender, Murdaugh, & Parsons, 2011, p. xv). *Nursing's Social Policy Statement* (American Nurses Association, 2010a) states, “Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (p. 3). Many people are aware of the relationship between lifestyle and illness and are developing health-promoting habits such as getting adequate exercise, rest, and relaxation; maintaining good nutrition; and controlling the use of tobacco, alcohol, drugs, and other substances that may be harmful to the body. Nurses need to reinforce these positive health-promotion



activities and help others to integrate such strategies into their own lifestyles.

The vision of health promotion was expressed nationally in the United States in 1979 in the Surgeon General's report *Healthy People* (U.S. Surgeon General, 1979). This report emphasized the role that individuals could play in modifying their lifestyle and personal behaviors to improve their health status. To a lesser extent, the influence of environmental factors on health was also considered. In 1980, the U.S. Public Health Service developed *Health Promotion/Disease Prevention: Objectives for the Nation* (U.S. Surgeon General, 1980). This report addressed more specifically the broad goals set forth in *Healthy People* by listing strategies to achieve each objective. These strategies included not only personal behavior changes but also the roles of institutions, legislation, and policy. In September 1990, *Healthy People 2000* was presented to the American public. This document encompassed 298 health-related objectives that provided a framework for a national health promotion, health protection, and preventive service strategy (U.S. Department of Health and Human Services, 1990). Individual nurses and 24 national nursing organizations were involved in the development of *Healthy People 2000* (Brown, Mattson, Newman, & Sirles, 1992, p. 204).

Currently, *Healthy People 2020* (U.S. Department of Health and Human Services, 2001, 2005, 2013a, b) is built on initiatives developed over more than two decades. The vision of *Healthy People 2020* is to improve the nation's health so that the United States is "a society in which all people live long healthy lives." *Healthy People 2020* strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

*Healthy People 2020* was developed through an alliance consisting of more than 400 national organizations, including professional nursing and medical associations, and state/territory health, mental health, substance abuse, and environmental agencies. *Healthy People 2020* is grounded in science, built through public consensus, and designed to measure progress in achievement of its goals. The public continues to be involved in the development of *Healthy People 2020* through an interactive website, [healthypeople.gov](http://healthypeople.gov). Thus, *Healthy People* is a collaborative effort of

private, professional, and governmental agencies, with consumer input to determine the future health of the people of the United States.

Globally, the World Health Organization operates within the United Nations to direct and coordinate international health. In 2015, there were 194 member states (World Health Organization, 2015). The World Health Organization produces guidelines and standards for health and helps countries to address public health issues such as control and containment of illness outbreaks (e.g., HIV/AIDS, malaria, and tuberculosis); disaster response; and mass immunization programs. Nurses have been actively involved in global health initiatives through governmental and nongovernmental organizations and through professional nursing organizations such as the International Council of Nurses (ICN).

## Challenges and Opportunities

Medicine and nursing have traditionally been more oriented toward curing and treating than preventing illness, injury, and disability. Shifting the focus toward maintaining and promoting health and wellness continues to be a challenge. Many forces in society, including cost containment and allocation of resources, have provided the impetus toward maintaining health rather than providing more resource-intensive care once health has been compromised. Nursing theories have been developed that focus on prevention and health promotion. The profession is challenged to use these theories and continue to develop its abilities to keep people healthy.

The role of health promoter provides the nurse with many opportunities to contribute to improved health. The nurse has an opportunity to educate individuals and groups in the community about disease/injury prevention and maintaining health. Nurses practice in a variety of community settings, such as school-based clinics; work-based employee health centers; free-standing primary care clinics; primary care clinics located in pharmacies, department stores, and shopping centers; prenatal and well-baby clinics; and public health departments, where they interact with healthy people and can provide guidance. However, the opportunities for health promotion can be found in more traditional health-care settings as well. People with acute and chronic illnesses can learn ways of caring for themselves that will enhance their health and increase their well-being.

## Defining Health Promotion

Considerable differences appear in the literature regarding the use of the terms *health promotion*, *primary prevention*, *health protection*, and *illness prevention*. The World Health

Organization (2015a) defines health promotion as “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.” O’Donnell (2009) defines health promotion as “the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health” (p. iv). He further defines optimal health as “a dynamic balance of physical, emotional, social, spiritual, and intellectual health” (p. iv). Maville and Huerta (2013) state that a “universally accepted definition of health promotion does not exist. In fact, health promotion is often confused with or used synonymously with health education,” and they define health promotion as “any endeavor directed at enhancing the quality of health and well-being of individuals, families, groups, communities, and/or nations through strategies involving supportive environments, coordination of resources, and respect for personal choice and values” (p. 3). These definitions suggest a more holistic approach to health promotion than in previous discussions of illness/injury prevention. In the 1986 Ottawa Charter for Health Promotion, the World Health Organization (2015b) lists the prerequisites for health, or fundamental conditions and resources for health as “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity.”

Pender, Murdaugh, and Parsons (2011) also state that “health promotion and health education are often used interchangeably,” and although they are “closely linked, they are not the same.” Health education is focused on the teaching and learning activities and experiences of people. Health promotion includes not only health education, but also illness/injury prevention and health protection.

In the 1960s, the discussion revolved around prevention. The question that arises now is “How does illness/injury prevention relate to health promotion?” Leavell and Clark (1965, p. 21) defined three levels of prevention: primary, secondary, and tertiary. There are five components within these levels: **Primary prevention** focuses on (1) health promotion and (2) protection against specific health problems. **Secondary prevention** focuses on (3) early identification of health problems and (4) prompt intervention to alleviate health problems. **Tertiary prevention** focuses on (5) restoration and rehabilitation to an optimal level of functioning.

In the model used by Leavell and Clark, primary prevention precedes any disease symptoms. The purpose of primary prevention is to encourage optimal health and to increase the person’s resistance to illness. Examples

of primary prevention include health education concerning the hazards of smoking and specific protection against a particular disease, such as vaccine against measles, influenza, and pneumonia. Primary prevention can also relate to actions taken to prevent injury, such as using seat belts, properly installed child protection car seats, or bike helmets.

The second level, secondary prevention, presumes the presence of a disease or illness. Screening procedures, such as a blood glucose testing for a client with diabetes mellitus, genetic testing of individuals where there is a strong family history of specific cancers, and the Denver Developmental Screening Test to assess for childhood developmental delays, are facets of secondary prevention. Screening procedures facilitate early discovery and allow treatment to begin before the illness progresses. Disability limitation, another step in secondary prevention, is also more effective in the early stages of a disease.

Tertiary prevention relates to situations in which a disability is already present. The goal of tertiary prevention is to restore individuals to their optimal level of functioning within the limitations imposed by their condition. For example, the elderly client who has had hip replacement surgery following a hip fracture can improve his or her function and mobility through rehabilitation therapy. Tertiary prevention can prevent complications and further disability related to the initial problem.

Health promotion is considered to be an approach behavior, whereas primary prevention is considered avoidance behavior. Health promotion is not disease oriented; that is, no specific problem is being avoided. By contrast, primary prevention activities are geared toward avoiding specific problems. Pender et al. (2011) add that “health promotion seeks to expand positive potential for health, whereas prevention seeks to thwart the occurrence of insults to health and well-being” (p. 5).

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### Reflect On . . .

- your personal definition of health promotion. How do your personal values and beliefs influence your definition of health promotion? How would you describe the difference between health promotion and illness/injury prevention?
  - how factors in society such as cultural beliefs, religious/spiritual beliefs, or political and economic factors influence health promotion practices.
  - whether health promotion can be offered to all clients regardless of their age, health, and illness status.
-



## RESEARCH CURRENT

## Teams of Community Health Workers and Nursing Students Effect Health Promotion of Underserved Urban Neighborhoods

The purpose of Zandee, Bossenbroek, Slager, and Gordon's study was to examine the effectiveness of teams consisting of a community health worker (CHW) and two nursing students in promoting secondary protection and improving access to health care for residents of three urban neighborhoods that were medically underserved. In this study, community health workers were lay workers who had been recruited from the service neighborhood, trained in their role, and paid by the university where the nursing students were enrolled. The study method was both quasi-experimental and nonexperimental. Evaluation measured changes in (1) knowledge and access to care for program participants (neighborhood residents) using a pre-/post-test tool, (2) program satisfaction (of CHWs and neighborhood residents) using a satisfaction survey, and (3) community assessment changes in the target neighborhood over time using a community assessment survey. All measurement tools were designed by the investigators and completed during the study period of 2005–2007. Findings: A total of 173 residents completed the knowledge and access pre-/post-test, 44% demonstrated an increase in knowledge

about area clinics and almost one-half had a greater knowledge of available community resources. There was an increase in residents who found a medical home clinic and a decrease in the number of residents who used the emergency room as a place to receive care or who did not seek care at all. There was also an increase in the number of residents who had had their blood pressure checked within the previous 2 years. Both resident and CHW satisfaction with the program was high, with resident scores ranging from 4.31 to 4.64 on a 5.0 scale, and CHW scores ranging from 4.63 to 5.00 on a 5.0 scale. The results of the community assessment showed an increase in the use of dental care and a decrease in the use of the emergency room for primary care. The conclusion of the researchers was that CHW/nursing student teams can have a positive influence on the health of medically underserved populations.

*Source:* "Teams of Community Health Workers and Nursing Students Effect Health Promotion of Underserved Urban Neighborhoods," by G. L. Zandee, D. Bossenbroek, D. Slager, and B. Gordon, 2013, *Public Health Nursing*, 30(5), pp. 439–447.



**InfoQuest:** Search the Internet for reliable sources of information about health promotion and disease prevention. How would you share this information with consumers of health care?

## Healthy People 2020

*Healthy People 2020* builds on prior *Healthy People* documents and envisions a “society in which all people live long, healthy lives.” The mission of *Healthy People 2020* (2015a) is to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

The goals of previous *Healthy People* documents were simply to increase the quality and years of healthy life, and to eliminate health disparities. The overarching goals of *Healthy People 2020* further explicate the goals of previous *Healthy People* documents. These new goals are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

*Healthy People 2020* identifies 42 topics associated with health and quality of life. For each topic, specific goals are described, and target measures for goal achievement identified, including how data will be obtained and disseminated to determine progress toward goal achievement. Note that 13 new topic areas were added in *Healthy People 2020* to address specific population health issues and emerging knowledge affecting health and quality of life. A list of *Healthy People 2020* topics can be found in the accompanying box. Topics, along with their objectives and measurement data, can be found at the *Healthy People 2020* website.

## Healthy People 2020 Topics

|                                                         |                                                               |                                              |
|---------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------|
| Access to health services                               | Genomics ( <i>New</i> )                                       | Nutrition and weight status                  |
| Adolescent health ( <i>New</i> )                        | Global health ( <i>New</i> )                                  | Occupational safety and health               |
| Arthritis, osteoporosis, and chronic back conditions    | Health communication and health information technology        | Older adults ( <i>New</i> )                  |
| Blood disorders and blood safety ( <i>New</i> )         | Healthcare-associated infections ( <i>New</i> )               | Oral health                                  |
| Cancer                                                  | Health-related quality of life and well-being ( <i>New</i> )  | Physical activity                            |
| Chronic kidney disease                                  | Hearing and other sensory or communication disorders          | Preparedness ( <i>New</i> )                  |
| Dementias, including Alzheimer's Disease ( <i>New</i> ) | Heart disease and stroke                                      | Public health infrastructure                 |
| Diabetes                                                | HIV                                                           | Respiratory diseases                         |
| Disability and health                                   | Immunization and infectious diseases                          | Sexually transmitted diseases                |
| Early and middle childhood ( <i>New</i> )               | Injury and violence prevention                                | Sleep health ( <i>New</i> )                  |
| Educational and community-based programs                | Lesbian, gay, bisexual, and transgender health ( <i>New</i> ) | Social determinants of health ( <i>New</i> ) |
| Environmental health                                    | Maternal, infant, and child health                            | Substance abuse                              |
| Family planning                                         | Medical product safety                                        | Tobacco use                                  |
| Food safety                                             | Mental health and mental disorders                            | Vision                                       |

Note: Topics marked *new* were not included in *Healthy People 2010*.

Source: *Healthy People, 2020 Topics and Objectives*, by the U.S. Department of Health and Human Services, 2015b. Retrieved from [www.healthypeople.gov/2020/topicsobjectives2020/default](http://www.healthypeople.gov/2020/topicsobjectives2020/default)

## Leading Health Indicators

Leading Health Indicators (LHIs) were developed reflecting high-priority issues in the United States. LHIs will be used to “assess the health of the Nation, facilitate collaboration across sectors, and motivate action at the national, State, and community levels to improve the health of the U.S. population” (U.S. Department of Health and Human Services, 2015c). For each of the LHIs, specific objectives will be used to track progress. For example, for the leading health indicator, tobacco, objectives include (1) reduce tobacco use by adults; (2) reduce tobacco use by adolescents; (3) reduce the initiation of tobacco use among children, adolescents, and young adults; (4) increase smoking cessation attempts by adult smokers; (5) increase recent smoking cessation success by adult smokers; (6) increase smoking cessation during pregnancy; and (7) increase

smoking cessation attempts by adolescent smokers. Additional objectives address health systems changes (e.g., increasing tobacco screening in healthcare settings), social and environmental changes (e.g., establishing laws on smoke-free indoor air that prohibit smoking in public places and worksites). In tracking progress toward the objectives, one must examine individual, health systems, social, and environmental data. The LHIs are listed in the accompanying box.

## Four Foundation Health Measures

As part of *Healthy People 2020*, there are four foundation health measures that will serve as indicators of progress toward achieving the overarching goals. These measures are general health status, health-related quality of life and well-being, determinants of health, and disparities.

## Healthy People 2020: Leading Health Indicators

- Access to health services
- Clinical preventive services
- Environmental quality
- Injury and violence
- Maternal, infant, and child health
- Mental health
- Nutrition, physical activity, and obesity
- Oral health
- Reproductive and sexual health
- Social determinants
- Substance abuse
- Tobacco

Source: *Healthy People 2020: Leading Health Indicators*, by the U.S. Department of Health and Human Services, 2015c. Retrieved from [www.healthypeople.gov/2020/Leading-Health-Indicators](http://www.healthypeople.gov/2020/Leading-Health-Indicators)

**CRITICAL THINKING EXERCISE**

Go to *Healthy People 2020* at [www.healthypeople.gov/2020/topicsobjectives2020/default](http://www.healthypeople.gov/2020/topicsobjectives2020/default) and select one *Healthy People 2020* topic that is of concern in your community. Review the topic, its objectives, and the data that will be gathered to measure progress toward achieving the objectives. Find data to determine the status of your community in meeting the topic objectives. (Where will

you go to find local/regional/state data?) In what ways is your community achieving the desired objectives? In what ways is your community not achieving the desired objectives? What, in your opinion, are the motivators for and barriers to achieving the objectives? How will you, as a nurse, assist your community in meeting the objectives?

**General Health Status**

General health status provides information on the overall health of a population. *Healthy People 2020* will monitor the general health status looking at (1) life expectancy (at birth and at age 65), (2) healthy life expectancy (expected years of life in good or better health, expected years of life free of limitation of activity, and expected years of life free of selected chronic diseases), (3) years of potential life lost, (4) the number of physically and mentally unhealthy days, (5) self-assessed health status, (6) limitation of activity (ADLs, IADLs, remembering, play, school, and work), and (7) the prevalence of chronic disease. Life expectancy and years of potential life lost in the United States will be compared with international data to determine where the

United States stands in global rankings. (See Table 7–1). In 2011, the United States ranked 32nd for life expectancy among the World Health Organization member nations (World Health Organization, 2013).

**Health-Related Quality of Life and Well-Being**

Health-related quality of life (HRQoL) and well-being considers physical, mental, emotional, and social functioning as an integrated whole of health status and examines the influence of health status on the quality of life. Well-being as part of quality of life, as described in *Healthy People 2020*, assesses “the positive aspects of a person’s life, such as positive emotions and life satisfaction.”

**TABLE 7–1 Life Expectancy at Birth by Gender Ranked by Selected Countries, 2011**

| Country                          | Years of Life Expectancy Female | Years of Life Expectance Male | Years of Life Expectancy Both Sexes |
|----------------------------------|---------------------------------|-------------------------------|-------------------------------------|
| Japan                            | 86                              | 79                            | 83                                  |
| Switzerland                      | 85                              | 80                            | 83                                  |
| Andorra                          | 85                              | 79                            | 82                                  |
| Israel                           | 84                              | 80                            | 82                                  |
| France                           | 85                              | 78                            | 82                                  |
| Iceland                          | 84                              | 81                            | 82                                  |
| Italy                            | 85                              | 80                            | 82                                  |
| Australia                        | 84                              | 80                            | 82                                  |
| Canada                           | 84                              | 80                            | 82                                  |
| United Kingdom                   | 82                              | 79                            | 80                                  |
| United States                    | 81                              | 76                            | 79                                  |
| China                            | 77                              | 74                            | 76                                  |
| Russian Federation               | 75                              | 63                            | 69                                  |
| Democratic Republic of the Congo | 51                              | 48                            | 49                                  |

Source: “Life Expectancy: Life Expectancy by Country,” by the World Health Organization, 2011. Retrieved from [apps.who.int/gho/data/node.main.688?lang=en](http://apps.who.int/gho/data/node.main.688?lang=en)

### Determinants of Health

Determinants of health are those factors—personal, social, economic, and environmental—that influence health status. In developing objectives that examine the relationship between health status and biology, individual behavior, health services, social factors, and policies, *Healthy People 2020* seeks to determine what makes some people healthy and others unhealthy. Understanding these relationships is important in developing strategies to improve individual health status as well as population health.

### Disparities

Concern regarding disparities in health status has been part of *Healthy People* since its inception. If there is a significant difference, either greater or lesser, in illness/injury occurrence, health access, or health outcomes based on race, ethnicity, sex, sexual identity, age, disability, socioeconomic status, and/or geographic location (e.g., urban versus rural, state differences, regional differences), then a disparity exists. An important overarching goal of *Healthy People 2020* is to “achieve health equity, eliminate disparities, and improve the health of all groups.” This requires determining what disparities exist, what factors or social determinants may be related to the disparities, and identifying strategies to reduce or eliminate the disparity.

The Agency for Healthcare Research and Quality (AHRQ) reports on “progress and opportunities for improving health care quality and reducing health care disparities” (p. 5). The 2013 NHQR and NHDR tracked more than 200 health care process, outcome, and access measures in 2010 through 2011 and compared the findings to previous reports to identify trends. The report states that there continue to be health disparities in the United States, including the following (Agency for Healthcare Research and Quality 2013):

- Blacks had worse access to care than Whites for one-third of measures.
- Hispanics had worse access to care than Whites for about 60% of quality measures.
- Blacks and Hispanics received worse care than Whites for about 40% of quality measures.
- American Indians and Alaskan Natives received worse care than Whites for one-third of quality measures.
- Poor people received worse care than high-income people for about 60% of quality measures. In 2011, 37.6% of poor Americans reported barriers that restricted their access to care.
- Blacks had more maternal deaths per 100,000 live births, and had a greater incidence of postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) per 1000 surgical admissions compared to Whites.

- Asians had a greater incidence of live-born low birth weight infants than Whites.
- Low-income (poor) people had a greater number of admissions with diabetes with short-term complications per 100,000 population than High-income people.

At the same time, there was improvement in many areas of existing health disparities. For example:

- There was a decrease in new AIDS cases and HIV infection deaths per 100,000 population in Black compared with White.
- There was a decrease in new AIDS cases and HIV infection deaths per 100,000 population in Hispanics compared with non-Hispanic White.
- There was a decrease in admissions for uncontrolled diabetes without complications per 100,000 population in Black compared with White.
- There was a decrease in admissions for uncontrolled diabetes without complications per 100,000 population in Hispanics compared with non-Hispanic White.

### Reflect On . . .

- yourself as a role model of healthy behaviors related to the achievement of the goals of *Healthy People 2020*. Do you smoke? Are you overweight? Do you engage in physical activity and exercise regularly? What are your own barriers to achieving the goals of *Healthy People 2020*? What are the factors that help you achieve healthy behaviors?



**InfoQuest:** Go to [www.healthypeople.gov](http://www.healthypeople.gov). What is the current status of *Healthy People 2020*? In what ways do the *Healthy People 2020* topics and objectives relate to your specific area of practice? Your community?

### Health Promotion Activities

Health promotion organizations, wellness centers, and traditional healthcare centers all offer a different approach to client care. Table 7–2 demonstrates these differences. Health promotion activities can be carried out either on a governmental level (e.g., a national or state program to improve knowledge of nutrition) or on a personal level (e.g., an individual exercise program).



**TABLE 7–2 Comparison of Three Foci of Health Care: Traditional, Health Promotion, and Wellness**

|               | Traditional                                          | Health Promotion                                                                                                                                                     | Wellness                                                                                                                    |
|---------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Primary goal  | Diagnosis and cure                                   | Illness/injury prevention and risk reduction                                                                                                                         | Improved overall health and wellness                                                                                        |
| Focus of care | Disease/injury                                       | Individuals, families, and communities                                                                                                                               | Individuals, families, and communities                                                                                      |
| Intervention  | Medical/surgical/mental health treatment             | Health risk appraisal, health information, strategies for behavior change                                                                                            | Health information, nutritional counseling, exercise/fitness, stress management, risk avoidance                             |
| Duration      | Until problem is resolved                            | Length of program                                                                                                                                                    | Lifelong                                                                                                                    |
| Location      | Hospitals, clinics, MD/ANP offices                   | Schools, workplaces, gyms/fitness centers, community centers, hospitals, clinics, MD/ANP offices                                                                     | Schools, workplaces, libraries, gyms/fitness centers, community centers, grocery stores, hospitals, clinics, MD/ANP offices |
| Example       | Treatment of client with acute myocardial infarction | Health risk appraisal for client with family history of heart disease and coaching for lifestyle change (e.g., smoking cessation, weight management, diet, exercise) | Programs to prevent obesity in childhood including developing lifelong nutrition and exercise habits                        |

Health promotion programs on an individual level can be active or passive. With passive strategies, the client is the recipient of the health promotion effort. Many health professionals participate in national programs to define and implement these passive strategies. Examples of passive governmental strategies are maintaining the cleanliness of water and air and promoting a healthy environment by enforcing sewage regulations to decrease the spread of disease. Active strategies depend on individuals' commitment to and involvement in adopting a program directed toward maintaining and promoting their health. Active strategies are important in that they encourage individuals to take control of their lives and assume the responsibility for their health. Examples of active strategies that involve changes in lifestyle are (1) a diet-management program to improve nutrition, (2) a self-help or meditation program to reduce stress, (3) an exercise program to improve muscle strength and endurance, and (4) a combination diet and exercise regimen for weight reduction or control. For optimal health and well-being, a combination of both active and passive strategies is suggested.

### Types of Health Promotion Programs

A variety of programs can be used to promote health, including (1) information dissemination, (2) health risk appraisal and wellness assessment, (3) lifestyle and behavior change, and (4) environmental control programs.

### Information Dissemination

Information dissemination is the most basic type of health promotion program. This method makes use of a variety of media to offer information to the public about the risk of particular lifestyle choices and personal behavior, as well as the benefits of changing that behavior and improving the quality of life. Billboards, posters, brochures, newspaper features, books, the Internet, and health fairs all offer opportunities for the dissemination of health promotion information. Nutrition, exercise, alcohol and drug abuse, diabetes, hypertension, sexually transmitted diseases (including HIV/AIDS), and the need for immunizations are among the topics frequently discussed. Information dissemination is a useful strategy for raising the level of knowledge and awareness of individuals and groups about healthy lifestyle choices and behaviors.

### Health Risk Appraisal/Wellness Assessment Programs

Health risk appraisal/wellness assessment programs are used to apprise individuals of the risk factors that are inherent in their lives in order to motivate them to reduce specific risks and develop positive health habits. Wellness assessment programs are focused on more positive methods of enhancement, in contrast to the risk factor approach used in health appraisal. A variety of tools are available to facilitate these assessments. Some of these tools are computer based and can therefore be offered to educational institutions and industries at a reasonable cost.

### Lifestyle- and Behavior-Change Programs

Lifestyle- and behavior-change programs require the participation of the individual and are directed toward enhancing the quality of life and extending the life span. Individuals generally consider lifestyle changes after they have been informed of the need to change their health behavior and become aware of the potential benefits of the process. Many programs are available to the public, on both a group and individual basis, some of which address stress management, nutrition awareness, weight control, smoking cessation, and exercise.

### Environmental Control Programs

Environmental control programs have been developed in response to the growth in the number of contaminants of human origin that have been introduced into the environment. The amount of contaminants that is already present in the air, food, and water will affect the health of the population for several generations. The most common concerns of community groups are toxic and nuclear wastes, nuclear power plants, air and water pollution, and herbicide and pesticide spraying.

### Sites for Health Promotion Activities

Health promotion programs are found in many settings. Programs and activities may be offered to individuals and families in the home or in community settings, at schools, in hospitals, at work sites, at religious organizations (e.g., churches, synagogues), at gyms and fitness centers, and at shopping malls. Some individuals may feel more comfortable having the nurse, diet counselor, or fitness expert come to their home for teaching and follow-up on individuals' needs. This type of program, however, is not cost-effective for most individuals. Many people prefer the group approach, find it more motivating, and enjoy the socializing and group support. Most programs offered in the community are group oriented.

Community programs are frequently offered by cities. The type of program depends on the current concerns and the expertise of the sponsoring department or group. Program offerings may include health promotion, specific protection, and screening for early detection of disease. The local health department may offer a community-wide immunization program or blood pressure screening. The fire department may disseminate fire prevention information; the police may offer bicycle safety programs for children and adults, safe-driving campaigns for young adults, or crime prevention and gun safety programs for all citizens. The recreation department may sponsor or provide facilities for group or individual sports programs for children and adults, such as youth baseball, football, and basketball programs or adult exercise programs. The

transportation department may provide free or low-cost transportation to local grocery stores, pharmacies, and doctors' offices for elderly who are no longer able to drive.

Hospitals and healthcare organizations began the emphasis on health promotion and prevention by focusing on the health of their employees. Because of the stress involved in caring for the sick and the various shifts that nurses and other healthcare workers must work, the lifestyles and health habits of healthcare employees were given priority. Programs offered by healthcare organizations initially began with the specific focus of prevention. Examples include infection control, fire prevention and fire drills, limiting exposure to X-rays, and the prevention of back injuries. Gradually, issues related to the health and lifestyle of the employee were addressed with programs on topics such as smoking cessation, exercise and fitness, stress reduction, and time management. Increasingly, hospitals have offered a variety of these programs and others (e.g., women's health) to the community as well as to their employees. In some larger organizations, a fitness center is available where employees can exercise before and/or after their work shift, and members of the surrounding community can participate in exercise and nutrition programs. This community activity of the healthcare institution enhances the public image of the hospital, increases the health of the surrounding population, and generates some additional income.

School health promotion programs may serve as a foundation for children of all ages to learn basic knowledge about personal hygiene and issues in the health sciences. Because school is the focus of a child's life for so many years, the school provides a cost-effective and convenient setting for health-focused programs. The school nurse may teach programs about basic nutrition, dental care, activity and play, drug and alcohol abuse, domestic violence, child abuse, bullying, and issues related to sexuality and pregnancy. Classroom teachers may include health-related topics in their lesson plans, for example, the way the normal heart functions or the need for clean air and water in the environment. School-based adult learning programs may include health promotion programs such as nutrition, exercise, or meditation techniques.

Work site programs for health promotion have developed out of the need of businesses to control the rising cost of health care and employee absenteeism. Many industries feel that both employers and employees can benefit from healthy lifestyle behavior and have employed occupational health nurses as part of their human resources department to plan and provide health promotion programs. The convenience of the work site setting makes these programs particularly attractive to many adults who would otherwise not be aware of them or motivated to

### CRITICAL THINKING EXERCISE

Review the Topics and Objectives of *Healthy People 2020* at [www.healthypeople.gov](http://www.healthypeople.gov). Select one topic; review the topic objectives, and measurement data. Create a

health-promotion program that would assist in meeting the topic objectives, and describe how you would measure the effectiveness of your program.

attend them. Health promotion programs may be held in the cafeteria so that employees can watch a film or have a discussion group during their lunch break. Work site programs may include programs that address air quality standards for the office, classroom, or plant; programs aimed at specific populations, such as accident prevention for the machine worker or back-saver programs for the individual involved in heavy lifting; programs to prevent repetitive stress injuries; programs to screen for high blood pressure; or health enhancement programs, such as fitness information and relaxation techniques. Benefits to the worker may include an increased feeling of well-being, fitness, weight control, and decreased stress. Benefits to the employer may include an increase in employee motivation and productivity, an increase in employee morale, a decrease in absenteeism, and a lower rate of employee turnover, all of which may decrease business and health-care costs.

Increasingly, health information is available on the World Wide Web. Internet sites such as WebMD offer information on prevention, screening, and management of many illnesses. Organizations such as the American Diabetes Association, American Heart Association, American Lung Association, and the Alzheimer's Association provide specific information about risk factors, ways to lower risk, and strategies for self-management. It is important that health professionals inform patients and consumers of the reliability of information on the Internet. Although there are many trustworthy sources of health information on the Web, there are also websites that present opinions of the website developer, which may or may not be supported by the scientific evidence. An example of health information disseminated on the Internet that must be viewed with caution is a website that espouses various alternative medicine strategies without providing the scientific evidence that supports the health-related claims.

### Reflect On . . .

- the availability and accessibility of health promotion and preventive care services to people of all ages and economic statuses in your community.

- the work-site wellness program at your place of employment. What services are provided? Do you participate in these services? How would you improve your current work-site wellness program?
- the effectiveness of environmental control programs in your community.
- health promotion activities you would like to see implemented in your community if there were no limits in resources such as time, expertise, and money.

## Health Belief Models

Several theories of health belief/behavior models have been developed to help determine whether an individual is likely to participate in disease prevention and health promotion activities. These models can be useful tools in the development of programs for helping people change to healthier lifestyles and develop a more positive attitude toward preventive health measures.

### Health Locus of Control Model

**Locus of control** is a concept from social learning theory that the nurse may consider when determining who is most likely to take action regarding his or her health, that is, whether clients believe that their health status is under their own or others' control. People who believe that they have a major influence on their own health status are internally controlled; that is, they have an *internal locus of control*. They are more likely than others to take the initiative in their own health care, to be more knowledgeable about their health, and to adhere to prescribed healthcare regimens, such as taking medication as prescribed, making and keeping appointments with physicians, and maintaining diets. By contrast, people who believe their health is large controlled by outside forces (e.g., chance, luck, or powerful others) and is beyond their control have an *external locus of control* and may need assistance to become more internally controlled if behavior changes are to be successful. Locus of control is a measurable concept that can be used to predict which people are most likely to change their behavior.

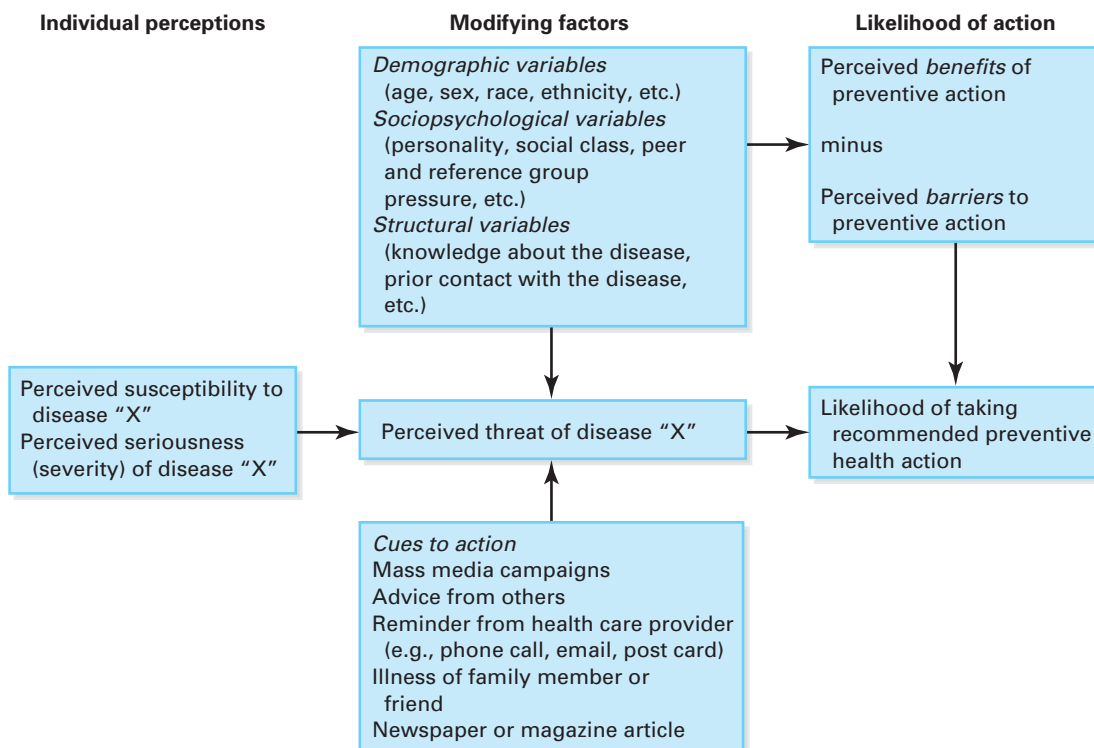
## The Health Belief Model

The *health belief model* (HBM), developed in the 1950s by Rosenstock (1974), provides a framework for understanding why people do not adopt disease prevention strategies or participate in screening tests for the early detection of disease (see Figure 7–1). As the model evolved, individual responses to symptoms and compliance with medical treatments were examined. Initially the model was used to explain why people do not take action to prevent disease/injury. While mostly associated with disease/injury prevention, the model may also be used to explain why people do or do not participate in health promotion behaviors. The major constructs of the health belief model are:

- Individual perceptions
  - Perceived susceptibility. The person's perception or belief about his or her risk of acquiring a certain disease
  - Perceived severity. The person's perceptions or beliefs about the seriousness of acquiring a certain disease.
- Modifying factors
  - Demographic (age, sex, race, ethnicity, etc.), psychosocial (personality, social class, peer/reference group pressure, etc.), and/or structural variables (knowledge about the disease, prior contact with the disease, etc.) that may influence the person's decision making.
- Cues to action. Internal (e.g., pain, difficulty breathing) or external (e.g., media, advice from others, family or friend illness) stimuli that trigger the decision-making process to follow a recommended health action.
- Likelihood of action
  - Perceived benefits. The person's perceptions or beliefs about the effectiveness of taking available actions to reduce the threat of disease or to cure an existing disease.
  - Perceived barriers. The person's perceptions or beliefs regarding obstacles that may prevent his or her taking action.
- Self-efficacy. The person's level of confidence in his or her ability to perform the recommended/required action.

**FIGURE 7–1**

The Health Belief Model



Source: "A New Approach to Explaining Sick-Role Behavior in Low-Income Populations," by M. H. Becker, R. H. Drachman, and J. P. Kirscht, 1974, *American Journal of Public Health*, 64(3), p. 206.



## Health Promotion Models

Pender's Health Promotion Model and the Neuman Systems Model are two models that can be used to describe factors influencing people's decisions about adopting health promotion behaviors.

### Pender's Health Promotion Model

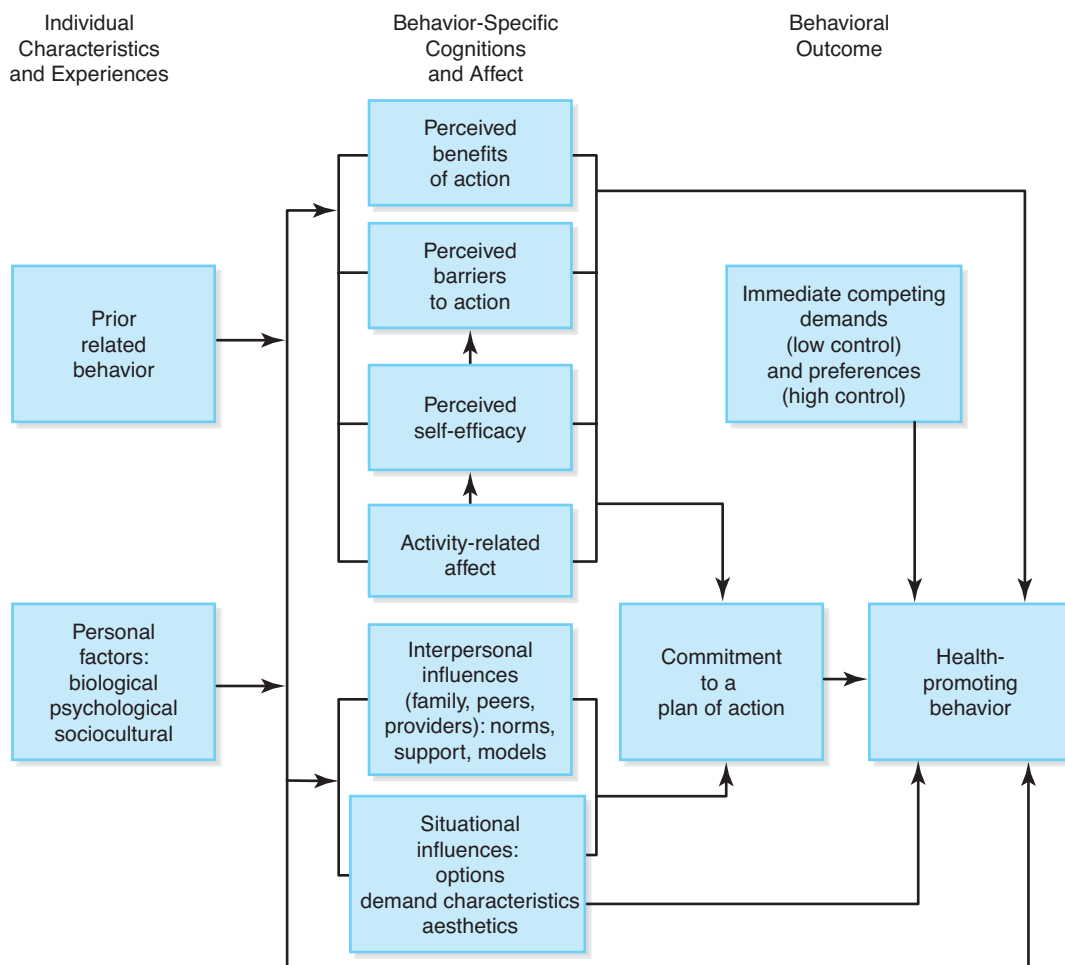
Nola Pender's Health Promotion Model (Pender et al., 2011, p. 45) was first published in the literature in the 1980s but has since been revised based on research using the model. It differs from the health belief model in that it focuses on health-promoting behaviors rather than health-protecting or preventive behaviors (see Figure 7–2).

The Pender Health Promotion Model is based on the following assumptions that “emphasize the active role of the client in shaping and maintaining health behaviors and in modifying the environmental context for health behaviors” (Pender, Murdaugh, & Parsons, 2002, p. 63):

1. Persons seek to create conditions of living through which they can express their unique human health potential.
2. Persons have the capacity for reflective self-awareness, including assessment of their own competencies.
3. Persons value growth in directions viewed as positive and attempt to achieve a personally acceptable balance between change and stability.
4. Individuals seek to actively regulate their own behavior.

FIGURE 7–2

Pender's Health Promotion Model



Source: *Health Promotion in Nursing Practice* (6th ed.), by N. J. Pender, C. L. Murdaugh, and M. A. Parsons, 2011, Upper Saddle River, NJ: Pearson Education.

5. Individuals in all their biopsychosocial complexity interact with the environment, progressively transforming the environment and being transformed over time.
6. Health professionals constitute a part of the interpersonal environment that exerts influence on persons throughout their life span.
7. Self-initiated reconfiguration of person-environment interactive patterns is essential to behavior change.

The components of the Pender model are (1) individual characteristics and experiences, (2) behavior-specific cognitions and affect, (3) commitment to a plan of action, (4) immediate and competing demands and preferences, and (5) health-promoting behavioral outcomes.

### Individual Characteristics and Experiences

*Individual characteristics and experiences* are unique to each person and influence his or her subsequent behavior. The component includes prior related behavior and personal factors. *Prior related behavior* comprises previous experiences, knowledge, and skill in health-promoting actions. For example, if a person has had positive prior experiences with health promotion and other health-related activities, he or she is more likely to maintain those activities than someone who had had negative prior experiences.

*Personal factors* include biological, psychological, and sociocultural factors. Biological characteristics include factors such as age, gender, familial or hereditary risk for specific diseases such as cancer, strength, agility, balance, pubertal status, menopausal status, and percentage of body fat and total body weight. Psychological factors include characteristics such as self-esteem, self-motivation, and perceptions of health status. Sociocultural factors include characteristics such as ethnicity, race, education, income, and acculturation. Personal factors can also include cognitions, affect, and health behaviors.

### Behavior-Specific Cognitions and Affect

*Behavior-specific cognitions and affect* are considered the “critical core for intervention, because they can be modified through interventions” (Pender et al., 2011, p. 46). The components of behavior-specific cognitions and affect are perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational influences. They are described as follows:

*Perceived benefits of action* affect the person’s level of participation in health-promoting behaviors and may facilitate continued practice. If the person has had prior positive experiences with a health-promoting behavior or has observed someone else who has had a positive experience, the person is more likely to adopt or maintain the health

behavior. For example, a person who starts losing excess weight by participating in a program of exercise is more likely to maintain the exercise program. Another example is a person who smokes who sees a friend successfully stop smoking using a specific smoking-cessation technique is more likely to try the same smoking-cessation technique. Repetition of such behavior can strengthen and reinforce beliefs about benefits.

*Perceived barriers to action* include a person’s perceptions about available time, expense, inconvenience, access to facilities, difficulty performing the activity, or other perceived negative consequences related to health promotion activities. These barriers may be imagined or real. Barriers to action result in avoidance or a decrease in health-promoting behaviors. For example, a person who believes that she will put on excess weight if she tries to stop smoking may choose not to attempt stopping smoking.

*Perceived self-efficacy* refers to the person’s conviction that he or she can successfully carry out the behavior necessary to achieve a desired outcome, such as maintaining an exercise program to lose weight. Often people who have serious doubts about their capabilities decrease their efforts and give up, whereas those with a strong sense of efficacy exert greater effort to master problems or challenges.

*Activity-related affect* includes the subjective feelings that occur before, during, and following an activity. These feelings can influence whether a person begins a health promotion activity or maintains the activity once it is begun. A person who has positive feelings about the activity is more likely to begin or maintain the activity. Individuals who have negative feelings about a health promotion activity are less likely to begin or maintain an activity. For example, a person might experience muscle pain after starting an exercise program. The negative feelings associated with the pain may result in the person stopping the exercise program.

*Interpersonal influences* are the perceptions (real or unreal) of “the health beliefs, behaviors or attitudes of others” (Pender et al., 2011, p. 48). Family members, peers, significant others, and healthcare providers are the primary sources of interpersonal influence on health-promoting behaviors. “Interpersonal influences include norms (expectations of significant others), social support (instrumental and emotional encouragement), and modeling (vicarious learning through observing others engaged in a particular behavior)” (Pender et al., 2011, p. 48). For example, an adult may maintain a dental hygiene program of brushing and flossing his teeth twice a day and visiting the dentist routinely for cleaning and screening because it is a habit that was established in childhood by his parents.

*Situational influences* include “perceptions of options available, demand characteristics, and aesthetic features of the environment in which a given behavior is proposed to take place” (Pender et al., 2011, pp. 48–49). Situational influences may be direct or indirect. An environment that contains cues or triggers for health-promoting behaviors is a direct influence, for example, environments that prohibit smoking by posting “no smoking” signs and eliminating ashtrays.

### Commitment to a Plan of Action

Commitment to a plan of action includes two underlying processes: “(1) commitment to carry out a specific health promotion activity at a given time and place and with specific persons or alone, and (2) identification of specific strategies for determining, initiating, and continuing the health-promotion behavior” (Pender et al., 2011, p. 49). It is important to determine the specific strategies so that the individual moves beyond the cognitive and emotional commitment to a realistic action plan that results in the initiation and maintenance of the desired health-promoting behavior.

### Immediate Competing Demands and Preferences

*Competing demands* are those factors over which the individual has a low level of control such as family or work responsibilities. For example, a parent may commit to working out every other evening after work at a health club, but the parental responsibility to attend a child’s sport activity competes for the same time. Failure to meet the competing demand (attending the child’s sport activity)

may result in negative consequences, such as the child’s being angry at the parent or thinking that the parent does not care. *Competing preferences* are those factors or behaviors over which the individual has a relatively high level of control. A competing preference may result in the person’s choosing a different or preferred behavior over the health-promoting behavior. For example, an individual on a low fat diet (health-promoting behavior) may select a high-fat choice on a restaurant menu because of the taste (competing preference).

### Behavioral Outcome

The behavioral outcome in the Health Promotion Model is the adoption and integration of (a) health-promoting behavior(s) into the individual’s lifestyle. Pender et al. (2011) state that “health-promoting behaviors, particularly when integrated into a healthy lifestyle . . . should result in improved health, enhanced functional ability, and better quality of life at all stages of development” (p. 50).

### Neuman Systems Model

The Neuman Systems Model is wellness oriented and views health promotion as an intervention component of primary prevention (Neuman & Fawcett, 2011). Further, Neuman and Fawcett (2011) state that “health promotion goals should ideally work in concert with both secondary and tertiary prevention as interventions to prevent recidivism and to promote optimal wellness” (p. 29). The Neuman Systems Model defines health promotion as “measures that the individual initiates to maintain health and wellness, controlling stress, and health screening” (p. 206).

## RESEARCH CURRENT

### Coronary Artery Disease and Smoking Cessation Intervention by Primary Care Providers in a Rural Clinic

Using a nonexperimental quality assurance design with a descriptive chart audit review, the study by Kelley, Sherrod, and Smyth evaluated whether a smoking cessation intervention was conducted by primary care providers (physicians and advanced practice nurses) for patients with a known history of coronary artery disease (CAD) within 1 year of the patients’ CAD diagnosis. The investigators chose Pender’s Health Promotion Model as a conceptual framework for the study because it had been used in studies examining influences on health-promoting behaviors. The specific concepts important to the investigators were interpersonal influences and their effect on commitment to action—for this study, the commitment to smoking cessation. Data were collected on a sample of 150 patients (69.3% male, 30.7% female, 92.3% males older than 50, 95.7% of females older than 50) from medical records using a researcher-developed

quality assurance tool. Slightly fewer than 90% (89.3%) had smoked for 10 years or more, and 83.3% smoked more than one pack per day. Results of the medical records review showed that 68.7% of patients received a smoking cessation education intervention prior to or within 1 year after CAD diagnosis, 31.3% of the sample received no smoking cessation intervention. Of those who had received smoking cessation intervention, 40.7% had received smoking cessation education prior to diagnosis. The investigators emphasize the importance of primary care providers discussing smoking cessation at every healthcare visit with patients who smoke.

*Source:* “Coronary Artery Disease and Smoking Cessation Intervention by Primary Care Providers in a Rural Clinic,” by J. A. Kelley, R. A. Sherrod, and P. Smyth, 2009, *Online Journal of Rural Nursing and Health Care*, 9(2), pp. 82–94.

## CRITICAL THINKING EXERCISE

Ann Johnson is a 38-year-old female who is the married mother of three children, ages 16 (female), 12 (male), and 8 (female). Her husband is a 42-year-old airline pilot. She has a family history of breast cancer, and her husband has a family history of heart disease. At the present time all members of the family are healthy. Use Pender's Health Promotion Model to analyze this family. What health promotion and illness/injury prevention activities should the nurse assist this family to adopt? Consider

the age and gender of all family members. What additional information about the family would help you develop a health promotion plan? Why is this additional information important? How would you as the nurse operationalize the various roles of the nurse in the care of this family, including the roles of care provider, health promoter and educator, research consumer, advocate, empowering agent, consultant, coordinator of care, proactive change agent, and role model?

Measures described to promote health in each stage of prevention are the following:

- Primary prevention occurs before the individual's response to a stressor occurs. Health promotion interventions focus on reducing the possibility of encountering the stressor and strengthening the individual's flexible line of defense.
- Secondary prevention consists of treating symptoms following a reaction to a stressor. Health promotion interventions include early case finding and access to care.
- Tertiary prevention focuses on maintaining optimal wellness following treatment. Health promotion interventions focus on readaptation, reeducation to prevent future occurrences, and maintenance of stability.

Additional information about the Neuman Systems Model can be found in Chapter 6, "Knowledge Development."

## Stages of Health Behavior Change

Health behavior change is a cyclical phenomenon in which people progress through several stages. Several behavior change models, also called *continuum models*, have been proposed. In the first stage, the person does not think seriously about changing a behavior; by the time the person reaches the final stage, he or she is successfully

maintaining the desired behavior. The transtheoretical model of change is an integrative model that describes how individuals progress toward adopting and maintaining a change in behavior. The stage model proposed by Prochaska and DiClemente (1982, 1992, 2009) is discussed here. The stages are (1) precontemplation, (2) contemplation, (3) preparation or planning, (4) action, (5) maintenance, and (6) termination.

In the *precontemplation stage*, the person does not think about changing behavior, nor is the person interested in information about the behavior. He or she has no intention of taking action or changing a behavior within the next 6 months. The negative aspects of making the change outweigh the benefits. Some people may believe the behavior is not under their control and may become defensive when confronted with information.

During the *contemplation stage*, the person seriously considers changing a specific behavior, actively gathers information, and verbalizes an intention to change the behavior in the near future (within 6 months). Both belief in the value of the change and self-confidence in the ability to change increase in this phase. It is common for a person to feel some ambivalence when weighing the losses against the rewards of changing the behavior.

In the *preparation stage*, also referred to as the *planning* or *determination stage*, the person is ready to take

## CRITICAL THINKING EXERCISE

Identify health-promotion interventions that you would incorporate in the nursing care of the following clients with chronic illness: a 58-year-old White male with

emphysema, a 76-year-old Black female with diabetes mellitus, a 44-year-old White male with coronary artery disease, and a 38-year-old Black male with hypertension.



**CRITICAL THINKING EXERCISE**

Identify a friend, family member, or client under your care who is considering a health behavior change. At what stage of Prochaska and DiClemente's model is the person? What barriers exist in the person's experience

that might interfere with his or her reaching the goal? What activities or interventions would you suggest or do to help the person successfully make the health behavior change?

action within the next 30 days. The individual undertakes cognitive and behavioral activities that prepare him or her for change. At this stage, the person believes that the advantages of changing the behavior outweigh the disadvantages and makes specific plans to accomplish the change. Some people in this stage change small aspects of the behavior, such as cutting out sugar in their coffee.

The *action stage* occurs when the person actively implements (within the last 6 months) behavioral and cognitive strategies to interrupt previous behavior patterns and adopt new ones. To prevent recurrences of previous behavior, the action stage needs to continue for several weeks or months.

During the *maintenance stage*, the person integrates newly adopted behavior patterns into his or her lifestyle for more than 6 months. This stage lasts until the person no longer experiences temptation to return to previous unhealthy behaviors.

In the *termination stage*, the person has no desire to return to the previous unhealthy behavior and believes he or she will not relapse. This stage is not often reached; the person generally stays in the maintenance stage. For example, a person may stop smoking but may be tempted to smoke during a stressful event.

These stages are cyclical; people generally move through one stage before progressing to the next. However, at any point in time a person may regress to any previous stage. Sudden or gradual relapses to previous behavior patterns may occur during the action or maintenance stage, for example. Individuals who relapse may return to

the stage of precontemplation, contemplation, or preparation before their next attempt to change. To identify whether the client is in the precontemplation or contemplation stage, ask whether the client is thinking about changing a behavior in the next 6 months or a year. Those in precontemplation will answer no; those in contemplation or preparation will answer yes. Table 7–3 relates nursing strategies appropriate for each stage of health behavior change.

**Reflect On . . .**

- your own experience in changing an unhealthy behavior (e.g., quitting smoking, losing weight, maintaining proper nutrition, adopting an exercise program, or reducing stress). How did you progress through the stages of Prochaska and DiClemente's model? What barriers to health behavior change did you experience? How did you overcome the barriers and effect a successful health behavior change?
- supports and barriers that exist in your community that interfere with individual and family health behavior change. What supports exist in your community to assist individuals and families in making health behavior changes? What barriers exist in your community to assist individuals and families in making health behavior changes? How might you promote and support health behavior changes in your community.

**CRITICAL THINKING EXERCISE**

Review the topics and objectives of *Healthy People 2020*. Identify health promotion activities you would consider when planning care for the following clients in

your community: an elderly client, an adolescent, a young adult, a school-age child, a newborn and her parents.

TABLE 7–3   Examples of Nursing Strategies for Each Stage of Health Behavior Change

| Stage                                       | Nursing Strategies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Precontemplation                            | <ul style="list-style-type: none"><li>• Raise the client’s awareness of healthy behaviors, such as exercising, changing the diet, quitting smoking, using sunscreen, using a condom, undergoing regular mammography screening.</li><li>• Provide personalized information about the benefits of specific health behaviors; for example, relate the client’s cough to smoking or excessive fat intake to heart disease.</li><li>• Explore the client’s beliefs and feelings related to the health behavior.</li><li>• Identify previous successful changes (e.g., weight loss, smoking cessation) to increase the client’s self-confidence, and offer positive feedback.</li></ul>                                                                                                                                                                                                                                                                                                                |
| Contemplation                               | <ul style="list-style-type: none"><li>• Continue to provide the interventions cited in the previous stage. In addition, provide adequate and accurate information about available alternatives to encourage clients to make appropriate choices and actively participate in decision making.</li><li>• Encourage the client to express ambivalent feelings. Include spouses, if appropriate (e.g., when recommending dietary changes, all family members need to be involved in accepting the change).</li><li>• Help the client further clarify his or her values in relation to the health behavior, and encourage the client to consider how it would feel, for example, to be at an appropriate weight or to be an ex-smoker.</li><li>• Help the client identify social pressures that encourage positive health behaviors, such as available exercise facilities or programs, or prohibitions on smoking at work sites and social gathering places (e.g., restaurants, theaters).</li></ul> |
| Preparation<br>(planning,<br>determination) | <ul style="list-style-type: none"><li>• Assist the client to make specific plans to implement the change; for example, discuss self-help groups and other available support persons or groups.</li><li>• Help the client identify stimuli that trigger unhealthy behavior and consider ways to remove or minimize those stimuli (e.g., changing the environment or removing himself or herself from a troublesome area).</li><li>• Teach the client to substitute activities to counteract the unhealthy behavior, such as relaxation exercises, internal dialogues, or thought stopping (suddenly saying, “Stop” out loud).</li><li>• Plan appropriate rewards (e.g., a movie, dining out) for clients to give themselves for having achieved their goals.</li></ul>                                                                                                                                                                                                                            |
| Action                                      | <ul style="list-style-type: none"><li>• Review plans and instructions discussed in the preparation phase.</li><li>• Help the client set realistic goals.</li><li>• Encourage positive self-talk that supports the behavior change.</li><li>• Provide positive feedback, support, and encouragement for partial or complete achievement of goals.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Maintenance                                 | <ul style="list-style-type: none"><li>• Encourage continuing use of support networks and open discussion of problems related to maintaining healthy behavior.</li><li>• Identify and encourage strategies that support healthy behavior.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Termination                                 | <ul style="list-style-type: none"><li>• Provide a list of available resources should the client relapse.</li><li>• Inform the client that if he or she relapses into previous unhealthy behaviors, assistance is always available to support another try. Relapse should not be considered failure, but an opportunity to try again.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

Sources: “Toward a More Integrative Model of Change,” by J. Prochaska and C. DiClemente, 1982, *Psychotherapy: Theory Research, and Practice*, 19, pp. 276–288; “Stages of Change in the Modification of Problem Behaviors,” by J. Prochaska and C. DiClemente, 1992, *Progress in Behavior Modification*, 28, pp. 183–218; and “A Stage-Based Approach to Helping People Change Health Behaviors,” by V. S. Conn, 1994, *Clinical Nurse Specialist*, 8, pp. 187–193.

## The Nurse’s Role in Health Promotion

Nurses are in a position to play a key role in the reformed healthcare delivery system through “promoting wellness and providing preventive health care” (American Nurses Association, 2010). Standard 5B of *Nursing: Scope and Standards of Practice* (American Nurses Association,

2010) requires nurses to “employ strategies to promote health and a safe environment.” Competencies that demonstrate compliance with Standard 5B are shown in the accompanying box.

Individuals, families, and communities that seek to increase their responsibility for personal health and self-care usually need health information about how to do so. The trend toward health promotion has created opportunities for

## Scope and Standards of Nursing Practice, Standard 5B: Health Teaching and Health Promotion, Selected Competencies

The registered nurse employs strategies to promote health and a safe environment.

Selected competencies:

The registered nurse:

- Provides health teaching that addresses such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living, and preventive self-care.
- Uses health promotion and health teaching methods appropriate to the situation and the healthcare consumer's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status.
- Uses information technologies to communicate health promotion and disease prevention information to the healthcare consumer in a variety of settings.

*Source: Nursing: Scope and Standards of Nursing Practice (2nd ed.), by the American Nurses Association, 2010, Silver Spring, MD: Author, p. 41. Reprinted with permission.*

nurses to strengthen the profession's influence on health promotion, disseminate information that promotes an educated public, and assist individuals, families, and communities to change long-standing health behaviors. Health promotion activities involve collaborative relationships between clients and their physicians and nurses. The role of the nurse is to work with people, not for them, that is, to act as a facilitator of the process of assessing, evaluating, and understanding health. In whatever setting the nurse practices, she or he can implement health promotion interventions. Inpatient hospital nurses can be as influential as nurses in clinics and community health in promoting health. For example, the patient who has been hospitalized for an acute respiratory problem may be more open to discussion of smoking cessation strategies if he or she believes it will prevent another acute respiratory occurrence. Maville and Huerta (2013, p. 59) identify the roles of the nurse in health promotion as activist/proactive change agent, advocate, educator, empowering agent, communicator, consultant, coordinator of care, leader/member of the profession, provider of care, user of research, researcher into health promotion models, and

role model of health behaviors. Many of these roles are further described in other chapters of this text. For examples of the nurse's role in health promotion, see the accompanying box.

### Reflect On . . .

- types of health-promotion activities in which you have previously been involved. How easy or difficult was it to begin and maintain these activities? What were the factors that contributed to your success in maintaining these activities? If you were unsuccessful, what were the factors that contributed to your lack of success? What have you learned from these experiences that might help you assist clients with health-promoting behaviors?
- what personal responsibility means in relation to health and how that meaning affects the nurse's role in health promotion.

## The Nurse's Role in Health Promotion

- Modeling healthy lifestyle behaviors and attitudes
- Facilitating client involvement in the assessment, implementation, and evaluation of health goals
- Teaching clients self-care strategies to enhance fitness, improve nutrition, manage stress, and enhance relationships
- Assisting individuals, families, and communities to increase their levels of health
- Educating clients to be effective healthcare consumers
- Assisting clients, families, and communities to choose and develop health-promoting options
- Guiding clients' development in effective problem solving and decision making
- Reinforcing clients' personal and family health-promoting behaviors
- Advocating in the community for changes that promote a healthy environment

## Chapter Highlights

- The goal of health promotion is to raise the level of health of an individual, family, or community.
- Health promotion activities are directed toward developing client resources that maintain or enhance well-being.
- Health promotion differs from health protection and disease/injury prevention in that health protection and disease/injury prevention are focused on avoiding specific problems, while health promotion seeks to expand positive potential for health.
- Leavell and Clark describe three levels of prevention: primary prevention, secondary prevention, and tertiary prevention.
- *Healthy People 2020* focuses on improving the health of individuals, families, communities, and the nation.
- The overarching goals of *Healthy People 2020* are to (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote high quality of life, healthy development, and healthy behaviors across all life stages.
- Leading Health Indicators (LHIs) are a component of *Healthy People 2020* that reflect high-priority issues in the United States.
- Health promotion programs include (1) information dissemination, (2) health risk appraisal and wellness assessment, (3) lifestyle and behavior change, and (4) environmental control programs.
- Health promotion programs and activities are found in many settings: the home, schools, community centers, hospitals, work sites, religious organizations, and shopping malls. Additionally, health promotion information can be easily found on the Internet; however, caution must be recommended in ensuring the accuracy and currency of the information presented.
- The concept of locus of control can be used to determine whether a client is internally or externally controlled or motivated when making healthcare decisions.
- The health belief model (HBM) is an early model that provides a framework for understanding why people do not adopt disease prevention strategies or participate in screening tests for early detection of disease. The major constructs of the HBM are individual perceptions, modifying factors, cues to action, likelihood of action, and self-efficacy.
- Pender's Health Promotion Model categorizes determinants of health-promoting behaviors as individual characteristics and experiences, behavior-specific cognitions and affect, commitment to a plan of action, immediate competing demands and preferences, and behavioral outcomes.
- The Neuman Systems Model includes dimensions of health promotion designed to strengthen a person's lines of defense and addresses primary, secondary, and tertiary levels of prevention.
- Prochaska and DiClemente propose a six-stage model for health behavior change. The stages are (1) precontemplation, (2) contemplation, (3) preparation and planning, (4) action, (5) maintenance, and (6) termination. If the person is not successful in changing his or her behavior, relapse may occur during the action, maintenance, or termination stages. At any point in these stages, people may move to any previous stage.
- The American Nurses Association *Scope and Standards of Nursing Practice* (2010) require the nurse to employ "strategies to promote health and a safe environment" (p. 41). The roles of the nurse in health promotion include activist/proactive change agent, advocate, educator, empowering agent, communicator, consultant, coordinator of care, leader/member of the profession, provider of care, user of research, researcher into health promotion models, and role model of health behaviors (Maville & Huerta, 2013, p. 59).

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# 8

## The Nurse as Learner and Teacher

### Chapter Outline

#### Challenges and Opportunities

#### Nurses as Learners

#### The Learning Process

#### Theories of Learning

- Behaviorism
- Social Learning Theory
- Cognitivism
- Humanism
- Categorization
- Constructivism
- Multiple Intelligences
- Bloom's Domains of Learning
- Applying Learning Theories

#### Cognitive Learning Processes

- Acquiring Information
- Processing Information
- Using Information

#### Factors That Facilitate Learning

- Motivation
- Readiness
- Active Involvement
- Feedback
- Simple to Complex
- Repetition
- Timing
- Environment

#### Factors That Inhibit Learning

- Emotions
- Physiological Factors
- Cultural and Spiritual Factors

#### Literacy

- Health Literacy

#### Nurses as Teachers

#### The Art of Teaching

- Guidelines for Learning and Teaching
- Assessing Learning Needs
- Planning Content and Teaching Strategies
- Implementing a Teaching Plan
- Evaluating Learning and Teaching
- Special Teaching Strategies
- Teaching Clients of Different Cultures

#### Documentation of Teaching

#### Chapter Highlights

### Objectives

1. Discuss selected learning theories as they apply to nurse and client learning.
2. Describe the various teaching roles of the nurse
3. Describe the three domains of learning and how they differ.
4. Identify guidelines for effective learning and teaching
5. Discuss the relevance of literacy for client learning.
6. Develop a teaching plan.
7. Describe strategies for teaching learners of different cultures.

**N**urses have professional responsibilities both for continued professional learning and for teaching others. They must continue to learn so that they can maintain their currency in practice amid the many changes in knowledge and techniques in health care. Nurses teach clients and their families, other healthcare providers, and healthcare subordinates to whom they delegate care (e.g., LPNs, LVNs, CNAs), and they share their expertise with other nurses and health professionals. Some teach their profession to others as nursing faculty. Teaching and learning are not limited to classroom experiences but can occur in all settings for practice.

Learning is a complex process, and there are many theories about how learning occurs. These learning theories are generally based on both assumptions and evidence about people, the nature of knowledge, and how people learn. The eclectic approach presumes that no one theory is more correct than another. There is continuing research regarding the best methods for people to learn.

There are also beliefs about how teaching can be most effective. These are commonly referred to as *principles of teaching*. Both learning and teaching are active and interactive processes. Currently, there is increasing focus on outcome-based teaching and evidence-based learning.

## Challenges and Opportunities

The challenges associated with teaching and learning in the current healthcare system are varied. Federal and state regulatory bodies as well as accreditation organizations such as The Joint Commission influence the content to be taught and the documentation required for compliance. Healthcare clients vary in age, ethnic diversity, socioeconomic status, primary language, and previous knowledge and experience. Information is constantly changing as new research becomes available. Today's resources are numerous and readily available through the Internet. Providing clients with accurate, current information is a challenge for nurses. Teaching is a major role of nurses, and it is often performed without adequate preparation in pedagogy. Effective teaching is a challenge.

Nurses today must also maintain their currency with theory and practice related to health care, medicine, and nursing. Nursing education programs prepare the new practitioner with effective beginning nursing skills. Changes occur quickly and often in nursing and health care; consequently, nurses must continue learning in order to stay current. Many states require nurses to complete continuing education programs designed to increase knowledge and skill: these may be provided by employers at the work site. Sometimes nurses travel to specialized centers to gain advanced specialized skills or to national and international nursing conferences to network and share information about practice. Many nurses return to school to obtain advanced degrees in nursing and other health-related disciplines.

The importance of the learning and teaching roles of nurses creates new opportunities for nurses as teachers of clients and their families, nursing assistants, colleagues and other health professionals, and the public through community health education programs. Nurses not only teach clients directly but also participate in the development of health education literature and Internet-based health information.

## Nurses as Learners

There are several ways in which the nurse may learn, including continued formal academic education, institution-based human resource development programs, voluntary

or legislatively mandated continuing education, or episodic individually selected educational pursuits.

Continued formal academic education includes post-baccalaureate study at the master's or doctoral degree levels. Education at the graduate level requires a more advanced level of critical thinking and knowledge of the research process.

Graduate study may be in nursing or other disciplines that enhance nurses' practice. For example, nurses in administration may choose to pursue master's degrees in nursing administration, healthcare administration, or business administration. There are many factors the nurse must consider in choosing a graduate education program. More information regarding graduate nursing education for advanced nursing practice can be found in Chapter 24, "Advanced Nursing Education and Practice."

Institution-based human resource development programs are administered by the employer. Human resource development may also be referred to as *organization development* or *organization learning*. According to the Academy of Human Resource Development (1999–2000), *human resource development* is activity "focused on systematic training and development, career development, and organization development to improve processes and to enhance the learning and performance of individuals, organizations, communities and society."

Human resource development (HRD) programs are designed to upgrade the knowledge and skills of employees. For example, an employer might offer programs to orient new staff members, to inform nurses about a new institutional policy, to familiarize nurses with a new piece of equipment or a new technique, or to prepare nurses for certification at specialty or advanced levels of practice within the institution. Some HRD programs also offer nurse tuition benefits to enroll in work-related courses or to attend professional conferences. It is important for the nurse to remember that the primary intended benefit of HRD programs is for the institution; however, nurses who take advantage of institution-based programs can also benefit their own professional practice.

The term *continuing education* refers to formalized experiences designed to expand the knowledge or skills of nurses. Continuing education programs tend to be more specific and shorter than formal advanced academic degree study. Continuing education is the responsibility of each practicing nurse. Constant updating and growth are essential for the nurse to keep abreast of scientific and technological changes and changes within the nursing profession. Continuing education can be part of an employer's HRD program or may be offered

by professional organizations or continuing education departments of colleges or universities. Continuing education may also be obtained through self-study programs offered through professional journals or through online or paper home study programs provided by private, public, and professional educational organizations.

Most states (35) and U.S. territories (2) require nurses to maintain competence through continuing education (CE) or some other specified means to increase knowledge and skills (e.g., national certification, active practice). In these states, required CE contact hours vary for every licensure period. Depending on the state, all, some, or none of these hours may be fulfilled through home study. Some states require specific content instruction as part of the legislated continuing education requirement, for example, current study in domestic violence, HIV/AIDS, medical errors, or infection control. Nurses who have licensure in multiple states must meet the continuing education requirements for each of those states. Continuing education/competence may be required for renewal of the nurse's license or registration in other countries as well; for example, in the United Kingdom, in addition to a minimum of 450 working hours, the nurse is required to have 35 "learning hours" every 3 years (Global Knowledge Exchange Network, 2009, p. 7).

Some professional organizations require continuing education to meet certification and recertification requirements for specialty practice. For example, to be certified as a gerontological nurse by the American Nurses Credentialing Center (ANCC), the nurse must have completed Category 1, 75 contact hours of continuing education applicable to gerontological nursing within the previous 5 years. Additionally, the nurse must complete one of five additional requirements: Category 2, Academic Credits; Category 3, Presentations; Category 4, Publication or Research; Category 5, Preceptor Hours; or Category 6, Professional Service (American Nurses Credentialing Center, 2014).

Episodic learning activities are determined by the individual nurse. *Episodic learning* activities are activities that are distinct and separate from formal or planned education.

Subscribing to and reading professional journals and newsletters or commercial newspapers and magazines are examples of nurses' episodic educational activities. The learning the nurse gains through these activities can be just as important as formal educational pursuits. Through reading about the contemporary understanding of health care in professional or commercial literature, the nurse gains an awareness of how nurses can influence the healthcare system. Nurses can also gain knowledge of personal benefit, such as knowledge about liability and malpractice issues, advanced practice and licensure issues, and portable pension plans and retirement planning.

### Reflect On . . .

- the various learning activities you have participated in during the last year. How many were episodic activities? How many were formal learning activities to obtain a degree or licensure as a registered nurse? How many were part of the human resource development program of your employer? How many were done to meet continuing education requirements for relicensure or recertification? How many were done for personal satisfaction? How important have these learning experiences been for you?
- your personal goals related to professional learning activities. Are your learning activities directed toward becoming certified? Toward achieving an academic degree? Toward achieving a different nursing position? For personal satisfaction?



**InfoQuest:** Search the Internet for information regarding continuing education requirements in the states, territories, or provinces where you are or plan to become licensed as a registered nurse. Is continuing education voluntary or mandatory in your state?

### CRITICAL THINKING EXERCISE

There is much debate regarding the value of mandatory continuing education as a requirement for relicensure or recertification. What are the benefits of mandatory continuing education for the patient/client, the healthcare system, the employing organization, the profession, the individual nurse? What are the negative

aspects of mandatory continuing education as they relate to the patient/client, the healthcare system, the employing organization, the profession, and the individual nurse? Is voluntary continuing professional education better than mandatory continuing professional education? Explain your answer.

## The Learning Process

People, including clients, have a variety of learning needs. A *learning need* is the gap or difference between what the learner or client currently knows about a given topic and what the learner needs to know in order to perform self-care or to provide care for another. For example, a sexually active older adult who expresses concern about acquiring a sexually transmitted disease (STD) may only be aware of condoms as a form of birth control. The learning need is to be informed of the use of condoms for prevention of STDs.

Often, people who are newly diagnosed with a disease have a very limited or inaccurate understanding of the management of the disease. The learning need is to correct inaccuracies in understanding and to obtain the knowledge to perform safe and effective self-care. Learning is a change in human disposition or capability that persists over a period of time and that cannot be accounted for solely by growth. Learning is represented by a change in behavior. See the accompanying box for attributes of learning.

An important aspect of learning is the individual's desire to learn and to act on the learning. This desire is best illustrated when the person recognizes and accepts the need to learn, willingly uses the energy required to learn, and then follows through with the appropriate behaviors that reflect the learning. For example, a person diagnosed as having diabetes willingly learns about the special diet needed and then plans and follows the learned diet.

*Andragogy* is “the art and science of helping adults learn” (Knowles, 1984, p. 43), in contrast to pedagogy, the discipline concerned with helping children learn. Although nurses use pedagogic teaching strategies when teaching children, they also use the following andragogic concepts about learners as a guide for teaching adult clients (Knowles, 1984):

- As people mature, they move from dependence to independence.
- An adult's previous experiences can be used as a resource for learning.
- An adult's readiness to learn is often related to a developmental task or social role.
- An adult is more oriented to learning when the material is immediately useful, not useful sometime in the future.

## Attributes of Learning

Learning is:

- An experience that occurs inside the learner
- The discovery of the personal meaning and relevance of ideas, attitudes, and/or skills

## Theories of Learning

Theories about how and why people learn can be traced to the 17th century. Psychologists first focused on the mental phenomena. Today, there is more focus on the behaviors or activities of learning. A number of theories and numerous psychologists are associated with theories of learning. Six contemporary theoretical constructs are behaviorism, cognitivism, humanism, categorization, constructivism, and multiple intelligences.

### Behaviorism

Behaviorism was originally advanced by Edward Thorndike (1913), who believed that transfer of knowledge could occur if the new situation closely resembled the old situation. To Thorndike, the term *understanding* was used in the context of building connections. One of his major contributions applicable to teaching is that learning should be based on the learner's behavior. He is known for his “laws of learning.” In addition to Thorndike, major behaviorist theorists include Ivan Pavlov (1849–1936), John Watson (1878–1958), and B. F. Skinner (1904–1990).

Behaviorists believe that the environment influences behavior and how a person controls it; moreover, they maintain that it is the essential factor determining human action. In the behaviorist school of thought, an act is called a *response* when it can be traced to the effects of a stimulus.

### Skinner's Operant Conditioning Theory

B. F. Skinner (1953) postulated two types of conditioning (behavioral responses to a stimulus) that cause the response or behavior. The first type of conditioning, termed *classical conditioning*, is illustrated by Pavlov's well-known experiments with dogs. Ivan Pavlov (1927) conditioned dogs to salivate in response to the sound of a tuning fork, a sound they heard when they received food. Classical conditioning is a procedure in which conditioned responses are established by the association of a new stimulus that is known to cause an unconditioned response. The resulting response is the conditioned response to the new (unrelated) stimulus.

The second type of conditioning is what Skinner referred to as *operant conditioning*, a process by which the frequency of a response can be increased or decreased

- A consequence of experience
- A collaborative and cooperative process
- An evolutionary process
- A process that is intellectual and emotional and may be physical



depending on when, how, and to what extent it is reinforced. Skinner believed that humans, like animals, will always repeat actions that bring pleasure. He considered the consequences of an action, what he termed **reinforcement**, to be all-important. Positive consequences foster repetition of the action; negative consequences or the absence of consequences can cause the action to cease.

**Extinction** is the process in which a conditioned behavior is “unlearned” because the reinforcement has been removed. Greater effort, however, is required to extinguish a behavior than to condition it. The procedure involves removing the unconditional stimulus or the reward from the training situation. When the conditioning procedure is again instigated following complete extinction, it does not take the subject as long to show the conditioned response as it did in the original conditioning.

Studies of conditioning produced laws of learning that were thought to be universal; that is, they were thought to apply to all ages, all cultures, and all types of behavior: motor, cognitive, emotional, and social. Examples follow.

- The more quickly reinforcement follows a response, the more effective is the reinforcement.
- A response to one stimulus generalizes to similar stimuli.
- Behavior that is reinforced only some of the time takes longer to extinguish than behavior that is reinforced continuously.

## Social Learning Theory

Social learning theorists such as Albert Bandura (1971) agree with Skinner that the environment exerts a great deal of control over overt behavior; however, they believe that the entire learning process involves the following three highly interdependent factors:

- Characteristics of the person
- The person’s behavior
- The learning environment

These factors influence and control each other through a process that Bandura calls *reciprocal determinism*. The major contribution of Bandura’s reciprocal determinism is the concept that the child’s (or learner’s) behavior affects or creates that child’s (or learner’s) environment. This idea differs from Skinner’s belief that the environment, viewed as a set of stimuli, controls behavior.

Bandura asserted that most learning comes from observational learning and instruction, rather than from overt trial-and-error behavior. **Observational learning** is the acquisition of new skills or the alteration of old behaviors simply by watching others. It is especially important for acquiring behavior in situations in which mistakes can

be life-threatening or costly, for example, driving a car or medication administration.

Bandura’s research focused on **imitation**, the process by which individuals copy or imitate what they have observed, and **modeling**, the process by which a person learns by observing the behavior of others. Imitation is regarded as one of the most powerful socialization forces. Various imitative behaviors are reinforced by a process of operant conditioning. For example, a boy may be praised for being “just like his father.” The child may even reinforce the imitations by repeating an adult’s words of praise. According to Bandura, models influence others mainly by providing information rather than by eliciting matching behavior, so that learning can occur without the learner’s performing the model’s behavior.

As Bandura (1971) continued his research, he focused more on the cognitive aspects and called his theory a “social cognitive theory.” He defined learning as “knowledge acquisition through cognitive processing information” (p. xii). For example, the effects of television and video games on children depend on both cognitive and imitative processes. Whether the child can comprehend the story affects the child’s perceptions of the model and his or her tendency to imitate the model. It is interesting to note that Bandura’s research raised concerns regarding the influence of televised violence on behavior.

## Cognitivism

Cognitivism depicts learning as a complex cognitive activity. Major cognitive theorists include Jean Piaget (1966), Kurt Lewin (1951), Robert Gagné (1974), Benjamin Bloom (1956), and Jerome Bruner (1966). Cognitivists view learning as the development of understandings and appreciations that help the individual function in a larger context. Learning is based on a change of perception, which itself is influenced by the senses and internal and external variables. In other words, learning is largely a mental, intellectual, or thinking process. The learner structures and processes information based on his or her perceptions of the information. The learner’s perceptions are influenced by his or her personal characteristics and experiences. Cognitivists also emphasize the importance of the social, emotional, and physical contexts in which learning occurs, such as the teacher-learner relationship and the environment. Developmental readiness and individual readiness (expressed as motivation) are other key factors associated with cognitive approaches.

### Piaget’s Phases of Cognitive Development

According to Jean Piaget (1966), cognitive development is an orderly, sequential process in which a variety of new experiences (stimuli) must exist before intellectual abilities



can develop. Piaget's cognitive developmental process is divided into four major phases: sensorimotor, preoperational, concrete operations, and formal operations. A person develops through each of these phases, although not everyone achieves the formal operation phase. Each phase has unique characteristics.

The *sensorimotor phase* lasts from birth to about 2 years of age. It includes reflexive actions, perceptions of events centered on the body, objects as an extension of self, mental acknowledgment of the external environment, and discovery of new goals and ways to attain those goals. The *preoperational phase* occurs from about 2 to 7 years of age and includes an egocentric approach to accommodate the demands of the environment. Everything is significant and relates to "me." The child is able to think of one idea at a time, can use words to express thoughts, and includes others in the environment. The *concrete operations phase* (about 7–11 years of age) involves a beginning understanding of relationships such as size, right and left, different viewpoints, and the ability to solve concrete problems. The *formal operations phase* may occur at about 11–15 years of age and includes the ability to use rational thinking and reasoning that is deductive and futuristic.

In each phase, the person uses three primary abilities: assimilation, accommodation, and adaptation. *Assimilation* is the process through which humans encounter and react to new situations by using the mechanisms they already possess. In this way, people acquire new knowledge and skills as well as insights into the world around them. *Accommodation* is the process of change whereby cognitive processes mature sufficiently to allow the person to solve problems that were previously unsolvable. This adjustment is possible primarily because new knowledge has been assimilated. *Adaptation*, or coping behavior, is the ability to manage the demands made by the environment.

### Lewin's Field Theory

Kurt Lewin's (1951) field theory involves theories of motivation and perception, which were considered precursors of the more recent cognitive theories. Lewin believed that learning involved four different types of change: change in cognitive structure, change in motivation, change in one's sense of belonging to the group, and gain in voluntary muscle control. His well-known theory of change has three

basic stages: unfreezing, moving, and refreezing. These stages are discussed in Chapter 15, "Managing Change."

### Gagné's Information-Processing Theory

Robert Gagné (1974) postulated eight levels of intellectual skills: (1) signal or cue; (2) stimulus-response, or response to the signal; (3) chaining, which involves at least two stimulus-response connections; (4) verbal association, which involves assembling knowledge chains from previous learning; (5) multiple discrimination involving differentiated responses to variable stimuli; (6) concept formation, which involves identifying and responding to a group of objects that serve as stimuli; (7) principle formation, which involves applying a principle that is made up of at least one chain of two or more concepts; and (8) problem solving, which involves processing two or more principles to produce a higher-level principle.

### Humanism

Humanistic learning theory focuses on both cognitive and affective (feelings and attitudes) areas of the learner. It centers on the whole person and therefore is pertinent to a holistic philosophy of care. Prominent members of this school of thought include Abraham Maslow (1970) and Carl Rogers (1961, 1969). According to humanistic theory, learning is self-motivated, self-initiated, and self-evaluated. Each individual is viewed as a unique composite of biological, psychological, social, cultural, and spiritual factors. Learning focuses on self-development and achieving full potential; it is best when it is relevant to the learner. Autonomy and self-determination are important; the learner identifies the learning needs and takes the initiative to meet these needs. The learner is thus an active participant and takes responsibility for meeting personal learning needs.

Maslow's hierarchy of needs suggests a way of prioritizing nursing interventions so that physiological needs are met first, followed by safety and security needs, love and belonging needs, esteem and self-esteem needs, and ultimately growth needs. Nurses must consider the level of clients' needs as they plan educational interventions. For example, a client who is experiencing pain should be medicated prior to teaching self-care because pain or discomfort will interfere with learning. Carl Rogers

### CRITICAL THINKING EXERCISE

Consider how a nurse can employ Piaget's theory of cognitive development when devising teaching strategies for learners of different ages and developmental stages,

for example, a toddler (egocentric and literal) or a teenager (rational thinking). Identify appropriate teaching strategies for these stages.

was particularly concerned with personalized approaches. He emphasized that independence, creativity, and self-reliance are all facilitated when self-criticism and self-evaluation are of primary importance; evaluation by others is of secondary importance.

## Categorization

According to Jerome Bruner (1966), perception, conceptualizing, learning, and decision making all depend on categorizing information. People interpret information in terms of the similarities and differences detected and arrange the information in related categories. For example, there are hundreds of bones in the body. Categorizing them into major bone types (e.g., long bones, flat bones) or areas of the body (e.g., bones of the head, bones of the arms, bones of the spine and pelvis) makes them easier to learn. This theory of cognitive learning emphasizes the formation of a coding system. These systems serve to facilitate transfer, enhance retention, and increase problem-solving motivation. Bruner advocated discovery-oriented learning to help students discover relationships between categories. Bruner's work is sometimes placed among the theories of the constructivists.

## Constructivism

*Constructivism* is a relatively recent term. It represents a collection of theories with a common thread of individuals actively constructing knowledge to solve realistic problems, often in collaboration with others. The ideas of constructivism emerged with John Dewey and continued with Bruner (learning as discovery). The constructivist describes learning as a change in meaning constructed from experience. Knowledge becomes an individual interpretation of experience; learning is the construction of new interpretations. Gagné, Bruner, and David Ausubel (1918–2008), as well as the social development theorist Lev Vygotsky (1896–1934) and social learning theorist Bandura, are associated with the constructivists. Their focus is more on the learning, not the teaching, with language as a process. Constructivists encourage learning inquiry, acknowledge the role of experience in learning, and encourage cooperative learning. Constructivist theory is applicable to learning with technology.

## Multiple Intelligences

Early psychologists gauged intelligence by the use of the intelligence quotient, or IQ. They believed that intelligence at too low a level inhibited individuals from participating in intellectually demanding learning situations and that intelligence at a higher level indicated a genius. Those in between were considered to have normal intelligence.

Many individuals were incorrectly labeled and as a result were never encouraged to reach higher potential. Intelligence was thought to be fixed and unchangeable by training. Research suggests that this is not so. Today, new theories have emerged disputing IQ as the only indicator of intelligence. Intelligence has a number of dimensions. Howard Gardner, head of the Project on Human Potential at Harvard University, presented a theory of multiple intelligences, based on observations of how brain damage from a stroke might affect one area, such as language, while other areas of mental functioning remained intact. Gardner cites nine intelligences (Gardner, 1983, 1999; Smith, 2002, 2008):

- Linguistic intelligence involves understanding of spoken and written language, the ability to learn and use language to express one's self effectively.
- Logical/mathematical intelligence involves the capacity to perform mathematical calculations and to analyze and solve problems logically.
- Musical/rhythmic (music) intelligence involves ability in the "performance, composition, and appreciation of musical patterns" (Smith, 2002, 2008).
- Spatial (visual) intelligence involves the "potential to recognize and use the patterns of . . . space."
- Body/kinesthetic/movement (body) intelligence involves the ability to use "mental abilities to coordinate bodily movement" (Smith, 2002, 2008).
- Intrapersonal intelligence involves the ability to understand oneself.
- Interpersonal intelligence relates to the capacity to understand the "intentions, motivations and desires of other people" (Smith, 2002, 2008).
- Naturalist intelligence involves the ability to recognize patterns in living things, such as identifying and classifying members of plant or animal species.
- Existential intelligence involves the ability to consider philosophical, moral, spiritual, and religious understandings of life and death.

## Bloom's Domains of Learning

Bloom (1956) identified three domains, or areas of learning: cognitive, affective, and psychomotor. Each of these domains has a developed hierarchical classification system; that is, the behaviors that demonstrate learning in each category are arranged from the simplest to the most complex. In the *cognitive domain*, Bloom included six intellectual skills: knowledge, comprehension, application, analysis, synthesis, and evaluation. In 2000, a revision of the cognitive domain resulted in new levels of cognition beginning with remembering, and continuing through comprehending (understanding), applying, analyzing, evaluating, and creating in order from simple to complex.

(Anderson, Krathwohl, Airasian, Cruikshank, & Mayer, 2000). The *affective domain* includes feelings, emotions, interests, attitudes, and appreciations. It involves five major categories: receiving, responding, valuing, organizing, and characterizing/internalizing. The *psychomotor*

*domain* includes motor skills such as playing a musical instrument or giving an injection. It includes five categories: imitation, manipulation, precision, articulation, and naturalization. See Table 8–1 for a further description of each of these categories.

**TABLE 8–1 Major Categories in Each Learning Domain**

| Category/Description                                                                                                           | Client Learning Example                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cognitive Domain</b>                                                                                                        |                                                                                                                                        |
| <i>Remembering</i> Recalls or recognizes previously learned material.                                                          | The client lists the side effects of a medication 2 days after instruction.                                                            |
| <i>Comprehending</i> Explains the meaning of learned material.                                                                 | The client describes how the side effects of a medication can be recognized and what to do about them.                                 |
| <i>Applying</i> Uses newly learned material in new concrete situations.                                                        | The client describes taking his medication after meals to minimize side effects.                                                       |
| <i>Analyzing</i> Distinguishes between different pieces of learned material and separates important from unimportant material. | The client describes which side effects are serious and require notification of the physician.                                         |
| <i>Evaluating</i> Judges the value of the learned material.                                                                    | The client takes steps to prevent side effects of the medication.                                                                      |
| <i>Creating</i> Pulls together many disparate elements or parts in order to create a new whole.                                | The client describes how the knowledge of self-care strategies can promote health and minimize complications of a chronic illness.     |
| <b>Affective Domain</b>                                                                                                        |                                                                                                                                        |
| <i>Receiving</i> Is willing to attend to particular stimuli.                                                                   | The client listens attentively to the nurse's description of the preparation for mastectomy and follow-up care.                        |
| <i>Responding</i> Actively participates by listening and reacting.                                                             | The client asks questions about the preparation for the scheduled surgery and the follow-up care.                                      |
| <i>Valuing</i> Demonstrates acceptance of or commitment to a particular object, phenomenon, or behavior.                       | The client joins a mastectomy support group.                                                                                           |
| <i>Organizing</i> Develops a value system by prioritizing different values and resolving conflicts between them.               | The client describes her thoughts regarding her self-image, the consequences of her mastectomy, and her desire for health and healing. |
| <i>Characterizing/internalizing</i> Acts according to a personal value system.                                                 | The client describes lifestyle changes she has chosen to make following her mastectomy.                                                |
| <b>Psychomotor Domain</b>                                                                                                      |                                                                                                                                        |
| <i>Imitation</i> Skill is performed following demonstration.                                                                   | The client demonstrates self-administration of insulin with coaching with minimal error.                                               |
| <i>Manipulation</i> Movements are coordinated.                                                                                 | The client performs self-administration of insulin with coaching without error.                                                        |
| <i>Precision</i> Skill is performed with a greater degree of precision.                                                        | The client performs self-administration of insulin without coaching and without error.                                                 |
| <i>Articulation</i> A series of actions is coordinated with minimal error in a reasonable time.                                | The client performs preparation and self-administration of insulin within 10 minutes without error.                                    |
| <i>Naturalization</i> Competence in skill performance is automatic and well coordinated.                                       | The client performs preparation and self-administration of insulin within 10 minutes without error and without hesitation.             |

Source: Adapted from *A Taxonomy for Learning, Teaching, and Assessing: A Revision of Bloom's Taxonomy of Educational Objectives*, by L. W. Anderson and D. R. Krathwohl, 2001, New York, NY: Longman; *Psychomotor Levels in Developing and Writing Objectives*, by R. Dave, 1970, Tucson, AZ: Educational Innovators Press; *Taxonomy of Educational Objectives: The Classification of Educational Goals: Book II. Affective Domain*, by D. R. Krathwohl, B. Bloom, and B. Masia, 1964, New York, NY: Longman; *Bloom's Taxonomy*, by R. C. Overbaugh and L. Schultz, 2013, Norfolk, VA: Old Dominion University. Retrieved from [ww2.odu.edu/educ/roverbau/Bloom/blooms\\_taxonomy.htm](http://ww2.odu.edu/educ/roverbau/Bloom/blooms_taxonomy.htm); and *Behavioral Objectives: Evaluation in Nursing* (3rd ed.), by D. E. Reilly and M. H. Oermann, 1990, New York, NY: National League for Nursing.

Nurses should include each of these three domains in client teaching plans. For example, teaching a client how to irrigate his own colostomy is in the psychomotor domain. An important part of such a teaching plan is to teach the client why a specific amount of fluid is used and when the irrigation should be carried out; this element is in the cognitive domain. Helping the client accept the colostomy and maintain self-esteem is in the affective domain.

When writing behavioral learning objectives, one must include (1) the learner, (2) a behavior to be learned that is observable and measurable, and (3) standards of performance, or the extent to which the behavior is to be performed. One can include conditions under which the behavior will be performed. For example, in the learning described above, one psychomotor objective may be the client (who) will describe (behavior) all equipment required (standard of performance [he can't forget any of the required equipment]) to perform a colostomy irrigation. It is important to note that learning objectives must be learner focused, that is, what the learner will be able to do after completing the learning experience. Examples of learning objectives can be found in a sample teaching plan for wound care in Table 8–4 and at the beginning of every chapter in this text.

## Applying Learning Theories

While many of these theories were developed to better understand the learning of children, many can also be applied to the learning of adults. The major attributes of behaviorist theories are the careful identification of what is to be taught and the immediate identification of and reward for correct responses. However, the theory is not easily applied to complex learning situations and is limiting in terms of the learner's role in the teaching process. Nurses applying behaviorist theory in learning situations will:

- Provide sufficient time for practice.
- Provide both immediate and recurring evaluation and repeat demonstration as needed.
- Provide opportunities for learners to solve problems by trial and error.
- Select teaching strategies that avoid distracting information and evoke the desired response.

- Praise the learner for correct behavior and provide positive feedback at intervals throughout the learning experience.
- Provide role models of desired behavior.

The major attributes of cognitive theory are its recognition of developmental levels of learners and its acknowledgement of the learner's motivation and environment. However, some or many of the motivational and environmental factors may be beyond the teacher's control. Nurses applying cognitive theory in learning situations will:

- Assess a person's developmental and individual readiness to learn and will adapt teaching strategies to the learner's developmental level.
- Provide a social, emotional, and physical environment conducive to learning.
- Encourage a positive teacher-learner relationship.
- Select multisensory teaching strategies because perception is influenced by the senses.
- Recognize that personal characteristics have an impact on how cues are perceived and develop appropriate teaching approaches to different learning styles.
- Select behavioral objectives and strategies that encompass the cognitive, affective, and psychomotor domains of learning.

The major attributes of humanism are its focus on the feelings and attitudes of learners: on the importance of the individual in identifying learning needs and taking responsibility for them; and on the self-motivation of the learners to work toward self-reliance and independence. Nurses applying humanistic theory in learning situations will do the following:

- Encourage learners to establish personal goals and promote self-directed learning
- Encourage active learning by serving as a facilitator, mentor, or resource for the learner
- Expose the learner to new, relevant information and ask appropriate questions to encourage the learner to seek answers

Nurses who choose a more eclectic approach to teaching may use strategies that are appropriate to the specific learner and not necessarily embedded in any specific educational theory.

### CRITICAL THINKING EXERCISE

Develop a teaching plan using each of the domains of learning (cognitive, affective, psychomotor) for a newly

diagnosed diabetic client who needs to learn how to self-administer insulin.



## Cognitive Learning Processes

Learning involves three cognitive (mental) processes: acquiring information, processing information, and using information. These three processes can occur sequentially or simultaneously.

### Acquiring Information

Acquiring information involves two processes: sensory reception and discrimination. *Sensory reception* is made possible by the neurosensory system. Stimuli in the environment signal the appropriate sense, such as sight, hearing, or smell. Impulses then travel by the nervous system to the brain. Sensory reception generally is continuous, but it is not always a conscious process.

The second aspect of acquiring information is discrimination. *Discrimination* is the ability to determine which stimuli are relevant in a particular situation. Stimuli can be objects, ideas, actions, or facts. They may be internal (i.e., inside the body) or external. Discrimination is the most difficult when there are multiple, complex stimuli.

### Processing Information

*Processing* provides meaning to the information. Information is processed in three steps: association, generalization, and concept formation. *Association* is the joining of two or more ideas. For example, a person may associate an object such as a needle with the word *needle* and/or with the experience of pain. *Generalization* is the perceiving of similarities among various stimuli, for example, the similarities between three different computers. *Concept formation* is the organization of stimuli that have some attributes in common. For example, a nurse who understands the concept of caring appreciates the characteristics associated with caring. The nurse can then help others to convey caring in the healthcare setting.

### Using Information

Using information is the application of information in the cognitive, affective, and/or psychomotor areas. (See “Bloom’s Domains of Learning” earlier in this chapter.) The ability to formulate and relate concepts is an essential critical thinking skill. In addition, relating concepts is essential for critical thinking and problem solving.

## Factors That Facilitate Learning

Learning is a complex phenomenon. It is an interactive process between the learner, the teacher, the environment and has many elements, including learning style and teaching style. Certain conditions or principles have been identified

throughout years of research. When planning instruction the nurse should consider the factors that can facilitate or inhibit learning for a specific learner as discussed in the following section.

### Motivation

*Motivation* to learn is the inspiration or incentive to learn. It greatly influences how quickly and how much a person learns. Motivation is generally greatest when a person recognizes a need and believes the need will be met through learning. It is not enough for the need to be identified and verbalized by the nurse; it must be experienced by the client. Often the nurse’s task is to help the client work through the problem and identify the need. Sometimes clients or support persons need help identifying relevant situational elements before they can perceive a need. For example, clients with heart disease may need to know the effects of smoking before they recognize the need to stop smoking. Or adolescents may need to know the consequences of an untreated sexually transmitted disease before they understand the need for treatment. Part of motivation is the need for the client to believe that he or she has the ability to control his or her situation.

### Readiness

*Readiness* to learn is the behavior that reflects motivation at a specific time. Readiness reflects a client’s willingness and ability to learn. The nurse’s role is to assess readiness to learn and often to encourage the development of readiness. Behaviors that might indicate readiness to learn include the client actively watching the nurse perform a procedure that the client may eventually have to do for himself or herself, or asking questions about a disease or a treatment plan. Developmentally, a client may not be able (ready) to learn self-care techniques. For example, a young child may not be able to administer his or her own medication. In this case, the parents must be taught until the child is developmentally ready to learn self-care.

### Active Involvement

Active involvement in the process makes learning more meaningful. If the learner actively participates in planning and discussion, learning is faster and retention is better. Passive learning, such as listening to a lecture or watching a film, does not foster optimal learning.

When learners have been successful in accomplishing a task or understanding a concept, they gain self-confidence in their ability to learn. This reduces their anxiety about possible failure and can motivate continued learning. Successful learners have increased confidence with which to accept and learn from failure. People learn best when they

## RESEARCH CURRENT

## The Timing of Breast Cancer Patient Education: Its Influence on Satisfaction

The purpose of this study by Sutherland and McLaughlan was to determine whether the timing of patient education influences the satisfaction levels of women being treated for breast cancer. The participants, 350 women, were separated into two groups. The participants in Group 1 received patient education following their first radiation therapy treatment. The participants in Group 2 received patient education on the same day as their computerized tomography (CT) appointment. Findings indicated no significant difference in satisfaction between the two groups. In both groups, satisfaction levels were high in relation to the timing of the patient education session. There were no significant differences between the two groups in responses to questions regarding satisfaction with the content of the educational session, and the majority of participants in both groups indicated “somewhat satisfied” or “very satisfied” with information about the number of treatments they would receive, the scheduling of

treatment appointments, possible side effects of radiation therapy, how to cope with side effects, what the treatment would be like, availability of support services, the ability of the therapist to answer questions, the amount of information provided, the quality of information provided, the amount of time the therapist spent with the participant, the opportunity to ask questions, and how the information prepared the participant for her treatments. Participants were asked to identify their preference regarding the timing of radiation therapy education sessions. The majority of participants in both groups indicated their preference as the same day as the CT scan. The study authors recommend that when possible, patient preferences regarding education sessions should be accommodated.

*Source:* “The Timing of Breast Cancer Patient Education: Its Influence on Satisfaction,” by J. Sutherland and L. McLaughlan, 2013, *Radiation Therapist*, 22(2), pp. 131–138.

believe they are accepted and will not be judged. The person who expects to be judged as a poor client will not learn as well as the person who feels no such threat.

## Feedback

*Feedback* is providing information or a critique about the learner’s performance in relation to the desired goal. Feedback has to be meaningful to the learner. Feedback that accompanies practice of psychomotor skills helps the person learn those skills. Support of desired behavior through encouragement and praise, positively worded corrections, and suggestions about alternative methods are ways of providing positive feedback. Negative feedback such as ridicule, anger, or sarcasm can lead people to withdraw from learning. Negative feedback may be viewed by the learner as a type of punishment and may result in the client avoiding the teacher in order to avoid punishment.

## Simple to Complex

Learning is facilitated by material that is logically organized and proceeds from the simple (or basic) to complex (or complicated). For example, a nursing student learns normal anatomy and physiology of the body before being introduced to pathophysiology or disease processes of the body. Such organization enables the learner to comprehend new information, assimilate it with previous learning, and form new understandings. Of course, simple and

complex are relative terms, depending on the level at which the person is learning. What is simple for one person may be complex for another learner.

## Repetition

Repetition of key concepts and facts facilitates retention of newly learned material. Repetition also helps to link new learning to prior learning. Repetition through practice of psychomotor skills, particularly with feedback from the nurse, improves performance of those skills and facilitates their transfer to another setting. Also, when a person appreciates the relevance of specific material, learning is facilitated.

## Timing

People retain information and psychomotor skills best when the *time between learning and use is short*; the longer the time interval, the more is forgotten. For example, a woman who is taught to administer her own insulin but is not permitted to do so until discharged from the hospital is unlikely to remember much of what she learned. However, if she is allowed to give her own injections while in the hospital, her learning will be enhanced and reinforced.

Timing can also include opportunity, sometimes referred to as a “teachable moment.” When a nurse is caring for a patient’s colostomy site, the patient may start asking questions about the procedure. Because the client has

expressed interest in the procedure, the time or opportunity for learning is then. Learning occurs best when the learner is free from worry, fear, or pain. For example, it may be better to delay teaching clients about lifestyle changes shortly after surgery if they are still experiencing the effects of anesthesia or are fearful about the outcome of the surgery.

## Environment

An *optimal learning environment* facilitates learning by reducing distraction and providing physical and psychological comfort. The learning environment should have adequate lighting that is free from glare, a comfortable room temperature, and good ventilation. Most students know what it is like to try to learn in a hot, stuffy room; the drowsiness that occurs in this situation interferes with concentration. Noise can also distract the student and interfere with listening and thinking. To facilitate learning in a hospital setting, nurses should choose a time when there are no visitors present and interruptions are unlikely. When possible, get the patient out of bed, because being in bed is associated with rest and sleep and is not usually considered a place for learning. Some facilities have a patient education classroom, or the clinical nurse educator may provide patient teaching in her or his office. Privacy is essential for some learning. For example, when a client is learning to irrigate a colostomy, the presence of others can be embarrassing and thus interferes with learning. However, when a client is particularly anxious, having support persons present often gives the client confidence.

## Reflect On . . .

- your own learning experiences. What were the circumstances of your most effective learning experiences? What were the circumstances of your least effective learning experiences? What does that difference tell you about your learning style?
- a teacher with whom you had a positive learning experience. What characteristics did he or she possess that enhanced your learning? Which learning theorist(s) did the teacher reflect in his or her teaching style?

- your experiences with teaching others. What were the circumstances of your most effective teaching experiences? What were the circumstances of your least effective teaching experiences? What is your teaching style?

## Factors That Inhibit Learning

Many factors inhibit learning. Some of the most common are described next and in Table 8–2.

### Emotions

A greatly elevated anxiety level can impede learning. Clients or families who are very worried may not hear spoken words or may retain only part of the communication. Extreme anxiety might be reduced by medications or by information that relieves uncertainty. By contrast, clients who appear apathetic, uninterested, and unconcerned may need to be cautioned about potential problems in order to enhance their motivation to learn.

### Physiological Factors

Learning can be inhibited by physiological factors such as critical illness, pain, or impaired hearing. Because the client cannot concentrate and apply energy to learning, the learning itself is impaired. The nurse should try to reduce physiological barriers to learning as much as possible before teaching. Providing analgesics to relieve pain before teaching is usually helpful. However, if analgesics cause the client to feel drowsy, learning may be affected.

### Cultural and Spiritual Factors

There are also cultural and spiritual barriers to learning, such as differences in language or values. Obviously, the client who does not understand the nurse's language will learn little. Western medicine may conflict with cultural or spiritual healing beliefs and practices. Nurses must deal directly with this conflict to be effective; otherwise, the client may be partially or totally nonadherent to recommended treatments.

Another impediment to learning is differing values held by the client and the healthcare team. For example, a client who comes from a culture that does not value slimness

### CRITICAL THINKING EXERCISE

Consider a new mother who believes a fat baby is a healthy baby. She has grown up with this value and been

told this repeatedly (by the baby's grandmother). Develop a plan for teaching infant nutrition to this mother.

TABLE 8–2 Barriers to Learning

| Barrier                                            | Explanation                                                                                                                    | Nursing Implications                                                                                                                                                              |
|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Acute illness                                      | Client requires all resources and energy to cope with illness.                                                                 | Defer teaching until client is less ill.                                                                                                                                          |
| Pain                                               | Pain decreases ability to concentrate.                                                                                         | Provide appropriate intervention for pain before teaching.<br>Allow sufficient time for pain medication to take effect.                                                           |
| Fatigue                                            | Fatigue decreases ability to concentrate.                                                                                      | Ensure that client is rested prior to teaching/learning activities.<br><br>Provide intervals for rest when teaching/learning activities are complex.                              |
| Age                                                | Small children may not understand health teaching.<br><br>Vision, hearing, and motor control can be impaired in the elderly.   | Include parents in teaching of small children.<br>Use language that both parents and children can understand.<br><br>Consider sensory and motor deficits in teaching plan.        |
| Prognosis                                          | Clients can be preoccupied with illness and unable to concentrate on new information.                                          | Defer teaching/learning activities to a better time.                                                                                                                              |
| Biorhythms                                         | Mental and physical performances have a circadian rhythm.                                                                      | Adapt time of teaching to suit client.                                                                                                                                            |
| Emotion (e.g., anxiety, denial, depression, grief) | Emotions require energy and distract from learning.                                                                            | Deal with emotions first and possible misinformation.                                                                                                                             |
| Language and ethnic background                     | Clients may not be fluent in the nurse’s language.                                                                             | Obtain services of an interpreter or a nurse with appropriate language skills.<br><br>Provide written information in the client’s primary language.                               |
| Iatrogenic barriers                                | The nurse may set up barriers by appearing condescending or hurried, ignoring client cues, or appearing incompetent or unsure. | Establish a helping/caring relationship and be sensitive to the client’s needs. Plan and prepare for teaching ahead of time with current information appropriate for the learner. |

may have difficulty learning about a reducing diet. See Chapters 21 and 22 for more information about cultural and spiritual factors affecting health care.

Literacy

The National Assessment of Adult Literacy (NAAL) defines literacy in two ways: skills-based literacy and task-based literacy. *Skills-based literacy* is “the successful use of printed material.” *Task-based literacy* is the “the ability to use printed and written information to function in society, to achieve one’s goals, and to develop one’s knowledge and potential” (White & McCloskey, 2005). In 2003, the National Center for Education Statistics (NCES) assessed three types of literacy: prose, document, and quantitative. Literacy was measured at four levels of proficiency: Below Basic, Basic, Intermediate, and Proficient. Of those assessed, 13% performed at or above the

Proficient level, which indicates “that they possess the skills necessary to perform complex and challenging literacy activities.” Of those assessed, 22% performed at Below Basic, which “indicates they possess no more than the most simple and concrete literacy skills”. (U.S. Department of Education, 2006). And 65% performed at the Basic or Intermediate levels of proficiency. An individual’s general literacy level affects his or her ability to read and understand healthcare information and effectively follow treatment plans. According to ProLiteracy (2013), the chance of individuals reporting “fair” or “poor” health are “four times greater for those with low literacy skills than for highly skilled adults.”

Health Literacy

The Centers for Disease Control and Prevention (2013) defines health literacy as “the capacity to obtain, process, and understand basic health information and services to



make appropriate health decisions.” Governmental concern about the health literacy of the population and its effect on overall population health is reflected in the topics and objectives of *Healthy People 2020* (U.S. Department of Health and Human Services, 2013). Within the major topic area, Health Communication and Health Information Technology, there is a major objective to “improve the health literacy of the population.” When planning teaching/learning activities, it is important for nurses to identify client factors that may suggest limited health literacy. Table 8–3 provides information about working with clients with limited health literacy.

Nurses as Teachers

Nurses have many teaching roles. They may teach individual learners, such as patients who need instruction about treatments, or they may teach groups of learners, such as prospective parents enrolled in Lamaze or parenting classes. They also teach different types of learners. They teach patients or clients and their families or caregivers. They teach health professionals, including nursing students, other nurses, and physicians. They teach health-care assistants in various settings, including patient care assistants and home health aides. Nurses also teach in the

TABLE 8–3 Working With Clients With Limited Health Literacy

|                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clients’ health literacy may be affected if they have:    | <ul style="list-style-type: none"><li>• Healthcare providers who use words (healthcare jargon) that clients don’t understand.</li><li>• Low educational skills.</li><li>• Cultural barriers to health care.</li><li>• Limited English proficiency.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Limited health literacy is more prevalent among:          | <ul style="list-style-type: none"><li>• Older adults</li><li>• Minority populations</li><li>• Those who are poor</li><li>• Those who are medically underserved</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Clients with limited health literacy may have difficulty: | <ul style="list-style-type: none"><li>• Locating providers and services.</li><li>• Filling out complex health forms.</li><li>• Sharing their medical history with providers.</li><li>• Seeking preventive health care.</li><li>• Understanding the connection between risky behaviors and health.</li><li>• Managing chronic health conditions.</li><li>• Understanding directions on medicine.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| How healthcare professionals can help:                    | <ul style="list-style-type: none"><li>• Identify clients with limited literacy levels.</li><li>• Use simple language, use short sentences, and define technical terms.</li><li>• Supplement instruction with appropriate materials (videos, models, pictures, etc.).</li><li>• Ask clients to explain your instructions (teach-back method) or demonstrate the procedure.</li><li>• Ask questions that begin with <i>how</i> and <i>what</i>, rather than closed-ended yes/no questions.</li><li>• Organize information so that the most important points stand out, and repeat this information.</li><li>• Reflect the age, cultural, ethnic, and racial diversity of clients in instruction and instructional materials.</li><li>• For clients with limited English proficiency, provide information in their primary language.</li><li>• Improve the physical environment by using universal symbols.</li><li>• Offer assistance with completing forms.</li><li>• Follow up with clients after initial instruction to determine if they have any questions or problems.</li></ul> |

Source: Adapted from *About Health Literacy*, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, 2015, Washington, DC: Author. Retrieved from [www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html](http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html)

community, providing instruction in health promotion and illness/injury prevention.

The primary teaching role of a nurse is in teaching patients and their families. Such instruction includes discharge teaching about how to perform self-care; about taking medications, including side effects; and about how to perform prescribed treatments. Most teaching is done directly with patients. However, family members or caregivers also may be instructed in care of the patient. This is especially important for patients who have difficulty performing self-care. For example, parents who need to give medication to their children must be instructed in the proper administration of that medication. A diabetic client who has visual impairment may need assistance in administering insulin or in assessing his or her feet and lower extremities for skin breakdown. The caregiver or family member must be included in the diabetic patient's instruction. When diet teaching is done, it is important to include the person who purchases and prepares the food.

Nurses also teach other nurses and health professionals. Experienced nurses often act as preceptors, teaching new nurses the policies and procedures of the nursing unit. Nurses develop and teach continuing education programs for other nurses. Continuing education programs may include specialty nursing courses such as intensive care nursing or perioperative nursing, or they may be classes updating nurses' knowledge regarding new research, medications, or procedures. Nurses teach nursing students either informally when students are on the nursing unit or formally in the classroom. Nurses

also teach other healthcare team members, including physicians. Nurse educators often provide classes in the work setting about new policies, and the learners may include all those who are affected by the policy, such as when a new computer-based documentation system is implemented.

Nurses teach subordinate or ancillary staff. Patient care assistants, volunteers, dietary aides, housekeeping personnel, and unit secretaries participate in patient care at various levels. Nurses may be responsible for teaching these staff members about their responsibilities.

Nurses also participate in community education activities. Nurses may teach high school students about sexually transmitted diseases, teenage pregnancy, and alcohol and drug abuse. They may teach elder citizens about self-medication or other self-care activities. They may teach community classes on hypertension or risk factors for heart disease or other illnesses. To prevent illness or injury, the public must be provided with information. Nurses are respected by the public and are knowledgeable about healthcare matters. They are in a position to provide such information.

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### Reflect On . . .

- the teaching activities you are involved in (in school, on the nursing unit, in your practice setting, in the community). What are your feelings about teaching others (fellow students, patients, nursing students, other nurses, other healthcare providers)?
- 

### Criteria for Evaluating Internet Websites

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- **Author.** Does the author have the experience and education to be considered an expert on the topic? Is the author identified? If not, what indicator is there that this site provides accurate and reliable information?
  - **User friendliness.** Is the site easy to explore for the user? Is the material presented in an easy to read manner (consider font size, color, and contrast)?
  - **Accuracy of the information.** Is the information reliable and verifiable? Is the information based on research/science? Are research sources identified?
  - **Currency of the information.** When was the information posted? Health information changes quickly. Question the information on sites that have not been updated within the last year.
  - **Objectivity of the presentation.** Is information presented in an objective and unbiased manner? Is the information based on fact or simply the author's opinion?
  - **Depth of coverage.** What is the depth of coverage? If the site uses a lot of technical jargon, it may not be appropriate for the lay public taking a community education program. If the site uses common everyday language, it may not be appropriate for a group of health professionals.
  - **Target audience.** Who is the target audience of the website? Is the information targeted toward health professionals? The public?
  - **Background information.** Does the site provide background information about the topic? Background information often helps the viewer to better understand the information.
  - **Other sources of the information.** Does the site provide referral to other sources of similar information? Such referral helps viewers to validate what they have viewed on the original site and to explore other information about the topic.
-



**InfoQuest:** Search the Internet for accurate and reliable sites for client health information. Select one health information site and evaluate it according to the criteria in the accompanying box. In what ways does the site meet the criteria? In what ways does it not meet the criteria? What recommendations would you make to improve the site?

## The Art of Teaching

Teaching is a system of activities intentionally designed to produce specific learning. It is a goal-directed activity that results in improved learning for the learner. Teaching is more than giving information; the art of teaching lies in developing the knowledge, skill, and desire within the learner to change some aspect of his or her life. Effective teaching requires knowledge of the subject matter, understanding of the learning process, judgment,

and intuition. It also entails strong social and communication skills.

The teaching/learning process involves dynamic interaction between teacher and learner. Each participant in the process communicates information, emotions, perceptions, and attitudes to the other.

The relationship between the teacher and the learner is essentially one of trust and respect. The learner trusts that the teacher has the knowledge and skill to teach, and the teacher respects the learner's ability to attain the recognized goals. Once a nurse starts to instruct a client and/or other learner, it is important that the teaching process continue until the participants achieve the mutually agreed-upon learning goals, change the goals, or decide that the goals cannot be met.

Nurses have a responsibility to keep their clinical knowledge current. The American Nurses Association (ANA) lists two standards of clinical nursing practice that relate directly to learning and teaching. See the accompanying box.

### American Nurses Association Standards of Professional Performance Related to Teaching and Learning

#### Standard 5B, Health Teaching and Health Promotion: The registered nurse employs strategies to promote health and a safe environment.

Competencies: The registered nurse:

- Provides health teaching that addresses such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living, and preventive self-care.
- Uses health promotion and health teaching methods appropriate to the situation and the healthcare consumer's values, beliefs, health practices, developmental level, learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status.
- Seeks opportunities for feedback and evaluation of the effectiveness of the strategies used.
- Uses information technologies to communicate health promotion and disease prevention information to the healthcare consumer in a variety of settings.
- Provides healthcare consumers with information about intended effects and potential adverse effects of proposed therapies.

#### Standard 8, Education: The registered nurse attains knowledge and competence that reflects current nursing practice.

Competencies: The registered nurse:

- Participates in ongoing educational activities related to appropriate knowledge bases and professional issues.
- Demonstrates a commitment to lifelong learning through self-reflection and inquiry to address learning and personal growth needs.
- Seeks experiences that reflect current practice to maintain knowledge, skills, abilities, and judgment in clinical practice or role performance.
- Acquires knowledge and skills appropriate to the role, population, specialty, setting, role, or situation.
- Identifies learning needs based on nursing knowledge, the various roles the nurse may assume, and the changing needs of the population.
- Participates in formal or informal consultations to address issues in nursing practice as an application of education and a knowledge base.
- Shares educational findings, experiences, and ideas with peers.
- Contributes to a work environment conducive to the education of healthcare professionals.
- Maintains professional records that provide evidence of competence and lifelong learning.

## Guidelines for Learning and Teaching

The following guidelines for effective learning/teaching may be helpful to nurses:

- Teaching activities should help a learner to meet individual learning objectives. These objectives should be mutually determined by the client (learner) and the nurse (teacher). If selected teaching strategies do not assist the learner, they need to be reassessed and other strategies used. For example, oral explanation alone may not be sufficient to teach a client how to handle a syringe. Demonstrating the use of the syringe, allowing the client to practice manipulating the syringe, providing feedback based on the observation, and allowing further practice will be much more effective.
- Rapport between teacher and learner is essential. A relationship that is both accepting and constructive is the best way to assist learning. The nurse should take time to establish rapport with the learner before teaching.
- The teacher who uses the client's previous learning in the present situation encourages the client and facilitates learning new skills. For example, a person who already knows how to cook can use this knowledge when learning to prepare food for a special diet.
- The nurse teacher must be able to communicate clearly and concisely. The words the nurse uses need to have the same meaning to the learner as to the teacher. For example, a client who is taught not to place water on an area of skin may think a wet washcloth is permissible for washing the area. In effect, the nurse needs to explain that no water or moisture should touch the area. This is especially important when teaching a client/family that is not proficient in the language of instruction.
- The nurse should have knowledge of the learners and the factors that affect their learning before planning teaching. For example, when teaching a group of senior citizens at a community center, the nurse should

ensure frequent breaks that allow the seniors to use the restrooms (increased frequency of urination is a physiological change associated with aging) and high-contrast instructional materials (decreased visual acuity and color discrimination is a physiological change associated with aging).

- Learning is enhanced when the patient/client is involved in planning the instruction.
- Teaching that involves multiple senses often enhances learning. For example, when teaching about changing a dressing, the nurse can tell the client about the procedure (hearing), demonstrate how to change the dressing (sight), and allow the learner to manipulate the equipment and practice the dressing change (touch).
- The anticipated behavioral changes that indicate that learning has taken place must always be within the context of the client's lifestyle and resources. For example, it would probably not be reasonable to expect a client to soak in a tub of hot water four times a day if he or she does not have a bathtub and has to heat water on a stove.

Client/patient teaching is valuable in that it generally provides better healthcare outcomes and is cost-effective; that is, the cost of the nurse's time spent in teaching a client/family is less than the cost of treating problems that occur when clients do not follow recommended treatments, fail to take medications correctly, or do not adapt their lifestyle to their changing health needs. See the accompanying box for characteristics of effective teaching.

## Assessing Learning Needs

The first step in teaching others is to assess their learning needs and the factors that may affect their learning. These factors include the learner's (1) age and developmental level, (2) health beliefs and practices, (3) cultural and spiritual factors, (4) economic factors, (5) learning styles, (6) readiness to learn, (7) motivation, and (8) reading level.

## Characteristics of Effective Teaching

Effective teaching:

- Is accurate and current, gathering information from reliable sources.
- Holds the learner's interest.
- Involves the learner in the learning process. Makes partners of the learner and the teacher.
- Fosters a positive self-concept in the learner: The learner believes learning is possible and probable.
- Sets realistic goals.
- Is directed toward helping the learner meet learning objectives.
- Supports the learner with positive reinforcement.
- Is appropriate for the learner's age, condition, and abilities.
- Is optimistic, positive, and nonthreatening.
- Uses several methods of teaching to accommodate a variety of learning styles and provides learning opportunities through hearing, seeing, and doing.



### Age and Developmental Level

Age provides information about the learner's developmental status that may indicate specific health teaching content and teaching approaches. Simple questions to school-age children and adolescents will elicit information about what they know. Observing children in play provides information about their motor and intellectual development as well as relationships with other children. For some elderly persons, conversation and questioning may reveal slow recall, limited psychomotor skills, decreased sensory capacities, diminished cognitive function, or learning difficulties.

The age of learners also affects the duration of instruction. Young children have a short attention span; therefore, instruction of children should be of shorter duration. Older adults may be uncomfortable sitting for long periods of time or may require more frequent bathroom breaks.

### Health Beliefs and Practices

A learner's health beliefs and practices are important to consider in any teaching plan. However, even if a nurse is convinced that a particular learner's health beliefs should

be changed, doing so may not be possible because of the many factors that are involved in a person's health beliefs. Values and beliefs related to people's life experience and education, culture, and religion often influence their decisions regarding their willingness to accept specific treatment plans.

### Cultural and Spiritual Factors

People of specific cultural groups or religions may have specific beliefs and behaviors related to health and healing; a number of them are related to diet, health, illness and healing, and lifestyle. Some of these cultural and spiritual healing practices may be in conflict with accepted health and healing practices in the United States. It is therefore important to know how the practices and values held by learners influence their health learning needs.

Cultural and spiritual beliefs may also affect learning. Although the learner may readily understand the health information being taught, this learning may not be implemented in the home where folk healing practices prevail. For example, if the client holds the belief that the oldest

## RESEARCH CURRENT

### Patient Education of Children and Their Families: Nurses' Experiences

The purpose of this qualitative study by Kelo, Martikainen, and Eriksson was to "describe significant patient education sessions and explore nurses' empowering and traditional behavior in the patient education process of children and their families." The participants in the study were 47 nurses. The study included tape-recorded interviews that lasted from 10 to 40 minutes. Participants were asked to recollect one significant (positive or negative) patient education session of a child and his or her family over the previous month. Topics used to guide the interviews were (1) context of the patient education session, (2) nurse's knowledge of the family, (3) nurse's knowledge of the child, (4) assessment of educational needs, (5) planning of patient education (preparation and objectives), (6) implementation of patient education (content, methods, and interaction), and (7) evaluation of patient education. The participants described 32 positive and 13 negative patient education incidents. Two categories were identified: challenges with children and their parents, and challenges with resources.

Challenges with children and their parents included the child's condition worsened, the child had learning difficulties, the child had fear of injections, the family had a different cultural or language background, the parent had a negative attitude or was not involved, and the parent had difficulties managing the treatment.

Challenges with resources included a lack of nurses, nurse's lack of experience, education could not be provided

step-by-step before discharge, no time for preparation, no quiet room for counseling, and not enough time for providing education. Educational outcomes that reflected empowerment of the family included parents expressed that they managed with the treatment, parents left the hospital with confidence, the parents' fears had subsided, a problem was solved unusually quickly and the family continued their life normally, and the family was not dependent on professionals as they managed the medication themselves.

Aspects of nurses' sense of empowering versus traditional nursing included professional success, professional development experience, and professional learning. Examples of professional success were "when parents were completely satisfied with care" or "parents noticed the changes in their child's condition." An example of professional development experience was when the nurse "had to consider ethical issues, offer all options, and not state her own opinion." An example of professional learning was "the nurse learned that she had to consider the education methods carefully to ensure that clients understood the counseling." The authors stated that "more training for nurses is needed in hospitals to enhance the empowering education of children and their families."

*Source:* "Patient Education of Children and Their Families: Nurses' Experiences," by M. Kelo, M. Martikainen, and E. Eriksson, 2013, *Pediatric Nursing*, 39(2), pp. 71–79.

male in the family (father, husband, brother) makes health decisions for all family members, a female client may not be willing to receive health information without permission of her male decision maker.

### Economic Factors

Economic factors can also affect learning. The nurse must consider the economic ability of the learner to follow through on learning goals that are related to treatment plans. For example, a learner who cannot afford to purchase prescribed medications or medical supplies may not get them. In such a situation, the nurse should either consult with social services to assist the learner with the purchase of the needed medications or supplies or contact the physician to determine if a different medication or generic medication can be substituted.

### Learning Styles

Considerable research has been done on people's learning styles. The best way to learn varies with each individual. Some people are visual learners and learn best by having printed material to refer to or by watching demonstrations. Other people do not visualize an activity well; they learn best by actually manipulating (psychomotor) equipment and discovering how it works. Other people can learn well from reading printed material presented in an orderly fashion. Still other people learn best in groups, relating to other people. For some, stressing the thinking (cognitive) part of a skill and the logic of something will promote learning. For others, stressing the feeling (affective) part or interpersonal aspect motivates and promotes learning. When material is presented in more than one learning domain and uses multiple senses (e.g., sight, hearing, touch), the chances for learning and retaining information are greatly increased.

The nurse seldom has the time or skills to assess each learner, identify the person's particular learning style, and then adapt teaching accordingly. What the nurse can do, however, is to ask learners how they have learned best in the past or how they like to learn. Many people know what helps them learn, and the nurse can use this information in planning teaching. Using a variety of teaching techniques and varying activities during teaching are good ways to match learners with learning styles. One technique will be most effective for some learners, whereas other methods will be suited to learners with different learning styles.

### Readiness to Learn

People who are ready to learn often behave differently from those who are not. A learner who is ready may search out information, for instance, by asking questions, reading books or articles, talking with others, and generally showing interest. Today people have access to information with

computers and the Internet. The person who is not ready to learn is more likely to avoid the subject or situation. In addition, the unready learner may change the subject when the nurse brings it up or ask to postpone health learning activities to a better time.

In assessing readiness to learn, the nurse observes for the following:

- **Physical readiness.** Is the learner able to focus on things other than his or her physical status, or is fatigue, pain, or disability using up all the learner's energy?
- **Emotional readiness.** Is the learner emotionally ready to learn? People who are extremely anxious, depressed, or grieving are not ready to learn.
- **Cognitive readiness.** Can the learner think clearly? For example, a client who has an altered level of consciousness is not cognitively ready to learn. Developmental level will also affect cognitive readiness. For example, a young child may not be cognitively ready to perform complex self-care requirements. An older client with memory impairment may also have difficulty learning about self-care activities. In these cases, parents, spouses, or other caregivers must be taught to perform the care requirements.

Nurses can promote readiness to learn by providing physical and emotional support before and during learning activities.

### Motivation

Motivation relates to whether the learner wants to learn and is usually greatest when the learner is ready, the learning need is recognized, and the information being offered is meaningful to the learner. Nurses can increase a learner's motivation by doing the following:

- Relating content to something the learner values and helping the learner see the relevance of the content
- Making the learning experience pleasant and non-threatening
- Encouraging self-direction and independence
- Demonstrating a positive attitude about the learner's ability to learn
- Offering continuing support and encouragement as the learner attempts to learn (i.e., using positive reinforcement)
- Creating a learning situation in which the learner is likely to succeed
- Rewarding the learner for his or her success

### Reading Level

The nurse should not assume that a learner's reading level is equal to the highest grade or level of formal education the

learner has completed. Most patient education literature is written above the 8th-grade level, the average level being between the 10th and 12th grades. However, as described previously, 22% of adults performed at Below Basic levels of literacy on the National Assessment of Adult Literacy, which means that their functional level of literacy (reading) is at the most simple and concrete level. Most current computer word-processing programs will determine the reading level of a document.

A variety of instruments exist to assess the readability of patient education materials. The most commonly used instruments to assess readability are the Flesch formula, Gunning's FOG formula, the Fry Readability Graph, and McLaughlin's SMOG (Simple Measure of Gobbledygook) formula. Several of these formulas can be used for both English and Spanish documents. The Flesch, FOG, and SMOG formulas can be used with documents less than 300 words and measure reading from 4th-grade level through college reading ability. The Fry Readability Graph should be used with documents longer than 300 words.

## Planning Content and Teaching Strategies

Developing a teaching plan (see a sample teaching plan for wound care in Table 8–4) is accomplished in a series of steps. Involving the learner at this time promotes the formation of a meaningful plan and stimulates learner motivation. The learner who helps formulate the teaching plan is more likely to achieve the desired outcomes.

### Determining Teaching Priorities

Learning needs must be ranked according to priority. The client and the nurse should do this ranking together, with the client's priorities always being considered. Once a client's priorities have been addressed, the client is generally more motivated to concentrate on other identified learning needs. For example, a man who wants to know all about coronary artery disease may not be ready to learn how to change his lifestyle until he meets his own need to learn more about the disease. Nurses can also use theoretical

frameworks, such as Maslow's hierarchy of needs, to establish priorities.

### Setting Learning Objectives or Outcomes

Outcome-based learning is prevalent in education today. Learning objectives can be considered the same as outcome criteria for other nursing diagnoses. They are written in the same way. Like client outcomes, learning objectives do the following:

- State the learner behavior or performance, not nurse behavior. For example, "The learner will choose her own diet as instructed" (client behavior), not "Teach the client about his diet" (nurse behavior).
- Reflect an observable, measurable behavior. The performance may be visible (e.g., walking) or invisible (e.g., adding a column of numbers). However, it is necessary to be able to deduce whether an unobservable activity has been mastered from some performance that represents the behavior. Therefore, the performance of an objective might be written: "Writes a meal plan for the day" (observable), not "Considers a daily meal plan" (not observable). Avoid using words such as *knows*, *understands*, *believes*, and *appreciates*; they are neither observable nor measurable. Some verbs that can be used for measurable objectives are shown in Table 8–5.
- May add conditions or modifiers as required to clarify what, where, when, or how the behavior will be performed. Examples are "Walks to the end of the hall and back *without crutches* (condition)." "Irrigates his colostomy *independently* (condition) as taught," or "States *three* (condition) factors that affect blood glucose level."
- Include criteria specifying the time by which the learning should have occurred. For example, "The client will state three things that affect blood glucose level *by the end of the second diabetes class*."

Therefore, the objective "The client will state three things that affect blood glucose level by the end of the second

### CRITICAL THINKING EXERCISE

Assess the readability of an example of patient education material from your healthcare setting using the Flesch, FOG, Fry, and SMOG formulas. All formulas are available on the Internet. What are the readability levels of the patient education material you selected? Based on your findings, what recommendations do you have

about the education materials you selected? If you have a large population of Spanish-speaking clients, assess both the English and Spanish versions of the same educational document. How do they compare in readability? What recommendations do you have for the English and Spanish versions of the document you assessed?

**TABLE 8–4 Teaching Plan: Wound Care**

**Assessment of Learner:** A 24-year-old male college student has suffered a 2.5-in (7-cm) laceration on the left lower anterior leg during a soccer match. The laceration has been cleaned, sutured, and bandaged. The client has been given an appointment to return to the health clinic in 10 days for suture removal. The client states that he lives in the college dormitory and is able to care for the wound if given instructions. The client is able to read and understand English.

**Nursing Diagnosis:** Knowledge deficit related to care of sutured wound.

**Long-Term Goal:** The client's wound will heal completely without infection or other complication.

**Intermediate Goal:** At clinic appointment, the client's wound will be healing without signs of infection, loss of function, or other complication.

**Short-Term Goal:** The client will respond to questions regarding wound care and perform a return demonstration of wound cleansing and bandaging.

| Behavioral Objective                                                              | Content Outline                                                                                                                                                                                                                                                                                           | Teaching Methods                                                                                                                                                             |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Upon completion of the instructional session, the client will:                    |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                              |
| 1. Describe normal wound healing.                                                 | I. Characteristics of normal wound healing                                                                                                                                                                                                                                                                | Describe normal wound healing with the use of audiovisuals.                                                                                                                  |
| 2. List signs and symptoms of wound infection.                                    | II. Infection <ul style="list-style-type: none"> <li>a. Signs and symptoms include wound warm to touch, malalignment of wound edges, and purulent wound drainage.</li> <li>b. Signs of systemic infection include fever and malaise.</li> </ul>                                                           | Discuss the mechanism of wound infection.<br>Use audiovisuals to demonstrate infected wound appearance.<br>Provide handout describing signs and symptoms of wound infection. |
| 3. Identify equipment needed for wound care.                                      | III. Wound care equipment <ul style="list-style-type: none"> <li>a. Cleansing solution as prescribed by physician (e.g., clear water, mild soap and water, antimicrobial solution, or hydrogen peroxide)</li> <li>b. Bandaging material: Telfa, gauze wrap, adhesive tape, large Telfa bandaid</li> </ul> | Provide handout listing equipment.<br>Demonstrate equipment needed for cleansing and bandaging wound.                                                                        |
| 4. Demonstrate wound cleansing and bandaging.                                     | IV. Demonstration of wound cleansing and bandaging on the client's wound or a mannequin                                                                                                                                                                                                                   | Demonstrate wound cleansing and bandaging on the client's wound or a mannequin.<br>Provide handout describing procedure for cleansing and bandaging wound.                   |
| 5. Develop a plan for appropriate action if questions or complications arise.     | V. Resources available for client questions, including telephone hotline, health clinic, emergency department                                                                                                                                                                                             | Discuss available resources. Provide handout listing available resources, their contact information, and follow-up treatment plan.                                           |
| 6. Identify date, time, and location of follow-up appointment for suture removal. | VI. Follow-up treatment plan: where and when                                                                                                                                                                                                                                                              | Provide written instructions with date and time of follow-up appointment.                                                                                                    |
| <b>Evaluation:</b> The client will:                                               |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                              |
| 1. Respond to questions regarding self-care of wound.                             |                                                                                                                                                                                                                                                                                                           | 3. State contact person and telephone number to obtain assistance.                                                                                                           |
| 2. Return demonstration of wound cleansing and bandaging.                         |                                                                                                                                                                                                                                                                                                           | 4. State date, time, and location of follow-up appointment.                                                                                                                  |

**TABLE 8–5 Selected Verbs for Behavioral Learning Objectives**

| Cognitive     | Psychomotor | Affective      |
|---------------|-------------|----------------|
| Analyze       | Arrange     | Accept         |
| Apply         | Calibrate   | Agree/disagree |
| Calculate     | Change      | Attempt        |
| Compute       | Construct   | Attend         |
| Defend        | Demonstrate | Choose         |
| Define        | Dissect     | Commit         |
| Describe      | Distinguish | Debate         |
| Differentiate | Manipulate  | Defend         |
| Discuss       | Mix         | Influence      |
| Distinguish   | Prepare     | Qualify        |
| Evaluate      | Walk        | Value          |
| Explain       |             |                |
| Identify      |             |                |
| Outline       |             |                |
| Prioritize    |             |                |
| Sort          |             |                |

diabetes class” has a behavior (“will state”) that is observable and includes conditions (“three things”) and a time criterion (“by the end of the second diabetes class”).

### Choosing Content

The content or what is to be taught is determined by the learning objectives. For example, “Identify appropriate sites for insulin injection” means the nurse will include content about all body sites suitable for insulin injections. Nurses can select among many sources of information, including books, nursing and medical journals, published research, organization Internet sites such as the American Heart Association ([www.heart.org](http://www.heart.org)), and other nurses and physicians. Governmental agencies are excellent sources of free patient education materials. For example the National Institute on Aging (NIA) provides large-print educational materials called Age Pages that are related to health topics appropriate for older adults. They can be downloaded free from the NIA website. Whatever sources the nurse chooses, instructional content should be:

- Accurate
- Current
- Based on learning objectives
- Adjusted for the learner’s age, culture, language, ability
- Consistent with information the nurse is teaching
- Selected with consideration of how much time and what resources are available for teaching.



**InfoQuest** Go to [www.nia.nih.gov](http://www.nia.nih.gov) and find the educational resources for older adults called Age Pages. Many are available in both English and Spanish. Using the Internet, obtain one or more of the readability formulas discussed in a previous section titled “Reading Level.” Review several of the Age Pages using one or more of the readability formulas. What is the reading level of the documents? Evaluate the website and documents using the criteria for evaluating information found on websites found in a previous box titled “Criteria for Evaluating Internet Websites.”

### Selecting Teaching Strategies

The method of teaching the nurse chooses should be suited to the individual, to the material to be learned, and to the teacher. For example, the person who cannot read needs material presented in other ways; a discussion is usually not the best strategy for teaching how to give an injection; and a teacher using group discussion for teaching should be a competent group leader. As stated earlier, some people are visually oriented and learn best through seeing; others learn best through hearing and having the skill explained.

Some health organizations provide instructional programs through their television systems. In these organizations a variety of educational programming is available throughout the day. In some cases, patients can choose the program they wish to watch at the time they want to see it. In other cases, educational programs are played in waiting areas. The nurse can help patients select programs and help them access the system. It is important when using such educational systems that the nurse evaluates what learning has occurred. See Table 8–6 for selected teaching strategies.

### Organizing Learning Experiences

To save nurses time in constructing their own teaching plans, many health agencies have developed standardized teaching guides for teaching sessions that nurses commonly give. These guides standardize content and teaching methods and make it easier for the nurse to plan and implement client teaching. Whether the nurse is implementing a plan devised by another or developing an individualized teaching plan, some guidelines can help the nurse order the learning experience:

- Start with something the learner is concerned about; for example, before learning how to administer insulin to himself, an adolescent may want to know how he can adjust his lifestyle and still play football.



**TABLE 8–6 Selected Teaching Strategies**

| Strategy                                   | Learning Domain        | Characteristics                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Explanation or description (e.g., lecture) | Cognitive              | <ul style="list-style-type: none"> <li>Teacher controls content and pace.</li> <li>Learner is passive and therefore retains less information than when an active participant.</li> <li>Feedback is determined by teacher.</li> <li>Can be used with individuals or groups.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| One-to-one discussion                      | Affective, cognitive   | <ul style="list-style-type: none"> <li>Encourages participation by learner.</li> <li>Permits reinforcement and repetition at learner's level.</li> <li>Permits introduction of sensitive subjects.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Answering questions                        | Cognitive              | <ul style="list-style-type: none"> <li>Teacher controls most of content and pace.</li> <li>If teacher is asking questions, the learner's knowledge and understanding can be evaluated.</li> <li>A learner's asking questions demonstrates motivation to learn and helps the teacher to understand what is important for the learner.</li> <li>Teacher must understand question and what it means to learner.</li> <li>Learner may need to overcome cultural perception that asking questions is impolite and may embarrass the teacher.</li> <li>Can be used with individuals or groups.</li> <li>Teacher sometimes needs to confirm whether question has been answered by asking learner, for example, "Does that answer your question?"</li> </ul> |
| Demonstration                              | Psychomotor            | <ul style="list-style-type: none"> <li>Often used with explanation.</li> <li>Can be used with individuals or small or large groups.</li> <li>Does not permit use of equipment by learners; learner is passive.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Discovery                                  | Cognitive, affective   | <ul style="list-style-type: none"> <li>Teacher guides problem-solving situation.</li> <li>Learner is an active participant; therefore, retention of information is high.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Group discussion                           | Affective, cognitive   | <ul style="list-style-type: none"> <li>Learner can obtain assistance from support group.</li> <li>Group members learn from one another.</li> <li>Teacher needs to keep the discussion focused and prevent monopolization by one or two learners.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Practice                                   | Psychomotor            | <ul style="list-style-type: none"> <li>Allows repetition and immediate feedback.</li> <li>Permits "hands-on" experience.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Printed and audiovisual materials          | Cognitive              | <ul style="list-style-type: none"> <li>Includes books, pamphlets, films/DVDs, programmed instruction, and computer learning.</li> <li>Learners can proceed at their own speed.</li> <li>Some materials may be interactive, which enhances learning.</li> <li>Nurse can act as a resource person but need not be present during learning.</li> <li>Potentially ineffective if reading level is too high.</li> <li>Teacher needs to select language that meets learner needs if English is second language.</li> </ul>                                                                                                                                                                                                                                 |
| Role playing                               | Affective, cognitive   | <ul style="list-style-type: none"> <li>Permits expression of attitudes, values, and emotions.</li> <li>Can assist in development of communication skills.</li> <li>Involves active participation by learner.</li> <li>Teacher must create supportive, safe environment for learners to minimize anxiety.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Modeling                                   | Affective, psychomotor | <ul style="list-style-type: none"> <li>Nurse sets example by attitude, psychomotor skill.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Computer-assisted learning program         | All types of learning  | <ul style="list-style-type: none"> <li>Learner is active.</li> <li>Learner controls pace.</li> <li>Provides immediate reinforcement and review.</li> <li>Can be used with individuals or groups.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Simulation                                 | All types of learning  | <ul style="list-style-type: none"> <li>Learner is active.</li> <li>Provides immediate reinforcement and review.</li> <li>Can be used with individuals and small groups.</li> <li>Provides safe environment to minimize learner anxiety.</li> <li>Is expensive.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

- Begin with what the learner knows, and proceed to the unknown. This gives the learner confidence. Sometimes you will not know the client's knowledge or skill base and will need to elicit this information either by asking questions or by having the client fill out a form, such as a pretest.
- Address first any area that is causing the learner anxiety. A high level of anxiety can impair concentration in other areas. For example, an elderly woman highly anxious about turning her husband in bed might not be able to learn about bathing him until she has successfully learned to turn him.
- Teach the basics first, and then proceed to the variations or adjustments. It is very confusing to learners to have to consider possible adjustments and variations before they master the basic concepts. For example, when teaching a female client how to insert a retention catheter, it is best to teach the basic procedure before teaching any adjustments that may be needed if the catheter stops draining after insertion.
- Schedule time for review of content and to answer questions the learner(s) may have to clarify information.

### Implementing a Teaching Plan

The nurse needs to be flexible and observant in implementing any teaching plan because the plan may need revising. The learner may tire sooner than anticipated or be faced with too much information too quickly; the learner's needs may change or external factors may intervene. For example, the nurse and the learner, Mr. Brown, have planned to irrigate his colostomy at 10 a.m., but when the time comes, Mr. Brown wants additional information before actually doing it himself. In this case, the nurse alters the teaching plan and discusses the desired information, provides written information, and defers teaching the psychomotor skill until the next day. It is also important for nurses to use teaching techniques that enhance learning and reduce or eliminate any barriers to learning such as pain or fatigue.

### Guidelines for Teaching

When implementing a teaching plan, the nurse may find the following guidelines helpful:

- The optimal time for each session depends largely on the learner. Some people, for example, learn best at the beginning of the day, when they are most rested; others prefer late afternoon, when no other activities are scheduled. Whenever possible, ask the prospective learner(s) for help in scheduling the best time.
- Include family or caregivers in teaching sessions, as appropriate. Family can reinforce information and

care at home when they have been included in client teaching sessions.

- The pace of each teaching session also affects learning. Nurses should be sensitive to any signs that the pace is too fast or too slow. A learner who appears confused or does not comprehend material when questioned may be finding the pace too fast. When the learner appears bored and loses interest, the pace may be too slow, the learning period may be too long, or the learner may be tired.
- The environment can detract from or assist learning; for example, noise or interruptions usually interfere with concentration, whereas a comfortable environment promotes learning.
- Teaching aids can foster learning and help focus a learner's attention. To ensure learning of a self-care skill, such as self-administration of insulin, the nurse should use the type of supplies or equipment the learner will eventually use. Before the teaching session, the nurse needs to assemble all equipment and visual aids and ensure that all audiovisual equipment is functioning properly.
- Learning is more effective when learners are assisted to discover the content for themselves. Ways to increase learning include stimulating motivation and self-direction, for example, by providing specific, realistic, achievable objectives; giving feedback and reinforcement; and helping the learner derive satisfaction from learning. The nurse may also encourage self-directed independent learning by encouraging the client to explore source of information, such as the Internet. When recommending use of Internet sources, the nurse should ensure that the patient is referred to accurate and reliable sources.
- Repetition helps reinforce learning. Summarizing content, rephrasing (using other words), and approaching the material from another point of view reinforce learning. For example, after discussing the kinds of foods that can be included in a diet, the nurse describes the foods again, but in the context of the number of meals eaten during 1 day (remember, not all people eat three meals a day, some eat only two, while others who prefer multiple small, frequent meals may eat six or seven).
- It is helpful to employ organizers to introduce material to be learned. Organizers provide a means of connecting unknown material to known material and generating logical relationships. For example, "You understand how urine flows down a catheter from the bladder. Now I will show you how to inject fluid so that it flows up the catheter into the bladder." The details that follow are then seen within their framework, and the details have added meaning.

- Using a layperson's vocabulary enhances communication. Often nurses use terms and abbreviations that have meaning to other health professionals but make little sense to clients. Even words such as *urine* or *feces* may be unfamiliar to clients, and abbreviations such as RR (recovery room) or PAR (postanesthesia room) are often misunderstood.
- Provide the learner with a handout that captures the key points of your instruction. Written material to which the learner can refer during and after the instruction provides security and reinforcement. Make sure that written materials are written at an appropriate reading level and in the language the patient understands.

## Evaluating Learning and Teaching

Evaluation can be considered the final stage of the learning and teaching process. The teacher needs to evaluate what the student has learned. Has the learner met the stated learning objectives? Whether or not the student meets the objectives, it is important to evaluate the teacher and the learning situation. Information obtained from evaluation of the student, the teacher, and the learning situation can be used to improve the program for future learners.

### Evaluating Learning

Evaluating is both an ongoing (formative) and a final (summative) process in which the learner, the nurse, and, often, the support persons determine what has been learned. Learning is measured against the predetermined learning objectives selected in the planning phase of the teaching process. Thus, the objectives serve not only to direct the teaching plan but also to provide outcome criteria for evaluation. For example, the objective "Selects foods that are low in fat" can be evaluated by asking the learner to name foods or to select low-fat foods from a list or a menu.

The best method for evaluating depends on the type of learning. In cognitive learning, the learner demonstrates acquisition and application of knowledge. Examples of the evaluation methods for cognitive learning include:

- Direct observation of behavior (e.g., observing the learner selecting the solution to a problem using the new knowledge)
- Follow-up observation (e.g., if diabetes instruction included diet and blood sugar monitoring, the client's loss of weight and record of blood sugars within the range established for him would indicate learning had occurred)
- Written measurement (e.g., quizzes, tests, papers, writing out a weekly menu that incorporates dietary requirements)

- Oral questioning (e.g., asking the learner to restate information or to provide verbal responses to questions)
- Self-reports and self-monitoring, which can be useful during follow-up phone calls and home visits. Evaluating individual self-paced learning, as might occur with computer-assisted instruction and simulation, often incorporates self-monitoring.

The acquisition of psychomotor skills is best evaluated by observing how well the learner carries out a procedure, such as changing a dressing or self-administering insulin.

Affective learning is difficult to evaluate. Whether attitudes or values have been learned may be inferred by listening to the learner's responses to questions, noting how the learner speaks about relevant subjects, and observing the learner's behavior that expresses feelings and values. For example, do learners who state that they value health actually use condoms every time they have sex with a new partner? Have parents learned to value health sufficiently to have their children immunized? Evaluation of affective objectives may be better evaluated at follow-up visits by determining if new behaviors have occurred (e.g., do parents return to the clinic with their child for routine immunizations as appropriate?).

Following evaluation, the nurse may find it necessary to modify or repeat the teaching plan if the objectives have not been met or have been only met partially. For the hospitalized client, follow-up teaching in the home, in the clinic or doctor's office, or by phone may be needed.

Behavior change does not always take place immediately after learning. Often individuals accept change intellectually first and then change their behavior only periodically (e.g., the client who knows that she must lose weight, diets and exercises sporadically). If the new behavior is to replace the old behavior, it must emerge gradually; otherwise, the old behavior may prevail. The nurse can assist learners with behavior change by allowing for vacillation and by providing encouragement.

### Evaluating Teaching

It is important for nurses to evaluate their own teaching. Evaluation should include consideration of all factors: the timing, the environment for learning, the teaching strategies used, the amount of information, whether the teaching was helpful, and so on. The nurse may find, for example, that the learner was overwhelmed with too much information or was bored or in pain, or the television or visitors were distracting.

Both the learner and the nurse should evaluate the learning experience. The learner may tell the nurse what was helpful and interesting or what was confusing or

difficult to understand. Feedback questionnaires and videotapes of the learning sessions also can be helpful. Reviewing videotaped learning sessions can help the nurse discover ways in which she or he may improve her or his teaching. For example, the nurse may not be aware that she speaks very quickly and quietly when she is doing the actual teaching. On later review of the videotape, she may see this and make a conscientious effort to speak more clearly and slowly in future teaching sessions.

The nurse should not feel ineffective as a teacher if the learner forgets some of what was taught. Forgetting is normal and should be anticipated. Having the learner write down information, repeating it during teaching, giving handouts on the information, and having the learner be active in the learning process all promote retention. Providing resources for later review can also help clients reinforce and retain learning.

### Special Teaching Strategies

There are a number of special teaching strategies that nurses can use: contracting, group teaching, computer-assisted instruction, multimedia presentations, discovery/problem solving, and behavior modification. Any strategy the nurse selects must be appropriate for the learner and the learning objectives.

#### Contracting

Contracting involves establishing a written agreement with a learner that specifies certain objectives and when they are to be met. The contract, drawn up and signed by the learner and the nurse, specifies not only the learning objectives but also the responsibilities of the learner and the nurse and the teaching plan. The agreement allows for freedom, mutual respect, and mutual responsibility.

#### Group Teaching

Group instruction is economical, and it provides members with an opportunity to share with and learn from others. A small group allows for discussion in which everyone can participate. A large group often necessitates a lecture technique or use of films, videos, slides, or role playing by the teachers.

It is important that all members involved in group instruction have a common need (e.g., prenatal health or preoperative instruction). Group instruction is not appropriate for everyone. It is important that social factors be considered in the formation of a group. While some learners may value sharing experiences, personal beliefs, and values with others, other learners may feel it is inappropriate to reveal their thoughts and feelings in a group setting, especially if they don't know the other members of the group.

### Computer-Assisted Instruction

Computer-assisted instruction (CAI) has become popular. Initially, cognitive learning of facts was the primary use of computer educational methods. Now, however, computers also can be used to teach:

- Complex problem-solving skills
- Application of information through simulation scenarios
- Psychomotor skills

Programs can be used for instruction of:

- Individual learners using one computer
- Small groups of three to five learners gathered around one computer and taking turns running the program and answering questions collaboratively
- Large groups, with the computer display screen projected onto an overhead screen and a teacher or one learner using a keyboard. Clicker devices can be used to evaluate learning quickly and in a nonthreatening way. The teacher projects a multiple choice question on a screen and learners indicate their answers with the clicker. The teacher can immediately identify how many learners chose the correct answer and how many chose each of the incorrect choices. The teacher can review misunderstood information immediately.

Individuals using a computer are able to set the pace that meets their learning needs. Small groups are less able to do this, and large groups progress through the program at a pace that may be too slow for some learners and too fast for others. It is therefore helpful to group learners of similar needs and abilities together. Whether using the computer alone or in groups, learners read and view informational material, answer questions, and receive immediate feedback. The correct answer is usually indicated by the use of colors, flashing signs, or written or auditory praise. When the learner selects an incorrect answer, the computer responds with an explanation of why that was not the best answer and encourages the learner to try again. Many programs ask learners whether they want to review material on which the question and answer were based. Some computer programs feature simulated situations that allow learners to manipulate objects on the screen to learn psychomotor skills. When used to teach such skills, CAI must be followed up with practice on actual equipment supervised by the teacher.

Some learners who have had little experience with computers may have a negative attitude about computers that could interfere with learning. The nurse can help these learners by explaining the steps to start and run the program, how to turn the computer on and off, and how to initiate the program so that the learner can

use the program when the nurse is not present. Because of the interactive nature of computer programs, most learners enjoy learning in this way. Most media catalogs, professional journals, and healthcare libraries contain information about computer programs available to the nurse for client education. The media specialist or librarian in a healthcare facility or university is an excellent resource to help the nurse locate appropriate computer programs. Computer educational materials are also available for learners with different language needs, for learners with special visual needs, and for learners at different developmental levels.

### Multimedia Presentations

Multimedia presentations combine audio, film, video, and computers to stimulate many senses. This enhances learning and provides consistent instruction. Learners can stop the instruction and replay it as needed. Nurse educators can use presentation software to create professional-looking lessons for clients. Storing the lessons on a memory stick drive makes them transportable from one computer to another, or programs can be networked to multiple computers.

### Discovery/Problem Solving

In using the discovery/problem-solving technique, the nurse presents some initial information and then asks the learner a question or presents a situation related to the information. The learner applies the new information to the situation and decides what to do. Learners can work alone or in groups. This technique is well suited to family learning. The teacher guides the learners through the thinking process necessary to reach the best solution to the question or the best action to take in the situation. This approach may also be referred to as *anticipatory problem solving*. For example, the nurse educator might present information on diabetes and blood glucose management. Then, the nurse might ask the learners how they think their

insulin and/or diet should be adjusted if their morning glucose is too low. In this way, clients learn what critical components they need to consider to reach the best solution to the problem.

### Behavior Modification

Behavior modification is an outgrowth of behavior learning theory. Its basic assumptions are that (1) human behaviors are learned and can be selectively strengthened, weakened, eliminated, or replaced, and (2) a person's behavior is under conscious control. Under this system, desirable behavior is regarded and undesirable behavior is ignored. The learner's response is the key to behavior change. For example, learners trying to quit smoking are not criticized when they smoke, but they are praised or rewarded when they go without a cigarette for a certain period of time. For some people a learning contract is combined with behavior modification and includes the following pertinent features:

- Positive reinforcement (e.g., praise, reward) is used.
- The learner participates in the development of the learning goals and plan.
- Undesirable behavior is ignored, not criticized.
- The expectation of the learner and the nurse is that the task will be mastered (i.e., the behavior will change).
- Success is maximized through positive reinforcement; failure and the threat of failure are minimized.

### Reflect On . . .

- the teaching strategies you employ with clients in your clinical setting. Examine the strategies described in Table 8–6. Which do you find most effective in your teaching? Which do you find least effective in your teaching? Why?

### CRITICAL THINKING EXERCISE

Using the teaching strategies described in Table 8–6,

1. Identify barriers that may influence the learning ability of young children and of older adults. What strategies would you employ to overcome these barriers? What teaching strategies would you select for children? What teaching strategies would you select for older adults?
2. Describe strategies you would use to teach a 15-year-old about management of his IDDM diabetes,

including dietary management and self-administration of insulin. Include strategies for the cognitive, affective, and psychomotor domains. How would you evaluate the effectiveness of your teaching?

3. Describe strategies you would use to teach a group community education program about hypertension. Include strategies for the cognitive, affective, and psychomotor domains. How would you evaluate the effectiveness of your teaching?



## Teaching Clients of Different Cultures

The nurse and learners of different cultural and ethnic backgrounds have additional barriers to overcome in the teaching-learning process. These barriers include language and communication differences, differing concepts of time, conflicting cultural healing practices, beliefs that may positively or negatively influence compliance with health teaching, and unique high-risk or high-frequency health problems needing health promotion instruction. Nurses should consider the following guidelines when teaching all learners and especially those from different ethnic backgrounds:

- Obtain teaching materials, pamphlets, and instructions in languages used by clients who frequent the health-care setting. Nurses who are unable to read the foreign language material for themselves can have a translator read the material to them. The nurse can then evaluate the quality of the information and update it with the translator's help as needed. Many of these materials are available from local or state health departments or federal health agencies.
- Use visual aids, such as pictures, charts, diagrams, slides or video, to communicate meaning. Audiovisual material may be helpful if the English is spoken clearly and slowly. Even if understanding the verbal message is a problem for the learner, seeing a skill or procedure may be helpful. In some instances, a translator can be asked to clarify the printed materials. Alternatively, printed materials and other audiovisual materials may be available in several languages, and the nurse can request the necessary version from the company.
- Use concrete rather than abstract words. Use simple language (short sentences, short words), and present only one idea at a time.
- Allow time for questions. This helps the learner mentally separate one idea or skill from another.
- Avoid the use of medical terminology or healthcare language, such as "taking your vital signs" or "apical pulse." Rather, nurses should say they are going to take a blood pressure or listen to the client's heart.
- If understanding another's pronunciation is a problem, validate information in writing. For example, during assessments, write down numbers, words, or phrases, and have the client read them to verify accuracy.
- Use humor very cautiously. Meaning can change in the translation process. What may be funny for one person may not be considered humorous to another.
- Avoid using slang words or colloquialisms. These may not be understood or may be interpreted literally.
- Do not assume that a learner who nods, uses eye contact, or smiles is indicating an understanding of what is being taught. These responses may simply be the learner's way of indicating respect. The learner may feel that asking the nurse questions or stating a lack of understanding is inappropriate because it may embarrass the nurse or be considered disrespectful.
- Invite questions during teaching. Let learners know they are encouraged to ask questions and to be involved in making the information clearer. When asking questions to evaluate learner understanding, avoid asking negative questions. These can be interpreted differently by people for whom English is a second language. "Do you understand how far you can bend your hip after surgery?" is better than the negative question "You don't understand how far you can bend your hip after surgery, do you?" With particularly difficult information or skills teaching, the nurse might say, "May I go over this with you one more time in case you have any further questions?" In some cultures, expressing a need is not appropriate, and expressing confusion or asking to be shown something again is considered rude.
- When explaining procedures or functioning related to personal areas of the body, it may be appropriate to have a nurse of the same sex do the teaching because of modesty concerns in many cultures and beliefs about what is considered appropriate and inappropriate in male-female interaction. It is wise to have a female nurse teach female learners about personal care, birth control, sexually transmitted diseases (STDs), and other potentially sensitive areas. If a translator is needed during explanation of procedures or teaching, the translator should also be of the same gender.
- Include the family in planning and teaching. This promotes trust and mutual respect. Identify the authoritative family member, and incorporate that person into the planning and teaching to promote adherence to and support of health teaching. In some cultures, the male head of the household is the critical family member to include in health teaching; in other cultures, it is the eldest female member.
- Evaluate whether learning objectives have been met. If learning objectives have not been met, identify what factors may have limited the learning. In collaboration with the client (and family, if appropriate), develop a plan to repeat the teaching/learning activity with accommodation for the identified barrier. For example, if it is identified that the client's English proficiency was not adequate for learning, get a qualified translator to provide instruction.



**InfoQuest:** Search the Internet for health education materials in languages used by clients who frequent your health organization. What language-specific materials are available for your clients? Is there a cost to use the material, or are the materials free?

## Documentation of Teaching

Documentation of the teaching process is essential when teaching clients in the clinical setting because it provides a legal record that the teaching took place and communicates the teaching to other health professionals. From a legal perspective, if teaching is not documented, it did not occur. It is also important to document the response of the client and support persons. What did the client or support person say or do to indicate that learning occurred? The nurse records this in the client's record as evidence of teaching/learning. The parts of the teaching process that should be documented in the client's record include:

- Diagnosed learning needs
- Learning objectives

- Topics taught
- Client learning outcomes achieved
- Need for additional teaching
- Resources provided

The written teaching plan that the nurse uses as a resource to guide future teaching sessions might also include the following elements and a copy may also be included in the medical record:

- Actual information and skills taught
- Teaching strategies used
- Time framework and content for each class.

### Reflect On . . .

- the learning needs of clients in your specific practice setting. Is the instruction given by different healthcare providers consistent in its content? What problems might occur if there was inconsistency in instruction? What strategies might you use to correct these inconsistencies?

## Chapter Highlights

- Nurses have the responsibility for personal lifelong learning to maintain currency and proficiency in the knowledge and skills essential for safe and effective practice.
- Teaching clients, families, and other health professionals is a major nursing role.
- Learning is represented by a change in behavior.
- There are many theories of learning that have been developed over time.
- Behaviorism focuses on careful identification of what is to be taught and the immediate identification of a reward for correct responses.
- Cognitivism emphasizes the importance of an integrated learning experience, one developing understanding and appreciation that help the person function in a larger context.
- Humanism focuses on the feelings and attitudes of the learner and stresses that individuals can become highly self-motivated learners.
- Constructivism describes the individual as actively involved in constructing knowledge.
- Multiple intelligences theory focuses on the many ways individuals are considered knowledgeable.
- Bloom identified three learning domains: cognitive, affective, and psychomotor. The cognitive domain contains six intellectual *thinking* skill levels. The affective domain includes five *feeling/believing* levels. The psychomotor domain includes five *doing* levels.
- Factors that facilitate learning include motivation, readiness to learn, active involvement, success at learning, feedback, and moving from simple to complex.
- Factors that can interfere with learning include anxiety, pain, fatigue, low literacy and health literacy levels, and cultural or spiritual beliefs/practices.
- Teaching is a system of activities intended to produce learning. These activities include assessing the learner, diagnosing learning needs, developing a teaching plan,

implementing the teaching plan, and evaluating learning outcomes and teaching effectiveness.

- Rapport between teacher and learner(s) is essential for effective teaching and learning.
- Learning objectives guide the content of the teaching plan and, like nursing objectives, are written in terms of desired learner outcomes.
- Teaching strategies should be suited to the client, the material to be learned, and the teacher. They should be adjusted to the client's developmental level and health status.

- A teaching plan is a written plan consisting of learning objectives, content to teach (program outline), a time frame for teaching, and strategies to use in teaching the content.
- Barriers to overcome when teaching clients of different cultural backgrounds include language and communication differences, different concepts of time, and cultural beliefs and practices that may conflict with those of Western medicine.
- Documentation of client teaching is essential to communicate the teaching to other health professionals and to provide a record for legal purposes.

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# 9

## The Nurse as Leader and Manager

### Chapter Outline

#### Challenges and Opportunities

#### Nursing Leadership

Leadership Characteristics  
Leadership Style

#### Nursing Management

Resources  
Management Competencies  
Management Roles

#### Magnet Recognition

#### Nursing Delivery Models

Total Patient Care  
Functional Method  
Team Nursing  
Primary Nursing  
Interdisciplinary Team Model

#### Case Management

#### Differentiated Practice

#### Shared Governance

#### Mentors and Preceptors

#### Networking

#### Chapter Highlights

### Objectives

1. Differentiate between leadership and management.
2. Describe American Nurses Association and American Organization of Nurse Executives competencies for nurses regarding leadership and management.
3. Compare and contrast the leadership styles: authoritarian, democratic, laissez-faire, situational, charismatic, transactional, transformational, caring, quantum, and servant leadership.
4. Describe the management concepts of authority, accountability, planning, organizing, leading and delegating, and controlling.
5. Discuss the competencies needed to be an effective nurse-manager.
6. Compare and contrast the following nursing delivery models: total patient care, the functional method, team nursing, and primary nursing.
7. Describe Magnet status and Pathway to Excellence as mechanisms for ensuring quality nursing care.
8. Describe case management as a mechanism for ensuring continuity and quality health care.
9. Describe shared governance as a mechanism for nursing involvement in organizational decision making.
10. Differentiate between the roles and functions of mentors and preceptors.
11. Discuss the benefits of professional networking.

Professional nurses today assume leadership and management responsibilities regardless of the activities in which they are involved. Although leadership and management roles are different, they are frequently intertwined. Grohar-Murray and Langan (2011, p. 4) define leadership as “a concept and process that is capable, through interactional phenomena, of influencing a group toward goal achievement.” Leadership can also be used in helping individuals and their families to achieve mutually determined goals. Management is the “concept and process of authority that uses resources (human, technical, financial, time, [equipment and materials] and so on) to meet specific goals efficiently and effectively” (Grohar-Murray & Langan, 2011, p. 4). Leaders focus on people, whereas managers focus on systems and structures. In order to be effective, managers should be leaders, but many leaders are not managers. See Table 9–1 for a comparison of leadership and management, and of leaders and managers.

**TABLE 9–1 Comparison of Leader and Manager**

| Leadership Is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Management Is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Based on influence and shared understandings</li> <li>• An informal role</li> <li>• An achieved position through experience and education</li> <li>• Part of every nurse’s responsibility</li> <li>• Requires initiative, innovative and independent thinking</li> </ul>                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>• Based on formally designated authority</li> <li>• A formal assigned role</li> <li>• An assigned position from a higher level of management</li> <li>• Usually responsible for resource management (e.g., budgets, scheduling, personnel, quality improvement, and organizational change)</li> <li>• Improved by the use of effective leadership skills</li> </ul>                                                                                                                                                                                                                                                                                                              |
| <p><i>Leaders</i></p> <ul style="list-style-type: none"> <li>• Do not have delegated authority; power derives from other means, such as personal influence</li> <li>• Have a wider variety of roles</li> <li>• May not be a part of the formal organization</li> <li>• Focus on group process, information gathering, feedback, and empowering others</li> <li>• Emphasize interpersonal relationships</li> <li>• Direct willing followers</li> <li>• Have goals that may or may not reflect those of the organization</li> <li>• May have management responsibilities</li> </ul> | <p><i>Managers</i></p> <ul style="list-style-type: none"> <li>• Have an assigned position in the formal organization</li> <li>• Have a legitimate source of power because of the delegated authority that is part of their position</li> <li>• Are expected to carry out specific functions, duties, and responsibilities</li> <li>• Emphasize control, decision making, decision analysis, and results</li> <li>• Manipulate personnel, the environment, money, time, and other resources to achieve organizational goals</li> <li>• Have a greater formal responsibility and accountability</li> <li>• Direct willing and unwilling subordinates</li> <li>• Are more effective when also viewed as leaders</li> </ul> |

Sources: Adapted from *Leadership and Management for Nurses* (2nd ed.), by A. Finkelman, 2012, Upper Saddle River, NJ: Pearson; *Leadership Roles and Management Function in Nursing* (4th ed.), by B. L. Marquis and C. J. Huston, 2003, Philadelphia, PA: Lippincott; *Effective Leadership and Management in Nursing* (8th ed.), by E. J. Sullivan, 2013, Upper Saddle River, NJ: Pearson; *Essentials of Nursing Leadership and Management* (5th ed.), by D. K. Whitehead, S. A. Weiss, and R. M. Tappen, 2010, Philadelphia, PA: F. A. Davis.

The ability to advocate for clients is linked to a nurse’s leadership ability. The nurse may be a leader or a manager in the care of the individual client, the client’s family, groups of clients, or the community. Nurses may assume leadership or management roles in the local, state, regional, national, or global communities in advocating for all people’s rights to health within a healthy environment. Regardless of the setting, the nurse must demonstrate leadership and management skills in interacting with patients and their families, nursing colleagues, nursing students, physicians, and other health professionals.

## Challenges and Opportunities

Leadership challenges for nurses in the current U.S. health-care system include continued problems with access to healthcare services for many, especially those who are the most vulnerable; limited resources for providing care; and the need to provide care for high numbers of uninsured or underinsured individuals and families. Even with passage of the Affordable Care Act in 2010, there continue to be difficulties for the most vulnerable residents of the United

States. Nurse-managers and administrators are faced with the need to recruit and retain high-quality nurses who are capable of assuming new and rapidly changing nursing roles. These challenges must be met during a time of severe fluctuations in the numbers of available nurses while there is an increasing need for nurses, especially those prepared to work in home and community settings and with the increasing numbers of elderly.

These challenges provide opportunities to develop innovative approaches to nursing care delivery and to redefine the roles of professional nurses. These innovations and changes provide opportunities to develop new recruitment and retention strategies that increase nursing satisfaction and commitment to the profession. For individual nurses, these challenges provide opportunities for continued professional growth through career development in leading and managing.

## Nursing Leadership

In *Nursing Scope and Standards of Nursing Practice* (2010), the American Nurses Association, charges nurses with leadership expectations. (See the accompanying box.)



## Standard 12: Leadership

The registered nurse demonstrates leadership in the professional practice setting and the profession.

### Selected Competencies:

- Oversees the nursing care given by others while retaining accountability for the quality of care given to the healthcare consumer.
- Abides by the vision, the associated goals, and the plan to implement and measure progress of an individual healthcare consumer or progress within the context of the healthcare organization.

- Mentors colleagues for the advancement of nursing practice, the profession, and quality health care.
- Develops communication and conflict resolution skills.
- Participates in professional organizations.
- Communicates effectively with the healthcare consumer and colleagues.
- Seeks ways to advance nursing autonomy and accountability.
- Participates in efforts to influence healthcare policy involving healthcare consumers and the profession.

Source: *Nursing: Scope and Standards of Nursing Practice*, by the American Nurses Association, 2010, Silver Spring, MD: Author, p. 55. Reprinted with permission.

Nurses may assume leadership roles in their work setting, their profession, and their community, whether or not they have designated positions of management. As leaders in the workplace, nurses advocate for improvements in the quality of patient care. As leaders in the profession, they may advocate not only for improvements in client care but also for improvements in the working environment of nurses and other health professionals. Because of their special knowledge and skill, nurses may also assume leadership roles in the community, advocating for changes that promote physical, psychological, and social well-being for the society as a whole.

On a wider scope, nurses can apply leadership skills as they apply nursing knowledge to issues of personal or civic concern. Nurses can demonstrate these leadership skills with their involvement in organizations such as their state nurses' association, their nursing specialty organizations, or civic organizations such as the American Cancer Society, March of Dimes, and the American Heart Association. Nurses demonstrate leadership activities as they advocate for vulnerable populations, including children, older adults, the homeless, persons living with AIDS, victims of violence, those with mental illness, and for programs that ensure a safe and healthy environment. In recent years, professional nurses have demonstrated a wide range of leadership and management skills to politicians and legislators in all parts of the country in their efforts to advocate and plan for a system of affordable health care for all residents of the United States. In some areas, nurses have been elected to local, state, and national office, where they provide a nursing perspective on the health issues of their communities. At present there are 6 registered nurse members of the U.S. Congress.

Leadership occurs when influencing others to act. Where managers are assigned their roles, usually by managers or administrators in positions above them, leaders

attain their roles through experience, education, and personal power. One person may be designated the manager and demonstrate minimal leadership skills, whereas another person may have no formal management title yet demonstrate excellent leadership skills.

## Leadership Characteristics

What are the characteristics of successful leadership? Whitehead, Weiss, and Tappen (2010, p. 9) describe 10 qualities of an effective leader: integrity, courage, positive attitude, initiative, energy, optimism, perseverance, balance, ability to handle stress, and self-awareness.

- Integrity is expected of all health professionals. A leader demonstrates integrity by being consistently truthful, honest, and reliable. A nurse leader adheres to both a personal code of ethics or system of moral values, and the *American Nurses Association Code of Ethics for Nurses*.
- Courage is an important aspect of leadership. A courageous leader is one who is willing to take risks, to persevere, in order to effect good or a common goal.
- Positive attitude – attitude is the way a person thinks and feels about someone or something. A leader has a positive attitude that helps to motivate others to join in the purpose.
- Initiative is taking action. It goes beyond talking about what should be done; it is taking the first step to make something happen.
- Leaders show energy and enthusiasm or the physical and mental strength that enables them to get things done.
- Optimism is similar to having a positive attitude, or believing that the outcome you hope for will occur. It is important that leaders not become discouraged when difficulties occur. “The ability to see a problem as an

opportunity is part of the optimism that makes a person an effective leader” (Whitehead et al., 2010, p. 9).

- Perseverance is the characteristic that allows a person to continue trying even when things become difficult. Effective leaders are persistent; they stick to the task and encourage others to do so.
- Balance in work and life. Effective leaders balance the various components of their lives: family, friends, work relationships, work tasks, play, and self-maintaining activities such as exercise and spirituality. Maintaining balance provides energy and support for getting things done in all aspects of life.
- Leadership can be stressful. Effective leaders have well-developed strategies that help them deal with stress. Coping strategies are individual and can be very different for different people. For example, one person may use meditation to manage stress while another person may use active exercise.
- Self-awareness or an understanding of one’s own personality is an important characteristic of leadership. Having an understanding of self helps leaders to “understand the motivations of others” (Whitehead et al., 2010, p. 9).

Additionally, leaders need to have vision, that is, the ability to visualize or imagine what the desired outcome (goal) will look or be like. As the leader describes the vision to his or her followers, and followers buy into the vision, both leader and followers can measure progress toward the goal.

Does the fact that effective leaders share certain characteristics imply that they all act the same? Not necessarily. Besides having the preceding characteristics, most effective leaders demonstrate the following: (1) achievement and ambition, (2) the ability to set direction, (3) the ability to learn from adversity, (4) high dedication to the job, (5) sound analytic and problem-solving skills, (6) a high level of people skills, and (7) a high level of innovation.

### Reflect On . . .

- leaders you have worked with. What characteristics did they possess that helped to motivate you?
- your own leadership experiences. What characteristics do you possess that help make you an effective leader? What characteristics do you need to acquire or improve?

## Leadership Style

Leadership styles are defined as “different combinations of task and relationship behaviors used to influence others to accomplish goals” (Huber, 2014, p. 5). Several leadership

styles, models, and theories have been described: authoritarian, or directive leadership; democratic, or participative leadership; laissez-faire leadership; situational leadership; charismatic leadership; transactional leadership; transformational leadership; caring leadership; quantum leadership; and servant leadership;

### Authoritarian Leadership

In **authoritarian leadership**, the leader makes the decisions for the group. This style of leadership has also been referred to as *directive*, *autocratic*, or *bureaucratic* leadership. Authoritarian leadership is likened to a dictatorship and presupposes that the group is incapable of making its own decisions. The leader determines policies, giving orders and directions to the group members. Authoritarian leadership generally has negative connotations and often makes group members dissatisfied. Because of the differences in status between the leader and group members, the degree of openness and trust between leader and group members is minimal or absent. Under this type of leadership, procedures are well defined, activities are predictable, and the group may feel secure. However, group members’ needs for creativity, autonomy, and self-motivation are not met. Authoritarian leadership may, however, be most effective in situations requiring immediate decisions, such as cardiac arrest, fire on the unit, airplane crash, or other emergency situations, when one person must assume responsibility without being challenged by other team members. Similarly, when group members are unable or unwilling to participate in making a decision, the authoritarian style effects resolution of the problem and enables the individual or group to move on. This style can also be effective when a project must be completed quickly and efficiently.

### Democratic Leadership

In **democratic**, or **participative leadership**, the leader seeks the participation or consultation of subordinates in decision making, actively guiding the group toward achieving the group goals. Providing constructive criticism, offering information, making suggestions, and asking questions become the focus of the participative leader. This type of leadership demands that the leader have faith in the group members to accomplish the goals. Although democratic leadership has been shown to be less efficient and more cumbersome than authoritarian leadership, it allows for more self-motivation and more creativity among group members. Democratic leadership calls for a great deal of cooperation and coordination among group members.

### Laissez-Faire Leadership

The **laissez-faire**, or **nondirectional**, leader “does very little planning or decision-making and fails to encourage others to do so. It is really a lack of leadership”

TABLE 9–2 Comparison of Authoritarian, Democratic, and Laissez-Faire Leadership Styles

|                                        | Authoritarian                                          | Democratic                                        | Laissez-Faire                                    |
|----------------------------------------|--------------------------------------------------------|---------------------------------------------------|--------------------------------------------------|
| Group member level of freedom          | Little freedom                                         | Moderate freedom                                  | Much freedom                                     |
| Leader level of control                | Strong control                                         | Moderate control                                  | No control                                       |
| Group level of participation           | Minimal participation, follows orders                  | Moderate to high participation                    | Each member goes own way, minimal group activity |
| Group members' motivation              | Fosters dependence                                     | Fosters independence                              | Fosters chaos                                    |
| Leader activity level                  | High                                                   | Moderate                                          | Minimal or none                                  |
| Who is responsible for planning?       | Leader                                                 | Leader and group together                         | Everyone and no one                              |
| Who is responsible for decision making | Leader                                                 | Leader and group together                         | Everyone and no one                              |
| Group output                           | High quantity, good quality, singularly leader focused | High quality, creative, reflective of group input | Variable, may be poor quality                    |
| Level of efficiency                    | Very efficient                                         | Moderately efficient                              | Inefficient                                      |

Source: Adapted from *Guide to Nursing Management and Leadership* (8th ed.), by A. Marriner St. Louis, MO: Elsevier, p. 183; *Essentials of Nursing Leadership and Management* (5th ed.), by D. K. Whitehead, S. A. Weiss, and R. M. Tappen, 2010, Philadelphia, PA: F. A. Davis.

(Whitehead et al., 2010). Although there are various degrees of nondirectional leadership, leadership participation is, in general, minimal. The group’s members may act independently of each other and suffer from a lack of cooperation or coordination. Apathy, chaos, and frustration may arise. The laissez-faire approach works best when group members have both personal and professional maturity, so that once the group has made a decision, the members become committed to it and have the required expertise to implement it. Individual group members then perform tasks in their area of expertise, with the leader acting as a resource person. Table 9–2 compares the authoritarian, democratic, and laissez-faire leadership styles.

Situational Leadership

In **situational leadership** levels of direction and support vary according to the level of maturity of the employees or group. According to Whitehead et al. (2010, p. 8), “Situational theories emphasize the importance of understanding all the factors that affect a particular group of people in a particular environment.” The situational leadership model poses some questions. First, can leaders actually choose one style over another when faced with a new situation? Second, how do such factors as personality traits and the leader’s power base influence the leader’s choice of style? And third, what should the leader choose for a group whose members are at different levels of maturity?

An important issue in situational leadership is the value placed on the accomplishment of tasks and on the interpersonal relationships between leader and group

members, and among group members. For example, the nurse-manager encourages input from staff members when planning daily work assignments so that the needs of both staff and clients are met. The nurse-manager may also solicit input from staff members when doing both short-range and long-range planning for the unit. However, when a new staff member is being oriented to the unit, the nurse-manager may be more directive in making assignments until the staff member develops experience and professional maturity. In emergency situations or situations in which the task needs to be completed quickly, the nurse-manager may be more authoritative in directing the actions of all staff members.

Charismatic Leadership

**Charismatic leadership** is described by Marriner-Tomey (2009, p. 181) as an emotional relationship between the leader and the group members in which the leader “inspires others by obtaining an emotional commitment from followers and by arousing strong feelings of loyalty and enthusiasm.” A charismatic relationship exists when the leader can communicate a plan for change and the followers adhere to the plan because of their faith and belief in the leader’s abilities. The followers of a charismatic leader may be able to overcome extreme hardship to achieve the goal because of their faith in the leader.

Transactional Leadership

**Transactional leadership** represents the traditional manager focused on the day-to-day tasks of achieving organizational

goals. Sullivan (2013, p. 42) states that “transactional leadership is based on principles of social exchange theory. The basic premise of social exchange theory is that individuals engage in social interaction expecting to give and receive social, political, and psychological benefits or rewards.” The transactional leader understands and meets the needs of the group. Relationships with followers are based on an exchange (or transaction) for some resource valued by the follower. These incentives are used to promote loyalty and performance. For example, to ensure adequate staffing on the night shift, the nurse-manager negotiates (transacts) with a staff nurse to work the night shift in exchange for a weekend shift off (reward).

### Transformation Leadership

In contrast, **transformational leadership** “emphasizes the importance of interpersonal relationships” (Sullivan, 2013, p. 43). Marriner-Tomey (2009, p. 187) describes transformational leadership as “inspirational leadership that promotes employee development, attends to needs and motives of followers, inspires through optimism, influences changes in perception, provides intellectual stimulation, and encourages follower creativity.” The transformational leader serves as a role model who encourages and empowers team members to achieve team goals while at the same time achieving personal/professional growth. This model combines elements of earlier theories and recognizes the influence and importance of the leader, the workers, the tasks, and the environment. Transformational leadership is vital in the

creation of a healthcare system that embodies community well-being, basic care for all, cost-effectiveness, and holistic nursing care.

### Caring Leadership

**Caring leadership** is a concept that is an extension of transformational leadership. The term *caring leadership* was introduced in 1994 by a Fortune 500 executive, who stated, “Good management is largely a matter of love. Or if you’re uncomfortable with the word, call it caring, because proper management involves caring for people, not manipulating them” (Brandt, 1994, p. 68). Caring leadership recognizes the importance of caring in the practice of nursing, combining concepts from both caring and leadership theories.

### Quantum Leadership

**Quantum leadership** is a more recently described theory evolving out of knowledge from quantum physics. Like charismatic, transactional, and transformational leadership, quantum leadership is a humanistic interaction involving the leader and the followers. The additional component to quantum leadership is the problem to be solved or goal to be achieved; the interaction and the outcomes are affected by the leader, the followers, and the task to be accomplished. The leader is creative, flexible, and encouraging. Each team member adds value to the team based on his or her own unique knowledge, skill, and experience. Quantum leaders plan for error and manage risks. They ask, “What problems or barriers may occur and how might we overcome them in order to achieve the goal?” They

## RESEARCH CURRENT

### Exploration of Transformational and Distributed Leadership

The purpose of Tomlinson’s qualitative study, which was done in Scotland, was to explore the leadership styles of senior charge nurses (SCNs) and the effects that the leadership styles may have on clinical teams. Data were collected from 20 staff nurses, working on acute surgical wards in four Glasgow hospitals, using semistructured interviews. “Participants were asked to describe how they felt about certain aspects of their senior charge nurse’s leadership style.” Four themes emerged from the interviews: transformational leadership, distributed leadership, team engagement, and pressures and priorities. While not all interviews reported transformational leadership, those that did reported “clear team priorities, good communication from the SCN, and clear vision of team and organizational objectives.” All participants reported some level of distributed leadership indicating that the experience

was positive and “accepted as normal working practice.” Participants reported that they worked in areas where they practiced autonomously, prioritized their daily routines, and managed their own workloads. Participants reported that “their teams were engaged with their work”; however, it was unclear whether this was related to the leadership style of the SCN. All participants reported that “stress was a factor in their daily working lives.” One source of stress identified was the perceived conflict between “the need to meet organizational goals and deliver patient-centered care.” The investigator concluded that where “there is transformational leadership and sharing of leadership roles across teams, staff members are more engaged and organizational goals are met.”

Source: “Exploration of Transformational and Distributed Leadership,” by J. Tomlinson, 2012, *Nursing Management*, 19(4), pp. 30–34.



## Characteristics of Effective Leaders

- Use a leadership style that is natural to them
- Use a leadership style appropriate to the task and the members
- Assess the effects of their behavior on others and the effects of others' behavior on themselves
- Are sensitive to forces acting for and against change
- Express an optimistic view about human nature
- Are energetic
- Are open and encourage openness, so that real issues are confronted
- Facilitate interpersonal relationships
- Plan and organize activities with the group
- Are consistent in behavior toward group members
- Delegate tasks and responsibilities to develop members' abilities, not merely to get tasks performed
- Involve members in all decisions
- Value and use group members' contributions
- Encourage creativity
- Encourage feedback about their leadership style

anticipate the next step and help team members to understand the importance of the goal.

### Servant Leadership

In contrast to traditional styles of leadership, which are based on hierarchical power, that is, the leader is generally higher on the power pyramid with the followers underneath, **servant leadership** is based on the desire “to serve first. Then conscious choice brings one to aspire to lead” (Greenleaf, 2013). Leader and followers work together to attain the desired goal; decision making is shared. Characteristics of servant leaders include (1) listening, (2) empathy, (3) awareness, (4) foresight, (5) stewardship, (6) commitment to the growth of people, and (7) community building (Marriner-Tomey, 2009, p. 199). The concept of servant leadership in nursing is appropriate as the profession is based on principles of caring, service, and the multidimensional growth of others. Nursing has often been described as a vocation, a calling, or a call to serve those who are ill or injured. O'Brien (2011, pp. 89–90) suggests that servant leadership in nursing is different from servant leadership in business and industry, in that in business and industry the servant leader is responsible only for the organization's workforce. In nursing “servant leaders, from the highest level nursing administrator in a medical center to the team leader of a small nursing subspecialty area, are responsible not only for the healthcare staff members they supervise but also for the well-being of the patients and families for whom those staff members care.” Sullivan (2013, p. 44) states that “nurses serve many constituencies, often quite selflessly, and

consequently bring about change in individuals, systems, and organizations.”

Effective leadership is a learned process requiring an understanding of the needs and goals that motivate people, the knowledge to apply leadership skills, and the interpersonal skills to influence others. Effective leaders see success as more than a goal attained, but also as an opportunity for personal and professional growth of themselves and the team members with whom they work. Some characteristics of effective leaders are listed in the accompanying box.

### Reflect On . . .

- leaders you admire. What characteristics of leadership do they have that you admire? Are there characteristics that you don't like? What leadership style or styles do they employ to influence others? Do they emphasize one style or several styles? Are the nursing leaders you admire well liked by other colleagues and health professionals?
- whether you believe that it is important to be liked when you are a leader.
- your own leadership activities. What characteristics of leadership do you have? What leadership style or styles are you most comfortable with when you are the member of a group? What leadership style or styles are you most comfortable with when you are the leader of a group? How might you improve your abilities as a leader?

### CRITICAL THINKING EXERCISE

Think about nursing leaders past and present. What qualities of leadership do they share? Has leadership in nursing changed over the years? If your answer is yes, in what ways

has leadership in nursing changed? How do contemporary nurses exhibit leadership in professional issues? How do contemporary nurses exhibit leadership in civic issues?

## Nursing Management

When considering the term *nursing management*, nurses often think only of those nurses who are in appointed administrative positions such as the nurse-manager, the nursing supervisor, or the chief nursing officer. In reality, registered nurses often are directing or managing the care provided by support personnel, such as vocational nurses, nursing assistants, or unit housekeeping personnel. For this reason, the phrase *nurse as manager* is used throughout this section to indicate the responsibilities that staff nurses have even when they don't have an official management title.

Nurses as managers are responsible for planning, organizing, directing/delegating, and controlling the resources used in the delivery of client care. Those resources include equipment and materials, technology, finances, environment, and personnel. Whether the nurse is planning care for one or more clients for 1 day on one nursing unit or is the nursing administrator planning the care of all clients served by the organization, the nurse must consider the resources needed and the desired quality outcomes while ensuring cost-effectiveness. The American Nurses Association charges nurses to be effective managers of resources in Standard 15 of *Nursing: Scope and Standards of Practice*. See the accompanying box.

### Resources

#### Equipment and Materials

The resource equipment and materials includes all disposable and nondisposable equipment needed to provide care to clients whether in the hospital, clinic, long-term-care setting, or the home. Disposable items need to be inventoried and replenished as they are used so that they

continue to be available when needed. Nondisposable equipment needs to be maintained so that it is safe and effective when it is used. It is important that nurses are involved in evaluating the evidence regarding the efficacy of specific equipment and materials when they are selected for use in client care. When new equipment or materials are introduced into the healthcare environment, it is important that care providers are informed regarding proper use of the new items.

#### Technology

Today's healthcare environment is increasingly more reliant on technology in the provision of care. Electronic monitoring systems, electronic medical records, and electronic communication devices all help to speed up assessment, communication, and intervention, thereby improving client care. Nurses must be proficient in the use of technologies that are used in their practice. As new technologies are introduced into the healthcare environment, nurses must learn how they may be used to enhance client care. At the same time, while technology can provide rapid and accurate information, the nurse must always be able to evaluate that information in relation to the actual client presentation.

Nurses can also be involved in the development of technologies that can improve the quality of client care, especially in those situations that are primarily in the purview of nursing. For example, nurses provide important information about electronic bed alarms that can be used to reduce client falls in hospitals and long-term-care facilities.

#### Finances

Nurses have a shared responsibility for considering the financial impact of healthcare decisions for individual clients and their families, for nursing units, and for healthcare

### Standard 15: Resource Utilization

The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible.

#### Selected Competencies:

The registered nurse:

- Assesses individual healthcare consumer care needs and resources available to achieve desired outcomes.
- Identifies healthcare consumer care needs, potential for harm, complexity of the task, and desired outcome when considering resource allocation.
- Delegates elements of care to appropriate healthcare workers in accordance with any applicable legal or policy parameters or principles.

- Identifies the evidence when evaluating resources.
- Advocates for resources, including technology, that enhance nursing practice.
- Modifies practice when necessary to promote positive interaction between healthcare consumers, care providers, and technology.
- Assists the healthcare consumer and family in identifying and securing appropriate services to address needs across the healthcare continuum.
- Assists the healthcare consumer and family in factoring costs, risks, and benefits in decisions about treatment and care.

Source: *Nursing: Scope and Standards of Practice*, by the American Nurses Association, 2010, Silver Spring, MD: Author, p. 60.

organizations. Nurse-managers often are responsible for determining the budget needs for their unit. Factors that must be considered in preparing the unit budget include equipment and supplies, unit maintenance and housekeeping, and personnel costs, including projected overtime needs.

### Environment

Nurses have the responsibility for maintaining a safe and effective environment for their clients. In the institutional setting, that responsibility includes ensuring effective housekeeping services that provide a safe and pleasant environment that is clean and odor-free to prevent nosocomial infections or injuries. Nurses need to consider noise levels and light in promoting a safe and comfortable environment.

In the home, nurses work with clients and their support persons to plan a safe environment that promotes wellness and minimizes the risk of injury. This may involve working with physical and occupational therapists in planning home renovation needs, such as entry ramps in place of steps, railings on stairs, or grab bars installed in bathrooms.

### Personnel

Nurses manage the assignment of appropriate personnel for client care. Whether a specific client's care can be provided by a nurse with experience on the specific nursing unit, an experienced nurse new to the nursing unit (e.g., an agency nurse, float nurse), a new graduate nurse, a vocational nurse (LPN/LVN), or a nursing assistant is a management decision. The nurse-manager must ensure that the right person is assigned based on the client's needs. More about personnel management will be discussed later in this chapter in directing and delegating.

### Management Competencies

The American Organization of Nurse Executives (2011) describes five areas of competency required for effective nurse executives: communication and relationship building, knowledge of the healthcare environment, leadership skills, professionalism, and business skills. Most of these competencies are important for any nurse functioning in a management position. See the accompanying box for a listing of specific competencies expected of an effective nurse executive.

## AONE Nurse Executive Competencies

### *Communication and relationship-building*

- Effective communication
- Relationship management
- Influencing behaviors
- Ability to work with diversity
- Shared decision-making
- Community involvement
- Medical staff relationships
- Academic relationships

### *Knowledge of the healthcare environment*

- Clinical practice
- Patient care delivery models and work design
- Healthcare economics
- Health care policy
- Governance
- Evidence-based practice
- Outcome measurement
- Patient safety
- Utilization/case management
- Quality improvement and metrics
- Risk management

### *Leadership skills*

- Foundational thinking skills
- Personal journey disciplines
- Systems thinking
- Succession planning
- Change management

### *Professionalism*

- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practice
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

### *Business skills*

- Financial management
- Human resource management and development
- Strategic management
- Marketing
- Information management and technology

The relative importance and skill mix of the listed competencies at each level of management change as the nurse moves from a first-line manager position to middle and top or upper management. Interpersonal and communication skills are of equal importance to all levels of management. Marquis and Huston (2012, p. 260) describe three levels of manager:

- **First-level manager.** The first-level manager is responsible for supervising nonadministrative personnel in the conduct of day-to-day activities on specific work units. Examples of first-level managers are charge nurses or unit-based nurse-managers.
- **Middle-level manager.** A middle-level manager supervises first-level managers within a specific area and is responsible for the personnel and work activities within those areas. The middle-level manager usually functions as a liaison between first-level and top-level managers. Examples of a middle-level manager would be the director of critical care services, or director of surgical services.
- **Top-level manager.** A top-level or upper-level manager is primarily responsible for establishing the goals and strategic plans for the entire nursing division. Middle-level managers generally report to the upper-level manager. Various titles are given to upper-level nurse-managers. Examples are director of nursing services, chief nursing officer, or vice president for nursing services. In large organizations, division directors may be considered upper-level management, for example, the director of ambulatory and outpatient services, or the director of maternal-child health services.

The professional nurse may be promoted into a first- or middle- level management position because of excellent clinical nursing skills. These new managers often rely on their nursing expertise, unaware that they also need to develop other skills associated with business and finance. First-level managers are often responsible for human resource functions such as developing unit goals, policies, and procedures; staff hiring, scheduling, and evaluation; and unit budget planning. The expert clinical nurse needs to develop competence in these management areas in order to be an effective manager.

The higher the manager's position in the organization, the greater the need for conceptual and interpersonal skills. Many of the responsibilities of top nurse-managers, such as allocating resources and developing overall strategies, require a broad outlook or the ability to see the "big picture." The ability to provide visionary leadership has become a highly valued managerial skill.

Offering educational programs such as workshops, seminars, and mentoring programs is one way the organization

and profession can help new nurse-managers build on their nursing knowledge. Nurse-managers may also choose to take classes in budgeting and finance, human resource development, conflict management, informatics, organizational development, and other business-related areas.

## Management Roles

Nurses function differently in various types of organizations. An autocratic organization confers primary knowledge and power to one person and places other persons in subordinate roles. Bureaucratic organizations exert control through policy, structured jobs, and compartmentalized actions. Other organizations decentralize control and emphasize self-direction and self-discipline of members. Still another type of organization is the component of a system that interacts independently with other components and adapts dynamically to change. This type of organization is particularly beneficial for the nurse who manages the care of individuals, families, and communities. On a larger scale, the nurse-manager must work within the organizational framework of the employing agency.

### Authority and Accountability

**Authority** is the official power given by the organization to direct the work of others. It is an integral component of managing. Authority is conveyed through leadership actions, it is determined largely by the situation, and it is always associated with responsibility and accountability.

**Accountability** is the ability and willingness to assume responsibility for one's actions and to accept the consequences of one's behavior. Accountability can be viewed within a hierarchical systems framework, starting at the individual level, through the institutional/professional level, and then to the societal level. At the individual or client level, accountability is reflected in the nurse's ethical integrity. At the institutional level, it is reflected in the statement of philosophy and objectives of the nursing department and nursing units. At the professional level, accountability is reflected in standards of practice developed by national or regional nursing organizations. At the societal level, it is reflected in legislated nurse practice acts.

To be successful, the nurse-manager must exert authority and assume accountability in implementing the managerial functions of planning, organizing, leading and delegating, and controlling. These functions help to achieve the goal of quality client care.

### Planning

Planning is often considered the first and most basic management function. Planning consists of four stages (Sullivan, 2013, p. 26):



- Establishing goals and objectives
- Evaluating the current situation and predicting future trends and events
- Formulating a planning statement
- Converting the plan into an action statement

Nurses as managers must keep in mind that plans are the means, not the ends. Quick fixes may cause one to neglect the big picture. Planning can help the nurse as manager (1) identify future opportunities, (2) anticipate and avoid future problems, and (3) develop strategies and courses of action.

### Organizing

**Organizing** is the “process of coordinating the work to be done” (Sullivan, 2013, p. 46). The nurse as a manager is responsible for identifying particular tasks that need to be accomplished, the resources needed, and assigning those tasks to the appropriate individuals or teams who have the training and expertise to carry them out. Along with organizing, the nurse as a manager is responsible for coordinating activities to meet the unit’s objectives. Healthcare reform, downsizing, restructuring, and nursing shortages can affect the management role of organizing.

### Leading/Delegating

The beginning of this chapter discussed many of the elements of effective leadership. These elements, even when combined with the motivation to lead and basic leadership skills, will not necessarily make for an effective leader; power is also an essential component of leading. Power is ability and authority to influence others. Sullivan (2013, p. 87) states that power is based on “honor, respect, loyalty, and commitment.”

Another component of leading is delegating. **Delegation** is defined as “getting work done through others or as directing the performance of one or more people to accomplish organizational goals” (Marquis & Huston, 2012, p. 448). The function of delegation in health care is often difficult because of the number and diversity of caregivers; the amount and complexity of different knowledge and skills needed to provide care; and the intricacy of the relationships between and among personnel, the client, his or her family and support persons, and the environment.

Delegation is a major tool in making the most efficient use of time. Delegation is a high-level implementation skill. To delegate effectively, the nurse must be aware of the needs and goals of the client and family, the nursing activities that can help the client meet the goals, and the skills and knowledge of various nursing and support personnel. The National Council of State Boards of Nursing (2013) describes the five “rights” of delegation as the right task, the right circumstances, the right person, the right

direction and communication, and the right supervision and evaluation.

In delegating, the nurse must determine how many and what type of personnel are needed. Decisions about delegation may be based on information from the client’s records, the client, the charge nurse, other nursing personnel, and the nurse’s own judgment.

After establishing that assistance is required, the nurse must identify what type of help is needed, how long help will be required, when it will be required, and what assistance is available. Before beginning the nursing activity, the nurse must arrange for assistance, usually by asking the appropriate person on the unit. Delegation does not require that the nurse have the personal knowledge and expertise to perform a specific nursing activity, but it does require that the nurse know who does have the knowledge and expertise and can recognize when it is needed. For example, a nurse may call a dietitian to assist a client in choosing foods from a menu or request a social worker to assist a client who needs financial assistance and homemaker services after discharge.

An important aspect of delegation is the development of the potential of nursing and support personnel. By knowing the background, experience, knowledge, skill level, and strengths of each staff member, a nurse can delegate responsibilities that help develop each person’s competence. Nursing personnel to whom aspects of care have been delegated need to be supervised and evaluated. The amount of supervision required is highly variable and depends on the knowledge and skill level of each staff member.

As the person who assigns the activity and observes the performance, the nurse contributes to the evaluation process. Because individual motivation varies, the nurse needs to realize that not all persons perform equally. Thus, the nurse must evaluate standards of performance against written job descriptions, rather than by comparing one person’s performance to that of another. It is essential, also, for the nurse to realize that people require ongoing feedback about their performance and to give feedback, including both positive and negative input, in an objective manner.



**InfoQuest:** Search the Internet at [www.ncsbn.org](http://www.ncsbn.org) and [www.nursingworld.org](http://www.nursingworld.org) to find more information about delegation.

### Controlling

Controlling is a method to ensure that behaviors and performances are consistent with the expectations (goals) developed in the planning process. The nurse as manager

**CRITICAL THINKING EXERCISE**

Consider the organizational structure of your practice or educational setting. How many levels of management are there? How many of these levels are managed by nurses?

Identify advantages and disadvantages to having nurses in mid-level and upper-level management positions in healthcare organizations or educational institutions.

assesses whether actual outcomes are consistent with desired goals. Control is not something managers should do to employees, but rather with them. Control functions may be shared with staff. In today's healthcare organizations, staff nurses participate in and lead teams that focus on improving the quality of care. Increasingly in healthcare agencies, more flexible controls, such as continuous quality improvement (CQI), shared governance, and team building help make control an easier and integral part of the management process.

**Reflect On . . .**

- the activities of nurse-managers at the unit level of your practice setting. What management activities do they perform? What management activities do staff nurses perform? What management activities do you perform? How do management responsibilities of the staff nurse differ from those of the nurse-manager? What is the relationship between good unit management and effective client care?
- the experience and educational background of nurse-managers at all levels of your organization. What are their clinical nursing experiences? What is their educational preparation for their nursing-management role? Do they have formal or informal education in management or business? Do the experience levels and educational background differ among nurse-managers at different levels of organizational or unit management? How could you best prepare yourself for management responsibility?

**Magnet Recognition**

**Magnet recognition** is a program of the American Nurses Credentialing Center (ANCC) that “recognizes healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice” (American Nurses Credentialing Center, 2013b). The impetus to the Magnet Recognition Program was the desire to identify the characteristics of hospitals that were successful in recruiting and retaining nurses so that they could be implemented in other hospitals and healthcare organizations. Research conducted by the American Academy of Nursing found “high-performing hospitals with well-qualified nurse executives in a decentralized environment, with organizational structures that emphasized open, participatory management” (as cited in Marquis & Huston, 2012, p. 272). In 2015, there were 406 Magnet-recognized healthcare organizations. Characteristics of Magnet organizations included low registered nurse (RN) turnover rates (overall = 10.72%), low RN vacancy rates (overall = 2.47%); almost 2/3 (overall = 62.66%) of RN decision makers were certified by a nationally recognized organization; more than 50% (overall = 57.33%) of RN decision makers had earned graduate degrees; and approximately one third (overall = 33.77%) of RN direct care providers were certified by a nationally recognized certifying organization. In those organizations with greater than 100 beds, approximately 50% (overall = 51.78%) of RN direct care providers had a baccalaureate degree in nursing (American Nurses Credentialing Center, 2015).

In the original study conducted by the American Academy of Nursing, 14 characteristics were identified that defined organizations that were most able to recruit and retain nurses during times of nursing shortages in the

**CRITICAL THINKING EXERCISE**

Interview nurses at different management levels (unit level nurse-manager, nursing supervisor, and chief nursing officer) in your organization. Why did they choose to take on management responsibilities? What is their vision for the level they manage? How is that vision communicated to their subordinates? What do they identify

as the advantages and disadvantages of taking on management responsibilities? After reviewing the interviews, what are your thoughts about assuming management responsibilities? What do you see as the advantages and disadvantages if you were asked to assume management responsibilities?

1970s and 1980s. Those characteristics are called Forces of Magnetism and relate to a healthcare organization's organizational structure and management, quality of care, nursing support and autonomy, and organization/community partnership.

Summers (2012) states that there is some debate about nurse satisfaction with Magnet hospitals, specifically on the part of nursing unions. She provides suggestions to improve Magnet recognition that include improving the safety and quality of the environment for patient care, strengthening nursing and nursing managers, improving inter-professional collaboration, and increasing nursing participation at the highest levels of organizational decision-making including the executive council and the boards of directors.



**InfoQuest:** Go to the American Nurses Credentialing Center Magnet Recognition Program website at <http://www.nursecredentialing.org/magnet.aspx> to obtain more information about the Magnet Recognition Program. What are the characteristics (Forces of Magnetism) of Magnet certified organizations? Are these characteristics of your health organization? If not, what could you do to help your organization move toward Magnet recognition?



**InfoQuest:** Go to Summers' (2012) article in the journal *The Truth about Nursing* at <http://www.truthaboutnursing.org/faq/magnet.html>. What is the source of debate about Magnet recognition? Discuss with your colleagues the suggestions made to incorporate into the Magnet program. Do you agree with the suggestions? Are there suggestions that you disagree with? Are there ideas that you would add? Provide a rationale for your thoughts.

In 2009, the ANCC launched the Pathway to Excellence Program to recognize health-care organizations and long-term-care facilities for having positive practice environments. Standards unique to the long-term-care environment have been developed to promote quality care in that environment.



**InfoQuest:** Go to the ANCC Pathway to Excellence website at <http://www.nursecredentialing.org/Pathway/AboutPathway/PathwayPracticeStandards> to obtain more information about the Pathways to Excellence program. What are the Practice Standards required to obtain Pathway to Excellence recognition? In what ways are those standards met or not met in your healthcare organization? What are your thoughts about the Pathway to Excellence program and the Practice Standards?

## Nursing Delivery Models

Common configurations for the delivery of nursing care have included total patient care (case method), the functional method, team nursing, and primary nursing.

### Total Patient Care

Total patient care, also referred to as the *case method*, is one of the earliest models of nursing care. This method was used by private-duty nurses in providing total care to the client. This method is client-centered: One nurse is assigned to and is responsible for the comprehensive care of a client or group of clients during a shift. For each client, the nurse assesses needs, formulates diagnoses, makes nursing plans, implements care, and evaluates the effectiveness of care. In this method, a client has consistent contact with one nurse during a shift but may have different nurses on other shifts. The case method, considered the precursor of primary nursing, continues to be used in a variety of practice settings, such as intensive care nursing. A form of case method is often used in home health care where one nurse is responsible for all nursing care provided within the home. However, some care may be provided by other team members. For example, the nurse may perform complex treatments in the home but have a certified nursing assistant come in daily to assist the client with hygiene needs.

With the shortage of nursing personnel during World War II, the case method could no longer be the chief mode of care for clients. To meet staff shortages, managers hired personnel with less educational preparation than the professional nurse and developed on-the-job training programs for auxiliary helpers. The case method became unfeasible in such situations, and the functional method was developed in response.

### Functional Method

The functional nursing method, which evolved from concepts of scientific management used in the field of

## RESEARCH CURRENT

## Patient Falls: Association With Hospital Magnet Status and Nursing Unit Staffing

The purpose of this retrospective cross-sectional observational study by Lake, Shang, Klaus, and Dunton was to examine the relationships between hospital Magnet status, nursing unit staffing, and patient falls. Data were gathered from 5,388 units in 108 Magnet and 528 non-Magnet hospitals using the National Database of Nursing Quality Indicators (NDNQI). The dependent variable examined was patient falls; independent variables studied were nurse staffing, RN staff composition, and hospital Magnet status. Nurse staffing was measured as nursing care hours per patient day (Hppd). RN composition measures included nurse educational level, that is, the proportion of unit nurses who had a baccalaureate or higher degree in nursing; national specialty certification, that is, the proportion of unit nurses who had obtained certification granted by a national nursing organization; and proportion of hours worked by agency employee nurses, that is, nurses supplied by a staffing agency and not full-time employees of

the hospital. Magnet recognition was used to measure the hospital's adherence to standards of nursing excellence. Study findings indicated significant relationships between nursing staff hours, hospital Magnet status, and the rate of patient falls. RN Hppd were negatively associated with the fall rate, indicating that the greater the RN Hppd, the lower the patient fall rate; however, LPN and nursing assistant Hppd were positively associated with fall rate, indicating that the greater the LPN and nursing assistant Hppd, the greater the patient fall rate. Average patient fall rates were 8.3% lower in Magnet hospitals when compared to non-Magnet hospitals. RN staff composition, including the proportion of BSNs, specialty-certified nurses, and agency nurse hours, were not significantly associated with patient fall rate in this study.

*Source:* "Patient Falls: Association With Hospital Magnet Status and Nursing Unit Staffing," by E. T. Lake, J. Shang, S. Klaus, and N. E. Dunton, 2010, *Research in Nursing & Health*, 33, pp. 413–425.

business administration, focuses on the jobs or tasks to be completed. In this task-oriented approach, personnel with less preparation than the professional nurse perform less complex care tasks. The functional method is based on a production and efficiency model that gives authority and responsibility to the person assigning the work, for example, the nurse-manager. Clearly defined job descriptions, procedures, policies, and lines of communication are required. The functional approach to nursing is economical and efficient and permits centralized direction and control. Its disadvantages are fragmentation of care (the client receives care from several different categories of nursing personnel) and the possibility that nonquantifiable aspects of care, such as meeting the client's emotional needs, may be overlooked. The functional nursing method is generally no longer used in hospital

settings; however, it may be seen in long-term-care or psychiatric/mental health settings, in which one nurse (often an LPN/LVN) administers all the medications of a residential unit or a nursing assistant does all vital signs or personal hygiene care.

## Team Nursing

In the early 1950s, Eleanor Lambertsen (1953) and her colleagues proposed a system of team nursing to overcome the fragmentation of care resulting from the task-oriented functional approach and to meet the increasing demands for professional nurses created by advances in the technological aspects of care. **Team nursing** is the delivery of individualized nursing care to clients by a nursing team led by a professional nurse. A nursing team consists of registered nurses, licensed practical/vocational

## CRITICAL THINKING EXERCISE

You and your colleagues are interested in finding out if your healthcare organization meets the requirements for Magnet certification. Using the Forces of Magnetism found at [www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram/ForcesofMagnetism](http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram/ForcesofMagnetism)),

describe your organization in each of those areas. How does your organization compare with the criteria for Magnet recognition? What strategies would you and your colleagues use to encourage your organization to achieve Magnet recognition?



nurses, and, sometimes, nursing assistants. This team is responsible for providing coordinated nursing care to a group of clients during a shift. Compared to the functional system, team nursing emphasizes humanistic values and responds to the needs of both clients and employees. It stresses individualized client care on a personal level rather than task-oriented care on an impersonal level. The professional nurse leader motivates employees to learn and develop skills and instructs them, supervises them, and provides assignments that offer potential for growth. Earliest models of team nursing focused on communication within the nursing care team and little communication, if any, with other members of the healthcare team (e.g., physicians, therapists). Finkelman (2012, p. 121) states that “the team model has been changed to meet changes in organizations and leadership corresponding to the needs for better consistency and continuity of care, as well as collaboration and coordination.”

## Primary Nursing

Primary nursing, a system focused on the therapeutic relationship between the patient and a named primary nurse who assumes responsibility for the patient’s plan of care for his or her length of stay, was introduced at the Loeb Center for Nursing and Rehabilitation in the Bronx, New York. Primary nursing is a method of providing comprehensive, individualized, and consistent care. Primary nursing should not be confused with primary care, in which care is focused on health promotion and illness/injury prevention.

Primary nursing uses the nurse’s clinical and technical knowledge and management skills. The primary nurse assesses and prioritizes each client’s needs, identifies nursing diagnoses, develops a plan of care with the client, and evaluates the effectiveness of care. Associates provide some care, but the primary nurse coordinates it and communicates information about the client’s health to other nurses and health professionals. Primary nursing encompasses all aspects of the professional role, including teaching, advocacy, decision making, and continuity of care. Concerns with this model related to whether this model required an all-RN staff, which was considered to be costly, and if 24-hour accountability required 24-hour availability, which was considered to be unfeasible.

## Interdisciplinary Team Model

The Institute of Medicine (2003) charged all healthcare professionals to improve the quality of health care by improving the communication and collaboration among and between healthcare professionals by focusing on

interdisciplinary or interprofessional team building. The interprofessional team consists of all disciplines required to provide quality care to an individual client. For example, the team of a client with a diagnosis of diabetes who has had a recent below-the-knee amputation will include the nurse, the primary physician, the surgeon who did the amputation, a dietitian, a physical therapist, an occupational therapist, and, possibly, a social worker or psychologist. Each team member brings his or her expertise to help the client (and his or her family) achieve a quality outcome. All team members focus on the client’s needs and collaborate to meet those needs based on the team member’s specific area of expertise, sharing that expertise with other members of the team. This team approach expects to improve client outcomes, while decreasing duplication of services and complications, and thereby, decreasing healthcare costs. Finkelman and Kenner (as cited in Finkelman, 2012, p. 123) cite the advantages of the interdisciplinary team as:

- Decreased fragmentation in a complex care system.
- Effective use of multiple discipline expertise.
- Decreased utilization of repetitive or duplicate services.
- Increased creative or innovative solutions to complex problems.
- Increased learning for team members about different roles and responsibilities, communication and coordination, and how to better plan care.
- Providing motivation and increased self-esteem in team and individual performance.
- Greater sharing of responsibility.
- Empowering members to speak up.

Healthcare organizations continue to explore models for delivering quality care to consumers. The goals in developing models of care include providing quality care at an affordable cost. In determining what constitutes quality care, one must consider methods of improving continuity of care through decreased fragmentation, decreasing medical errors that lead to longer hospital stays, decreasing complications that lead to rehospitalization, and improving health education to clients and their families.

## Reflect On . . .

- the delivery of nursing and health care in your practice setting. How would you describe the model of care? What problems do you see in the delivery of healthcare services to your clients? What suggestions do you have for improving healthcare delivery in your practice setting?

- interdisciplinary team care. What are your experiences in working with other members of the healthcare team? What have you learned from other healthcare professionals? How have other healthcare professionals helped you in providing better outcomes for your patients?

## Case Management

Case management was pioneered at the New England Medical Center in the 1980s. Initially, public health and psychiatric/mental health nurses served as case managers. Today, case management is used in insurance-based programs, employer-based health programs, workers' compensation programs, maternal-child health settings, mental health settings, and hospital-based practice. **Case management** is defined as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes" (Case Management Society of America, 2015). Case managers assist clients through the complex healthcare system with the goal of increasing the quality of life in a cost-effective way. Case management enables patients, their families, and their healthcare providers to be actively involved in providing for ongoing care needs. Nurse case managers

combine their clinical knowledge, communication skills, and nursing process skills to assist clients in a variety of clinical settings. The activities of case management require the nurse to integrate a variety of disciplines and services in coordinating care throughout the client's span of illness. For clients with chronic illness, case management focuses on assisting the client to adapt to the illness through mobilization of appropriate resources to ensure quality outcomes. Collaboration, coordination, information processing, and information exchange are essential competencies in this role. The case manager must be familiar with eligibility criteria for the different services that the client needs.

Effective case managers must have strong skills in critical thinking, communication, negotiation, and collaboration in addition to expert knowledge in clinical nursing. Case managers serve as patient advocates because they provide the link between the client, the healthcare provider, and the payer. Case managers also function as client advocates by providing for client and family education, wellness, and prevention services. They also work to obtain resources, improve access, and achieve a smooth transition for clients along the care continuum. Functions of nurse case managers can be seen in the accompanying box.

To be eligible for certification as a nurse case manager, the American Nurses Credentialing Center (2013a) requires that the applicant "possess a current, active RN

## Functions of Nurse Case Managers

### Assessing and Analyzing

- Review client demographic data
- Administer assessment tools and risk screens
- Review client history and current health status
- Validate clinical data
- Identify client problems
- Identify and communicate with members of the client's interdisciplinary healthcare team
- Identify educational needs of clients and their support persons and their readiness to learn
- Identify target populations in disease management programs

### Planning

- Identify client health goals
- Identify available resources
- Plan and coordinate client care with members of the interdisciplinary healthcare team

### Implementing/Intervening

- Promote coordination, cooperation, collaboration, and consistency within and among healthcare team members
- Assist client in navigating through the healthcare system
- Interpret benefits available to client
- Link client to needed services
- Identify opportunities for health promotion and injury/illness prevention
- Advocate for client needs

### Evaluating

- Monitor adherence
- Identify barriers to availability, accessibility, and affordability of illness/injury management
- Evaluate support systems (individual, family, significant other, and community)
- Monitor delivery of services
- Examine patterns of over- and/or underutilization of resources

license in a state or territory of the United States, or the professional, legally recognized equivalent in another country,” have practiced full time as an RN for the equivalent of 2 years, have at least 2,000 hours of clinical practice in case management nursing within the previous 3 years, and have completed 30 hours of continuing education in case management during the last 3 years.



**InfoQuest:** Search the Internet at [www.nursingworld.org](http://www.nursingworld.org) for information about becoming certified as a case manager.

## Differentiated Practice

**Differentiated nursing practice**, as described by Clark (2009), differentiates “nurses by level of education, expected clinical skills or competencies, job descriptions, pay scales, and participation in decision making” (p. 357). Differentiated practice models recognize the broad domain of professional nursing, the multiple roles and responsibilities that nurses assume, and the contribution of all nursing personnel as valuable and unique. Differentiated practice models include nurses prepared at all levels: associate degree/diploma, baccalaureate degree, master’s degree, and doctorate, recognizing the diversity of these roles. Marriner-Tomey (2009) suggests that “the competency model of differentiated practice can use the levels of practice defined by Benner (1984); (1) novice, (2) advanced beginner, (3) competent, (4) proficient, and (5) expert” (p. 398). Additionally, the ANA standards of practice, which differentiate between the competencies of the RN and the advanced practice nurse (APN), can be used to determine roles and responsibilities. The ANA standards of practice include assessment, diagnosis, outcomes identification, planning, implementation, coordination of care, health teaching and health promotion, consultation (APN only), prescriptive authority and treatment (APN only), and evaluation. Standards of professional performance include ethics, education, evidence-based practice and research, quality of practice, communication, leadership, collaboration, professional practice evaluation, resource utilization, and environmental health.

Differentiated practice can improve client care and contribute to client safety. Used effectively, differentiated practice models allow for the effective and efficient use of resources. Additionally, differentiated practice can help nurses to develop their own career goals within a professional framework.

## Reflect On . . .

- your own nursing practice. To what degree do you meet each of the Standards of Clinical Practice as described in the *ANA Nursing: Scope and Standards of Practice*? To what degree do you meet each of the Standards of Professional Performance as described in the *ANA Nursing: Scope and Standards of Practice*?

## Shared Governance

In **shared governance**, staff nurses are empowered to actively participate in decision making at all levels of the organization. Shared governance is designed to integrate the core values and beliefs that professional practice embraces as a means of achieving quality care. Many of these core values are addressed in the ANA publication *Nursing: Scope and Standards of Practice* (2010), and some are discussed throughout this text. The focus of shared governance is to encourage nurses to participate in decision making at all levels of the organization, either at their own request or as part of their job criteria. More commonly, nurses participate through serving in decision-making groups, such as committees or task forces. Nurses may serve on committees such as institutional safety and security, pharmacy and therapeutics, patient satisfaction, infection control, and others that affect the organizational environment. The decisions they make may address employment conditions, cost-effectiveness, long-range planning, productivity, and wages and benefits. Hospitals aspiring to ANCC Magnet status are required to demonstrate active involvement of nurses in organizational decision making. The underlying principle of shared governance is that employees will be more committed to an organization’s goals if they have had input into planning and decision making. Huber (2014, p. 249) states that “shared governance promotes involvement, investment, participation, sharing of power, interdependence, cooperation, horizontal relationships, autonomy, and accountability for nursing decisions.”

## Reflect On . . .

- the organization where you work. Is there a system of shared governance in place? What opportunities do staff nurses have to participate in the decision-making processes of the organization? Do you serve on any organizational committees? If you do, what types of decisions has your committee or task force made? What have you learned by participating in shared governance?

### CRITICAL THINKING EXERCISE

You are the nurse-manager on a 30-bed nursing unit. You and your staff have decided to analyze the effectiveness of your unit's current model of nursing care delivery and are considering making a change to a different model. What are the advantages and disadvantages of your current model of nursing care delivery? What specific

outcomes would you like to see by making a change? Which model might be more effective for your nursing unit? What factors will influence your decision about making a change to a different model of nursing care delivery? How would you go about implementing a different model of nursing delivery in your current practice setting?



**InfoQuest:** Search the Internet at [www.nursingworld.org](http://www.nursingworld.org) for additional information about shared governance and Magnet hospital criteria. Does your organization meet the requirements for Magnet status?

## Mentors and Preceptors

Mentoring is widely used as a strategy for career development in nursing. A **mentor** is a “wise and trusted advisor who guides others on a particular journey. A mentor provides support, challenge, and vision” (Porter-O’Grady & Malloch, 2013, p. 393). Thus, the nurse being mentored, also called a *mentee*, is often early in her or his career development. Most nursing literature describes the nurse-mentor/mentee relationship as important for career development in nursing administration or nursing education. Through mentoring, the experienced nurse can also foster the professional growth of the nurse mentee, who may, in turn, choose to mentor those who follow. Marriner-Tomey (2009, p. 373) describes three phases to the mentoring process:

1. The *invitational phase*. In this phase, the mentor must be willing to use time and energy to nurture an individual (mentee) who is goal directed, willing to learn, and respectfully trusting of the mentor. The nurse-mentor invites the mentee to share knowledge, skill, and personal experiences of professional growth.
2. The *questioning phase*. In this phase, the nurse-mentee experiences self-doubt and fear of being unable to meet the goals. The mentor helps the mentee clarify goals and the strategies for achieving them, shares personal experiences, and serves as a sounding board and a source of support during times of doubt.
3. The *transitional phase*. In this phase, the mentor assists the mentee to become aware of the mentee’s own strengths and uniqueness. The mentee now is able to mentor someone else.

Mentors provide support. Often, the mentor relationship is one of teacher-learner. The mentor instructs the mentee in the expected role, introduces the mentee to those who are important to the achievement of goals, listens to and helps the mentee evaluate ideas in light of institutional policy, and challenges the mentee to advance her or his own professional practice. Marriner-Tomey (2009, p. 373) describes a mentor as “a confidant who personalizes role modeling and serves as a sounding board for decisions.”

Nurses who wish to improve and advance their professional practice, whether in education, administration, or clinical practice, should seek mentors to assist them. Mentors usually are of the same gender, 8–14 years older, and in a position of authority in the organization. Most are knowledgeable individuals who are willing to share their knowledge and experience. Mentors often choose mentees because of their leadership or managerial qualities. Mentoring is a process that can promote the personal professional growth of both mentor and mentee.

A **preceptor** is an experienced nurse who orients a nurse who is new to the nursing unit and the organization. Preceptors are usually assigned to nurses who are new to the nursing unit to assist them in improving their clinical nursing skill and judgment necessary for effective practice in their environment. They also assist new nurses in learning the routines, policies, and procedures of the unit. Preceptors must be patient and willing to teach new nurses, and they must be willing to answer questions and clarify the expectations of the nurse’s role within the practice environment.

Although preceptors are usually assigned, mentors are more often sought out by the person being mentored. Mentors and preceptors are important for the successful development of a nurse from a beginning care provider to an expert practitioner and professional.

### Reflect On . . .

- your own mentoring experiences. Were you mentored, or did you seek out a mentor as a new graduate or as a new employee in a new practice



## RESEARCH CURRENT

## Is Our Focus Right? Workforce Development for Primary Health Care Nursing

The purpose of this study by McKinlay, Clendon, and O'Reilly was to explore the workforce development needs of experienced primary healthcare (PHC) nurses working in a provincial area of New Zealand. The study was conducted in three parts. First, a comprehensive review of the primary healthcare nursing workforce literature was done. The review of 58 papers revealed several themes: PHC clinical competencies, attributes and skills, overall education needs, preferred educational methods, and barriers and enablers to education. Based on these themes, a participant survey and questions for two focus groups (one leader/manager nurses [ $n = 13$ ], the other clinical nurses [ $n = 18$ ]) were developed. The study sample included 31 primary healthcare nurses who were invited to complete the survey and participate in a 1-hour focus group. The participant nurses represented a variety of PHC specialties: mental health, palliative care, district nursing, public health nursing, occupational health, and school and youth health nursing. Key education needs identified were leadership skills, computer skills, patient education approaches,

advanced assessment, evidence-based practice documentation and report writing, and political/strategic engagement. When asked to rank the 4 most important of 73 items discussed, the most frequently cited by the leader/manager nurses were (1) the need for and value of leadership; (2) the need for local availability of courses; (3) access to, promotion of, and guidance about educational courses and pathways; and (4) the need for career mentoring. When asked to rank the 4 most important of 65 items discussed, the clinical nurses cited (1) the cost of courses, (2) the need for career mentoring, (3) a desire to access library databases, and (4) attendance at educational courses. The investigators conclude that "when education, career mentoring and leadership development is simultaneously undertaken within a coordinated workforce development initiative, PHC nurses will be able to optimally use their skills in nursing service provision."

Source: "Is Our Focus Right? Workforce Development for Primary Health Care Nursing," by E. McKinlay, J. Clendon, and S. O'Reilly, 2012, *Journal of Primary Health Care*, 4(2), pp. 141–149.

setting? What qualities would you seek in a mentor? If you have been mentored, how did your mentor assist you in your socialization to your work setting, the organization, and the nursing profession?

- your own preceptoring experiences. Were you preceptored as a new employee in a new practice setting? What qualities would you seek in a preceptor? If you have been preceptored, how did your preceptor assist you in your orientation to your work setting, the organization, and the nursing profession?
- your own ability to mentor or preceptor a new nurse or new employee. What knowledge, attitudes, and skills do you have that would make you an effective mentor or preceptor? How will you develop additional knowledge, attitudes, and skills to be an effective mentor or preceptor?

## Networking

To function effectively in all nursing roles, but especially in leadership and management roles, the nurse needs to network with other professionals. A professional **network**

consists of people that nurses "may call on throughout their careers for assistance, support of ideas, and guidance" (Grossman & Valiga, 2013, p. 194). **Networking** builds linkages with people not only in nursing, but throughout the health professions and those organizations that are committed to quality health care. Networking takes place both within and outside the work environment; networking can take place in social venues as well as professional activities. Getting to know people helps build a trust relationship that can facilitate achievement of professional goals. It is easier to access people one knows than it is to access strangers. Networking is a long-term, deliberate process, a powerful tool for building relationships. Networking requires time, commitment, and follow-through. Networking is an opportunity for nurses to develop their careers, share information, organize for political action, and effectively promote change.

Active membership in professional organizations may be the nurse's most important networking tool. Other networking opportunities include (1) continuing education or university classes; (2) local, national, and international meetings of professional organizations; (3) socializing with professional colleagues; and (4) keeping in touch with former professors and nursing associates.

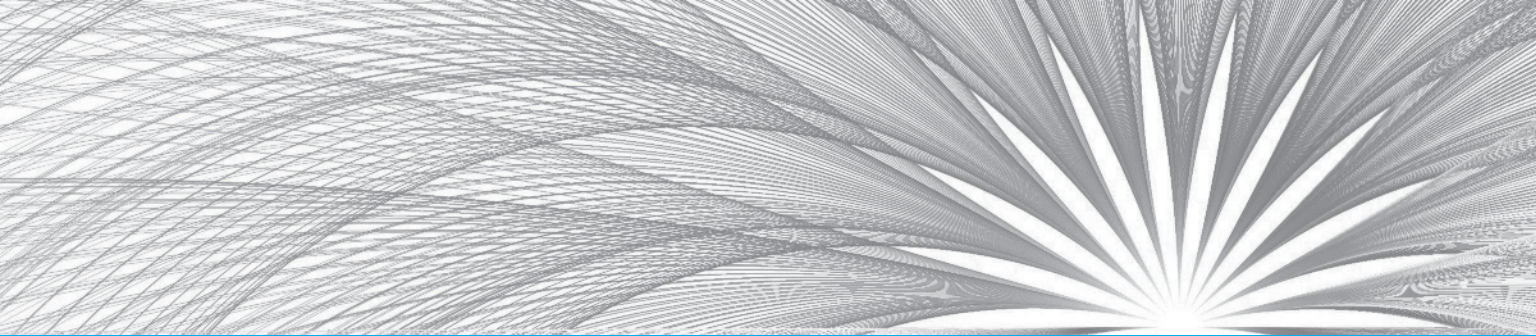
## Chapter Highlights

- Leadership and management are the responsibility of all professional nurses. Knowledge of the different, yet intertwined, roles of leader and manager is vital to nurses' ability to work within the ever-changing healthcare system.
- The American Nurses Association charges nurses with responsibilities in leadership and resource management through the document *Nursing: Scope and Standards of Practice*.
- Leadership is an informal role, achieved through experience and education, and requires initiative and innovative and independent thinking.
- Characteristics of successful leaders include integrity, courage, positive attitude, initiative, energy, optimism, perseverance, balance, ability to handle stress, and self-awareness.
- Leadership styles include authoritarian, democratic, laissez-faire, situational, charismatic, transactional, transformational, caring, quantum, and servant leadership.
- Management is a formal role based on designated authority. Management is usually responsible for resource management and requires use of effective leadership skills.
- Resources to be managed include equipment and materials, technology, finances, the environment, and personnel.
- The American Organization of Nurse Executives identifies five important areas of competency for nurse-managers and executives: communication and relationship building, knowledge of the healthcare environment, leadership skills, professionalism, and business skills.
- Management involves the basic functions of planning, organizing, leading and delegating, and controlling.
- The degree to which a nurse functions in these various responsibilities depends on the position the nurse holds in the organization.
- The Magnet Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence, and innovations in professional nursing practice. There are 14 forces of magnetism described by the American Nurses Credentialing Center.
- Nursing delivery models include total patient care, the functional method, team nursing, and primary nursing.
- The Institute of Medicine charges all healthcare professionals to improve the quality of health care by improving the communication and collaboration among and between healthcare professionals by focusing on interdisciplinary or interprofessional team building.
- Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
- Differentiated practice differentiates nurses by level of education, expected clinical skills or competencies, job descriptions, pay scales, and participation in decision making.
- Shared governance is a mechanism for nurses to be involved in the decision making of healthcare organizations.
- Mentors and preceptorships can have a positive influence on nurses' career development. Mentoring and preceptorships can assist in the personal and professional growth of both the mentee/precepted and the mentor/preceptor.
- A professional network consists of people that the nurse may call on throughout their careers for assistance, support of ideas, and guidance.

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# 10

## The Nurse's Role in Evidence-Based Health Care

### Chapter Outline

#### Challenges and Opportunities

#### Evidence-Based Practice

#### Research in Nursing

- Roles in Research
- Historical Perspective
- Ethical Concerns
- Approaches in Nursing Research
- Steps in the Research Process

#### Using Research in Practice

- Critiquing Research Reports
- Integration of Research into Practice

#### Chapter Highlights

### Objectives

1. Discuss the trend toward evidence-based practice in nursing.
2. Describe the nurse's role in research.
3. Analyze ethical concerns in nursing research.
4. Differentiate approaches in nursing research.
5. Identify the criteria for using research in nursing practice.
6. Identify available resources for evidence-based practice in nursing.

**E***vidence-based practice* (EBP) means using the best available evidence to guide care. That evidence typically comes from high-quality research. It brings together theory, clinical decision making and judgment, and knowledge of the research process; it incorporates them into the evaluation of research and scientific evidence. The result of this process is applying the best available research evidence to a specific clinical question and the application of clinically meaningful evidence to nursing practice.

The evidence-based practice movement began in medicine during the 1970s but has evolved within nursing since that time. Medicine tends to look at randomized clinical trials for evidence, but nursing has a broader perspective. Hierarchies of evidence have been developed that can be used in the selection of the best available evidence to support decision making and care. In 1998 the journal *Evidence-Based Nursing* was established to advance evidence-based nursing practice with the goal of facilitating the highest quality of care and the best client outcomes.

### Challenges and Opportunities

Closing the gap between research and practice is a continuing challenge. Nursing has often based practice upon tradition, authority, or past experience. Looking to research to provide answers represents a change in thinking for many. Implementing practice changes based upon research and evaluating those changes are also challenges.

Opportunities for providing high-quality care with accountability to clients and families are presented when practice decisions are based on scientific evidence and data. There is more



confidence in decision making when it is based upon information that has been tested and has demonstrated effectiveness in providing the best strategies to care for those needing nursing.

## Evidence-Based Practice

Evidence-based practice begins with questions about current practice, which are sometimes referred to as *burning questions*. For instance, does this procedure work well or would another work better? The question leads to a literature search or a systematic review. Systematic reviews are developed around specific aspects of care using the best available evidence and are available through resources such as the Agency for Health Care Research and Quality (U.S. Department of Health and Human Services) or the Cochrane Database of Systematic Reviews, which is available worldwide. These reviews are time-saving resources when they are available on the topic of concern. If no systematic review is available, then a literature search is needed using a search engine such as the Cumulative Index to Nursing and Allied Health (CINAHL). The identified studies must be critiqued in order to identify the best evidence, and from the best evidence a practice guideline can be developed. Measurable outcomes must be established so that effectiveness of the guideline can be tested. The guideline is then implemented, and outcome data are collected and evaluated to determine whether the guideline should be continued or revised. The process is often ongoing as practice evolves and improves and as new evidence emerges.

Nursing research represents a systematic search for the knowledge needed to provide high-quality care. It is one of the requirements for professionalism and supplies a foundation for accountability. A sound knowledge base is necessary for decision making in practice.

The knowledge base for practice in nursing has relied on information from a number of sources, representing varying degrees of rigor. Tradition as a source of knowledge has provided a substantial amount of the foundations for practice. Nursing has developed ways of doing things that have continued in practice simply because the way it has been done has been passed down. One such example is the routine monitoring of vital signs at specified times during a shift, regardless of the client's condition.

Another source of nursing knowledge is authority. Things are done a certain way because a physician or other person with a perceived higher level of knowledge or authority has recommended a particular way of providing care. Experience and trial and error have also provided an impetus for decision making and procedure development. As nurses become more grounded in a scientific rationale for practice, then logical reasoning and the application of research findings become the focus when care is planned.

### Reflect On . . .

- how nurses apply research in daily practice.
- what happens when problems related to care are identified by nurses.
- how solutions to problems are developed. What sources of information are used?

## RESEARCH CURRENT

### Defining What Evidence, Linking It to Patient Outcomes, and Making It Relevant to Practice: Insight from Clinical Nurses

A qualitative study was done by Jeffs, Beswick, Lo, Campbell, Ferris, and Sidani to explore nurses' perceptions of what constitutes evidence as part of evidence-based practice and how applicable it is to their everyday practice. An open-ended interview using three questions was conducted with 116 nurses at a hospital that had just implemented EBP guidelines. The three questions asked were:

1. How do you define evidence?
2. What are the sources of evidence that support your practice?
3. What makes evidence applicable to your daily practice?

Content analysis was used to identify themes. Nurses' perceptions of evidence were that it is research based, and

they also described it as "proven practice." Evidence was linked to patient outcomes, that is, improving patient satisfaction and benefiting patient care. Evidence was also an outcome of experience of other nurses, and although this evidence was recognized as less rigorous, the nurses believed it was a valid source of support for practice when observed patterns of outcomes were positive. Recommendations were made to create reports of evidence that are practical, readily available, and easy to read. This process would increase use in daily practice.

*Source:* "Defining What Evidence, Linking It to Patient Outcomes, and Making It Relevant to Practice: Insight from Clinical Nurses," by L. Jeffs, S. Beswick, J. Lo, H. Campbell, E. Ferris, and S. Sidani, 2013, *Applied Nursing Research*, 26, pp. 105–109.

## RESEARCH CURRENT

## The Experience of Implementing Evidence-Based Practice Change

This qualitative study by Irwin, Bergman, and Richards describes the experience of 19 teams of nurses from various healthcare settings who participated in the Institute for Evidence-Based Practice Change program. The program consisted of a 2½-day workshop of lectures and small-group work that provided content on evidence-based practice, literature searching, and development of an implementation plan, project management, and outcome measurement. Data were collected from reflective log entries reviewed by the two authors using content analysis to identify themes and concepts. The sample consisted of 140 log entries, and the following major themes were identified: key implementation actions, critical success factors, difficulties and frustrations, and the process of discovery.

The implementation strategies included these actions:

- Educational activities to inform staff and other disciplines
- Marketing by showcasing to administration and others
- Recognition of the work to provide incentive
- Development of Tools for Implementation such as flowcharts and templates

- Obtaining institutional review board (IRB) approval for the new protocols that require evaluation of outcomes

Critical success factors were time, support of administration, teamwork and engagement, communication, planning, and maintaining focus. Useful plan characteristics included small steps, clear and simple actions, and establishing deadlines. The difficulties and frustrations encountered were competing priorities, data collection and measurement, and staff turnover.

Discoveries were made along the way about practice and about each other in the teams, especially interdisciplinary discoveries. The spirit of inquiry was ignited and the nurses found empowerment through evidence. In the end the challenge was sustaining change, but that was found to be rewarding.

The implications for practice were identified as incorporating the critical success factors into the plan. The evidence-based project can lead to team building and interdisciplinary collaboration. Plans are needed that include small steps, clear actions, and deadlines.

*Source:* "The Experience of Implementing Evidence-Based Practice Change: A Qualitative Analysis," by M. M. Irwin, R. M. Bergman, and R. Richards, 2013, *Clinical Journal of Oncology Nursing*, 17(5), pp. 544–549.

The purposes of scientific research are description, exploration, explanation, and prediction and control. Empirical knowledge comes from scientific evidence and is developed through research. It is a characteristic of the scientific approach that it includes order and control and allows generalization of results. The findings are then applied to practice.

One way for a nurse to access empirical knowledge is to learn about research methods and be able to assess strengths and weaknesses of studies when reading them in professional journals. Another mechanism is to use systematic reviews that are conducted by expert groups for the purpose of critiquing studies and providing recommendations to guide practice. The Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research) is a federal agency that provides evidence reports on numerous topics through its Evidence-Based Practice Centers. The evidence reports may be accessed online through the agency's website. As nurses move toward evidence-based care, they must be involved in clinical decision making and protocol development that strive to incorporate the best information available.



**InfoQuest:** Visit the website of the Agency for Healthcare Research and Quality and look at the topics for which there are evidence reports. Select a topic that is of interest to you and read the report. How much of the information was based upon nursing research?

Visit the website of the Cochran Collaboration and review the international efforts of the organization as a resource in retrieving evidence for health care worldwide.

## Research in Nursing

Research is directed toward building a body of nursing knowledge about the effects of nursing action on human responses of individuals, families, groups, or communities, within which the client is seen holistically incorporating physiological, psychological, spiritual, social, cultural, developmental, and economic aspects. For example, when a person has a head injury, the nurse needs to understand the body's processes for dealing with the increased pressure

within the head and the changes these bring about in the patient's condition. At the same time, the nurse focuses on care that can maintain the person's cognitive (thinking and feeling) processes. A nurse would also examine the person's life patterns that could lead to other head injuries. In addition to reflecting the concern for the whole person, a nursing perspective implies 24-hour responsibility. Thus, this viewpoint encompasses all of the factors in a client's environment, such as fatigue, noise, sensory deprivation, nutrition, and positioning that may influence coping patterns.

The information revolution that is transforming the present and shaping the future has made reading, understanding, and using nursing research as fundamental to professional practice as the knowledge of asepsis, application of the nursing process, and communication skills. Research enables the nurse to describe situations about which little is known, explain phenomena that have not been well understood, predict probable outcomes, control the occurrence of undesired outcomes, and initiate activities to promote desired client outcomes. Research guides nurses' decisions and actions so that they are clinically appropriate and cost-effective and result in positive outcomes.

## Roles in Research

Florence Nightingale (1860/1969) is credited with being the first to identify the need for empirical evidence and research to support practice. She emphasized the need for facts rather than opinions. One hundred years later nurses began to follow her advice with the foundation of institutions of higher learning for nursing education and the

creation of advanced degrees. The American Nurses Association (2010) describes evidence-based practice as making the best clinical decisions using evidence from research “blended with internal evidence (i.e., practice-generated data), clinical expertise, and healthcare consumer values and preferences to achieve the best outcomes for individuals, groups, populations, and healthcare systems” (pp. 16–17). The ANA's Standard of Practice 9, shown in the accompanying box, says that integrating evidence and research findings into practice is expected of the registered nurse.

Research-based practice is seen as essential for effective and efficient patient care. The development and utilization of research depends upon the interaction between researchers and clinicians. Nurses in clinical practice identify the problems in need of investigation and collaborate with researchers from nursing and other disciplines, who design studies to address the identified problems and collect and analyze the data. It is again up to the clinicians to determine the appropriate application of those findings to practice.

Nurses are sometimes employed on care units or in services where research is conducted by a variety of disciplines. It is the nurse's responsibility to support the research protocol and uphold the scientific rigor of the study by carefully maintaining the research protocol. At the same time, it is the right of the nurse to be informed of the purpose of the study and to understand the protocol. Likewise, the nurse has a right to know that human subjects are being protected, that the study has been reviewed and approved by an IRB (Institutional Review Board), and that the researchers are qualified to do the research.

## ANA Standard on Evidence-Based Practice and Research

### Standard 9. Evidence-Based Practice and Research

The registered nurse integrates evidence and research findings into practice.

#### Competencies

The registered nurse:

- Utilizes current evidence-based nursing knowledge, including research findings, to guide practice.
- Incorporates evidence when initiating changes in nursing practice.
- Participates, as appropriate to education level and position, in the formulation of evidence-based practice through research.
- Shares personal or third-party research findings with colleagues and peers.

### *Additional competencies for the graduate-level prepared specialty nurse and the APRN*

The graduate-level prepared specialty nurse or the advanced practice registered nurse:

- Contributes to nursing knowledge by conducting or synthesizing research and other evidence that discovers, examines, and evaluates current practice, knowledge, theories, criteria, and creative approaches to improve healthcare outcomes.
- Promotes a climate of research and clinical inquiry.
- Disseminates research findings through activities such as presentations, publications, consultation, and journal clubs.

Source: *Nursing Scope and Standards of Practice* (2nd ed.), by the American Nurses Association, 2010, Silver Spring, MD: Publishing Program of ANA, p. 51. Used by permission.

Preparation for these research roles begins at the undergraduate level as the student learns about research and develops practice that is based on the critical analysis of research findings. The preparation of nurse scientists who have primary responsibility for conducting research occurs in graduate education. It begins at the master's level and is concentrated at the doctoral and postdoctoral level.

During the curriculum of the BSN program, students will have a course in research that provides the tools needed for implementing evidence-based practice. It is not the purpose of this chapter to present research in that depth, but a brief overview is given to provide a context for the discussion of evidence-based practice.

## Historical Perspective

As early as 1854, Florence Nightingale demonstrated the importance of research in the delivery of nursing care. When Nightingale arrived in the Crimea that November, she found the military hospital barracks overcrowded, filthy, rat- and flea-infested, and lacking in food, drugs, and essential medical supplies. As a result of these conditions, men died from starvation and diseases such as dysentery, cholera, and typhus (Woodham-Smith, 1950, pp. 151–167). By systematically collecting, organizing, and reporting data, Nightingale was able to demonstrate that by instituting sanitary reforms, mortality rates from contagious disease could be significantly reduced.

Although the Nightingale tradition influenced the establishment of American nursing schools in 1873, the research approach did not take hold until the beginning of the 20th century. Recognizing the need for nurses prepared to conduct research, nursing leader Isabel Stewart integrated research into the graduate nursing curriculum at Teachers College, Columbia University, and published the first research journal in nursing in the late 1920s, the *Nursing Education Bulletin*. The journal *Nursing Research* was established in 1952 to serve as a vehicle to communicate nurses' research and scholarly productivity. The publication of many other nursing research journals followed, some dedicated to research and others combining clinical and research articles in the publications.

The National Institute of Nursing Research (NINR) was established as a Center at the National Institutes of Health (NIH) in 1986. In 1993, it was elevated to an institute, placing it among the Institutes and Centers within NIH and adding a clinical and nursing perspective to the mainstream of the biomedical and behavioral research in the United States. According to its mission statement:

The mission of the National Institute of Nursing Research (NINR) is to promote and improve the health of individuals, families, communities, and

populations. The Institute supports and conducts clinical and basic research and research training on health and illness across the lifespan to build the scientific foundation for clinical practice, prevent disease and disability, manage and eliminate symptoms caused by illness, and improve palliative and end-of-life care. (National Institute of Nursing Research, 2013)

The strategic plan for NINR identifies five areas of research in which it will invest to advance the science of health:

- Enhance health promotion and disease prevention
- Improve quality of life by managing symptoms of acute and chronic illness
- Improve palliative and end-of-life care
- Enhance innovation in science and practice
- Develop the next generation of nurse scientists (National Institute of Nursing Research, 2011).

Sigma Theta Tau International (STTI) is the honor society for nursing, and its mission is to support the learning, knowledge, and professional development of nurses committed to making a difference in health worldwide. In support of its mission, STTI offers a variety of research grants, many of which are cosponsored with other nursing organizations; information is available on the STTI website. The Virginia Henderson International Nursing Library provides online dissemination of nursing research and evidence-based practice materials.



**InfoQuest:** Visit the website of Sigma Theta Tau International and explore the resources available that support nursing research and evidence-based practice. Scroll through the resources available through the Virginia Henderson Global Nursing e-Repository.

The American Nurses Foundation also maintains a Research Grants Program that was founded over 50 years ago to encourage the research career development of nurses. This program continues to grow and support scientific research for advancing the practice of nursing, promoting health, and preventing disease.

## Ethical Concerns

Because nursing research usually focuses on humans, a major nursing responsibility is to be aware of and to advocate on behalf of clients' rights. Participation in research studies must be voluntary, and all clients must be informed



about the consequences of consenting to serve as research subjects. In other words, there must be informed consent to participate. The client must be able to assess whether an appropriate balance exists between the risks of participating in a study and the potential benefits, either to the client or to the development of knowledge.

Research ethics not only protect the rights of human subjects but also encompass a broader range of principles. These guidelines are based on historic documents, such as the Nuremberg Code (1949) and the Declaration of Helsinki (adopted in 1964 by the World Medical Assembly and revised in 1975), and on U.S. federal regulations, all of which set standards governing the conduct of research involving human subjects. The notorious Tuskegee study in Alabama, which began in 1932 and ended in 1972, studied Black men with syphilis. The study violated ethical principles in that informed consent was not obtained, confidentiality was violated, and treatment was withheld when it became available. This study illustrates how subjects' human rights were violated for a period of 40 years while a research study was being conducted.

All nurses who practice in settings where research is being conducted with human subjects or who participate in such research as data collectors or collaborators play an important role in safeguarding the following rights.

### Right Not to Be Harmed

The U.S. Department of Health and Human Services defines risk of harm to a research subject as exposure to the possibility of injury going beyond everyday situations. The risk can be physical, emotional, legal, financial, or social. For example, withholding standard care from a client in labor for the purpose of studying the course of natural childbirth clearly poses a potential physical danger. Risks can be less overt and involve psychological factors, such as exposure to stress or anxiety, or social factors, including loss of confidentiality or privacy.

### Right to Full Disclosure

Even though it may be possible to collect data about a client as part of everyday care without the client's particular knowledge or consent, to do so is considered unethical. Full disclosure is a basic right. It means that deception, either by withholding information about a client's participation in a study or by giving the client false or misleading information about what participating in the study will involve, violates ethical principles.

### Right of Self-Determination

Many clients in dependent positions, such as people in nursing homes, feel pressured to participate in studies. They feel that they must please the doctors and nurses who are responsible for their treatment and care. The right of

self-determination means that subjects should feel free from constraints, coercion, or any undue influence to participate in a study. Masked inducements, such as suggesting to potential participants that by taking part in the study they might become famous, make an important contribution to science, or receive special attention, must be strictly avoided. Nurses must be assertive in advocating for this essential right.

### Right of Privacy and Confidentiality

Privacy enables a client to participate without worrying about later embarrassment. There should be either anonymity or confidentiality, depending upon the nature of the study. **Anonymity** of a study participant is ensured when even the investigator cannot link a specific person to the information reported. **Confidentiality** means that any information collected in a study will not be made public or available to others without the person's consent. Confidential information is not necessarily anonymous. Investigators must inform research subjects about the measures that provide for these rights. Such measures may include the use of pseudonyms or code numbers or reporting only aggregate or group data in published research.

### Approaches in Nursing Research

There are two major approaches to investigating phenomena in nursing research. These approaches originate from different philosophical perspectives and use different methods for collection and analysis of data.

#### Quantitative Research

**Quantitative research** uses precise measurement for data collection and analyzes numerical data. The design is rigorously controlled, and statistical analysis is used to summarize and describe findings or to test relationships among variables. The quantitative approach is most frequently associated with a philosophical doctrine called *logical positivism*, which asserts that scientific knowledge is the only kind of factual knowledge. It is viewed by some as hard science and tends to use deductive reasoning and emphasize measurable aspects of the human experience. The following are examples of research questions that lend themselves to a quantitative approach:

- What are the differential effects of continuous versus intermittent application of negative pressure on tracheal tissue during endotracheal suctioning?
- Is the use of therapeutic touch effective in reducing pain perception postoperatively?
- Are there differences in skin breakdown between premature infants bathed with plain water and those bathed with bacteriostatic soap?

### Qualitative Research

**Qualitative research** investigates phenomena through narrative data that describe the phenomena in an in-depth and holistic fashion. The research design is typically more flexible and less controlled than quantitative designs. The data may be the transcription of an unstructured interview, and the analysis looks for patterns and themes that come from the narrative data by using an inductive approach. This allows exploration of the subjective experiences of human beings and can provide nursing with a better understanding of phenomena from the client's perspective. Qualitative research does not allow for conclusions to be drawn or comparisons to be made; it does not show cause and effect. The results are in-depth descriptions that may assist the nurse in understanding a phenomenon that is not well understood. The qualitative approach is appropriate for the following types of questions:

- What is the nature of the bereavement process in spouses of clients with terminal cancer?
- What is the nature of coping and adjustment after a radical prostatectomy?
- What is the process of family caregiving for older family relatives with Alzheimer's dementia as experienced by the caregiver?

### Mixed Methods

**Mixed-methods** research combines two or more methods in the same study and integrates qualitative and quantitative data. This allows for a conclusion generated by integrating the results. The results from one method may inform the other. For instance, the qualitative descriptions may provide an explanation and a context for the quantitative results, and the quantitative results may provide more generalizability for the qualitative findings. When the mixed methods produce results that reinforce each other and are complementary, the validity of the findings is enhanced. Mixed methods allow collaboration among researchers working on similar problems but with different methods.

Mixed-methods research can be more expensive because it takes more resources to collect, analyze, and integrate the data from more than one method. Likewise it takes more researcher time to complete. The development of new data collection tools may use mixed methods; qualitative data may be collected to suggest items for new quantitative instruments that are then subjected to statistical analysis to establish reliability and validity.

The most important consideration in selecting a research design is appropriateness to the question. The method must use a design that collects the data that will answer the research question.

### Steps in the Research Process

There are several important steps in the conduct of research, and each of these requires decision making by the researcher. The first step is identification of the problem. Ideally, this is the step at which the nurse in clinical practice makes known the need for information to support practice. Once the problem is clearly identified and a statement is formulated, the next step is a search of existing literature, especially related research. Before the researcher designs a study to answer the question, the state of current knowledge should be known.

A literature review will identify other studies related to the topic and can serve several purposes. It can provide an answer or partial answer to the question and may even eliminate the need to conduct further research, or it may change the problem focus. Gaps in the literature will support the need for research. In performing a literature review, the focus should be on primary rather than secondary sources. A **primary source** is a publication authored by the person who conducted the research. A **secondary source** is a description of a study or studies prepared by someone other than the person who conducted the research. Review articles describing a number of studies on a particular topic are considered secondary sources. The secondary sources are helpful in identifying studies that are related to the topic of interest, but a researcher needs to rely on primary sources when designing a study.

One of the challenges in conducting a literature review is identifying the sources to be included. Electronic databases and computer searches have become the mainstay of literature searches. The Cumulative Index of Nursing and Allied Health Literature is one of the most common databases accessed by nurses. MEDLINE also references nursing journals. Google Chrome and other popular search engines are not good choices for literature reviews when one is interested in research and evidence-based practice. They do not provide the most reliable scientific information. Sources such as Wikipedia likewise do not provide carefully selected and verifiable information. Articles found in peer-reviewed professional journals are necessary when developing a basis for practice.



**InfoQuest:** Choose a topic of interest to you and conduct a literature search using CINAHL. How many of those articles are research reports?

Once the researcher has identified the problem, reviewed the literature, and identified specific research questions or hypotheses (predictions of outcomes), an

appropriate study can be designed to answer the questions or test the hypotheses. Decisions need to be made regarding who should be included in the study and how data are to be collected and analyzed. If the study is quantitative, the researcher needs to select a sample that is representative of the population of interest so that findings from the study are applicable or generalizable to that group. Data collection methods will determine the quality of the data being analyzed in the study. The researcher will have to decide on a reasonable way to either observe or measure the concepts in the study; this is referred to as the **operational definition of the variable**.

Data collection can be done according to three categories: biophysiological measures, observation, and self-report by the study participants or subjects. Decisions need to be made about the amount of control over outside influences (extraneous variables) and timing of data collection. The tools selected for data collection need to be evaluated for reliability and validity, that is, how well they measure what they claim to measure and how consistently they do so. A procedure or protocol must be developed, clearly spelled out, and consistently adhered to during the study. An appropriate method of data analysis must be selected, whether the study is quantitative (descriptive or inferential statistics) or qualitative (content analysis and a search for themes).

Once the data are analyzed and results are known, the researcher must be very careful about the interpretation of those results and be certain that any conclusions are directly supported by the study data. It is at this point that the practicing nurse is again a valuable team member. The utilization of research in practice and the development of evidence-based practice require a close partnership between the nurse scientist and the nurse in clinical practice.

## Using Research in Practice

### Critiquing Research Reports

If professional nurses are to use research, they must first learn to conduct a critical appraisal of research reports published in the literature. A research critique enables the nurse as a research consumer to evaluate the scientific merit of the study and decide how the results may be useful in practice. Critiquing involves intensive scrutiny of a study, including its strengths and weaknesses, statistical and clinical significance, and the generalizability of the results.

Polit and Beck (2012) proposed that the following elements be considered in conducting a research critique: substantive and theoretical dimensions, methodological

dimensions, ethical dimensions, interpretive dimensions, and presentation and stylistic dimensions.

- **Substantive and theoretical dimensions.** For these dimensions, the nurse needs to evaluate the significance of the research problem, the appropriateness of the conceptualizations, and the theoretical framework of the study, along with the congruence between the research question and the methods used to address it.
- **Methodological dimensions.** The methodological dimensions pertain to the appropriateness of the research design, the size and representativeness of the study sample as well as the sampling design, the validity and reliability of the instruments, the adequacy of the research procedures, and the appropriateness of the data analysis techniques used in the study.
- **Ethical dimensions.** The nurse must determine whether the rights of human subjects were protected during the course of the study and whether any ethical problems compromised the scientific merit of the study or the well-being of the subjects.
- **Interpretive dimensions.** For these dimensions, the nurse needs to ascertain the accuracy of the discussion, conclusions, and implications of the study results. The findings must be related back to the original hypotheses and the conceptual framework of the study. The implications and limitations of the study should be reviewed, together with the potential for replication or generalizability of the findings to similar populations.
- **Presentation and stylistic dimensions.** The manner in which the research plan and results are communicated refers to the presentation and stylistic dimensions. The research report must be detailed, logically organized, concise, and well written. Research that is poorly presented or poorly communicated is of little value to nurses in practice.

Nurses in practice often do not feel comfortable critiquing research. A partnership with nurse researchers may be helpful; the nurse researcher can provide expertise in research methods and serve as a mentor to practicing nurses.

### Integration of Research into Practice

Research utilization, while often used synonymously with evidence-based practice, is actually narrower in scope. In the 1970s, the lag between publication of research and the transfer of findings into actual practice was recognized. The Western Interstate Commission for Higher Education (WICHEN) and the Conduct and Utilization of Research in Nursing (CURN) projects were developed to promote the dissemination and utilization of nursing research

(Horsley, Crane, & Bingle, 1978; Krueger, Nelson, & Wolanin, 1978). As a result, research-utilization training programs and research-based innovations were implemented. The focus was solely on research and might have included only a single study.

Research on the process of adoption of research-based innovations has used the theory of diffusion of innovation devised by Everett Rogers (2003). According to this theory, a nurse passes through four stages before adopting research-based ideas or practices:

1. *Knowledge stage*—when a nurse learns about an innovation
2. *Persuasion stage*—when a nurse develops a positive or negative attitude about the innovation
3. *Decision stage*—when a nurse determines whether to adopt or reject the innovation
4. *Implementation stage*—when the nurse uses the innovation regularly

### **Inhibitors and Facilitators of Integrating Research**

Factors that inhibit and facilitate the process of using research in clinical settings have been identified. The availability of research findings and nurses' attitudes toward research are related to research utilization.

Barriers to evidence-based practice have been summarized as clinician barriers and environmental barriers (Sams et al., 2004). Clinician barriers include a lack of training in the use of evidence, resulting in a low level of comfort with implementing evidence-based practice. This accompanies a lack of awareness of the research that is available. Nurses perceive a lack of authority to make change and believe that the benefits of change will be minimal. Environmental barriers include a lack of infrastructure support including access to evidence, little incentive to use evidence, and insufficient time allotted to develop evidence-based practice. There is a lack of collaboration, staff support, and management support.

Facilitators of evidence-based practice come from an understanding that effective change comes from a systematic approach that has administrative support within the organization. However, there must be education to support the process. Training can assist the practicing nurse to develop the knowledge and comfort level needed to participate. Innovations will be needed to bring the nursing workforce to a level where adoption of evidence into practice is integrated into everyday practice. The factors facilitating research utilization are those that provide nurses with information about research developments, including monthly research newsletters, research meetings, continuing education programs, computer networks, and research study guides (Caramanica et al., 2002; Tsai, 2003).

### **Criteria for Research Utilization**

If a nurse reads in a research journal that teaching guided imagery to clients was found to be effective in enabling clients to manage postoperative pain, should the nurse utilize the intervention in her or his own clients? How would a nurse know that the research she or he reads is ready for use in practice?

Haller, Reynolds, and Horsley (1979) formulated criteria for utilization of research in nursing practice, based on the CURN project. These criteria are replication, scientific merit, risk, clinical merit, clinical control, feasibility, cost, and potential for clinical evaluation.

**Replication** The criterion of replication requires that the results of a study be replicated a number of times before its findings are accepted as credible and applicable to practice. A change in current practice or procedure ordinarily should not be based solely on one study. Establishing a research base of three or more studies confirms the likelihood that the findings are true and prevents nurses from committing a type I error. A type I error is concluding that the intervention was effective when in reality it was not; in other words, it is a false positive.

**Scientific Merit** The scientific merit of a study is probably the single most important criterion in judging its readiness for application in practice. Scientific rigor is evident in all steps of the research project: the clarity of the research problem; adequacy of the literature review; and the appropriateness of the design, sampling, data collection procedures, and data analytic techniques. The validity and reliability of the data collection instruments used must also be evaluated.

Internal validity and external validity are key concerns. Internal validity is the degree to which the independent variable influences the dependent variable. A classic monograph by Campbell and Stanley (1963) discusses factors that threaten internal validity. An example is selection bias if subjects in a study are not randomly assigned to the experimental or control groups. If a statistically significant difference is found, it would be difficult to conclude whether the change in the dependent variable is truly attributable to the independent variable (the intervention) or whether it is related to some preexisting differences between the groups (extraneous variables).

External validity pertains to the degree to which the findings of the study can be generalized to similar settings and populations. Even if statistically significant differences are demonstrated, findings can be generalized to other settings or populations only if these settings and populations are similar to those of the study, that is, if the sample is representative of the target population.



**Risk** The degree of risk involved in using the findings of a study is another criterion to be considered. Nursing interventions that have been found effective through research may be readily implemented if they carry little risk. According to Haller et al. (1979), risk must be evaluated along with scientific merit. If a protocol entails serious risks, then the evaluation of scientific merit must be applied more stringently. The higher the risk the more precaution is needed in deciding to implement the findings.

**Clinical Merit** The criterion of clinical merit evaluates the degree to which research findings have the potential to solve an existing problem in the clinical setting. For example, nurses working in a neonatal nursery may be concerned about the pain that infants experience during blood drawing for laboratory tests or during surgical procedures. For nurses working on this unit, a published study by Campos (1994) that reported the effects of rocking and pacifiers on relieving heelstick pain in infants would be rated high for clinical merit.

**Clinical Control** Clinical control refers to the degree to which nurses are in control of the circumstances related to the implementation and evaluation of the research-based innovation. Nurses may not be able to exert clinical control if a research-based protocol requires collaboration or decision making by a team of health professionals. There may also be instruments or methods documented to be effective in research but unavailable to nurses in certain settings.

**Feasibility** The criterion of feasibility is defined as the degree to which resources—time, personnel, expertise, equipment—are available to implement the innovation. For example, the introduction of a new intervention may require the ordering and purchasing of equipment or supplies and in-service training for nursing staff, thus reducing the feasibility.

**Cost** Cost is always a vital consideration and is closely related to feasibility. A cost-benefit analysis would be important in order to weigh the costs against the benefits of implementing a new intervention. Benefits may include improved client outcomes or improved staff satisfaction.

**Potential for Clinical Evaluation** Potential for clinical evaluation pertains to the degree to which the variables in the original research base can be evaluated by nurses in the clinical setting. Specifically, this criterion requires that nurses have control over the variables in the protocol and that they possess the knowledge and skills needed to measure the outcome of the innovation.

What began in nursing as research utilization or the process of transforming research knowledge into practice has expanded into evidence-based practice. EBP is broader than research utilization and recognizes other sources of evidence, including the “value of the intuitive aspects of nursing practice” (Caramanica et al., 2002). Other sources of evidence include reliable data from quality improvement programs, evaluation projects, consensus of experts, and clinical experience. A number of models showing a hierarchy of evidence have been developed in nursing. Two examples of these models are the Stetler Hierarchy of Evidence and Melynck and Fineout-Overholt’s Rating for Hierarchy of Evidence. Stetler’s (2001, 2003) hierarchy lists the following sources of evidence, beginning with the strongest and ending with the weakest:

- Meta-analyses of controlled studies
- Individual experimental studies
- Quasi-experimental studies or matched case-control studies
- Nonexperimental studies
- Program evaluations, quality improvement (QI) projects, research utilization studies, and case reports
- Opinions of respected authorities and of expert committees

This model suggests that the value of the evidence be based upon the source of the information alone.

Melynck’s (2004) and Melynck and Fineout-Overholt’s (2005) hierarchy has some differences from Stetler’s. Beginning with the highest level and going to weakest, their hierarchy is as follows:

- Evidence from systematic review or meta-analysis of all relevant randomized clinical trials (RCTs) or evidence-based clinical practice guidelines based on systematic reviews of RCTs.

### CRITICAL THINKING EXERCISE

Select a research article from one of the nursing research journals. Apply the Haller et al. criteria for research utilization. Ask yourself whether the study has sufficient strength related to each of the criteria.

Decide whether you are comfortable applying the research findings to practice or whether you feel more research should be done before implementing a research-based protocol.

- Evidence obtained from at least one well-designed RCT
- Evidence obtained from well-designed controlled trials without randomization
- Evidence from well-designed case-control and cohort studies
- Evidence from systematic reviews of descriptive and qualitative studies
- Evidence from a single descriptive or qualitative study
- Evidence from the opinion of authorities and/or reports of expert committees

This model introduces the idea that the source of the evidence may not necessarily be the only criterion for evaluating it. The idea that the study must be well designed is incorporated in recognition that some research produces better evidence than other research. Figure 10.1 illustrates a hierarchy of levels of evidence.

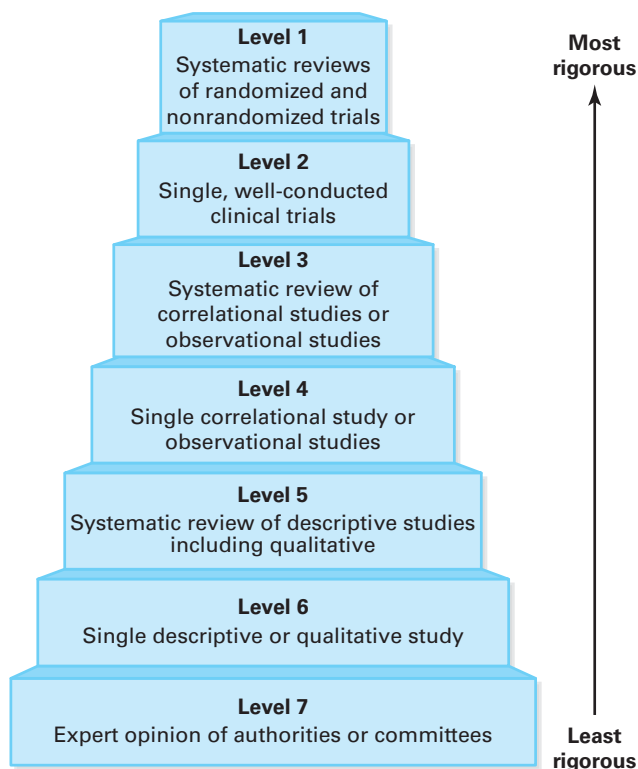
Evans (2003) has suggested that evidence be ranked as excellent, good, fair, or poor on three criteria: effectiveness/usefulness; appropriateness/applicability; and feasibility/cost benefit. Considering the level of evidence and the ranking of that evidence, the nurse can reach one of several conclusions:

- Strong evidence in support
- Evidence less well established
- Benefits balance with harms
- Inadequate data to support
- Evidence does not support
- Risk or harm or undue cost burden

Depending upon the conclusion, the nurse can then decide (1) to implement a protocol based upon the evidence along

**FIGURE 10-1**

An Evidence Hierarchy of Designs for Cause-Probing Questions



with an evaluation plan or (2) to not use the evidence in practice.

## RESEARCH CURRENT

### Collaborative Care for Depression and Anxiety Problems

Archer, Bower, Gilbody, Lovell, Richards, Gask, Dickens, and Coventry created a systematic review with meta-analysis to address the following question: How effective is collaborative care for anxiety and depression? The review included 79 randomized clinical trials of collaborative care with adults who were being treated for depression or anxiety. Changes in depression or anxiety were reported by self-report or by clinician-rated instruments. The outcomes were classified as short term (0–6 months), medium term (7–12 months), long term (13–24 months), and very long term (25 months or longer).

Collaborative care had to include a structured management plan, a multiprofessional approach (general practitioner plus at least one other health professional), scheduled follow-up to provide further treatment,

facilitated compliance or monitored symptoms and adverse events, and organized interprofessional communication. The comparison group received usual care that was not collaborative care.

Random effects meta-analysis was conducted. Collaborative care significantly improved depression symptoms and response in the short term, medium term, and long term but not the very long term. It significantly improved anxiety symptoms and response for the same periods of time. Collaborative care was associated with improvements in symptoms of depression and anxiety although the effect sizes were modest.

Source: "Collaborative Care for Depression and Anxiety Problems," by J. Archer, P. Bower, S. Gilbody, K. Lovell, D. Richards, L. Gask, C. Dickens, and P. Coventry, 2012, *Cochrane Database of Systematic Reviews*, Issue 10. Art. No.: CD006525.

**CRITICAL THINKING EXERCISE**

The previous Research Currents box shows an example of a systematic review and meta-analysis. It would fit at the top of the hierarchy of evidence. Looking at the

conclusions listed above that can result from the information, what conclusion would you reach? Would you use this evidence to guide practice?

**Research-Based Protocols and Procedures** Many hospitals and clinical agencies follow a compendium of policies, procedures, and protocols in specific client care situations. For example, there are procedures to be followed

when irrigating a Foley catheter, administering a nasogastric tube feeding, or performing wound care. Current research literature must be the basis for developing or revising these procedures or protocols.

**CRITICAL THINKING EXERCISE**

Nurses in a surgical trauma ICU noticed that patients were arriving on the floor mildly hypothermic. The nurses' burning question was: What is the best way to prevent heat loss in trauma patients before they are transferred to the ICU? A literature review indicated that a number of approaches might be effective but did not compare effectiveness. In cooperation with a nurse researcher, a comparative study was planned and implemented. The results of the study showed that warmed cotton blankets, forced-warm-air blankets, and reflective covering were all effective in maintaining body temperature. The patient assessment indicated a need for the intervention, but resources were not equal within the institution for each of the methods. The cost and availability of each were not equal. The nurses' experience identified problems in the use of two of the methods:

forced-warm-air blankets were difficult to transport and warmed cotton blankets cooled quickly and needed frequent replacement. Patient preference indicated that the forced-warm-air blankets were not as comfortable. The nurses in this example had data from a well-conducted RCT to show that all three methods were effective. However, other evidence pointed to the preference of using reflective blankets because they were more acceptable to the patients and were easier to manage by the nurses. The cost of the reflective blankets was somewhat more than cotton blankets alone. Based upon this information, what would your recommendation be for a heat loss prevention protocol in this situation?

*Source:* Based on "Evidence-Based Practice and Heat Loss Prevention in Trauma Patients," by J. S. Hayes, S. Tyler-Ball, S. S. Cohen, J. Eckes-Roper, and I. Puente, 2002, *Journal of Nursing Care Quality*, 16(4), pp. 13–16.

## Chapter Highlights

- Nursing research refers to research directed toward building a body of nursing knowledge about human responses to actual or potential health problems.
- Research is important in nursing to expand the scientific body of knowledge, to maintain specific accountability to the public, to document nursing contribution to healthcare delivery, and to provide the bases for sound clinical decision making in client care.
- Reading, understanding, and using nursing research is fundamental to professional practice.
- The Cumulative Index to Nursing and Allied Health Literature, or CINAHL, is an excellent online resource for locating published research on a phenomenon of interest.
- Nursing research may use quantitative, qualitative, or mixed methods to investigate phenomena of interest.
- The clinical nurse must know the process and language of research, be sensitive to protecting the rights of human subjects, participate in identifying significant researchable problems, and be a discriminating consumer of research findings.

- All nurses who practice in settings where research is conducted with human subjects or who participate in research as data collectors or collaborators play an important role in safeguarding the rights of human subjects.
- The utilization of research findings in practice has evolved into evidence-based practice (EBP).
- Nursing has incorporated a broader source of evidence than research and clinical trials.
- Several models suggest a hierarchy of evidence that is helpful in assessing for quality and appropriateness for protocol development.
- Decisions about integrating research into practice must be based upon careful review and critique.
- Evidence-based protocols or guidelines must be evaluated for effectiveness.

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# 11

## The Nurse's Role in Quality and Safety

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### Chapter Outline

#### Challenges and Opportunities

##### Overview of Patient Safety and Quality

Historical Context  
Current Trends and Concepts

##### Professional and Regulatory Standards of Safety and Quality

The Joint Commission  
Centers for Medicare and Medicaid Services  
State Regulatory Agencies  
Other Influential Organizations

##### Evaluating Patient Safety and Quality of Care

Quality Indicators: Measuring Performance  
Benchmarking and Comparing Safety and Quality

##### Improving Patient Safety and Quality of Care

Methods and Tools  
Just Culture Principles  
Teamwork and Collaboration  
Patient-Centered Care

#### Chapter Highlights

### Objectives

1. Discuss regulatory and professional standards that guide patient safety and quality of care.
2. Analyze ways in which safety and quality of care can be evaluated.
3. Explain system and person factors that affect safety and quality of care.
4. Compare and contrast various improvement strategies to enhance safety and quality in healthcare systems.
5. Describe barriers and facilitators to quality improvement in healthcare.
6. Discuss the leadership role of nurses in improving outcomes related to safety and quality of care.

Nurses are inseparably linked to patient safety and high-quality health care (Institute of Medicine, 2004a). Representing the largest group of healthcare professionals, nurses are the care providers patients and families are most likely to encounter, spend the greatest amount of time with, and are dependent upon for their recovery. A significant proportion of the demands of patient care center on the work of nurses. In many instances nurses intercept healthcare errors before they can adversely affect patients, and nursing actions focused on ongoing monitoring of patients' status are directly related to better patient outcomes (Kahn et al., 1990; Mitchell & Shortell, 1997; Rubenstein, Chang, Keeler, & Kahn, 1992).

Patient safety is the foundation for high-quality health care. In Volume 1 of *Medicare: A Strategy for Quality Assurance* (2001), the Institute of Medicine (IOM) defines patient safety as “freedom from accidental injury; ensuring patient safety involves the establishment of operational *systems and processes* that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur.” The IOM (2001) also identified key elements of quality of care for the 21st century: Quality care is safe, effective, patient-centered, timely, efficient, and equitable. These elements provide the underpinnings for quality goals for healthcare systems and processes, many of which are vitally dependent upon nurses. In order to achieve the goals for patient safety and quality, and thus positively affect health care across the nation, it is imperative that nurses assume a leadership role.

## Challenges and Opportunities

Though significant attention has been given to inpatient settings, challenges to patient safety and quality exist in all settings in which health care is delivered: hospitals, nursing homes, ambulatory care settings, homes, schools, and work sites. These care environments are characterized by complex interactions among a number of factors: patients, the disease process, clinicians, technology, organizational policies, procedures, and resources. Unintended consequences of the interaction of these complex factors can sometimes lead to harmful and unanticipated outcomes. The following statistics demonstrate the gravity of the problem:

- The 1999 IOM report *To Err Is Human* indicated that as many as 98,000 patients die each year in the United States from preventable errors, exceeding deaths due to motor vehicle accidents, breast cancer, or AIDs.
- In 2013 the *Journal of Patient Safety* released updated estimates developed from studies published between 2008 and 2011, indicating the true number of premature deaths associated with preventable harm to patients was estimated at more than 400,000 per year (James, 2013).
- One in five Americans reports that he or she or a family member experienced a medical or a prescription drug error in a doctor's office or hospital (Davis et al., 2002).
- Medication errors injure more than 1.5 million people each year (Institute of Medicine, 2006).
- Nearly 2 million people experienced harm due to an adverse drug event (medication side effects or the wrong type or wrong dose of medication) in 2008 (Agency for Healthcare Research and Quality, 2011).
- A 13.5% rate of harm was identified within the U.S. Medicare population by the Office of the Inspector General, using the Institute for Healthcare Improvement's Global Trigger Tool (Griffin & Resar, 2009).
- In 2008, the Society of Actuaries estimated that medical errors cost the United States nearly \$20 billion each year (Ledue, 2010).

A number of factors have combined to create these challenges. Medical science and technology have advanced at an unprecedented rate during the past half century, resulting in a confounding rate of change in medical knowledge (Nembhard & Edmonson, 2006). The growing complexity of health care is characterized by more to know, more to do, more to manage, more to watch, and more people involved than ever before. The public's healthcare needs have changed as well. Americans are living longer, due at least in part to advances in medical science and technology, and with this increase in the aging

population comes an increase in the incidence and prevalence of chronic conditions. Such conditions, including heart disease, diabetes, and asthma, are now the leading cause of illness, disability, and death.

Faced with such rapid changes, the nation's healthcare delivery system is challenged in its ability to translate knowledge into practice and to apply new technology safely and appropriately. Despite some advances made, in part due to the 2010 Patient Protection and Affordable Care Act (U.S. Department of Health and Human Services, 2014), significant opportunities still exist for nurses to contribute to developing processes that can improve clinical care, such as safe transitions across the healthcare continuum, teamwork and collaborative communication, implementation of evidence-based processes to reduce hospital-acquired conditions, and partnering with patients and families to lead quality of care improvements.

## Overview of Patient Safety and Quality

### Historical Context

Understanding the history and origins of patient safety concerns provides a contextual foundation to view how the current safety and quality movement grew to a distinct set of ideas, viewpoints, and initiatives. The current mind-set underpinning patient safety and quality has been influenced by a number of issues: an evolving perspective on errors and causal factors, specific high-profile cases, psychology and human factors, lessons learned from high-risk industries (such as aviation), pressure from patients and consumer groups, court cases, and governmental agencies. The American Nurses Association Code of Ethics (2001) emphasizes advocacy for patient safety as an essential component of professional nursing practice. The code is consistent with nursing history, as Florence Nightingale advocated for safe care and conducted the earliest nursing studies focused on factors related to outcomes of patient care (Nightingale, 1859/1992). Based on these early traditions, nurses have a legacy of patient safety and quality that continues today.

Medical errors and patient safety issues had been described by a handful of pioneers over the last century. And though health care involves inherent risks, nurses and other health professionals historically did not seem to recognize the extent or the seriousness of the problem (Vincent, 2010). In fact during the 1980s there is such a paucity of research and literature focused on safety that some scholars suggest this in itself is evidence of negligence (Vincent, 1989). The literature that did exist primarily focused on safety issues related to anesthesia occurrences.

During the early 1990s Dr. Lucian Leape and colleagues released the findings of their seminal research, the Medical Practice Study, revealing adverse events occurred in nearly 4% of the 30,000 hospitalizations reviewed, with 28% due to negligence (Brennan et al., 1991). Investigating the cause of errors, Leape followed with his precedent-setting paper in the *Journal of the American Medical Association*, “Error in Medicine” (1994), challenging the prevalent mind-set that if nurses and physicians were well trained and educated and motivated enough, errors would not occur. The “perfectibility model,” as he named it, also advocated that if errors were made, disapproval and disciplinary action were the best solution for future prevention. Leape introduced concepts from the psychology of error and human performance suggesting that some occurrences were outside the control of individuals and acknowledged human limitations. He contended that challenges to safety were precipitated by a range of factors, and through applying systems theory with a larger contextual view, he focused on changing work conditions and processes. His *JAMA* paper continues to be cited today and contributed to the IOM’s future reports, eventually leading to the founding of the National Patient Safety Foundation in 1997.

In 1999 the landscape of patient safety and quality radically changed with the release of the IOM’s report on medical errors, *To Err Is Human*. This publication launched the modern day patient safety movement and thrust the issue into the public and political consciousness of the United States. The report described the nation’s healthcare system as fractured, prone to errors, and detrimental to safe patient care, indicating that between 44,000 and 98,000 people die each year as a result of medical errors (see the accompanying box). It

also made the issue of patient safety relatable to the public as it described high-profile personal experiences in the opening paragraph:

The knowledgeable health reporter for the Boston Globe, Betsy Lehman, died from a drug overdose during chemotherapy. Willie King had the wrong leg amputated. Ben Kolb was eight years old when he died during “minor” surgery during a drug mix up. These horrific cases that made the headlines are just the tip of the iceberg. (Institute of Medicine, 1999)

In order to disperse emphasis on patient safety throughout the healthcare system, the report provided recommendations including establishing national centers and programs, developing improved reporting systems, and compelling patient safety into clinical practice by involving clinicians, purchasers of health care, patients, and regulatory agencies. *To Err Is Human* was followed by *Crossing the Quality Chasm* (2001) and a series of other reports that provide a vision for radical transformation of the healthcare system and related policies with the goal of closing the gap between good quality care and what actually exists in practice.

While the IOM was certainly a primary driver of the current patient safety and quality movement, a number of other developments involving major governmental and professional organizations were instrumental. The World Health Organization (WHO), the Agency for Healthcare Research and Quality (AHRQ), The Joint Commission, the National Quality Forum, the Institute for Healthcare Improvement (IHI), and professional organizations such as the American Nurses Association (ANA) and the American Academy of Nursing have all contributed to the collaborative efforts that over time have resulted in the current safety and quality movement. See Table 11–1.

### Primary Recommendations From *To Err Is Human*

- Creation of a nationally funded Center for Patient Safety.
- Establishment of a mandatory national reporting system.
- Encourage voluntary reporting by practitioners.
- Congressional legislation to protect confidentiality of patient safety data.
- Increase focus on patient safety through explicit performance standards.
- Increased attention from the Food and Drug Administration on safe use of drugs in both the pre- and post-marketing processes.
- Healthcare organizations and affiliated professionals articulate clear goals for continually improved patient safety through patient safety programs.
- Develop safety systems within healthcare organizations to ensure medication safety practices.

From more detail read the IOM publication, *To Err Is Human: Building A Safer Health System*. <https://www.iom.edu/~media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf>

**TABLE 11–1 Milestones of the Patient Safety Movement**

| Year | Milestone                                                                                                                                                                                                                                                                                                                                   |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1999 | Release of the IOM report <i>To Err Is Human</i> creates a media sensation and launches the modern patient safety movement.                                                                                                                                                                                                                 |
| 2000 | U.K. National Health Service releases another major report, <i>An Organization With a Memory</i> .                                                                                                                                                                                                                                          |
| 2001 | IOM releases its <i>Crossing the Quality Chasm</i> report.                                                                                                                                                                                                                                                                                  |
| 2001 | AHRQ receives \$50 million from the U.S. Congress to begin a patient safety research and improvement program.                                                                                                                                                                                                                               |
| 2002 | The Joint Commission releases its first National Patient Safety Goals, followed by dozens more over the next 7 years.                                                                                                                                                                                                                       |
| 2002 | NQF releases its initial list of serious adverse events, commonly called the <i>never events</i> list.                                                                                                                                                                                                                                      |
| 2003 | ACGME institutes duty hours regulations, limiting residents to 80 hours per week.                                                                                                                                                                                                                                                           |
| 2003 | Jessica Santillan, age 17, dies at Duke University Medical Center as the result of a mismatched heart-lung transplant; the error receives international media attention.                                                                                                                                                                    |
| 2003 | Minnesota becomes the first U.S. state to create a statewide error-reporting system based on the NQF list of serious adverse events; 26 states follow suit over the next 6 years.                                                                                                                                                           |
| 2004 | U.S. government creates the Office of the National Coordinator for Health IT (ONC), the first federal initiative to computerize health care.                                                                                                                                                                                                |
| 2004 | WHO forms the World Alliance for Patient Safety (later renamed WHO Patient Safety).                                                                                                                                                                                                                                                         |
| 2004 | IOM publishes <i>Keeping Patients Safe: Transforming the Work Environment of Nurses</i> . The report reveals that the work environment of nurses is characterized by many serious threats to patient safety and recommends fundamental transformation in the work environment of nurses and the culture of organizations.                   |
| 2005 | IHI launches its first national campaign (100,000 Lives Campaign) to promote the use of patient safety interventions.                                                                                                                                                                                                                       |
| 2005 | U.S. Congress authorizes the creation of Patient Safety Organizations (PSOs)—voluntary associations of healthcare entities to promote error reporting and shared learning. The implementation of PSOs is delayed until detailed guidelines are released in late 2008.                                                                       |
| 2006 | Publication of the Michigan ICU study in the <i>New England Journal of Medicine</i> , demonstrating remarkable reductions in catheter-related bloodstream infections through the use of a checklist and associated interventions.                                                                                                           |
| 2007 | Twin children of actor Dennis Quaid nearly die after a massive overdose of heparin at Cedars-Sinai Medical Center in Los Angeles, California.                                                                                                                                                                                               |
| 2008 | Medicare launches its “no pay for errors” initiative, the first use of the payment system to promote patient safety.                                                                                                                                                                                                                        |
| 2009 | U.S. Congress appropriates \$19 billion to promote implementation of electronic health records and health information technology (IT), partly to improve patient safety.                                                                                                                                                                    |
| 2010 | IOM releases the <i>Future of Nursing</i> (FON) report, which outlines recommendations to ensure that nurses are well positioned to lead change and advance health.                                                                                                                                                                         |
| 2010 | President Obama signs the Affordable Care Act (ACA) into law, with the goals of increasing access to quality and affordable health care, decreasing the uninsured rate, and reducing costs of health care. It is the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. |
| 2014 | Insurance coverage begins for health plans through the health insurance exchanges established by ACA.                                                                                                                                                                                                                                       |

NOTES: IOM, Institute of Medicine; AHRQ, Agency for Healthcare Research and Quality; NQF, National Quality Forum; ACGME, Accreditation Council for Graduate Medical Education; WHO, World Health Organization; IHI, Institute for Healthcare Improvement.

Source: Adapted from “Patient Safety at Ten: Unmistakable Progress, Troubling Gaps,” by R. M. Wachter, 2010, *Health Affairs*, 29(1), 165–173.





**InfoQuest:** Go to the website of the Institute of Medicine to learn more about its work and its published reports.

Go to the official website of the Commonwealth of Massachusetts and search for the Betsy Lehman Center for more information about how patient safety and reduction of errors is facilitated by this organization and how consumer information is provided.

## Current Trends and Concepts

Today the patient safety and quality movement has progressed to the point of having specific terms and phrases that are important for nurses to understand. Quality and safety competencies have been recommended for the undergraduate and graduate levels of nursing education (Cronenwett et al., 2007; Barnsteiner et al., 2013). Specialized staff roles and departments have been created that focus primarily on planning, implementing, and evaluating safety and quality initiatives. However, safety and quality are integrated into the everyday work of nurses as they care for patients and families. The following paragraphs explain common terms and phrases found in the language of safety and quality. **Patient safety** is freedom from accidental injury or preventable injuries produced by medical care. It involves establishing operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur (Institute of Medicine, 2001). Further, patient safety emphasizes a system of care delivery that (1) prevents errors; (2) learns from errors when they occur; and (3) is built on a culture of safety that involves healthcare professionals, healthcare organizations, and patients (Institute of Medicine, 2004b).

The National Patient Safety Foundation defines *patient safety* as the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care. Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. *Patient safety practices* “reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions” (Saunders et al., 2001).

**Harm** is defined as the impact and severity of a process of care failure; it includes temporary or permanent physical or psychological impairment. Reporting systems

for adverse events typically include a harm scale to indicate the level of harm experienced by the patient.

**Risk** is the reasoned judgment of the likelihood of, and/or effects of, adverse events occurring, in relation to clinical practice or work environment (Mooney, 2009). Nurses are responsible for assessing the risk for specific adverse events. Risk assessment for falls and pressure ulcers in a variety of settings has been extensively researched and integrated into the nursing workflow.

**Adverse events/occurrences** are injuries that result from medical management rather than the underlying disease (Bates et al., 1997; Brennan et al., 1991); these are classified as either preventable or not (Leape, 1994; Leape et al., 1995). Though the actions closely preceding an adverse event typically appear to be due to human error system-level flaws and factors that are beyond the control of an individual, they are often the underlying cause (Blumental, 1994; Phillips, 1999). Factors that contribute to adverse events include human factors such as teamwork, communication, fatigue, stress, and burnout; structural factors such as reporting systems, infrastructure, workforce loads, and the environment; and clinical factors such as complexity of care and length of stay.

**Error** is the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim; not all errors result in injury and may include problems in practice, products, procedures, and systems. Errors can be classified as:

- **Latent**—Outside of the purview of the clinician, can involve organizational policies, procedures, allocation of resources, sometimes referred to as the *blunt end*
- **Active**—Involves direct contact with the patient, usually encompasses direct care provided by clinicians or bedside staff, also known as the *sharp end*
- **Organizational system**—Indirect failures involving management, organizational culture, protocols/processes, transfer of knowledge, and external factors
- **Technical**—Indirect failure of facilities or external resources (National Quality Forum, 2004)

**Never event** is a term that describes serious, mostly preventable patient safety incidents that should not occur if the available preventive measures have been implemented. The term was initially introduced by Ken Kizer, MD, founding president and former CEO of the National Quality Forum (NQF), in reference to particularly shocking medical errors (such as wrong site surgery) that should never occur. NQF expanded the list to 29 events. Never events usually are clearly identifiable and measurable, serious (resulting in death or significant disability), and preventable. The Centers for Medicare and Medicaid Services (CMS) list of healthcare-acquired

## Examples of Always Events

- Using more than one source to identify patients
- Mandatory “readbacks” of verbal orders for high-alert medications
- Transparency and authentic disclosure when adverse events occur
- Strategies to reduce medication errors
- Surgical time-out
- Anesthesia monitoring that is appropriate for the level of sedation
- Critical imaging, lab, and pathology result tracking
- Handoffs or transitions in care that include critical information (Lembitz & Clarke, 2009)

conditions (HACs) corresponds with the NQF never events, including incidents such as wrong site surgery, retained instruments postoperation, and surgical site infection.

**Root cause analysis** is a structured method used to analyze serious adverse events, with focus on identifying what, how, and why an event occurred in order to understand and eliminate the root causes and prevent recurrence. Root cause analysis uses a multidisciplinary team approach to reconstruct the events leading up to the occurrence with particular focus on underlying problematic system factors. It usually involves medical record review and staff interviews

**Quality of care** is defined as the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Institute of Medicine, 1990). Safety is the foundation for quality of care. According to the IOM (2001), quality care is:

Safe—avoids injuries to patients from the care that is intended to help them.

Effective—provides services based on scientific knowledge to all who could benefit and refrains from providing services to those not likely to benefit.

Patient-centered—provides care that is respectful of and responsive to patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Timely—reduces waits and sometimes harmful delays for both those who receive and those who give care.

Efficient—avoids waste, including waste of equipment, supplies, ideas, and energy.

Equitable—provides care that does not vary in quality because of personal characteristics such as gender, geographic location, and socioeconomic status. (Institute of Medicine, 2001)

**Always events** is a relatively new term describing a positive behavior that helps to facilitate improved patient safety and better outcomes; it represents a positive approach

toward patient safety (Lembitz & Clarke, 2009). (See the accompanying box.)

**Nursing work environment** consists of a combination of factors including organizational characteristics (culture and stability of an organization), leadership, teamwork (among nurses and interdisciplinary), workload, opportunities for professional development, salary, autonomy in practice, participation in decision making, physical environment, innovation, clarity of responsibilities, and recognition. The IOM (2004a) described the typical work environment of nurses as characterized by numerous serious threats to patient safety. Demands on nurses’ time (such as extensive documentation), frequent interruptions, and long work hours are examples of threats to safety in the work environment of nurses.

**Psychological safety** is a shared belief that the work environment is a safe place to engage in discussions about care without fear of blame or punishment; individuals are not inhibited by the prospect of disapproval and or negative consequences that they might experience as a result of speaking up. Research indicates a sense of threat or risk is a major determinant of staff’s willingness to speak up freely. Psychological safety is an important factor in event reporting and team communication (Ashford, Rothbard, Piderit, & Dutton, 1998; Detert & Edmondson, 2005; Edmondson, 2003; Milliken, Morrison, & Hewlin, 2003; Ryan & Oestreich, 1991).

**Culture of patient safety** encompasses attitudes, shared core values, goals, and behaviors that are related to patient safety and that are expected to promote patient safety (Agency for Healthcare Research and Quality, 2014.). It includes nonpunitive responses to adverse events and errors, promotion of safety through education, focus on teamwork, patient involvement, openness/transparency, and accountability, with the establishment of safety as an organizational priority (Lamb, Studdert, Bohmer, Berwick, & Brennan, 2003). Commitment to safety must be diffused throughout the organization and include bedside providers, middle managers, and executive leadership.

Key features of a culture of safety are:

- Recognition of the high-risk nature of healthcare activities and the determination to achieve consistently safe practice and processes
- An environment where individuals can report errors or near misses without fear
- A collaborative interdisciplinary approach to developing solutions to patient safety problems
- An organizational commitment of resources to address safety concerns

Validated instruments to measure staff ratings of safety culture include AHRQ's Patient Safety Culture Surveys and the Safety Attitudes Questionnaire. Ratings of safety culture at the unit and organization level assess work environment conditions that can lead to adverse events, provide awareness about safety issues, assess current status of organizational culture related to safety, inform interventions, and can be used as a measure of effectiveness of improvements over time. Research indicates that a poor perceived safety culture has been linked to increased error rates. NQF's Safe Practices for Healthcare and the Leapfrog Group mandate safety culture assessment, and AHRQ recommends regular measurement of safety culture as one of its 10 patient safety tips for hospitals.

**High reliability organizations (HROs)** are those that are able to sustain excellent safety records despite operating in very complex, hazardous environments where risk is high for injury to individuals and damage to equipment or environment (examples include nuclear power plants, aviation, firefighting) (Henriksen, Dayton, Keyes, Carayon, & Hughes, 2008). Healthcare organizations are modeling their systems after HROs in an effort to improve safety for patients and families. Organizations become HROs due to conscious cognitive processes (mindfulness) on the part of staff that keeps them highly aware of the challenges to safety in their environment. Key concepts of HROs are:

- **Sensitivity to operations:** Leaders and staff have a continual awareness of the systems and processes that can affect care and an ability to see risks and prevent them.
- **Reluctance to simplify:** Avoidance of overly simple explanations of failure and risk, delving deeper to understand system issues that place patients at risk.
- **Preoccupation with failure:** Viewing near misses as evidence of areas in need of focus and attention to reduce risk of harm to participants.
- **Deference to expertise:** Leaders and supervisors are open to listen, learn, and respond to staff insights regarding processes and risks.

- **Resilience:** Leaders and staff are educated in ways to respond when errors do occur.

**Human factors science** relates understanding of human strengths and limitations to interrelated systems of individuals, equipment, and the environment in an effort to enhance effectiveness and safety (Reason, 1997). A human factors framework provides a systems approach to understanding challenges to patient safety by taking into consideration individuals' characteristics, such as their knowledge, skills, sensory/physical capabilities, the work performed, the physical environment, human-system interfaces, organizational/social environment, management, and external factors. Error occurrence is seen as the starting point rather than the end point of determining defects throughout a system that led to the error. The human factors framework aligns with Reason's Swiss Cheese model of causation: When the weaknesses within a system line up like the holes in pieces of Swiss cheese, the protective layers of defense that promote safety are penetrated and adverse events occur (Reason, 2000; Reason, Carthey, & deLeval, 2001).

## Professional and Regulatory Standards of Safety and Quality

A number of federal, state, and professional organizations contribute to regulatory standards of safety and quality. Selected organizations with broad-based influence are described here.

### The Joint Commission

The mission of The Joint Commission (JC), a federal agency, is to improve health care for the public with the goal of inspiring healthcare organizations to provide safe and high-quality care. The JC evaluates care delivery and currently provides accreditation and certification to over 20,500 organizations and programs in the United States. The JC also established a National Patient Safety Goals (NPSGs) program in 2002 in an effort to assist organizations in addressing specific patient safety issues. Each year the Patient Safety Advisory Group, a panel of nurses, physicians, pharmacists, and other healthcare professionals, guide the JC on updating and developing new NPSGs. Healthcare organizations are evaluated on their performance in meeting the NPSGs and other specific standards. Accreditation and subsequent federal funding for organizations is dependent upon the ability and efforts to meet the standards and goals. Table 11–2 outlines the 2014 Joint Commission National Patient Safety Goals.

**TABLE 11–2 2014 National Patient Safety Goals****Patient Identification**

|                                                        |                                                                                                   |                                                                                                                                                     |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Goal 1: Improve the accuracy of patient identification | NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment, and services. | Applies to ambulatory, behavioral health care, critical access hospital, home care, hospital, laboratory, nursing care center, office-based surgery |
|                                                        | NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.                 | Applies to ambulatory, critical access hospital, hospital, office-based surgery                                                                     |

**Improve Communication**

|                                                                      |                                                                                              |                                                           |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Goal 2: Improve the effectiveness of communication among caregivers. | NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis. | Applies to critical access hospital, hospital, laboratory |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------|

**Medication Safety**

|                                                 |                                                                                                                                                               |                                                                                                                                         |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Goal 3: Improve the safety of using medications | NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. | Applies to ambulatory, critical access hospital, hospital, office-based surgery                                                         |
|                                                 | NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anti-coagulant therapy.                                                       | Applies to ambulatory, critical access hospital, hospital, nursing care center                                                          |
|                                                 | NPSG.03.06.01: Maintain and communicate accurate patient medication information.                                                                              | Applies to ambulatory, behavioral health care, critical access hospital, home care, hospital, nursing care center, office-based surgery |

**Clinical Alarm Safety**

|                                                                |                                                              |                                               |
|----------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------|
| Goal 6: Reduce the harm associated with clinical alarm systems | NPSG.06.01.01: Improve the safety of clinical alarm systems. | Applies to critical access hospital, hospital |
|----------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------|

**Health Care-Associated Infections**

|                                                              |                                                                                                                                                                    |                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Goal 7: Reduce the risk of health care-associated infections | NPSG.07.01.01: Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current WHO hand hygiene guidelines. | Applies to ambulatory, behavioral health care, critical access hospital, home care, hospital, laboratory, nursing care center, office-based surgery                                                                                                        |
|                                                              | NPSG.07.03.01: Implement evidence-based practices to prevent health-care-associated infections due to multidrug-resistant organisms in acute-care hospitals.       | Applies to critical access hospital, hospital                                                                                                                                                                                                              |
|                                                              | NPSG.07.04.01: Implement evidence-based practices to prevent central-line-associated bloodstream infections.                                                       | Applies to critical access hospital, hospital, nursing care center                                                                                                                                                                                         |
|                                                              | NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.                                                                         | Applies to ambulatory, critical access hospital, hospital, office-based surgery                                                                                                                                                                            |
|                                                              | NPSG.07.06.01: Implement evidence-based practices to prevent indwelling-catheter-associated urinary tract infections (CAUTIs).                                     | Applies to critical access hospital, hospital<br>(Note: This NPSG is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is no consensus that these practices apply to children.) |

**Reduce Falls**

|                                                              |                                          |                                           |
|--------------------------------------------------------------|------------------------------------------|-------------------------------------------|
| Goal 9: Reduce the risk of patient harm resulting from falls | NPSG.09.02.01: Reduce the risk of falls. | Applies to home care, nursing care center |
|--------------------------------------------------------------|------------------------------------------|-------------------------------------------|

*(Continued)*



TABLE 11–2 2014 National Patient Safety Goals (Cont.)

|                                                                                       |                                                                                                                                                       |                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pressure Ulcers                                                                       |                                                                                                                                                       |                                                                                                                                                                         |
| Goal 14: Prevent health-care-associated pressure ulcers (decubitus ulcers)            | NPSG.14.01.01: Assess and periodically reassess each resident’s risk for developing a pressure ulcer and take action to address any identified risks. | Applies to nursing care center                                                                                                                                          |
| Risk Assessment                                                                       |                                                                                                                                                       |                                                                                                                                                                         |
| Goal 15: The organization identifies safety risks inherent in its patient population. | NPSG.15.01.01: Identify patients at risk for suicide.                                                                                                 | Applies to behavioral health care, hospital (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals) |
|                                                                                       | NPSG.15.02.01: Identify risks associated with home oxygen therapy, such as home fires.                                                                | Applies to home care                                                                                                                                                    |
| Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery   |                                                                                                                                                       |                                                                                                                                                                         |
|                                                                                       | UP.01.01.01: Conduct a preprocedure verification process                                                                                              | Applies to ambulatory, critical access hospital, hospital, office-based                                                                                                 |
|                                                                                       | UP.01.02.01: Mark the procedure site.                                                                                                                 | Applies to ambulatory, critical access hospital, hospital, office-based                                                                                                 |
|                                                                                       | UP.01.03.01: A time-out is performed before the procedure.                                                                                            | Applies to ambulatory, critical access hospital, hospital, office-based                                                                                                 |

The JC also reviews organizations’ responses and activities surrounding sentinel events (an unexpected occurrence that results in death or serious physical or psychological injury, including loss of limb or function). Sentinel events also encompass any variations in practice for which a recurrence would place a patient at significant risk of experiencing a serious adverse outcome. Accredited organizations are expected to conduct an appropriate

investigation, including root cause analysis; implement improvements to reduce risk; and monitor the effectiveness of the improvements. Though not required, organizations are encouraged to voluntarily report sentinel events to the JC. Other means by which the JC becomes aware of reviewable sentinel events is through notification from patients, families, or employees, or through the media. See the accompanying box.

Reviewable Sentinel Events

The reviewable sentinel event is one that has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or the event is one of the following (even if the outcome was not death or major permanent loss of function):

- Suicide of an individual under the care of a 24-hour staffed facility, or within 72 hours of discharge
- Unexpected death of a full-term infant
- Abduction of an individual from a facility
- Discharge of an infant to the wrong family

- Rape
- Transfusion reaction resulting from administration of incompatible blood products
- Surgery on the wrong individual or part of body
- Unintentional object retention after surgery
- Severe neonatal jaundice
- Prolonged, inappropriate or excessive exposure to radiation through fluoroscopy

More details can be found through the Joint Commission website in the article Sentinel Events (SE).

Source: Sentinel Events (SE) by The Joint Commission. Published by The Joint Commission, © 2011.

## Preventable Complications (Never Events) Not Reimbursed by CMS

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
- Fractures and dislocations
- Intracranial injuries
- Crushing injuries
- Burns
- Electric shock
- Catheter-associated urinary tract infection
- Vascular-catheter-associated infection
- Manifestations of poor glycemic control:
  - Diabetic ketoacidosis
  - Nonketoacidosis
  - Nonketotic hyperosmolar coma
  - Hypoglycemic coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolality
- Surgical site infection following:
  - Coronary artery bypass graft (CABG), mediastinitis
  - Bariatric surgery
  - Laparoscopic gastric bypass
  - Gastroenterostomy
  - Laparoscopic gastric restrictive surgery
  - Orthopedic procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
  - Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement—with pediatric and obstetric exceptions
  - Surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery

Source: "Medicaid Program: Adjustment for Provider Preventable Conditions Including Health Care-Acquired Conditions," by Centers for Medicare and Medicaid Services, 2011, 42 CFR Parts 434, 438, and 447 [CMS-2400-F]. RIN 0938-AQ34. Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2011-02-17/html/2011-548.htm>

## Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) issued a ruling to deny reimbursement of federal funds to pay for services by physicians and hospitals for treatment of never events, which are preventable errors, injuries, and infections (see the accompanying box). The initial ruling in 2007 was updated in 2011 and expanded nationwide. The ruling also indicated that hospitals cannot pass on the costs to patients for any additional care required to address the never event. Shortly after the CMS ruling, private insurers, such as Health Partners, Cigna, Blue Cross, Aetna, and Well Point, implemented similar policies. In response to urging from CMS, individual states are now passing similar rulings. The actions by CMS send a clear message to healthcare organizations and the public of the strong commitment to improve quality, cut unnecessary costs, and prevent suffering.

## State Regulatory Agencies

State departments of health provide protection for the public through licensing of health professionals and care facilities based on minimum health and safety standards established by regulations and rules. Departments of health conduct inspections of facilities to determine standard compliance. In addition, organizations are required

to report sentinel events to their individual state health department. All states have processes that facilitate public reporting of complaints regarding safety and quality of care and have specifically identified mandatory reportable sentinel events (based on NQF standards). A reported event may trigger an inspection by state health department representatives. Similar to the JC, the states require certain procedures and processes related to investigation and prevention of the event.

For example, Florida requires facilities to report adverse events that are associated with medical intervention and that:

1. Result in one of the following injuries:
  - Death
  - Brain or spinal damage
  - Permanent disfigurement
  - Fracture or dislocation of bones or joints
  - A resulting limitation of neurological, physical, or sensory function that continues after discharge from the facility
  - Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition to which the patient has not given his or her informed consent

- Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident
2. Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition
  3. Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
  4. Was a procedure to remove unplanned foreign objects remaining from a surgical procedure

## Other Influential Organizations

A number of other organizations and agencies have been influential in developing quality and safety standards. These organizations may provide input in developing indicators and measures, work closely with other governmental agencies, or participate with private/public partnerships to facilitate safety and quality. These organizations can be excellent references for nurses as they provide education and resources for implementing and evaluating safe practices.

AHRQ is the primary governmental agency focused on designing research to improve safety and quality of care, control costs, and increase access to essential services. Research is typically focused on a broad view of safety issues within the larger context of care delivery. AHRQ has an extensive website with safety and quality information and implementation tool kits for consumers and healthcare professionals. AHRQ is foundational in developing quality-of-care indicators and is responsible for the Consumer Assessment of Health Plans (CAHPS). AHRQ works closely with NQF and CMS.

The NQF is a nonprofit organization focused on improving the quality of American health care through consensus building on national priorities and goals for performance improvement, and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. NQF includes a variety of healthcare stakeholders, including consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and healthcare research and quality improvement organizations. NQF is known for its diligent

endorsement process for indicators of health care and works closely with CMS.

The National Association for Healthcare Quality (NAHQ) is the professional organization for healthcare quality professionals, publishes the *Journal for Healthcare Quality* (JHQ), and provides a number of products focused on continuous quality improvement (CQI) in healthcare teams. NAHQ provides the only professional certification in healthcare quality (CPHQ, Certified Professional in Healthcare Quality). Nurses interested in safety and quality can pursue additional education and certification through NAHQ.

The National Patient Safety Foundation (NPSF) has had an influential voice for the advancement of patient safety since 1997. It provides significant resources for research, education and campaigns to raise awareness with hospitals, healthcare systems, doctors, nurses, and patients in the United States and worldwide.

The Leapfrog Group involves both private and public purchasers of healthcare benefits. Healthcare organizations voluntarily submit data related to quality and patient safety efforts and receive comparison reports to assess their performance. This information is also readily available to consumers to assist them in making decisions about hospital care.

The Institute for Healthcare Improvement (IHI) is an independent, nonprofit organization working since 1991 to accelerate improvement in healthcare systems in the United States, Canada, and Europe. IHI focus is on facilitating collaboration among organizations through broad improvement campaigns. Its most recent 5 Million Lives Campaign partners with hospitals and providers to reduce harm and death by preventing adverse events. It provides extensive education, seminars, and collaborative efforts to foster safety and quality.



**InfoQuest:** Explore the AHRQ website and find resources that would be useful to you in implementing a practice improvement. Also find resources you could use for patients and families.

Spurred by the IOM call to improve quality and safety in health care, nursing leaders developed the Quality and Safety Education for Nurses (QSEN) initiative in 2005. With support from the Robert Wood Johnson Foundation (RWJF), the American Association of Colleges of Nursing (AACN) led the nationwide effort to develop quality and safety competencies and content that can be integrated into the nursing education curriculum. The QSEN initiative advanced through four phases that included development of undergraduate and

graduate competencies and related knowledge, skills, and attitudes; pilot testing of teaching strategies; national forums and workshops to educate nursing faculty; development of resources for faculty and students; creation of innovative educational models; and evaluation of the impact of QSEN content (Dolansky & Moore, 2013). These ongoing efforts led to what is now known as the QSEN Institute.

The focus of the QSEN Institute is to meet “the challenge of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work” (QSEN Institute, 2013). The creation of the six QSEN competencies (based on the IOM reports) and related KSAs represents a significant contribution to healthcare education and a means to identify gaps in curriculum (Table 11–3) (Cronenwett et al., 2007; Barnsteiner et al., 2013). The QSEN Institute provides an accessible centralized web-based source of information on the six core competencies: quality improvement, safety, teamwork and collaboration, patient-centered care, evidenced-based practice, and informatics. The QSEN competencies have been widely recognized by national nursing organizations such as the ANA, the National Council of State Boards of Nursing Nurse Residency program and individual state associations (Dolansky & Moore, 2013). In an ongoing effort to improve nursing knowledge and skills, the focus of the QSEN Institute is expanding to include education for all nurses.



**InfoQuest:** Go to the website of Quality and Safety Education for Nurses (QSEN) and review the competencies for your level of education. Assess your current practice based on the KSAs, and identify your strengths and opportunities for improvement.

## Evaluating Patient Safety and Quality of Care

### Quality Indicators: Measuring Performance

Measuring performance and various aspects of care is foundational to safety and quality as it provides information that can guide planning and implementation for future care. Information regarding current and past performance provides a starting point (baseline) and a means of comparison for the future. Measuring performance provides a way to trend over time within an organization, department, or unit as well as compare performance with other organizations, departments, or units. Performance measurement can bring a specific issue to light, motivate action, and provide important impetus for change.

Selecting what to measure is a foundational determination. While it may seem simplistic, the challenge to selecting a measure is complex. The National Quality Forum (2004) endorses a wide range of quality indicators as measures of health care and has established specific criteria.

Quality indicators should be:

- Important to measure and report to keep our focus on priority areas, where the evidence is highest that measurement can have a positive impact on healthcare quality.

- Scientifically acceptable, so that the measure when implemented will produce consistent (reliable) and credible (valid) results about the quality of care.

- Useable and relevant to ensure that intended users—consumers, purchasers, providers, and policy makers—can understand the results of the measure and are likely to find them useful for quality improvement and decision making.

**TABLE 11–3 QSEN Competencies**

Quality Improvement (QI) involves: Using data to make changes in health care processes; testing those changes to determine the true effects; placing value on the process of monitoring outcomes to improve care.

Safety involves: Minimizing risk of harm to patient and staff; valuing monitoring and analyze errors to identify potential improvements in processes; making the connection between communication and safety outcomes.

Teamwork and collaboration involves: Nursing and inter-professional teams sharing decision-making and integrating their contributions related to quality care; respect for the unique characteristics of all team members.

Patient-centered care involves: Care providers partnering with the client; valuing the patient or client expertise about their health and symptoms; respecting their preferences, values, and needs in all parts of the care plan.

Evidence-based practice (EBP) involves: Conscientious use of research and resources to provide and improve patient care and nursing outcomes; seeks reasoning and science behind practices; utilizes data collection and analysis.

Informatics involves: Valuing technology's role in clinical decision support and the nurse's role in technology integration and management; using high quality electronic resources; identifying essential information to supply quality care.

For the complete definitions visit the QSEN website.



Feasible to collect with data that can be readily available for measurement and retrievable without undue burden.

The AHRQ has also led the way in developing quality indicators that are evidence-based for both inpatient and outpatient care. The ARHQ organizes quality indicators as Patient Safety Indicators, Prevention Quality Indicators, Inpatient Quality Indicators, and Pediatric Quality Indicators.

While patient care outcomes are essentially dependent upon the entire healthcare team, nurses are particularly concerned with indicators that reflect nursing care. However, challenges with applying administrative or clinical data sources can affect the usefulness of an indicator. Data access and quality are important considerations and vary by organization, department, and unit. Sources of data include clinical data usually accessed through the medical record, administrative data such as billing records, operational data such as staffing and staff mix, and survey data

such as patient satisfaction and employee engagement. Given the complex nature of health care, a set of measures derived from multiple data sources will likely provide a more comprehensive view of quality of care. An example of a data quality challenge relates to tracking hospital-acquired pressure ulcers. If there is no documentation of a preexisting pressure ulcer in the medical record when the patient was admitted, the hospital may be “credited” with a hospital-acquired pressure ulcer due to the lack of verification of the patient’s skin condition.

Measurement selection should be given significant thought based on the purpose, focus, and timing of the improvement project. The selected indicators should feasibly be affected by the interventions within a reasonable time frame. It is important to collect baseline measures prior to implementation and to allow time for the intervention to be adequately disseminated into practice. Measures of quality are used for multiple purposes: to drive quality improvement, for public accountability, to inform consumer decisions, and to pay for performance.

## RESEARCH CURRENT

### Patient Safety, Satisfaction, and Quality of Hospital Care: Cross Sectional Surveys of Nurses and Patients in 12 Countries in Europe and the United States.

The purpose of this cross-sectional study conducted by Aiken, Sermeus, Van den Heede, Sloane, Busse, McKee, Kutney-Lee, and others was to examine the organization of care in hospitals in 12 countries in Europe and the United States. The researchers hypothesized that those hospitals with good organizational context of care benefited patients and enhanced the stability of the nurse workforce. Nurses and patients were surveyed in 1,105 general acute hospitals from 12 European countries and 4 U.S. states (New Jersey, California, Pennsylvania, Florida). Key measures included nurse staffing (ratio of patients to nurses), nurse work environment (measured by the Practice Environment Scale of the Nursing Work Index), nurse burnout, patient safety culture, overall patient satisfaction and patient satisfaction with nursing. Data were collected from 33,659 nurses and 11,318 patients in European hospitals and 27,509 nurses and 120,000 patients in U.S. hospitals. Nurse and patient survey instruments were translated, piloted, and validated using rigorous quantitative methods.

Results indicated a significant number of nurses in each country reported quality-of-care deficits, nurse burnout, job dissatisfaction, and intent to leave their positions. Burnout and dissatisfaction were similar in European and U.S. nurses; however, the percentage of nurses

intending to leave their jobs was higher in all European countries. The nurse-patient ratio in European countries was worse than in U.S. hospitals. Nurses and patients were consistent in their overall ratings of hospitals across all countries. Patients in hospitals with better work environments rated their hospital highly in Europe and the United States. Patients were less satisfied in hospitals with higher nurse burnout or dissatisfaction with management. Nurse reports of poor quality of care were associated with less likelihood of patients’ recommendation and lower patient ratings of the hospital. Overall, the hospital work environment was associated with outcomes in every country. This study supports the statement from the World Alliance for Patient Safety that organizational culture and behaviors are important to promoting safe patient care. Given the consistent findings between nursing and quality and safety across hospitals, it is likely improvement efforts from any of the study countries could be generalized and adapted to produce similar effects in other countries.

*Source:* From “Patient Safety, Satisfaction, and Quality of Hospital Care: Cross Sectional Surveys of Nurses and Patients in 12 Countries in Europe and the United States,” by L. Aiken, W. Sermeus, K. Van den Heede, D. Sloane, R. Busse, M. McKee, . . . A. Kutney-Lee, 2012, *British Medical Journal*, 50(2), 143–153.

## Benchmarking and Comparing Safety and Quality

### National Database of Nursing Quality Indicators

The National Database of Nursing Quality Indicators (NDNQI) is the primary registry for nursing-sensitive indicators and is supported by the ANA's National Center for Nursing Quality (NCNQ). In the mid-1990s the ANA released the first Nursing Care Report for Acute Care (American Nurses Association, 1995), which included 21 proposed measures of hospital performance that were linked to the availability and quality of nursing care. Subsequently, the ANA sponsored a series of pilot studies to test selected nurse-sensitive indicators to establish definitions, data collection methods, and instrument development. This early research provided the foundation for the current database of indicators and the expansion of new indicators and projects over the last two decades (American Nurses Association, Nursing World, n.d.). The NDNQI database is currently housed at the University of Kansas School of Nursing.

NDNQI provides evidence-based comparative data reflecting the relationship of nursing care to patient outcomes at a national level. The nursing-sensitive indicators represent the structure, process, and outcomes of nursing care and are reported at a unit level. Comparisons can be made at the state, national, and regional level.

Similar units and facilities are compared on specific indicators. For example, a medical ICU in a large academic medical center would be compared to other medical ICUs in similar facilities, based on category and size (based on number of beds). Member organizations submit data related to the specific nursing-sensitive indicators on a routine basis and are provided with quarterly comparison reports for their units and organizations. These reports provide valuable information that assists nurses and organizations in identifying areas for safety and quality improvement and serves as a means to track outcome-based results trended over time.

In addition, hospitals have used the reports to assist in recruitment and retention of nurses, research and education, nursing administration, patient recruitment, and for reporting requirements for regulatory agencies or Magnet designation. Over 1,500 U.S. hospitals participate in NDNQI.

The NDNQI nursing-sensitive indicators are based on Avedis Donabedian's model of structure-process-outcomes (1980). The indicators reflect the structure (number of nursing staff, skill level, education, certification), process (interventions, job satisfaction), and outcomes (falls, pressure ulcers) of nursing care (see the accompanying box). Outcome indicators are based on the premise that they are affected by the quantity and quality of nursing care.

### Current NDNQI List of Nursing-Sensitive Indicators

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|                                                                                                                                     |                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Nursing hours per patient day                                                                                                       | Pediatric peripheral intravenous infiltration                                                                                                                                                                                          |
| Registered nurse (RN) hours per patient day                                                                                         | Psychiatric physical/sexual assault                                                                                                                                                                                                    |
| Licensed practical/vocational nurses (LPN/LVN) hours per patient day                                                                | RN education/certification                                                                                                                                                                                                             |
| Unlicensed assistive (UAP) hours per patient day                                                                                    | RN survey                                                                                                                                                                                                                              |
| Nursing turnover                                                                                                                    | Job satisfaction scales                                                                                                                                                                                                                |
| Nosocomial infections: catheter-associated urinary tract infection (CAUTI), central-line-associated blood stream infection (CLABSI) | Practice environment scale (PES)                                                                                                                                                                                                       |
| Patient falls                                                                                                                       | Restraints                                                                                                                                                                                                                             |
| Patient falls with injury                                                                                                           | Staff mix NQF                                                                                                                                                                                                                          |
| Injury level                                                                                                                        | RNs                                                                                                                                                                                                                                    |
| Pressure ulcer rate                                                                                                                 | LPN/LVNs                                                                                                                                                                                                                               |
| Community-acquired                                                                                                                  | UAPs                                                                                                                                                                                                                                   |
| Hospital-acquired                                                                                                                   | Percentage agency staff                                                                                                                                                                                                                |
| Unit-acquired                                                                                                                       | Additional data elements collected: patient population—adult or pediatric, hospital category (e.g., teaching, non-teaching, type of unit (e.g., critical care, step-down, medical, surgical, combined med-surg, rehab and psychiatric) |
| Pediatric pain assessment, intervention, reassessment (AIR) cycle                                                                   | Number of staffed beds designated by the hospital                                                                                                                                                                                      |

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## Reflect On . . .

- fall or pressure ulcer prevention practices you have seen or implemented in a healthcare setting. What barriers did you see or encounter? For example, were risk assessments performed accurately and in a timely manner? Were preventive measures implemented consistently across staff and over time?

## National and State Report Cards

As interest in assessments of healthcare quality have grown substantially, parallel efforts by governmental agencies, accrediting bodies, insurers, and consumer groups to publish comparative reports have increased. A number of state, federal, and private organizations have developed web-based report cards as a means to provide the public and healthcare professionals information regarding the quality of health care. This information has been used to link quality of care to financial incentives (such as pay for performance or withholding pay for poor performance), facilitate quality improvement projects, and direct the public toward higher quality providers.

Report cards typically include selected quality indicators or measures developed and endorsed broadly by agencies such as the NQF, AHRQ, and CMS. Data are organized and presented based on disease conditions, procedures, quality and safety, nurse staffing, patient satisfaction, and costs of services. For example, some report cards provide information based on recommended guidelines of care for conditions such as heart failure, acute MI, and pneumonia. Consumers can determine how often the recommended treatments were provided for patients admitted to a specific facility (e.g., for pneumonia care: blood cultures drawn in the emergency room, appropriate and timely antibiotics). Comparisons can be made within regions, and specific facilities can be selected to compare with other facilities and overall benchmarks. Data are represented in a variety of ways such as percentages, bar graphs, and stars that indicate at, below, or above state averages.

Examples of report cards:

### CMS Nursing Home Compare

**Individual state report cards:** Search by state.

**Consumer Reports Hospital Ratings:** Comparison rating of hospitals by area, or select individual hospitals, patient safety score, as well as individual measures relating to patient experience, patient outcomes, and certain hospital practices

**AHRQ Health Care Report Card Compendium:** Searchable database of a large number of report cards,

includes descriptions and links to other report cards, collection of healthcare performance reports designed for consumers.



**InfoQuest:** Visit the website for your state's healthcare quality report card and compare selected facilities on specific indicators. What nursing-sensitive indicators are included in your state's report card?

## Improving Patient Safety and Quality of Care

Nurses are well suited to address safety and quality issues, as they have in-depth experiences interacting with patients and families in multiple settings and provide care management across the continuum of health (Kronick, 2014). Having a foundational understanding of quality improvement strategies and processes can increase the likelihood of successful improvement efforts. Continuous quality improvement (CQI) is a broad, overarching philosophy with its roots in management that focuses on applying scientific methods in order to improve all aspects of care and service on an ongoing basis. The CQI framework promotes asking questions such as “How are we doing?” and “Can we do it better, more efficiently, more effectively, and in a more timely manner?” Along with facilitating this inquisitive CQI organizational culture, a key to successful CQI initiatives is the use of a structured planning approach to assess current practice and implement improvements to achieve a desired outcome and vision for a desired future state.

## Methods and Tools

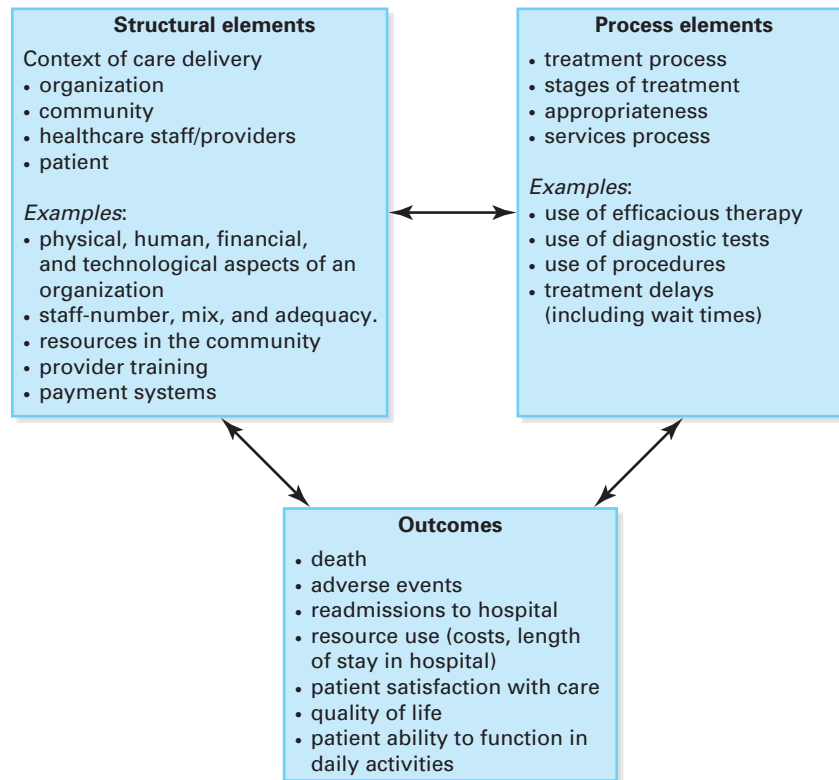
Developing an effective CQI strategy should include:

- Selection and use of a formal model for QI
- Monitoring specific metrics to evaluate quality improvements and outcomes on a routine basis
- Ensuring staff members understand the measures of success
- Ensuring a multidisciplinary effort; healthcare team members, providers, patients, and families are involved in improvement activities.

Regardless of the selected QI model, any CQI initiative should consider the primary components of *structure*, *process*, and *outcomes* (Donabedian, 1980). See Figure 11–1. Structure relates to the context of care delivery and includes the physical, human, financial, and technological aspects of an organization. It can focus on specific characteristics such as location, number, mix, and adequacy. Examples of structure

FIGURE 11-1

The Donabedian Model of Measuring Healthcare System Performance



components are physical space and buildings, equipment, finances, staff and providers, IT capability, resources, and organizational characteristics (staff training, payment systems). Structural factors are usually easy to observe and measure and can cause problems identified within processes.

Process focuses on the actions that comprise health care and include the tasks, activities, and flow of work that are involved to achieve a result or outcomes. Clinical and administrative workflows fit within the component of process. Examples of process components include the diagnosis and treatment of illness, patient education, and interpersonal processes.

Outcomes are the end result of care processes and represent the effects of health care on patients, families, and communities. Examples of outcomes include changes in measures of health, behavior, knowledge, quality of life, and satisfaction with care. Outcomes are often considered the most important indicator, as they represent the composite effects of structures and processes. They represent a change in current and or future patient health status due to previous interventions (Donabedian, 2003).

CQI also includes a feedback loop in which the changes made to structures and/or processes are evaluated to see if

the desired outcome was achieved. In this iterative process, a continuous assessment of the effectiveness of the improvement efforts is compared to the desired outcomes, and other possible changes are considered for the future. A number of quality improvement models have been developed. However, the most prominent models are the Toyota Lean Model, the IHI Model for Improvement, and Six Sigma.

### Toyota Lean Model

Lean is a quality improvement framework that is based on the Toyota production system and has gained increasing application in health care over the last decade. The primary focus is on eliminating waste in the system through the application of manufacturing-based strategies. Quality of care is improved by focusing on streamlining value-added activities (as identified by customers), eliminating non-value-added activities, and mapping and monitoring processes from start to finish. Lean initiatives focus on:

- Improving flow to eliminate waste and decrease delays
- Getting things right the first time (eliminating redundancy and rework, resulting in quality and cost improvements)



- Empowering and motivating staff to sustain results
- Applying evidence to make good decisions
- Learning by doing to get results rapidly

Lean strategies are particularly useful for simplifying complicated processes and have been used in large, complex health systems. One of the strengths of Lean is its thorough, all-inclusive approach, which includes a perspective of interrelated workflow activities and processes. One caveat is that Lean is not considered a tool for staff reduction or irresponsible cost cutting. Lean tools should be implemented with a sufficient understanding of the larger system and how strategies fit within the organization.

Lean initiatives aim to alleviate burden and inconsistencies in organizations, eliminate or reduce waste, and create a process that delivers results in a systematic and efficient way (Holweg, 2007). Improvement teams are created to include all possible stakeholders and one or more individuals with minimal familiarity with the problem who can serve as fresh eyes. The improvement process is accomplished through a series of intensive work meetings known as rapid improvement events (RIEs), with the goal of making radical changes within a short time frame. The five Lean principles are:

**Identify value.** Value is specific to the particular process or problem that is being addressed and is viewed through the perspective of various customers: patients, families, staff, and providers. An example of value from the patient perspective is reduced wait time for appointments or in line to obtain prescriptions.

**Determine the value stream.** The value stream consists of the series of activities that contribute to the selected issue or process. The activities are sequenced in the value stream and non-value-added activities are identified for elimination.

**Improve flow to create an efficient process.** Team efforts focus on ways to facilitate a smooth, uninterrupted flow of activities (value-added activities and non-value-added activities that are deemed necessary) and information to create a new or revised process. Non-value-added activities and waste that are often identified for elimination focus on overproduction, waiting (time in queue), transportation, unnecessary inventory, motion, costs, and rework.

**Test the new process.** The newly developed process should be pilot-tested in smaller scale.

**Revise and perfect the process.** Based on the pilot testing, revisions are made before the final process is implemented. Ongoing monitoring is based on metrics (measures of success) established by the value stream team (see Figure 11–2).

### IHI Model for Improvement

The IHI Model for Improvement was developed as a strategy to accelerate quality improvement processes in health-care organizations and can be used as an adjunct to other CQI models. The IHI model is a simple, straightforward strategy that focuses on three foundational questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

The IHI Model for Improvement has been used in a number of healthcare organizations internationally. It is best suited for improvement initiatives that would benefit from a gradual, incremental, and sustained approach (Hughes, 2008). It is useful in conjunction with other CQI models.

The IHI model focuses on developing goals for improvement and team building. Strategies are based on the plan-do-study-act (PDSA) cycle, a sequential series of steps focused on gaining knowledge and learning for ongoing improvement of a process. PDSA is also known as *the Deming Wheel*, named after Dr. W. Edward Deming (1993), who popularized its use in a number of industry settings. See Figure 11–3.

The PDSA cycle entails:

**Plan:** Determine the purpose or goal, define metrics of success, and establish the steps and actions of the plan.

**Do:** Implement the plan.

**Study:** Monitor outcomes and assess the plan for progress, success, problems, and areas for improvement.

**Act:** Integrate what has been learned by the entire cycle, adjust the goals, revise the plan, and adjust implementation processes as needed.

**Cyclical nature:** Repeat the four steps over and over in a continual process of improvement.

The IHI model includes the following steps:

**Form a team.** Assemble the right composition of team members based on the project needs. Having the right balance of team members is a critical first step.

**Establish aims/goals.** Determine time-specific and measureable goals. The goals and aims should clearly define the patients or staff or systems that the improvement efforts will affect. This step addresses the question: What are we trying to accomplish?

**Determine measures.** Determine measures of success to evaluate if the change indeed leads to an improvement. Specific outcomes should be identified as a

**FIGURE 11-2**

Five Principles to Guide the Activities for Operational Efficiency

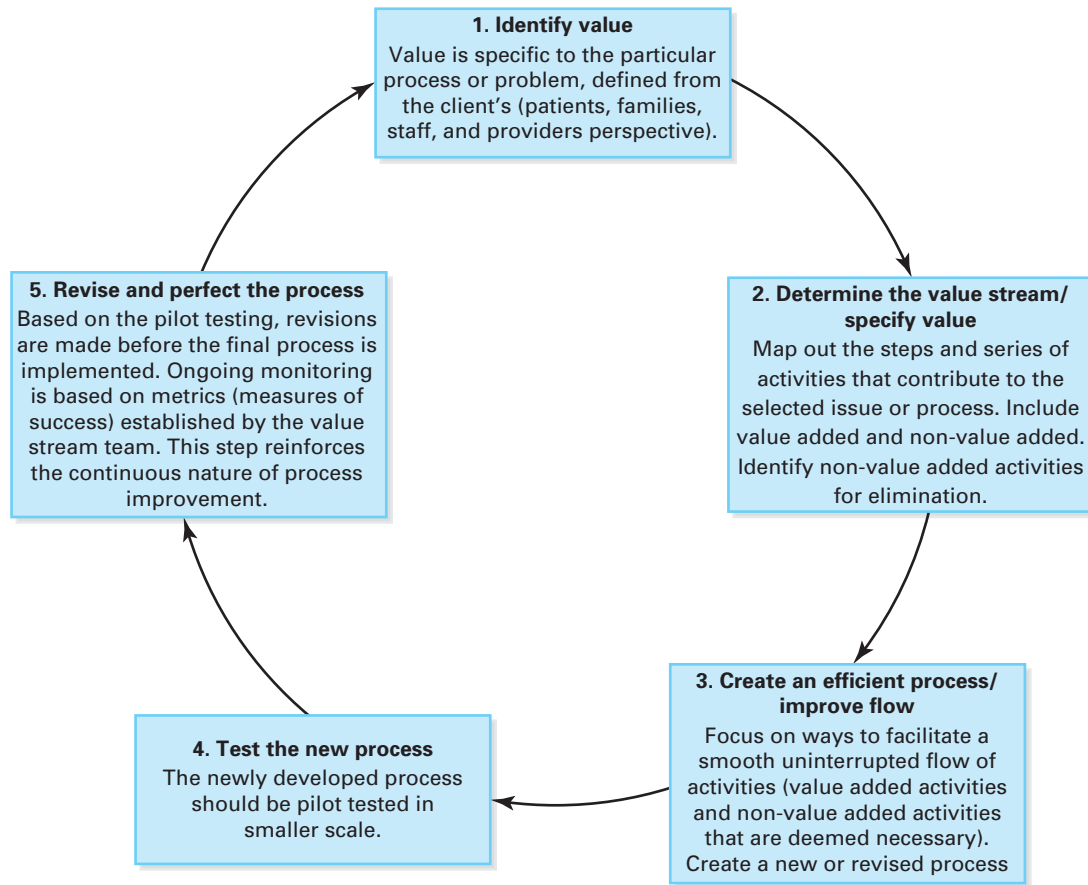
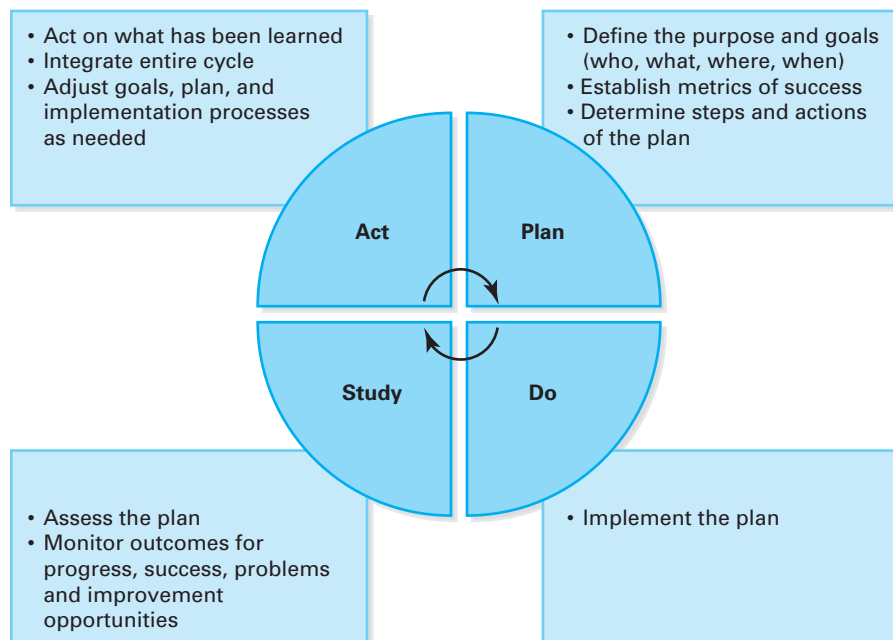


**FIGURE 11-3**

PDSA Cycle for Process Improvement



means to evaluate if the aims were met. Measures should be data that are feasible for the team to collect. This step answers the question: How will we know that a change is an improvement?

**Select the changes.** Change ideas come from a variety of sources: team members whose work is affected, evidence from other successful improvements, and creative brainstorming. This step answers the question: What changes can we make that will result in improvement?

**Test the changes.** Use the PDSA cycle to test the change in the work setting, first on a small scale, continually revising based on what is learned. As changes are piloted, observations regarding results should be made to determine if they had the desired outcome so that lessons learned can influence future changes.

**Implement the changes.** After revising based on what was learned from small-scale testing and refining through several PDSA cycles, implement the change broadly (patient population or whole unit or department).

**Spread the changes.** Diffuse new changes even more broadly, across the organization or system as applicable.

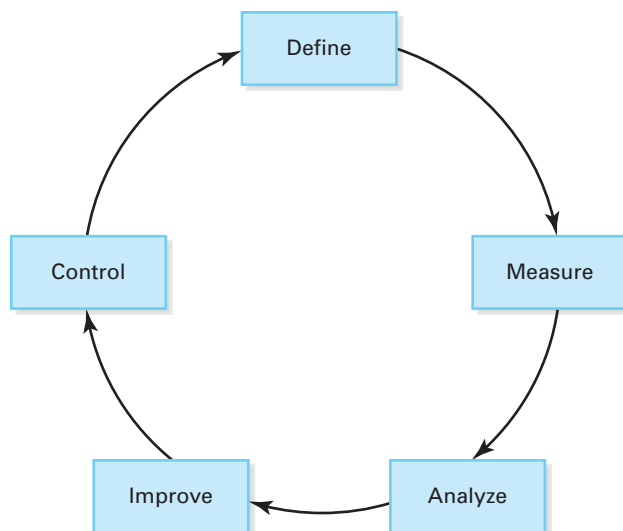
### Six Sigma

Six Sigma is a QI approach that is data-driven and focuses primarily on eliminating defects and minimizing variability in processes. It has been used successfully to make improvements in products and processes in a variety of manufacturing industries and more recently in health care. The concept of *sigma* is based on a statistical measure that quantifies how well a process is performing. The goal is to limit defects to 3.4 per million opportunities. Training in Six Sigma can be obtained through a well-developed program at the Six Sigma Academy and involves increasing expertise within an organization represented by levels called *belts* (Green Belt through Black Belt). See Figure 11–4.

Proponents of Six Sigma indicate that a typical Black Belt can facilitate significant cost savings to organizations, multiple times greater than their salary. Six Sigma is sometimes combined with Lean strategies to focus on quality and efficiency in broad-scale implementation projects. More focused or limited initiatives may benefit from just one specific strategy. Six Sigma is dependent on the ability to collect data on processes and outcomes within an organization on a continual basis.

Six Sigma strategies focus on measurement-based methods of improvement and reduction of variation using multiple improvement projects. Improvement projects

**FIGURE 11–4**  
DMAIC Roadmap



focus on five strategies represented in the acronym DMAIC (Define, Measure, Analyze, Improve, and Control):

**Define.** The initial step is to identify and define the process and outcome for improvement, including specific characteristics, process inputs and desired outputs/outcomes. This first step establishes the scope and boundaries for the project.

**Measure.** Monitoring and tracking performance through data collection focused on the defined processes and outcomes is the second step. Measures can include data from the medical record, observations of care processes, and survey feedback.

**Analyze.** Analysis of the data provides information to determine performance both at baseline and after new processes are implemented. It should be done routinely. The data are reviewed as a component of the ongoing process to continually identify causes of problems.

**Improve.** Findings from the analyses inform further improvements and revisions of processes. If the findings do not indicate improvement, the project team should revise the changes and determine new implementations or strategies to improve the process.

**Control.** Continual monitoring and ongoing improvements provide necessary control of the process over time.

Further quality improvement resources can be found on the web (see the accompanying box).

## Quality Improvement Resources on the Web

### Lean Enterprise Institute

[www.lean.org/whatslean/](http://www.lean.org/whatslean/)  
[www.lean.org/WhoWeAre/HealthcarePartner.cfm](http://www.lean.org/WhoWeAre/HealthcarePartner.cfm)

### PM\_Vantage

[www.pmvantage.com/leanbusiness.php](http://www.pmvantage.com/leanbusiness.php)

### ASQ

[asq.org/learn-about-quality/lean/overview/overview.html](http://asq.org/learn-about-quality/lean/overview/overview.html)  
[asq.org/healthcaresixsigma/lean.html](http://asq.org/healthcaresixsigma/lean.html)

### IHI

[www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx](http://www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx)

### iSixSigma

[www.isixsigma.com/dictionary/dmaic/archian.wordpress.com/2012/11/05/marketing-wisdom-of-understanding-six-sigma/](http://www.isixsigma.com/dictionary/dmaic/archian.wordpress.com/2012/11/05/marketing-wisdom-of-understanding-six-sigma/)

## Just Culture Principles

The Just Culture model was developed as an alternative to a punitive system that focused on blaming individuals when errors occurred rather than taking a systems perspective. Dr. Lucian Leape described the consequences of a blaming, punitive strategy:

Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes. (Leape, 2000)

Just Culture was first introduced in 2001 by David Marx and has been applied in industries such as aviation in an effort to encourage error reporting so that the contributing factors can be identified, analyzed, and prevented. In 2010 the ANA issued a position statement supporting the Just Culture model and encouraging regional and statewide Just Culture initiatives.

The Just Culture model focuses on a balance of three duties with organizational and individual values. The model is based on the premise that staff working in an organization have a duty to avoid causing risk or harm, a duty to produce an outcome, and a duty to follow procedural rules. These duties are balanced within the framework of organizational and individual values such as safety, cost, effectiveness, equity, and dignity.

The model also suggests three distinct types of behaviors related to error occurrence. Human error is the first

type of behavior and is identified as inadvertently doing something other than what should have been done. This represents a slip, lapse, or mistake. Second is at-risk behavior, which is characterized by a behavioral choice that increases risk where it is not recognized or is mistakenly believed to be justified. The third is reckless behavior, a conscious behavioral choice to disregard substantial and unjustified risk.

In contrast to the blame-free approach, which minimizes professional responsibility, the Just Culture model strives to create an open and fair culture that provides a level of accountability based on individual behavior. A Just Culture facilitates an environment of learning, designing safe systems, and managing behavioral choice appropriately. The model recommends specific responses on the part of supervisors. Human error should be responded to with consoling and potential changes in processes, procedures, training, and design. When individuals demonstrate at-risk behavior, coaching and increasing situational awareness and de-incentivizing at-risk behaviors while providing incentives for healthy behaviors is recommended. Reckless behavior suggests the need for remedial or punitive actions. Staff expectations within a Just Culture include looking for risks in the environment, reporting errors and hazards, helping to design safe systems, and making safe choices.

Nursing organizations and state boards of nursing have endorsed implementation of Just Culture principles as an ideal for healthcare systems. Other industries, such as aviation, have applied the Just Culture concept with

### CRITICAL THINKING EXERCISE

Consider a specific safety or quality issue in your current or past nursing experience. If you were going to lead an improvement project to address this issue, how would you apply one of the CQI models to approach it? What

stakeholders would you include on your team? How would you define success, and what metrics would you use to evaluate your project?



resultant improvements in safety and error reduction. Likewise, a Just Culture in health care can have similarly successful effects and provides nurses and other health-care professionals ownership in quality improvement in an open fair environment.

### Reflect On . . .

- the principles of a Just Culture. Have you worked in settings that reflect Just Culture principles? If not, how would a Just Culture have changed the work environment? If so, how did you experience the effects of a Just Culture?

### Teamwork and Collaboration

Healthcare delivery involves a number of different individuals from different disciplines working together to provide safe and quality care for patients and families. The work of nurses and other health professionals is intertwined and cannot be accomplished without collaboration and communication. Yet research indicates that poor communication among the healthcare team is one of the leading causes of medical errors and patient harm (Tocco & DeFontes, 2014; Woolf, Kuzel, Dovey, & Phillips, 2004; Lingard et al., 2004; Leonard, Graham, & Bonacum, 2004). Similarly, the JC indicates that failures in communication were associated with over 70% of sentinel events (Joint Commission, 2005). According to the National Council of State Boards of Nursing (2008), nurses cite communication issues with physicians as one of the highest contributing factors to patient care error. Poor collaborative communication among nurses and physicians contributed, in part, to nearly double patient risk-adjusted mortality and length of stay in a multisite ICU study (Knaus, Draper, Wagner, & Zimmerman, 1986; Shortell et al., 1994; Zimmerman et al., 1993).

Teamwork and collaboration can decrease the potential for error and improve system resistance to errors (Morey et al., 2002). Factors that enhance teamwork and result in decreased adverse events include using planned, standardized team processes; being aware of all team members' responsibilities; ongoing monitoring of team members' performance to prevent errors before they cause harm; and working well together (Institute of Medicine, 1999; Risser et al., 1999; Firth-Cozens, 2001). Team training in health care was initially based on crew resource management (CRM) strategies adapted from commercial aviation and the military. These strategies emphasize communication skills such as briefings,

speaking up, monitoring and repeating back critical communications, and leveling the workplace hierarchy. In addition, TeamSTEPPS, a team-building program developed by AHRQ provides comprehensive educational strategies that are adaptable to most care delivery settings.

### Building Effective Teams

The following characteristics provide the foundation for effective healthcare teams (Mickan & Rodger, 2005):

1. **Common purpose:** Sharing a clear and common purpose enhances teamwork and shared ownership.
2. **Measurable goals:** Setting goals that are measurable and focused on the team's purpose provides a common direction.
3. **Effective leadership:** Teams need effective leadership that sets and maintains structures, manages conflict, listens to team members, and trusts and supports members. Also, various leadership functions should be shared among the team as needed.
4. **Effective communication:** Good communication includes the sharing of ideas and information quickly and regularly. Keeping written records and allowing time for team reflection (as feasible) helps facilitate communication.
5. **Good cohesion:** Cohesive teams have a definite commitment and have greater longevity, as team members want to continue working together.
6. **Mutual respect:** Members who respect the talents and beliefs of each person in addition to their professional contributions make for more effective teams. This mutual respect facilitates an acceptance of diverse opinions among members.

Structured communication strategies have also been found to be useful when communicating (Tocco & DeFontes, 2014). Physicians, nurses, and other healthcare professionals are educated within their individual disciplines to communicate in a specific way. Physicians focus on concise diagnoses, while nurses often describe assessment findings such as signs and symptoms. Having a structured communication strategy provides common ground that transcends unique disciplinary perspectives. SBAR (Situation Background Assessment Recommendation) is a structured communication technique that has been used in a number of healthcare settings and is particularly helpful when communicating information about a patient that requires attention and action. In addition, SBAR has been adapted to be used for shift reports and handoffs. See the accompanying box.

## CRITICAL THINKING EXERCISE

Think about the issue of psychological safety as it relates to a situation in your current or a past clinical setting. As a manager, how would you facilitate psychological safety among your staff? As a staff member, how would you

encourage it among your peers? Consider your past responses and behaviors toward your peers and determine if they were potential facilitators or barriers to psychological safety.

## SBAR

**Situation:** 5–10 second “punch line.” What is happening now? What are the chief complaints or acute changes?

*This is \_\_\_\_\_. I'm calling about \_\_\_\_\_*  
 \_\_\_\_\_  
 \_\_\_\_\_

**Background:** What factors led up to this event? Pertinent history (e.g., admitting diagnosis) and objective data (e.g., vital signs, labs) that support how patient got here.

*The patient has \_\_\_\_\_*  
 \_\_\_\_\_  
 \_\_\_\_\_

**Assessment:** What do you see? What do you think is going on?

A formal diagnosis is not necessary; include the severity of the problem.

*I think the problem is \_\_\_\_\_*  
 \_\_\_\_\_  
 \_\_\_\_\_

**Recommendation:** What action do you propose?

State what the patient needs (get a time frame).

*I request that you \_\_\_\_\_*  
 \_\_\_\_\_

## RESEARCH CURRENT

## The Consequences of Poor Communication During Transitions from Hospital to Skilled Nursing Facility: A Qualitative Study

A qualitative design applying grounded dimensional analysis (GDA) was used by King, Gilmore-Bykovskyi, Roiland, Polnaszek, Bowers, and Kind to explore how nurses in skilled nursing facilities (SNFs) transition the care of patients admitted from hospitals, and to identify barriers and outcomes associated with the quality of transitions. Focus group interviews conducted with 27 registered nurses from four Wisconsin SNFs were audiotaped and transcribed word for word. Data were analyzed concurrently with interviews, and questions were modified along the way to provide relevant comparisons. Analyses included line-by-line coding to determine how nurses understood and reacted to hospital-to-SNF-transitions and coding for the interrelationships of conditions and consequences associated with the transition processes. Results indicated that the primary source of transition information was the written hospital discharge record, as well as the individual, the family, and the hospital. Nurses described difficult SNF transitions as the norm and noted multiple deficiencies and barriers to safe, effective transitions, including poor quality discharge communication. A significant amount of information necessary to design a medical care plan was missing, incomplete, conflicting, or inaccurate.

Consistent with GDA, a conceptual model of the transition processes SNF nurses experience was developed: Seeking, Reviewing, Gathering, and Reconciling Hospital Information. Difficult hospital-SNF transitions resulted in significant care delays, such as untimely pain management, risk of hospital readmission, patient and family dissatisfaction, and stress and frustration on the part of nurses. Nurses were overwhelmed with the inefficient and time-consuming process of continually having to gather and reconcile information. Nurses' recommendations for improving SNF transitions included a minimum standard set of elements to be communicated to provide high-quality, safe care. While interventions to improve transitions exist, each organization should assess the inclusion of information that nurses deem critical for development of a complete, individualized medical plan of care. This study highlights the importance of effective communication in transitions across the care continuum and the effect on patient safety and quality.

*Source:* From “The Consequences of Poor Communication During Transitions From Hospital to Skilled Nursing Facility: A Qualitative Study,” by B. King, A. Gilmore-Bykovski, R. Roiland, B. Bowers, and A. Kind, 2013, *Journal of the American Geriatric Society*, 61, pp. 1095–1102.

Nurses participate in a variety of teams over the course of their careers and are well positioned to impact the quality of care for patients with enhanced team strategies and collaborative communication.



**InfoQuest:** To learn more about TeamSTEPPS™, on the Internet look up TeamSTEPPS at the website of the Agency for Healthcare Research and Quality (AHRQ) for strategies and tools to enhance performance and patient safety, from the Department of Defense in collaboration with the AHRQ. An additional resource is the SBAR Toolkit at the Institute for Healthcare Improvement found at the IHI website.

## Patient-Centered Care

Patient-centered care (PCC) is one of the six key elements of quality care described by the IOM (2001). The IOM advises that health care in the 21st century should be redesigned to focus on a continual healing relationship, personalized inclusion of patient needs and values, engagement with patients as the source of control, and a basis of shared knowledge and free flow of information. This description is well aligned with the concepts of **patient-centered care**, which is defined as care organized around the patient. It is an approach to health care (planning, delivery, and evaluation) that is grounded in partnering with patients and families and is built on the core concepts of dignity and respect, information sharing, participation, and collaboration (Institute for Patient and Family Centered Care, 2014). One key feature of the PCC model is its focus on staff experiences as caregivers and the inclusion of caring for staff concurrently with patients.

Organizations that have been most successful in implementing PCC assert it requires buy-in and commitment from all levels (staff, physicians, board members, leadership, and volunteers) and describe it as a cultural transformation in their organization (Frampton & Guastello, 2010). The first step to implementation is a self-assessment to determine the organization's commitment to PCC, provide direction for future planning, and identify opportunities for improvement. Implementation of PCC approaches focus on effective communication with patients and families, personalization of care, continuity of care, access to information, family involvement, environment of care, spirituality, caring for the community, and caring for the caregiver (staff).

A number of organizations have used creative strategies to implement PCC including using photos of staff on

whiteboards, patient participation in rounds and shift report, providing aromatherapy and other integrative therapies, flexible visiting hours, family initiation of rapid response, timing of procedures based on patient routines, developing a patient and family advisory council, conducting regular focus groups with patients and families, implementing pet therapy, and attending to ethnic, cultural, and spiritual practices. Leadership strategies include walking the talk (conducting regular walking rounds), increasing accessibility through open office hours (sometimes referred to as *fireside chats*), and ensuring that staff have adequate resources to support PCC.

The PCC model has gained support over the last decade as a significant care delivery model that extends beyond efforts that previously were viewed as peripheral and secondary to clinical care. Since 2007 CMS has required hospitals to publicly report data related to patients' perspectives of hospital care as a requirement for reimbursement. Using the national standard survey, HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), hospitals are expected to assess patient care experiences focused on nurse and physician communication, responsiveness of the hospital staff, pain management, cleanliness and quietness of the environment, and discharge information. The Joint Commission, the American Hospital Association, the Accreditation Council for Graduate Medical Education (ACGME), and ANA all support implementation of PCC strategies. Healthcare organizations can obtain recognition as a patient-centered facility through Planetree's Patient-Centered Hospital Designation Program, which is recognized by The Joint Commission as a special designation. Hospitals designated by this program exceeded national averages on CMS core measures (quality indicators) and performed above the national average in 9 out of 10 categories of the HCAHPS (Frampton & Guastello, 2010). A recent 5-year retrospective study of comparable hospital units found the patient-centered care unit demonstrated shorter length of stays and lower cost per case, reduced RN hours per patient day, increased use of lower cost personnel, and had higher patient satisfaction compared to the units that had not implemented PCC (Stone, 2008).

Additional research indicates nursing care has one of the single most influential effects on patient perceptions. An extensive study of over 14,000 cases indicates that ratings of nursing care have the most direct effect on overall ratings of quality of care and services and that a negative experience with nursing care had a disproportionately negative effect on perceptions of quality (Otani, 2010). These findings underscore the importance of nurses in patient perceptions and highlight the priority to focus on high-quality nursing care.

## Chapter Highlights

- Nurses are inseparably linked to patient safety and high-quality health care and often intercept errors before they adversely affect patients.
- Nursing care focused on vigilance and monitoring patients is directly connected to patient outcomes and safety. Starting with Florence Nightingale's early advocacy for safe care and studies of patient outcomes, nurses have a legacy of patient safety and quality that continues to have impact today.
- Quality care is described by the IOM as safe, effective, patient-centered, timely, efficient, and equitable.
- Nurses can lead efforts to improve quality of care, such as safe transitions across the healthcare continuum, teamwork and collaborative communication, implementation of evidence-based processes to reduce health-system-acquired conditions, and partnering with patients and families in quality and safety improvements.
- Today's patient safety and quality movement has progressed over time, based on an evolving perspective on errors and causal factors, specific high-profile cases, psychology and human factors, lessons learned from high-risk industries (such as aviation), pressure from patients and consumer groups, court cases, and governmental agencies.
- The release of the IOM report *To Err Is Human* launched the modern-day patient safety movement and thrust the issue into the public and political consciousness of the United States. The IOM has published a subsequent series of reports.
- Federal, state, and professional organizations such as The Joint Commission, CMS, state departments of health, AHRQ, NQF, and ANA contribute to regulatory standards of safety and quality by developing safety goals, endorsing quality indicators, conducting research, and providing implementation tool kits to support improvement efforts. One means that CMS has used to promote safe quality care is to deny reimbursement of federal funds to pay for services by physicians and hospitals for treatment of never events, that is, preventable errors, injuries, and infections.
- Interest in assessments of healthcare quality has grown substantially, paralleled by increasing efforts by governmental agencies, accrediting bodies, insurers, and consumer groups to publish comparative reports on healthcare quality.
- NDNQI is the primary registry for nursing-sensitive indicators and provides evidence-based comparative data reflecting the relationship of nursing care to patient outcomes at a national level. The nursing-sensitive indicators reflect the structure (number of nursing staff, skill level, education, certification), process (interventions, job satisfaction), and outcomes (falls, pressure ulcers) of nursing care. Outcome indicators are based on the premise that they are affected by the quantity and quality of nursing care.
- Other organizations have published report cards including selected quality indicators developed and endorsed broadly by agencies such as the NQF, AHRQ, and CMS. Data are organized and presented based on disease conditions, procedures, quality and safety, nurse staffing, patient satisfaction, and costs of services.
- Information from these reports has been used to link quality of care to financial incentives (such as pay for performance or withholding pay for poor performance); for value-based purchasing of services; to facilitate quality improvement projects; and to direct the public toward higher quality providers.
- Continuous quality improvement (CQI) applies scientific methods to improve all aspects of care and service on an ongoing basis.
- CQI focuses on evaluating current practices and processes and exploring ways to improve efficiency, effectiveness, and timeliness.
- One key to successful CQI initiatives is the use of a structured planning approach to assess current practice and implement improvements to achieve a desired outcome and vision for a desired future state.
- The most prominent QI models are the Toyota Lean model, the IHI Model for Improvement, and Six Sigma. These models use a multidisciplinary team approach to reduce waste or defects in the system, create and implement efficient processes, and monitor outcomes as a means of evaluation and for the direction of future revisions.
- Factors that enhance safety and quality include facilitating a Just Culture, integrating human factors when designing systems of care, effective teamwork and collaboration, and implementing patient-centered care.
- As an alternative to a blaming, punitive system, the Just Culture model strives to create an open, fair environment that considers system factors while providing accountability based on individual behaviors.
- The model suggests three distinct types of behaviors related to error occurrence: human error (a lapse or mistake), at-risk behavior (increasing risk where it is not recognized or mistakenly believed to be justified), and reckless behavior (consciously disregarding substantial and unjustified risk).



- Specific managerial responses, such as consoling, changing processes, training, coaching, incentivizing, and remedial actions, are also recommended based on individual behaviors.
- Human factors science relates an understanding of human strengths and limitations to interrelated systems of individuals, equipment, and the environment in an effort to enhance effectiveness and safety.
- A human factors framework provides a systems approach to understanding patient safety by taking into consideration individuals' knowledge, skills, and sensory/physical capabilities, as they relate to the work performed; the physical, organizational, and social environment; and management.
- This framework aligns with Reason's Swiss Cheese model of causation, where the weaknesses within a system line up like the holes in pieces of Swiss cheese, the protective layers of defense that promote safety are penetrated, and adverse events occur.
- Teamwork and collaboration can decrease the potential for error and improve quality of care.
- Effective teams are characterized by mutual respect, sharing a common purpose, strong leadership and communication, commitment and a sense of cohesion, and measurable goals based on a distinct purpose.
- Structured communication strategies such as SBAR have been used in various settings to facilitate effective,

concise communication among interdisciplinary health-care professionals.

- Patient-centered care is an approach to health care (planning, delivery, and evaluation) that is grounded in partnering with patients and families and built on the core concepts of dignity and respect; information sharing; participation; and collaboration.
- Implementing PCC involves a transformation in organizational culture and requires buy-in and commitment from all levels (staff, physicians, board members, leadership, and volunteers).
- PCC approaches focus on effective communication with patients and families, personalization of care, continuity of care, access to information, family involvement, environment of care, spirituality, caring for the community, and caring for the caregiver (staff).
- Research indicates nursing care has one of the single most influential effects on patient perceptions.
- An extensive study of over 14,000 cases indicates ratings of nursing care have the most direct effect on overall ratings of quality of care and services and that a negative experience with nursing care have a disproportionate negative effect on perceptions of quality.
- Nurses are well suited to address safety and quality issues, as they have in-depth experiences interacting with patients and families in multiple settings and provide care management across the continuum of health and illness.

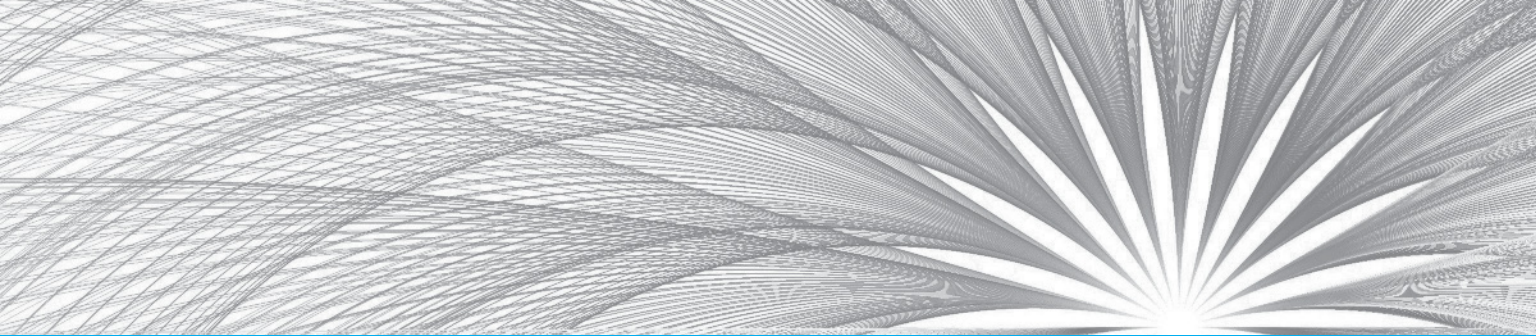
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# 12

## The Nurse's Role as Political Advocate

### Chapter Outline

#### Challenges and Opportunities

##### Power

- Empowerment
- Sources of Power
- Caring Types of Power
- Laws of Power

##### Politics

- Nursing and Political Action
- Strategies to Influence Political Decisions
- Developing Political Astuteness and Skill
- Seeking Opportunities for Political Action

#### Chapter Highlights

### Objectives

1. Discuss the role that power plays in nursing practice.
2. Discuss the relevance of political action to nursing.
3. Explain various strategies used to influence political decision making.
4. Identify skills that are essential to political action.
5. Identify ways in which nurses can participate in the political arena.

**N**urses are actively participating in political processes to promote change within the profession and to influence policy making regarding nursing and healthcare policy issues. The realities of health care, such as more government regulation and increasingly scarce resources, demand that nurses become knowledgeable about and capable of influencing the development of healthcare policy and the delivery of care to clients.

Although political action is ordinarily associated with governmental concerns, Mason, Leavitt, and Chaffee (2012) identify four spheres of political action: the workplace, government, professional organizations, and community. These spheres are interconnected and overlapping. In the workplace, policies and procedures may be the focus of political action, and government and professional organizations as well as the community may influence these workplace policies. Professional organizations play a key role in influencing the practice of nursing through standards of practice, lobbying, and collective action.

### Challenges and Opportunities

Political power is a concept that has not been traditionally associated with nursing. In fact, nursing has been seen as having little control with regard to decisions about clinical practice. Nursing is challenged to change that perception and assume more power over its own practice.

In recent years, more nurses have been appointed to senior administrative positions and elected to public office, and the image is changing. These changes create opportunities for nurses



to influence policy and assume power commensurate with their knowledge and expertise as care providers.

## Power

Power is difficult to define and measure. One definition is “Power is the potential capacity to influence events, cause change, initiate action, and control outcomes” (Lee, 2000, p. 26). Often, the terms *power*, *influence*, and *authority* are used interchangeably, but they need to be differentiated. Influence is the use of power, but it is more subtle than power. Authority is based on one’s position within an organization, which assigns power to the person assuming the role. Authority may be delegated for certain tasks.

## Empowerment

The concept of empowerment has been associated with attempts to increase the power and influence of oppressed groups. Recently the concept has been more broadly applied to various groups and the individual. The basic element of empowerment is taking action to generate positive results at both the individual and organizational levels.

A useful theoretical framework for application of empowerment to practice is Kanter’s (1993) theory of organizational empowerment. Assumptions of this theory are that people react rationally to their situations and that situations structured to support employees’ feelings of empowerment result in benefit to the organization in effectiveness and employee attitude. The organizational structures that promote the growth of empowerment are (1) having access to information, (2) receiving support, (3) having access to resources necessary to do the job, and (4) having the opportunity to learn and grow. Management can create conditions for work effectiveness by ensuring that employees have the

access they need to information, support, and resources in order to do their job and that they have opportunity for development. The result is employees are more productive and effective in meeting the organization’s goals.

Conger and Kanungo (1988) pose additions to the Kanter model by arguing that managers or leaders need to eliminate situations fostering powerlessness and use motivation strategies. They further pose that task accomplishment builds a sense of competence and self-determination. Attempts at empowerment without consideration of employee capability may not result in empowerment if people are incapable or overwhelmed or unmotivated.

## Sources of Power

Power theorists describe a variety of sources from which a person derives power. Understanding these sources of power is prerequisite to formulating a plan for developing one’s own power and recognizing it in others. French and Raven (1960, pp. 607–623) identified five sources of power: legitimate, reward, coercive, referent, and expert powers. Hershey, Blanchard, and Johnson (2001) added two more: connection (association) and information powers. Most leaders use all types of power at different times, depending on the particular situation.

- *Legitimate* (or *positional*) power derives from one’s formal position or title in an organization. It is associated with the authority that the position gives its holder to make and enforce decisions. The title “vice president for nursing” implies that the holder has power by virtue of the position, regardless of who holds that position or how effective that person is.
- *Reward power* is derived from the perception of one’s abilities to bestow rewards or favors on others.

## RESEARCH CURRENT

### Work-Related Empowerment of Nurse Managers

A systematic review of nurse managers’ work-related empowerment by Trus, Razbadauskas, Doran, and Suominen looked at the level and relationships of empowerment. The databases used for the search were MEDLINE, CINAHL, Wiley Online Library, and Science Citation Index Expanded, using the keywords *empowerment*, *nurse manager*, *nurse administrator*, *nurse leader*, *head nurse*, and *empowered nurse*. Of the 277 articles identified, 51 full-text articles were screened, 34 were reviewed, and 9 articles were of sufficient relevance to be included in the review. The most frequently encounter framework was Kanter’s view of structural empowerment. The majority of the studies reviewed found

the nurse managers’ structural, psychological, and work empowerment was high; their scores were higher than staff nurses’ scores, suggesting that they perceived themselves to have greater access to empowering structures. The empowerment of nurse managers correlated positively with job satisfaction, perceived organizational support, role satisfaction, and managerial self-efficacy, and it correlated negatively with emotional exhaustion and the nurse managers’ own health outcomes.

Source: “Work-related empowerment of nurse managers: A systematic review,” by M. Trus, A. Razbadauskas, D. Doran, and T. Suominen, 2012, *Nursing and Health Sciences*, 14, pp. 412–420.

- *Coercive power*, by contrast, arises from the perception of one's ability to threaten, harm, or punish others.
- *Information power* is associated with persons who are perceived to control key information.

Reward, coercive, and informational power all relate to the degree that an individual can control the distribution of resources.

- *Referent (charismatic or personal) power* is derived from an individual's own vision, sense of self, and ability to communicate these so that others regard the person with admiration and are motivated to follow.

- *Connection (associative) power* derives from the perception that one has important contacts or relationships with others. These connections can be an aspect of both formal and informal networks.
- *Expert (or knowledge) power* is derived from one's expertise, talents, and skills. One can include in this category Benner's (1984) vision of power, that is, the positive power the nurse brings to the nurse-client relationship. This power enables the nurse to transform the client's life through advocacy and other means of caring.

The accompanying box provides guidelines for the use of each source of power.

## Guidelines for the Use of Power in Organizations

### Using Authority

1. Make polite requests, not arrogant demands.
2. Make requests in clear, simple language; check for understanding.
3. Explain reasons for requests.
4. Follow up to check for compliance.

### Using Rewards

1. Don't overemphasize incentives; staff will expect rewards for every request. Emphasize mutual loyalty and teamwork.
2. Rewards are unlikely to produce commitment.
3. Reinforce past behavior; don't bribe for future performance.
4. The size of rewards should reflect total performance.
5. Money is not the only (and is often the least effective) reward.
6. Avoid appearing manipulative at all costs.

### Using Coercive Power

1. Avoid coercion and punishment except when absolutely necessary.
2. Punish only to deter extremely detrimental behavior.
3. Try to determine genuine responsibility or liability before taking corrective action.
4. Discipline promptly and consistently without favoritism. Fit the punishment to the seriousness of the infraction.
5. State consequences without hostility; remain calm and express a desire to help subordinates comply with requirements and avoid discipline.
6. Invite subordinates to share in responsibility for correcting disciplinary problems; set improvement goals and develop improvement plans.
7. Warn before punishing; don't issue idle or exaggerated warnings you are not prepared to carry out.

### Using Expert Power

1. Preserve credibility by avoiding careless statements and rash decisions.
2. Keep informed about technical developments affecting the group's work.
3. In a crisis, remain calm; act confidently and decisively.
4. Avoid arrogance or talking down to staff; show respect for staff ideas and suggestions and incorporate them whenever feasible.
5. Do not threaten subordinates' self-esteem.
6. Recognize subordinates' concerns; explain why a proposed plan of action is best and what steps will be taken to minimize risk to them.

### Using Referent Power

1. Be considerate, show concern for staff needs and feelings, treat them fairly, and defend their interests to superiors and outsiders.
2. Avoid expressing hostility, distrust, rejection, or indifference toward subordinates. Actions speak louder than words.
3. Explain the personal importance of requests and your reliance on staff support and cooperation.
4. Don't make requests too often; make requests reasonable.
5. Be a good role model.

### Using Connection Power

1. Consider carefully the appropriate use of the connection or relationship.
2. Avoid name dropping.
3. Provide sound rationale for using the relationship.
4. Recognize the likelihood of being expected to reciprocate for favors provided in a relationship.
5. Recognize the reasonable limits of the connection. Don't overuse or exploit.

Source: From *Effective Leadership and Management in Nursing* (8th ed., p. 89), by E. J. Sullivan, 2013, Upper Saddle River, NJ: Prentice Hall. Used by permission.



**InfoQuest:** Find the website of the American Nurses Credentialing Center Magnet Program. Review the criteria for a hospital to achieve Magnet designation. How does this designation reflect power for nurses within that institution?

## Caring Types of Power

Benner (1984), in her classic work on clinical nursing excellence, describes six types of power that nurses can use when dealing with clients and significant others. These are powers that are associated with caring: transformative, integrative, advocacy, healing, participative/affirmative, and problem-solving powers.

### Transformative Power

Transformative power represents the ability of the nurse to assist clients to change their views of reality or their own self-images. Nurses display this type of power in caring for clients who have long-term illness. Providing compassionate care to clients who are unable to perform their normal hygienic care can help transform their self-image from one of worthlessness to one of value.

### Integrative Power

Integrative power is the nurse's ability to assist a client to return to a normal life. In this process, the nurse helps clients integrate any disabilities into their lives and assists them back into the family and society.

### Advocacy Power

Advocacy power enables the nurse to help a client and significant others deal with a healthcare bureaucracy. The nurse can explain to the client what services are available. In addition, the nurse can act as an interpreter between the client and physician. For example, a client may hesitate to express a concern to a busy physician. Recognizing that the physician may be able to ease the client's mind, the nurse may act as a liaison between the two.

### Healing Power

With healing power, nurses can establish a healing relationship and a healing climate with a client. According to Benner (1984), nurses can do this by mobilizing hope in themselves, the staff, and the client; finding an interpretation or understanding of a specific situation; and assisting the client to use social, emotional, and/or spiritual support. Benner writes that an affirming and caring nurse-client relationship provides a basis for healing. A healing relationship empowers the client by bringing hope, confidence, and trust (p. 213).

### Participative/Affirmative Power

Participative/affirmative power is the nurse's ability to draw strength by investing it in others. Benner (1984) disputes the more traditional view that nurses have only so much emotional strength to draw on and suggests that involvement and caring permit nurses to obtain strength (p. 214).

### Problem-Solving Power

A committed person is more sensitive to cues than a less committed person; thus, a caring and involved nurse is able to solve problems at a higher level than a less involved nurse. Commitment and caring enhance the nurse's receptivity to cues and enables the nurse to recognize solutions that are not obvious. These abilities may be due partly to intuition and feeling.

## Laws of Power

Berle (1969) describes power as a "universal experience and human attribute of man with five discernable natural laws" (p. 32).

**Law 1: Power invariably fills any vacuum** People generally prefer peace and order and are usually willing to give power to someone who will restore order and thereby reduce their discomfort. When a problem arises, an individual will usually show the initiative to handle the problem and thus will exert power. Nurses should be aware that these are opportunities to assume power.

**Law 2: Power is invariably personal** In many instances, people who effect change find common ground and come together committed to that change. To be successful, nurses must develop personal power, that is, the power one develops in oneself: self-esteem, self-respect, and self-confidence. Through their professional organizations, nurses can then exert personal power in the healthcare field.

**Law 3: Power is based on a system of ideas and philosophy** When people demonstrate behaviors that indicate power, they reflect a personal belief or philosophy. It is this belief or philosophic system that gains followers and their respect. Nurses, however, have traditionally been comfortable taking direction and accommodating a hospital hierarchy rather than taking the initiative in such spheres as clients' rights and health promotion. Current problems in the healthcare system, such as increasing technology and cost, offer nurses an opportunity to fill a vacuum for change in the healthcare system and thereby offer solutions to these problems.

**Law 4: Power is exercised through and depends on organizations** Individuals can feel powerless and unable

## Rules for Using Power

1. Use the least amount of power you can to be effective in your interactions with others.
2. Use power appropriate to the situation.
3. Learn when not to use power.
4. Focus on the problem, not the person.
5. Make polite requests, never arrogant demands.
6. Use coercion only when other methods don't work.
7. Keep informed to retain your credibility when using your expert power.
8. Understand you may owe a return favor when you use your connection power.

Source: From *Effective Leadership and Management in Nursing*, by E. J. Sullivan, 2013, p. 92. Upper Saddle River, NJ: Pearson. Used by permission.

to deal with many situations in a hospital, community agency, government agency, or other institution. By banding together with others through a state or provincial nursing organization, nurses can magnify their power and support changes in health care.

**Law 5: Power is invariably confronted with, and acts in the presence of, a field of responsibility** Nurses in power positions act on behalf of other nurses or clients. Power is communicated to people observing the situation and is reinforced by positive responses. If group members believe that their beliefs or ideals are not represented, the vacuum will be filled by another person who can carry out the role and is supported by the organization. Rules for using power are shown in the accompanying box.

### Reflect On . . .

- sources of power available to you in clinical practice. How can you enhance your expert power, your advocacy power, your healing power, your connection power, and your participative/affirmative power?
- how a nurse's self-image can affect that nurse's referent power.
- how expert power can enhance legitimate power.

## Politics

**Politics** can be defined as “influencing—specifically, influencing the allocation of scarce resources” (Mason, Leavitt, and Chaffee, 2012, p. 5). Defined in this way, the word denotes more than action in the governmental arena; it is also applicable to every sphere of life where resources are limited and more than one person or group competes for them. It is altering the outcome in decisions about how to divide resources among competing people or groups. *Resources* may refer not only to money but also to any number of cherished assets that are limited, such as personnel, programs, time, status, and power. Policy exists in

the legislative sphere, in the community, in the workplace, and within professional organization. Nurses are involved in each of these.

## Nursing and Political Action

Nurses have long been involved in politics. For example, the founder of modern nursing, Florence Nightingale, used her contacts with powerful men in government to obtain needed personnel and supplies for wounded soldiers in the Crimea. Subsequent nursing leaders such as Lavinia Dock, Lillian Wald, Harriet Tubman, and Margaret Sanger—who were all skilled politicians and made significant contributions to the profession and society—may have been influenced by these wise words of Nightingale:

When I entered service here, I determined that, happen what would, I never would intrigue among the Committee. Now I perceive that I do all my business by intrigue. I propose in private to A, B, or C the resolution I think A, B, or C most capable of carrying in Committee, and then leave it to them, and I always win. (Huxley, 1975, p. 53)

Professional organizations, such as the National League for Nursing and the American Nurses Association, began forming in the late 1800s and early 1900s, and interests expanded from practice issues to social and policy issues. Political action committees (PACs) of nursing organizations such as the American Nurses Association (ANA) have endorsed candidates, and nurses themselves have run for and held political office. Consciousness-raising by the women's movement from the 1960s to the present has increased activism. Nursing journals such as *Policy*, *Politics*, and *Nursing* have emerged.

There is need for nurses to continue advocacy and lobbying as healthcare reform unrolls in the United States. Nursing efforts are needed to evaluate and restructure healthcare policy, advocate for the reimbursement of nursing care, fund nursing education, develop the role of the nurse in health and medical homes, do studies on comparative effectiveness of healthcare interventions, and raise



## Steps in Political Action

1. Determine what you want.
2. Learn about the players and what they want.
3. Gather supporters and form coalitions.

4. Be prepared to answer opponents.
5. Explain how what you want can help them.

Source: From *Becoming Influential: A Guide for Nurses* (2nd ed., p. 70), by E. J. Sullivan, 2013, Upper Saddle River, NJ: Pearson.

awareness of issues related to health information technology. The ANA has created the American Nurses Advocacy Institute, a 1-year mentoring program for developing leadership in political action.

The allocation of scarce resources involves everyone in some way. The following are examples of situations of scarce resources:

- A student applying for a college loan or competing with other students for his or her fair share of a teacher's time and attention
- A client advocate competing for hospital education funds in order to provide more preoperative teaching
- A citizen lobbying against the school board's proposal to divide one RN's time between two large schools
- A member of a professional association seeking association action on a practice issue, such as care of clients with acquired immune deficiency syndrome (AIDS)

*Political action* refers to action by a group of individuals that is designed to attain a purpose through the use of political power or through the established political process. **Policy** is shaped by politics and has been defined as the principles that govern actions directed toward given ends: Policy statements outline a plan, direction, or goal for action. Policy results from political action and encompasses the choices that a society, a segment of society, or an organization makes regarding its goals and priorities and how it will allocate its resources. Governmental bodies form public policy. Social policy pertains to directives that promote the welfare of the public. Institutional policies govern the workplace. Organizational policies govern professional organizations. Policies may be laws, guidelines, or regulations that govern behavior in government, workplaces, organizations, and committees.

## Strategies to Influence Political Decisions

Advocacy in the legislative arena begins with the desire to address a specific issue or problem. That idea must be communicated effectively to a policy maker or staff member who is then convinced that it is worth addressing through legislation and is willing to work on developing a bill. Lobbyists are often employed at this point to assist in

moving the process forward. A bill is most effectively introduced by an official who is well respected and sits on a key committee that carries significant weight. Like-minded nurses or other individuals can be recruited and organized on behalf of the proposed legislation. A hearing is most often held so that testimony can be given. Once the hearing process is completed, the bill can go to either the lower legislative house or the upper house for a vote, and if the bill passes, it can then go to the other chamber for a vote. On the state level, the bill can then go to the governor for signing into law once it is adopted by both chambers. On the federal level, the bill would proceed to the president for a signature.

Many of the strategies used to influence political decisions will serve the nurse well in everyday professional activities. Steps to follow in planning and implementing political action can be found in the accompanying box.

### Negotiating

*Negotiation* is a give-and-take process between individuals and groups to work out differences of opinion regarding the best solution to an issue. Two basic forms of negotiation are problem-solving negotiation and trade-off negotiation. In *problem-solving negotiation*, both parties confer to resolve a complex situation together so that a win-win outcome results. In *trade-off negotiation*, one party gives some concessions, or points, to the other party in exchange for other concessions, or points.

Negotiating demands good communication skills on the part of all participants. Before beginning negotiation, the nurse needs to know all the essential facts of the issue and gather data to support a particular viewpoint. A familiar example of the negotiating process for nurses is the collective bargaining (contract negotiations) process between employees and employers. Guidelines for negotiation are found in the accompanying box.

### Networking

*Networking* refers to a process in which people with similar interests and goals communicate, share ideas and information, and offer support and direction to each other. Network development builds linkages with people throughout the profession, both within and outside the work environment. Getting to know people helps build a trust

## Guidelines for Negotiation

- Obtain all of the essential facts of the issue beforehand.
- Explore the other party's viewpoint. If the other party is a legislator, for example, obtain information about his or her views from news media and congressional records.
- Consider the consequences of the issue and how you can deflect those consequences to support your viewpoint.
- Verify the strength of your own viewpoint and ways to strengthen it further; then consider ways to counteract or weaken the other party's viewpoint.
- Determine any limitations surrounding your viewpoint, such as time constraints or other resources.
- Consider other groups that support your viewpoint or that of the other party.

relationship that can facilitate the achievement of professional goals: It is easier to access people one knows than it is to access strangers.

Nurses can develop networks by (1) attending local, regional, and national conferences; (2) taking classes for continuing education or toward an academic degree; (3) joining alumni associations and attending alumni meetings; (4) joining and participating in professional organizations; (5) keeping in touch with former teachers and coworkers; and (6) socializing with professional colleagues.

Political networks generally have three functions: (1) to provide information about legislative activities on particular issues, (2) to increase political action and awareness, and (3) to promote issues through the legislative process. These networks may be formal, with signed agreements and fee structures, or informal, requiring minimal monetary contributions.

### Preparing Resolutions

*Resolutions* are formal statements expressing the opinion, will, or intent of an individual or group. Most nurses will be familiar with the specific format used to present resolutions at annual association meetings or conventions about nursing and healthcare concerns. Resolutions are an effective means of writing concise reasons and proposed recommendations for action, particularly for areas where services are inadequate. Nurses who present resolutions must, however,

be well informed about the data presented, be prepared to offer additional data others might request, and be willing to consider amendments to the recommendations.

### Establishing Political Action Committees

*Political action committees* endorse candidates for public office, such as the U.S. Senate and House of Representatives. Because tax laws limit nonprofit professional organizations from participating in various types of political activities, PACs provide an avenue for professional political action activities. Groups such as nursing organizations, women's groups, church groups, and civic groups may form PACs. Members of a PAC provide additional donations or pay dues to support the organization's activities because general membership fees in any nonprofit organization cannot be used to support such activity. Because they are used for political purposes, donations made to a PAC are not tax deductible.

The American Nurses Association Political Action Committee (ANA-PAC) is a political organization formed by the ANA. Many state nursing organizations also have political action organizations that serve similar functions on the state level as ANA-PAC does on the national level. PACs support legislative candidates based on their stands on key issues. For example, ANA-PAC would consider a candidate's stand on such specific health and nursing issues as healthcare reform, third-party reimbursement for nurses, funding for biomedical and nursing research, and

## CRITICAL THINKING EXERCISE

Using the Guidelines for Negotiation found in the accompanying box, plan a strategy for the following situations:

1. Your institution has money available for a 6% salary increase for RNs. Administration wants to give it all on the basis of merit (reward). You and several of your colleagues believe there should be an across-the-board cost-of-living raise for all RNs.
2. Your state legislature or provincial government is considering whether mandatory continuing education units (CEUs) should be a condition of relicensure. You can assume the position of advocating either for or against mandatory continuing education.

elder abuse. Although nursing PACs have not created power equal to that of such groups as labor, education, and medicine, nurses are becoming more sophisticated in the political process and are gaining increased power.



**InfoQuest:** Find the American Nurses Association's statement on Health System Reform: Nursing's goal of quality affordable care for all on the ANA website. What are the implications for political action?

### Communicating with Legislators

Nurses can communicate with legislators through telephone calls, telegrams, face-to-face meetings, email, fax, and written letters. For each method, the nurse needs to identify clearly the issue and the bill (by number if possible), explain reasons for interest in the issue, and provide constructive information and ideas. Telephone calls are usually received by a legislative assistant who keeps a record of all calls and the positions of the callers. In many regions, a toll-free number is available during the legislative session.

For visits to legislative officials, contact must be made with the local offices; they will provide assistance in arranging the visit and may additionally arrange other activities, such as tours of the legislature, attendance at committee hearings, and visits to a legislative session. Before the visit, the nurse should obtain information about the legislator's background, such as the legislator's occupation, previous professional and civic activities, political affiliation, voting record, and interests. Because only a few minutes may be allotted to the visit, the nurse should be prepared to be succinct in presenting personal ideas and facts, allow time for the legislator to answer questions, and leave a summary of facts and recommendations with the legislator to emphasize her or his perspective of the visit. Visitors should be aware that promptness for an appointed time is essential in order to be seen.

Letters are probably the most common mode of communicating with elected officials. Personal letters that reflect thoughtful and informed comments about an issue often receive more attention from legislators than form letters or postcards. When writing to legislators, the nurse should use a professional letterhead and address the public official appropriately. For example, in written communication, the president, vice president, senators, and state representatives are cited as The Honorable (full name) followed by their position (e.g., President of the United States) and the specific address. Salutations in letters are written as Dear Mr. (or Madame) President/Vice President

or Dear Senator (full name), or Dear Representative (last name). When communicating in person it is appropriate to say the following: Mr. or Madame President/Vice President or President (last name); Senator (last name); and Representative or Mr./Ms. (last name). Elements to include in the letter follow:

- A statement of the request in the first sentence (e.g., "I request that you support Bill XY604") and a brief summary of the issue
- A brief rationale for the request (e.g., "The bill is vital to improving . . ." or "The bill will adversely affect . . .").
- Factual data that support your viewpoint
- A closing statement thanking the legislator for his or her concern and continuing support or attention
- Appropriate closing. For a letter to the president of the United States, the appropriate closing is "Very respectfully yours"; for all other letters, "Sincerely yours."

In general, email messages and faxed copies are useful when time constraints exist, but they tend to have less impact.

### Building Coalitions

*Coalitions* are alliances that distinct bodies, persons, or states form to achieve a common purpose. Coalitions are like networks in function but differ in that the members of the coalition represent groups with numerous purposes and issues. The groups negotiate, compromise, and merge to achieve specific goals. Groups or organizations may be in coalition on one issue but adversaries on another. Building coalitions is a strategy to empower oneself; thus, nurses solicit organizations whose power is greater than their own. Groups with whom nurses may form coalitions are as diverse as the topics that are of concern to nurses; women's issues, child care, and the environment are only a few examples.

Professional specialty organizations frequently form coalitions for areas of common interest. For example, the American Association of Critical Care Nurses has built coalitions with the American Nurses Association, the Emergency Nurses Association, and the American Hospital Association in order to advocate for common interests of those groups.

### Lobbying

*Lobbying* is a process in which individuals or groups attempt to influence legislators to support or oppose particular legislation. Lobbyists monitor legislative activities and communicate the group's position to members of the legislature. Groups from various sources may employ professional lobbyists: public relations firms, management relations firms, legal firms, legislative consultants, and

independent lobbyists, many of whom are former legislators. Which source is used depends on the issue. Law firms, for example, can provide legal advice as well as lobbying; public relations firms generally provide media resources for campaigns. Individuals and groups can lobby independently, but such efforts require considerable time, personnel, and funding. Lobbyists must follow various legal guidelines. Lobbying techniques include negotiating, media and letter-writing campaigns, testifying, endorsements, and donations.

### Testifying

Decisions related to health care and nursing are often made by committees and commissions of various levels of government. These committees frequently conduct hearings to obtain information before making a decision. Hearings generally include people or groups with opposing views. Testifying refers to the presentation of information at a committee hearing, usually about controversial aspects of a proposed bill. Nurses may testify either as independent individuals or as official representatives of an organization. Opportunities to testify may be found in professional publications or newspapers. Guidelines for testifying are shown in the accompanying box. Most committees will accept written testimony if the individual cannot be present.

### Developing Political Astuteness and Skill

By contributing to political activities in various ways, nurses can develop their political astuteness and skills. All nurses, as citizens and employees, can join and participate in organizations and participate in election processes. However, nurses who are employed by a governmental

agency, such as the Veterans Administration or a public health department, must follow restrictions defined in the Hatch Act regarding their political activity. These restrictions do not apply to the general public and include serving as an officer or spokesperson of a particular political party. The major objective of the Hatch Act, initiated in the 1930s, was to prevent government workers from being forced to support political activities. The Hatch Act Modernization Act of 2012 now allows most state or local government employees to run for partisan political office unless the employee's salary is paid completely by federal loans or grants. Because states have ethics rules that govern political activity, nurses who are employed by state governmental agencies are advised to investigate specific limitations in their state of employment.

A statement of three key assumptions must precede a discussion of when and where to engage in political action:

1. **Individuals who are deeply concerned about a particular issue or cause are most likely to identify ways to take action.** Before becoming politically involved, an individual must make choices, including the conscious decision to set aside the necessary resources. For example, a student who wants his or her school to offer evening or weekend clinical practice hours may decide to seek election to the student council to work for this change from within.
2. **Political action in any sphere is best carried out by a group.** Individual activism is laudable, but group action is much more effective. It provides change agents with the collegiality and support necessary to sustain a vision for change and fosters creative thinking and planning.

### Guidelines for Testifying

- Confirm the time to register. In some instances, registration occurs at the meeting place on the day of testifying; in others, you must notify the committee of your visit to testify at a specified time before the hearing.
- Prepare your testimony concisely and clearly in advance. Avoid the use of professional terminology that may not be understood by the legislators, or explain any technical terms used.
- Dress appropriately to convey your professional status, and introduce yourself. Make your position clear so that legislators know whether you are representing an organization. Some places may have a dress code; for example, men may be required to wear a suit and tie when testifying before a legislative body. The dress code may be stated or inferred. It is always a good idea to ask if you are unsure.
- Maintain a courteous, professional composure throughout the hearing. Adhere to the rules of the proceedings.
- Verify any time limits to your presentation so that you can present essential facts and arguments first.
- Provide copies of your written testimony, including any graphs or other illustrations, to each committee member.
- Present your material without reading it to make the presentation more interesting for the listeners. Summarize the main ideas. Convey knowledge of the subject.
- Answer any questions completely. Be prepared to support any facts and figures you present with appropriate sources.
- Thank the committee for allowing your testimony.



3. **Successful political action requires the thoughtful application of change theory.** Before embarking on a project, the politically astute nurse will review the principles of change theory. Achieving goals for change requires thoughtful planning. Effective political activists plan strategy, much as nurses use the nursing process to evaluate clients' needs for care.

### Seeking Opportunities for Political Action Workplace

The workplace for nurses may be a public or a private (for-profit or nonprofit) organization; this designation can influence who sets policies and the values underlying the policies. Workplace policies can have a profound influence on a nurse's professional life, and it is therefore important to examine ways to influence them. A nursing perspective must be made available, listened to, and incorporated into decisions about the administration of the organization. Expertise, position, and economic power can be exerted by negotiating to place nurse members on standing committees and the board of various agencies.

In most hospitals, nursing homes, and public health agencies, a system of committees exists to deal with specific issues. For example, a nursing department has an equipment evaluation committee that selects and evaluates client care products used by the nursing staff. A pharmacy committee in the same hospital has representatives from nursing, medicine, and the pharmacy. In addition to formal standing committees, ad hoc committees or task

forces can be appointed to deal with particular issues or problems. For example, a task force on a nursing unit might examine the best way to initiate a case management program.

Nurses who have an idea or problem they want addressed are advised to look for existing committees that might already be dealing with the concern or are likely to do so. For example, concern about staff safety in the parking lot may already be a focus of the hospital security committee.

Another way to generate interest in an issue is to write an article for the hospital or nursing department newsletter. Nurses who are present at nursing grand rounds also have the opportunity to inform their colleagues of an issue of mutual concern and enlist their aid in dealing with it. If there are no newsletters or grand rounds, a task force of concerned nurses may be formed and, using a model for change, plan a strategy to establish ways of helping nurses communicate with one another through a newsletter, grand rounds, or possibly a support group.

The politics of and policies related to client care impinge on the practice of every nurse. For example, the prospective payment system has drastically shortened hospital stays in efforts to reduce hospital costs. Preparing clients for earlier discharge has brought about the need for nurses to be faster and smarter in delivering client care and client education.

How can nurses ensure that cost containment measures do not impair the quality of nursing care? One way is

## RESEARCH CURRENT

### Political Astuteness of Baccalaureate Nursing Students Following an Active Learning Experience in Health Policy.

Byrd, Costello, Gremel, Schwager, Blanchette, and Malloy measured the political astuteness of baccalaureate nursing students both before and after participation in course-related public policy learning activities. The participants in the study were 300 students who were enrolled in a public/community health nursing course. Learning activities included information sessions at the State Department of Health and the State House, a legislative assignment, and a public policy group project. The Political Astuteness Inventory (PAI) was used to compare levels of political astuteness and to identify conceptual factors that contributed to political involvement. Based on total scores, the PAI categorizes into four levels: (1) totally unaware, (2) slightly more aware of the implications of political activity for nursing, (3) beginning political astuteness, and

(4) politically astute. At the beginning of the study, most students were totally unaware or slightly more aware. PAI scores significantly increased after the learning activities were completed. At the end of the study most of the students had moved to beginning political astuteness or being politically astute. Participation in professional organizations and knowledge of the legislative and policy processes were predictive of political involvement. The Byrd et al. study concluded that active learning experiences in public policy can increase the knowledge and skills that future nurses need to influence public policy.

"Political astuteness of baccalaureate nursing students following an active learning experience in health policy" by M. E. Byrd, J. Costello, K. Gremel, J. Schwager, L. Blanchette, and T. E. Malloy, 2012, *Public Health Nursing*, 29(5), pp. 433–443.

for nurses to collaborate with each other and with other providers to delegate nonnursing tasks, such as answering the telephone, emptying the garbage, and transporting nonacute clients. Developing a demonstration project that compares cost and quality-of-care issues under different hospital unit structures can provide the necessary data and generate support from other providers and administrators for changing the role of staff nurses. This sort of proactive planning can empower nurses to take charge of nursing practice in ways that benefit clients and health professionals while conserving scarce resources such as money, time, and supplies.

### Nursing Organizations

Powerful and influential professional associations, such as the American Nurses Association and Canadian Nurses Association (CNA) and their affiliated state/province and district associations, provide a collective voice for promoting nursing and quality health care. Associations monitor and influence laws and regulations affecting nursing and health care. Their role in workplace matters ranges from studying practice issues to acting as the collective bargaining agent for nurses. Additionally, the professional nursing organization is often a visible presence in the community because it presents the nursing perspective on health care issues.

Professional organizations—including the ANA, CNA, National League for Nursing (NLN), and National Student Nurses Association (NSNA)—publish articles and updates on legislative matters and encourage nurses to take action on behalf of healthcare consumers and the nursing profession. Nursing lobbyists at the state and national level work to influence the development of health policy and legislation, but their success depends on the active support of nurses who back up these paid lobbyists by doing personal lobbying among their own elected officials.

Collective efforts influence the federal government through political action committees such as the ANA-PAC. ANA-PAC also counts on nurses at the grass roots level to work for these candidates and to serve as congressional district coordinators (CDCs). CDCs are responsible for organizing nurses in their congressional districts for lobbying and campaigning. This effort has provided a mechanism for nurses to influence governmental politics collectively at the federal level.

Individuals can become politically active in local, state or provincial, and national organizations by participating in the activities of their professional associations, by serving as delegates at conventions, by becoming members of commissions, and by supporting national

association efforts. Student nurses can benefit from participation in the NSNA by learning about the politics of professional associations.

### Community

The community in which the nurse lives and works can include the local neighborhood, the corporate world, the nation, and the international community. The community encompasses the workplace, professional organizations, and government. Many nurses, including Lillian Wald, founder of the Henry Street Settlement House and modern public health nursing, view the community as more than a practice setting. Nurses who live in the community where they work can understand and influence the complex interplay among individuals and groups that compete for scarce resources.

Many communities depend on expert nurses to help with a wide variety of health and social policy decisions, such as environmental pollution and health care for the homeless. For example, a nurse who serves as an elected member of the community school board can influence decisions that affect the health and health care of students, such as the hiring of nurses for the school system. Nurses' opinions on matters of public health are frequently sought, and the enterprising nurse looks for opportunities to promote a positive image of nursing while serving the community.

Political involvement in the community often arises out of one's own interest in living and working in a community that is supportive of the health and well-being of its citizens, for example, becoming involved with an ad hoc committee to stop unlawful dumping of hazardous wastes in the neighborhood. As a member of such a group, the nurse wears two hats, as a concerned citizen and as an expert on health issues. At the same time, the position in the group enables the nurse to extend networks and expand a support base.

As the self-help movement continues to expand, nurses are realizing how influential consumer groups can be. In many instances, such groups are founded by nurses who realize the need for a self-help group for their clients. Sometimes nurses who have been clients themselves start postmastectomy support groups or similar groups. Nurses contribute their leadership skills to many organizations, including the National Alliance for the Mentally Ill (NAMI). The personally devastating experience of having a child with schizophrenia can be a powerful motivating force toward working on behalf of others through a group such as NAMI. The political power of groups with particular health concerns—including the Gray Panthers, the American Association of Retired Persons, and the Juvenile Diabetes Association—can generate extraordinary

political influence on elected and appointed officials. Such groups offer a variety of ways to learn about grass roots political activism. These groups can also provide a community support base.

A variety of other opportunities for community involvement exist. Since many nurses are also parents, they can work on health issues through their school board. Those who ultimately run for government office have frequently begun their careers by running for the school board. Other nurses volunteer for community action groups, such as a community planning board or a fund-raising committee for the city's art museum. Or a nurse may get involved in the tenants' organization in her or his apartment building. Regardless of the issue, the same opportunity to organize and plan for change exists in the community as it does in the workplace, government, or professional association.

### The Government

Numerous ways to personally influence governments are open to nurses. Of course, the most basic step is registering to vote. Voter registration drives are sponsored by a variety of organizations, including NSNA, which has developed a kit for nursing students to hold such drives. By voting, responsible citizens convey their opinions to elected and appointed officials on matters of concern.

The laws and regulations of local, state, and federal governments greatly influence nursing practice and health care. For example, federal laws and regulations establish funding of health care for the elderly, poor, and disabled (Medicare and Medicaid); authorize care services for special groups (including Native Americans, migrant workers, and veterans); set policies and formulas for reimbursement of healthcare services (as with prospective payment); and appropriate funding for special health care

and social services (such as community health centers, the food stamp program, and the school lunch program).

State and provincial laws are responsible for defining and regulating nursing practice. Nurse practice acts in some states prohibit nurses from providing a broad range of services and can effectively limit nurses' ability to compete with other healthcare professionals in providing primary care services.

Nurses can become involved with political parties and local political clubs, work with elected officials, and accept political appointments as a means to influence health policy as well as practice. Involvement in political parties and local political clubs enables influence over affairs in the community and developing a nonnursing support base.

Actively participating in campaigns of politicians who support nursing and health care can lead to becoming a candidate for legislative office and can act as an information source for legislative representatives. The accompanying box lists ways to influence the legislative process and to become politically active.

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### Reflect On . . .

- ways in which you have participated in political activities in the past—in the work setting, in professional organizations, in the community, and in government.
  - how you would like to increase your participation in political activities.
  - whether you believe nurses have an obligation to be politically active. Why or why not?
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## Steps in Becoming Politically Active

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| <ul style="list-style-type: none"> <li>• Inform yourself about the policies currently active in the political arena such as proposals in the state legislature that impact nursing and health care.</li> <li>• Introduce yourself to public officials who serve on committees that affect your concern in the legislature or other appropriate arenas.</li> <li>• Communicate with those officials about your position on the issue, being clear about your position and noting your expertise as a registered nurse in that legislator's district.</li> </ul> | <ul style="list-style-type: none"> <li>• Network with professional associations and other interested persons to influence elected officials.</li> <li>• Attend public hearings and show support. Contribute well-prepared testimony on the issue.</li> <li>• Support candidates by working on their campaigns.</li> <li>• Expand your political influence through appointments to task forces, election to public office, or volunteer experiences at the local, state, or national legislative levels.</li> </ul> |
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**CRITICAL THINKING EXERCISE**

Select a political issue affecting nursing, such as one of the following:

1. Reimbursement of nursing services
2. Equal pay for work of comparable value

3. National health insurance
4. Healthcare reform

Applying the information from the box titled, “How to Influence Legislative and Regulatory Processes”, plan a strategy to bring about change you believe is needed.

## Chapter Highlights

- Power is an invaluable instrument, the effects of which can be positive or negative depending on the way it is used and the ends to which it is applied.
- Power is assumed by a person; it is a skill that can be learned and effectively practiced.
- Sources or bases of power are described as reward, coercive, legitimate, referent, expert, connection, and information powers.
- An understanding of these sources helps nurses formulate a plan to develop their own power and to recognize it in others.
- Benner describes six types of power that nurses use when caring for clients: transformative power, integrative power, advocacy power, healing power, participative/affirmative power, and problem-solving power.
- Empowerment enables individuals and groups to participate in actions and decision making in a context that supports an equitable distribution of power.
- Politics is the process of influencing the allocation of scarce resources in the spheres of government, workplace, organizations, and community.
- Political action in one sphere often affects other spheres.
- Strategies to influence political decisions include negotiating, networking, establishing political action committees, communicating with legislators, building coalitions, lobbying, and testifying.
- All nurses can contribute to political activities in numerous ways—by voting, joining organizations, becoming members of committees, supporting deserving candidates, and so on.
- To make an effective contribution, nurses must keep themselves informed about healthcare and nursing issues, be able to analyze an issue, voice an opinion, participate constructively, use power bases, and communicate clearly.
- Nurses who value the nursing perspective on health issues recognize that a powerful voice for nurses is a powerful voice for healthcare consumers, the profession, and the nation.

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# 13

## The Nurse as Colleague and Collaborator

### Chapter Outline

#### Challenges and Opportunities

##### Collaborative Health Care

- Collaborative Practice
- The Nurse as a Collaborator
- Benefits of Collaborative Care

##### Factors Leading to the Need for Increased Collegiality and Collaboration

- Healthcare Consumers
- Personal Responsibility Initiatives
- Changing Demographics and Epidemiology
- Healthcare Access
- Technological Advances

##### Competencies Basic to Collaboration

- Communication Skills
- Mutual Respect and Trust
- Giving and Receiving Feedback
- Decision Making
- Conflict Management

##### Interprofessional Health Care

- Physicians
- Pharmacists
- Dietitians and Nutritionists
- Social Workers
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Respiratory Therapists

##### Interprofessional Focus

##### Global Collaboration

##### Chapter Highlights

### Objectives

1. Explain the essential aspects of collaborative health care.
2. Discuss the nurse's role in collaboration.
3. Describe competencies needed for collaborative practice.
4. Analyze factors that affect collaboration in health care.
5. Compare and contrast the roles and expectations of other disciplines providing care for clients.

Because of changes in healthcare delivery in recent years, previously perceived traditional roles of nurses as “handmaidens” and physicians as “captains of the ship” have required modification to a more collaborative model that also includes other health professionals (e.g., pharmacists, social workers, physical therapists, occupational therapists) who are important in the delivery of quality health care. The very definition of collaboration describes the mutual goal of all healthcare providers to achieve quality health for consumers through joint action.

In 2001, the Institute of Medicine published its report *Crossing the Quality Chasm*, which called for a redesign of the healthcare system based on the principles of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Among the report's recommendations was an improvement in collaboration and coordination among health-care providers in providing care to clients with the client being a key member of the healthcare team. Through Provision 8 of the *Guide to the Code of Ethics for Nurses: Interpretation and Application*, the American Nurses Association (2010a) presents the ethical mandate that “the nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs” (p. 103).

Traditionally, models of health care presented a one-sided distribution of power in provider-client relationships. Health care had been physician-dominated and focused on cure of illness. Recently, however, the healthcare system has moved toward more collaborative efforts and initiatives in the promotion of health, prevention of illness/injury, and treatment of disease/disability, in which providers and clients become partners in care. Today, that care is client-centered and client-directed and involves collaboration between and among the various providers of care and the client.

## RESEARCH CURRENT

## The Ethics of Interprofessional Collaboration

This paper examines the ethics of interprofessional collaboration in Canada and the United States. Engel and Prentice describe the historical and policy dictates in Canada and the United States that have called for increased collaboration in health care. They define *interprofessional* as being different from *multidisciplinary* in that with collaboration there “is a much greater intent to have professionals engage in interaction with one another and for decision-making to be shared” (Engel & Prentice, 2013, p. 430). Collaboration is defined as “a unique form of relationship that is goal and action oriented” (p. 433). Because interprofessional collaboration in health care is about relationships between and among

healthcare professionals and their patients/clients, ethical characteristics of “honesty, humility, integrity, fairness, courage, and respect” are important to achieving the goal of quality care. Engel and Prentice question the “viability of true collaboration in health care.” They raise ethical questions about the “process of collaboration and its implications for education and practice, which includes implications” for healthcare providers, patients and clients who receive care, health profession educators, and health profession students who are being taught to provide care.

Source: “The Ethics of Interprofessional Collaboration,” by J. Engel and D. Prentice, 2013, *Nursing Ethics*, 20(4), pp. 426–435.

With the restructuring of health care, the old systems and practices have changed health jobs in ways designed to improve care and control costs across the health/illness continuum. This restructuring has changed roles and created new ways of interacting among the members of the healthcare team.

## Challenges and Opportunities

Resistance to change is inevitable when the traditional ways of providing care have been so drastically disrupted by changes in health care that were outside the control of those affected by the change. Changes in power structure are particularly difficult to manage. Nurses need to work both within the profession and with those in other health professions, who may be less accepting of an interprofessional collaborative approach to client care. Education of healthcare providers needs to include opportunities for students in the various health professions to work together during their educational process so they know the responsibilities of each health professional and can include them as appropriate to the client’s needs on the healthcare team. The Institute of Medicine (2013, p. 2) states that “when contributions from each specialty field are well coordinated, the individual person or patient benefits from the communication among all the providers, resulting in improved health and better care as well as less duplication of services and cost savings.” Nurses need to increase their own expertise in teamwork and collaboration so that they can assume a position of leadership and nursing expertise on healthcare teams.

Opportunities to create new practice models and redefine relationships with colleagues from the various health professions are now abundantly available to nurses. It is

time for a reshaping of practice under the direction of those willing to assume leadership.

## Collaborative Health Care

During the early years, the nurse was seen as providing assistance to the physician in caring for patients and the term *handmaiden* was used to describe that role. However, during wars and times of crisis, nurses worked in a more collegial and autonomous manner. As early as the American Civil War, there is documentation of a more independent practice (American Nurses Association, 1998). The emergence of advanced practice nursing roles provided impetus to the emerging concerns about collegiality and collaboration. In 1992, the ANA held a Congress on Nursing Practice and adopted the following operational definition of collaboration:

**Collaboration** means a collegial working relationship with another healthcare provider in the provision of (to supply) patient care. Collaborative practice requires (may include) the discussion of patient diagnosis and cooperation in the management and delivery of care. Each collaborator is available to the other for consultation either in person or by communication device, but need not be physically present on the premises at the time the actions are performed. The patient-designated healthcare provider is responsible for the overall direction and management of patient care. (American Nurses Association, 1992).

Virginia Henderson (1991, p. 44), one of nursing’s pioneers, defined collaborative care as “a partnership relationship between doctors, nurses, and other healthcare providers with patients and their families.” More recently, the

## Characteristics and Beliefs Basic to Collaborative Health Care

- Clients have a right to self-determination: That is, clients have the right to choose to participate or not to participate in healthcare decision making.
- Clients and healthcare professionals interact in a reciprocal relationship. Instead of making decisions about the client's health care, healthcare professionals foster joint decision making. Client participation in the healthcare process is maximized; client dependency and professional dominance are minimized.
- An attitude of equality among human beings is essential in healthcare relationships. The ideas of both clients and healthcare professionals receive equal consideration.
- Responsibility for health falls on the client rather than on healthcare professionals.
- Each individual's concept of health is important and legitimate for that individual. Although clients lack expert knowledge, they have their own ideas about health and illness. Healthcare professionals need to understand these ideas to be able to help the client effectively.
- Clients have the right to accept or refuse all or any aspect of recommended treatment.
- Collaboration involves negotiation and consensus seeking rather than questioning and ordering.

American Nurses Association (2010b,, p. 65; 2010c, p. 40) defined collaboration as “a professional healthcare partnership grounded in a reciprocal and respectful recognition and acceptance of each partner’s unique expertise, power, and sphere of influence and responsibilities; the commonality of goals; the mutual safeguarding of the legitimate interest of each party; and the advantages of such a relationship.” Thus, collaboration is a process by which healthcare professionals work together with clients to achieve quality health outcomes. Mutual respect and a true sharing of both power and control are essential elements. Ideally, collaboration becomes a dynamic, interactive process in which clients (individuals, groups, or communities) confer with physicians, nurses, and other healthcare professionals to meet their health objectives. Effective collaboration requires cooperation and coordination between client(s) and various healthcare professionals across the continuum of care. See the accompanying box.

The ANA *Nursing: Scope and Standards of Practice* (2010b) includes collaboration by the registered nurse with clients and families as well as other healthcare providers (Standard 13). See the accompanying box.

### Collaborative Practice

The overall objectives of collaborative initiatives are high-quality client care resulting in desired positive health outcomes. In addition, many healthcare professionals believe that a multidisciplinary, interprofessional, collaborative framework can limit costs as well as enhance quality. Collaborative practice models propose to achieve the following objectives:

- Provide client-directed and client-centered care using a multidisciplinary, integrated, participative framework
- Enhance continuity across the continuum of care from wellness and prevention, illness/injury diagnosis, through

## American Nurses Association’s Standards of Professional Nursing Performance

### Standard 13. Collaboration

***The Registered Nurse collaborates with healthcare consumer, family, and others in the conduct of nursing practice.***

#### Competencies

The registered nurse:

- Partners with others to effect change and produce positive outcomes through the sharing of knowledge of the healthcare consumer and/or situation.
- Communicates with the healthcare consumer, the family, and healthcare providers regarding healthcare consumer care and the nurse’s role in the provision of that care.
- Promotes conflict management and engagement.
- Participates in building consensus or resolving conflict in the context of patient care.
- Applies group process and negotiation techniques with healthcare consumers and colleagues.
- Adheres to standards and applicable codes of conduct that govern behavior among peers and colleagues to create a work environment that promotes cooperation, respect, and trust.
- Cooperates in creating a documented plan focused on outcomes and decisions related to care and delivery of services that indicates communication with healthcare consumers, families, and others.
- Engages in teamwork and team-building process.



an acute episode of illness, to transfer or discharge and recovery or rehabilitation

- Improve client(s) and family satisfaction with care
- Provide quality, cost-effective, evidence-based care that is outcome driven
- Promote mutual respect, communication, and understanding between client(s) and members of the health-care team
- Create a synergy among clients and providers, in which the sum of their efforts is greater than the parts
- Provide opportunities to address and solve system-related issues and problems
- Develop interdependent relationships and understanding among providers and clients.

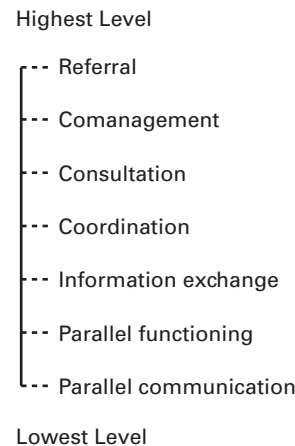
Collaborative practice can include nurse-physician interaction in joint practice and client caregiving, nurse-nurse collaboration in caregiving, or participating on interprofessional teams or committees comprised of health professionals representing various health disciplines.

Collaborative healthcare teams provide comprehensive care by providing a full range of expertise. Through better communication and sharing of discipline-specific expertise, they can manage care with less redundancy and more efficiency, resulting in better client outcomes at lower cost. These interdisciplinary healthcare teams have been particularly effective in outpatient services, where patients are seen by a primary care physician or by a nurse practitioner, and consultations are implemented as needed. The teams manage specific patient-related problems as well as move patients through the clinic and hospital to home or rehabilitation as required.

The ability to collaborate becomes particularly important when nurses implement advanced practice roles; collaboration has been designated as a core competency for advanced practice nurses. The drivers for this role have been healthcare reform, leading to group practice and managed care, as well as certification and practice standards. A continuum of collaboration begins with parallel communication at the lowest level, whereby everyone is communicating with the client independently and asking the same questions. Parallel functioning may have more coordinated communication, but each professional has a separate plan of care with separate interventions. Information exchange involves planned communication, but decision making is unilateral, involving little, if any, collegiality. Coordination and consultation represent midrange levels of collaboration seeking to maximize the efficiency of resources. Comanagement and referral represent the upper levels of collaboration, whereby providers retain responsibility and accountability for their own aspects of care and patients are directed to other providers when the problem is beyond their expertise. Figure 13–1 illustrates this continuum.

**FIGURE 13–1**

Continuum of Collaboration



Characteristics of effective collaboration include the following:

- Common purpose and goals identified at the outset by all team members including the client
- Clinical competence of each provider
- Interpersonal competence
- Humor
- Trust and respect
- Valuing and respecting diverse, complementary knowledge

Processes associated with these characteristics include recurring interactions among the providers of health care that bridge professional boundaries and develop linkages. Interpersonal skills and respect for the competence of collaborators are essential to the outcome. Successful consultation comes about when there is recognition of the unique contribution that each person can make so that a unified plan can be implemented.

### The Nurse as a Collaborator

The Quality and Safety Education for Nurses (QSEN) project, funded by the Robert Wood Johnson Foundation has recognized teamwork and collaboration as a combined competency. The goal of QSEN is to “meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes necessary to continuously improve the quality and safety of the healthcare systems within which they work” (Quality and Safety Education for Nurses, 2014). QSEN defines teamwork and collaboration as the ability to “function effectively within nursing and interprofessional teams, fostering open communication,

## The Nurse as a Collaborator

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With clients, the nurse:

- Acknowledges, supports, and encourages clients' active involvement in healthcare decisions.
- Encourages a sense of client autonomy and an equal position with other members of the healthcare team.
- Helps clients set mutually agreed-upon goals and objectives for health care.
- Provides client consultation in a collaborative fashion.

With peers, the nurse:

- Shares personal expertise with other nurses and elicits the expertise of others to ensure quality client care.
- Develops a sense of trust and mutual respect with peers that recognizes their unique contributions.
- Acknowledges, supports, and encourages peers' active involvement in decision making.
- Recognizes the contribution that each member of the nursing team can make based on her or his knowledge and experience.

With other healthcare professionals, the nurse:

- Recognizes the contribution that each member of the interprofessional team can make by virtue of his or her expertise and view of the situation.
- Listens to each individual's views.
- Shares healthcare responsibilities in exploring options, setting goals, and making decisions with clients, families, and communities.

- Participates in collaborative interprofessional research to increase knowledge about a clinical problem or situation.

With employer institutions, the nurse:

- Collaborates with administration and other organizational healthcare professionals to define institution mission and goals.
- Participates on interprofessional committees (e.g., ethics committee, pharmacy committee) to create institutional policy, solve institutional problems, and consider institutional issues.

With professional nursing and interprofessional organizations, the nurse:

- Seeks out opportunities to collaborate with and within professional organizations.
- Serves on committees in state, regional, national, and international nursing and interprofessional organizations or specialty groups.
- Supports professional organizations in political action to create solutions for professional and healthcare concerns.

With legislators, the nurse:

- Offers expert opinions on legislative initiatives related to health care.
  - Collaborates with other healthcare providers and consumers on healthcare legislation to best serve the needs of the public.
- 

mutual respect, and shared decision-making to achieve quality patient care" (Quality and Safety Education for Nurses, 2014).

Nurses collaborate with clients, peers, and other healthcare professionals. They frequently collaborate about client care but they also may be involved, for example, in collaborating on bioethical issues, on legislation, on health-related research, and with professional organizations. The accompanying box outlines selected aspects of the nurse's role as a collaborator.

Collaboration is important in professional nursing practice as a way to improve client outcomes. To fulfill a collaborative role, nurses need to assume accountability and increased authority in practice areas. Education is integral to ensuring that the members of each professional group understand the collaborative nature of their roles, specific contributions, and the importance of working together. Each professional needs to understand how an integrated delivery system centers on the client's healthcare needs rather than on the particular care given by one group.

Collaboration is not limited to healthcare professionals. Collaboration with clients is essential. The theory of collaborative decision making in nursing practice of H. S. Kim (1983, 1987) describes and explains collaborative interactions between clients and nurses in making healthcare decisions and the effect on outcomes. Dalton (2003) expanded the theory to include the client, nurse, and family caregiver. In this theory, all three enter into the collaboration from their own context of role expectations and attitudes, knowledge, personal traits, and perspective of the situation. The three combine to form a coalition with opportunities for collaboration within the context of the situation. The level of collaboration achieved and the nature of the decision are the primary outcomes leading to secondary outcomes of goal attainment, autonomy, and satisfaction. The level of collaboration can range from complete domination of the decision making by the nurse to equal influence on a joint decision by all three. In any client situation, it is imperative that the client's views are heard and respected if mutually desired outcomes are to be achieved.

**CRITICAL THINKING EXERCISE**

Consider a nursing situation in which you participated as a member of an interprofessional team. Describe the situation. What other individuals or groups were members of the team? What were the desired outcomes or goals for the situation? Who decided the desired outcomes/goals? What was the role of each team member in achieving the desired outcome/goal? Was the desired outcome/goal achieved? What barriers or facilitators

occurred that influenced achievement of the outcome/goal? If the desired outcome/goal was achieved, in what ways did each team member contribute to achieving the desired outcome/goal? If the desired outcome/goal was not achieved, in what way did the team or individual team members contribute to the failure to achieve the desired outcome/goal? What strategies would you use to improve team functioning?

**Reflect On . . .**

- your own strengths, limitations and values as a member of a team.
- your own collaborative activities in client care, with clients and their families, peers, other health-care professionals, institutional committees, professional organizations. What specific roles do you assume in these collaborative activities?

- your own collaborative activities in political action with clients and families, communities, peers, and professional organizations. What specific roles do you assume in these collaborative activities?

**Benefits of Collaborative Care**

A collaborative approach to health care ideally benefits clients, professionals, and the healthcare delivery system. Care becomes client-centered and, most importantly, client-directed.

**RESEARCH CURRENT****Interdisciplinary Collaboration: The Role of the Clinical Nurse Leader**

The purpose of this study was to “develop a clinical nurse leader (CNL) workflow that would specifically impact empirical determinants of interdisciplinary collaboration and determine if the role could be successfully integrated into a fragmented acute care microsystem” (Bender, Connelly, & Brown, 2012). Specific goals were to develop, implement, and assess the acceptability of the CNL role by members of the healthcare team. The study used a nonexperimental, descriptive design to examine the feasibility and acceptability of a CNL role “developed to improve interdisciplinary collaboration.” The CNL role was developed in collaboration with the unit managers and clinical leaders. The CNL role was implemented on a “26-bed high-acuity progressive care unit that served surgical-oncology, cardiac, pulmonary, bone marrow transplant and neurology patients.” Three CNLs were assigned to the unit. A six-item Likert scale survey was used to measure acceptance of the CNL role by RN and support staff. A one-page questionnaire was used to assess the physician team (i.e., attending physicians, fellows, residents, and nurse practitioners) acceptance of the CNL role and satisfaction one year after implementation of the role. Both questionnaires included an open-ended section for comments and suggestions. After one year, results of the RN and staff survey

indicated (1) increased satisfaction, (2) increased meaningful notification of new policies/standards of care, (3) increased support, (4) increased positive feedback, (5) increased communication, and (6) increased use of the patient’s plan of care as a resource to track progress. The results from the survey of RN-physician team survey conducted one year after CNL implementation indicated that both communication with RN staff and CNLs had increased and that the “perceived increase in RN-Physician team collaboration resulted in better quality patient care.”

Additional benefits identified by Bender et al. were (1) increased communication and collaboration with ancillary staff, (2) an improved electronic patient charting system, (3) creation of standardized care plans, and (4) better coordination between the nursing unit staff and physical therapy and occupational therapy related to rehabilitation needs of patients. This study was implemented on one nursing unit. The authors plan to determine if the plan for implementation on the study unit can be applied to other nursing units within the organization or if the plan will need to be adapted for use on other units.

*Source:* “Interdisciplinary Collaboration: The Role of the Clinical Nurse Leader,” by M. Bender, C. D. Connelly, and C. Brown, 2012, *Journal of Nursing Management*, 21, pp. 165–174.

Clients become informed consumers and actively participate with the healthcare team in making decisions about their health goals, treatment plans, and continuing care. When clients are empowered to participate actively and professionals share mutually set goals with clients, everyone—including the organization and the healthcare system—ultimately benefits. When quality improves, adherence to therapeutic regimens increases, lengths of stay decrease, and overall costs to the system decline.

When professional interdependence develops, collegial relationships emerge and overall satisfaction increases. The work environment becomes more supportive and acknowledges the contributions of each team member. A sense of “WE-ness” develops, and when a desired outcome occurs, the team can feel that “WE did it.” And when the desired outcome does not occur, the team analyzes the processes together to determine strategies to improve team functioning.

## RESEARCH CURRENT

### Impact of Interprofessional Education on Collaboration Attitudes, Skills, and Behavior Among Primary Care Professionals

The purpose of this mixed-methods study, which was conducted in the Netherlands by Robben et al., was to evaluate the effectiveness of a 9-hour interprofessional education program for primary care professionals from seven disciplines (nurses, general practice physicians, pharmacists, physiotherapists, occupational therapists, dietitians, and gerontological social workers) involved in the care of frail elderly. The investigators (who included physicians and nurses) developed the program, which consisted of three interactive interprofessional workshops, each lasting between 2.5 and 3 hours. Content of the first two workshops included frailty and identification of frailty, providing self-management support to frail elderly, interprofessional collaboration, and sharing of discipline expertise and skills. Content was provided using lecture, case-based exercises, and group discussion. The third workshop took place approximately 3 months after the second workshop and reviewed previously discussed topics with “special attention to collaborative goal setting in a role-play.” This workshop also allowed participants to discuss experiences with the topics. A total of 119 health professionals participated in the study: 26 general practitioners, 9 pharmacists, 37 nurses, 25 physiotherapists, 6 occupational therapists, 4 dietitians, 10 social workers, and 2 undesignated social discipline workers. The majority of participants from each discipline were female, and the mean age of participants ranged from 41.3 years for pharmacists to 46.8 years for social disciplines. Methods of evaluation included the Attitudes Toward Health Care Teams Scale, the Interprofessional Attitudes Questionnaire, the Team Skills Scale, and semistructured interviews with 10 purposefully selected participants. Questionnaires were administered prior to the program and within 1 week after completion of the program. The semistructured interviews were conducted at least 4 months after completion of the program. The interview guide asked questions regarding

“the professional’s experience with the program, their attitude toward collaboration, and whether they had made changes in their work with regard to collaboration.” Participants’ rating of the program overall was an average of 6.9 out of 10 (*SD* 0.8). The majority of the participants ( $n = 60$ , 70%) said (1) they would recommend the program to others, (2) their time in the program was well spent, and (3) they felt their participation in the program increased their knowledge about interprofessional collaboration, about frail elderly, and about self-management support, and (4) they were better equipped to collaborate with other primary care professionals. There was no significant difference in pre- and postprogram scores on the Attitudes Toward Health Care Teams Scale. There was a significantly higher score on the Team Skills Scale following completion of the program. Results of the semistructured interviews were mixed. Barriers to collaboration identified were time constraints, lack of reimbursement, not knowing other healthcare professional disciplines, and not having a reason to collaborate. The program helped participants to know the other professionals, and to be more likely to contact them. However, some stated that “the effects on collaborative behavior diminished over time.” The authors state that “a brief interprofessional education intervention for primary care professionals involved in the care of frail elderly has the potential to improve attitudes toward other disciplines, increase self-reported team skills, and might even be able to improve collaborative behavior.” Further, the social interaction between health professionals and the opportunity to hear each other’s viewpoints seemed to be “as important as the education content.”

*Source:* “Impact of Interprofessional Education on Collaboration Attitudes, Skills, and Behavior Among Primary Care Professionals,” by S. Robben, M. Perry, L. Van Newuwenhuijzen, T. Van Achterberg, M. O. Rikkert, H. Schers, M. Heinen, and R. Melis, 2012, *Journal of Continuing Education in the Health Professions*, 32(3), pp. 196–204.



## Factors Leading to the Need for Increased Collegiality and Collaboration

Collaboration is necessary to effectively meet the current problems facing the healthcare system. Among those problems are unmet healthcare needs of vulnerable populations such as older adults, people who are uninsured or underinsured; disparities in health care, health status, and healthcare outcomes among different segments of society; the increasing number of people with chronic illnesses; the numbers of people who live in poverty or are homeless; and threats of terrorism and bioterrorism. *Healthy People 2020* (U.S. Department of Health and Human Services, 2014) lays out ambitious goals for the nation's health: (1) to “attain high quality, longer lives free of preventable disease, disability, injury, and premature death”; (2) to “achieve health equity, eliminate disparities, and improve the health of all groups”; (3) to “create social and physical environments that promote good health for all”; and (4) to “promote quality of life, healthy development, and healthy behaviors across all life stages.” To achieve these goals will require the active participation, collaboration, and integration of the knowledge, skill, and expertise from members of all health professions. There are a number of challenges to achieving these goals.

### Healthcare Consumers

Although the diagnosis and treatment of illness are still necessities, the focus of health care has shifted from curing disease to promoting health and preventing illness/injury. Healthcare consumers are demanding improved access to comprehensive, holistic, and compassionate health care that is also affordable. Clients expect that healthcare providers will view each person as a biopsychosocial whole and respond to his or her individual needs. Clients want wellness-related care that focuses on the quality of life. They want expert, humanistic care that integrates available technology and provides information and services related to health promotion and illness prevention.

Consumers have also become aware of how lifestyle affects health. As a result, they desire more information and services related to health promotion and illness prevention. As people actively assume more responsibility for their level of health and are more willing to participate in health-promoting activities, they are beginning to view healthcare professionals as a resource to guide these activities. Many health plans already provide participants with memberships to physical fitness clubs and nutrition classes or offer free attendance at smoking-cessation classes. For example, seniors who have Medicare Part B can receive up

to eight face-to-face visits per year for smoking cessation counseling by a qualified healthcare provider. Yearly wellness visits to provide personalized health advice, determine risk factors for disease, and schedule routine health screenings are also covered under Medicare Part B.

Today's healthcare consumers have greater knowledge about their health than previously, and they are increasingly influencing the delivery of health care. Formerly, people expected a physician to make decisions about their care; today, however, consumers expect to be actively involved in making these decisions and in choosing which healthcare providers will best meet their needs. They want healthcare providers to communicate with each other to prevent confusion and redundancy in care. Consumers also want to have direct access to the healthcare providers of their choice.

### Personal Responsibility Initiatives

Responsibility for oneself is a major tenet underlying holistic health that recognizes the interconnectedness of body, mind, and spirit. Increasingly, people are adopting the view that the person is empowered with the ability to create or manage his or her own health or disease state. This mandate for personal responsibility requires that the client be an active member of the collaborative healthcare team.

Today many individuals seek answers for acute and chronic health problems through nontraditional approaches to health care. Alternative medicine and support groups are among two of the most popular self-help choices. Each year, more adults are using alternative, complementary, or unconventional therapies to treat numerous health problems. The most commonly used therapies include relaxation techniques, chiropractic treatments, massage, imagery, spiritual healing, weight-loss programs, and herbal medicine. Back problems, fibromyalgia, cancer, allergies, arthritis, insomnia, chronic fatigue syndrome, strains or sprains, headaches, high blood pressure, digestive problems, anxiety, and depression are common conditions for which individuals seek unconventional therapies.

In addition to alternative and complementary therapies, many adults participate in one or more self-help groups during their lifetime. In North America, there are hundreds of different mutual support or self-help groups that focus on nearly every major health problem or life crisis people experience. These groups developed, in part, because people felt such organizations could meet needs not addressed by the traditional healthcare system. Alcoholics Anonymous (AA), which formed in 1935, serves as a model for many of these groups. The National Mental Health Consumers' Self-Help Clearinghouse in the United States provides information on current support groups and

guidelines about how to start a self-help group. Groups vary in effectiveness, but most provide education to encourage self-care as well as offering social and emotional support.

Personal responsibility for health does not mean avoiding or abandoning traditional healthcare providers. Rather, all of these self-help initiatives require consultation between the client and the various members of his or her personal healthcare team to determine the most effective approach for the client to achieve optimal health.

## Changing Demographics and Epidemiology

The U.S. Census Bureau (2014) estimates that by 2020 there will be almost 55 million people over the age of 65, or 16% of the total population, living in the United States. The percentage of older adults will increase to approximately 20% of the total population by 2050. The fastest growing segment of society by age is older adults over the age of 85. The growing number of older adults, combined with the fact that the average older adult has three or more chronic health conditions, will greatly influence the healthcare system and healthcare insurers in the future.

According to the National Coalition for the Homeless (2014), homelessness and poverty are inextricably linked. Limited resources result in difficult choices when trying to pay for housing, food, child care, health care, and so on. The number of poor in the United States has remained fairly stable in recent years; however, the number of people living in extreme poverty has increased. Limited access to healthcare services significantly impacts the health of the poor and the homeless. It is anticipated that the expansion of Medicaid under the Patient Protection and Affordable Care Act of 2010 will help to provide health care to those who have previously been unable to afford health insurance.

It will become increasingly important for coordination of services through collaboration of healthcare providers in order to effectively meet the healthcare requirements of vulnerable groups, especially older adults, the homeless, and those living in poverty. Collaboration in prevention and wellness services can improve the quality of life while lowering healthcare costs.

## Healthcare Access

The Patient Protection and Affordable Care Act of 2010 (PPACA) was created to make health insurance available to all, to protect those with preexisting disease, and to prevent the loss of health insurance for those who become ill with chronic disease. At the time of publication of this text, it is too early to see the effect of this legislation on people's ability to afford and maintain health insurance. However,

an estimated 11.7 million people enrolled in insurance marketplaces during the 2015 open enrollment and 5.7 million young adults stayed on a parent's insurance plan. This increase in access to health care will require that more health professionals are available to provide care, and collaboration among these health professionals will be essential to the success of achieving the goal of health for all.



**InfoQuest:** Explore the Internet to determine the effects of the PPACA on healthcare access through expansion of Medicaid and governmental health insurance marketplaces.

## Technological Advances

Technology has had a major influence on healthcare costs and services. In fact, available technology often influences decisions about the level of care and intervention. With advances in medicine and technology, an individual's life span can often be extended. However, that same technology may result in fragmentation of care and acceleration of healthcare costs. New medical devices, technological advances, and new medications frequently are introduced with limited consideration to the associated costs or the efficacy of their use, and, most importantly, the client's wishes. For example, the vital functions of circulation and breathing of a client who has no measurable brain activity can be maintained through advanced life support. In 2006, more than 25% of Medicare dollars were expended during the last year of life. At the societal level, the difficult questions of when and how life should be extended through use of technology have not been answered. When the client and his or her family are active participants (collaborators) in making decisions about the use of technologies and other life-sustaining measures, the client's quality of life may improve, and overall healthcare costs may decrease.

## Competencies Basic to Collaboration

Key competencies necessary for collaboration include effective communication skills, mutual respect and trust, giving and receiving feedback, decision making, and conflict management.

## Communication Skills

Collaborating to solve complex problems requires effective communication skills. Initially, the healthcare team needs to define collaboration clearly, establish its goals and objectives, and specify role expectations.

Effective communication can occur only if the involved parties are committed to understanding each other's professional roles and appreciating each other as individuals as well as members of the interprofessional team. Additionally, they must be sensitive to differences in communication styles. Instead of focusing on differences, each professional needs to attend to the team's common goal: the client's needs.

Communication styles are especially important to successful collaboration. Norton's (1983) theory of communication style defines style as the manner in which one communicates and includes the way in which one interacts. Therefore, what is said and how it is said are both important. This theory describes nine specific communicator styles that are commonly used and influence the nature of the relationship between communicants. Three of these communicator styles (dominant, contentious, and attentive) have been used in a nursing study of collaboration styles as they relate to degree of collaboration and improved quality of care (Van Ess Coeling & Cukr, 2000). Using attentive style and avoiding contentious and dominant styles made a significant difference in nurse-physician collaboration, positive patient outcomes, and nurse satisfaction. The researchers assert that the attentive style can be taught by modeling the behavior of obvious listening, such as making eye contact while communicating and refraining from participating in other activities (e.g., checking emails or text messages) that interrupt communication while someone is trying to communicate. Verbal feedback and repeating back offer the opportunity to reflect on what was said and to correct misunderstanding. Questioning provides an opportunity to share concerns and initiate dialogue. Developing a noncontentious style means developing judgment in recognizing when it is necessary to stop a conversation and insist on clarification because it is an important point and when it is better to ignore a comment that is disagreed with because it is not essential to the goal. Developing a nondominant style involves controlling one's behavior of monopolizing the conversation or speaking so forcefully that others feel pushed back and unwilling to respond. Combining role playing with follow-up discussion and role modeling has been identified as an effective strategy for developing positive communicator styles.

Much of communication specific to patient care is through the client's medical record. Electronic medical records allow health professionals at various locations to access information about the client; the treatment plan, including goals of treatment and activities of various healthcare team members; and a record of the care given. Health professionals can use communication technology such as smart phones, Skype, FaceTime, and distance

conferencing systems to communicate even when they are not in the same location. These new technologies can be used for individual communication between team members and with the client, and for team conferences.

## Mutual Respect and Trust

Mutual respect occurs when two or more people show or feel honor or esteem toward one another. Trust occurs when a person is confident in the ability, strength, reliability, and honesty of another person. Both mutual respect and trust imply a mutual process and outcome. They must be expressed both nonverbally and verbally. In true collaboration, healthcare providers demonstrate mutual respect and trust not only in colleagues of their own professional discipline, but also in colleagues from other healthcare disciplines. That is, they respect and call upon the expertise of healthcare providers both within their own discipline and from other disciplines, with the goal of quality health outcomes for their clients. For example, physicians and nurses work together to ensure positive health outcomes for the clients under their care. When the physician writes treatment orders, he or she relies on information provided by the client and the nurse regarding the client's status; he or she relies on the nurse to perform the prescribed treatments, and to inform the physician of the client's response to the treatment. The nurse relies on (trusts) the physician to respond promptly if there is an untoward reaction to the treatment. Each trusts the other's expertise. The same is true when the expertise of other health professionals is needed, such as the social worker or physical therapist.

## Giving and Receiving Feedback

One of the most difficult challenges for professionals is giving and receiving timely, relevant, and helpful feedback to and from each other and their clients. When professionals work closely together, it may be appropriate to address attitudes or actions that affect the collaborative relationship. Feedback may be affected by each person's perceptions, personal space, roles, relationships, self-esteem, confidence, beliefs, emotions, environment, and time.

Negative feedback does not imply negative content but rather a lack of communication or a negative communication style, such as an attitude of condescension. Negative feedback is an example of closed communication. Positive feedback is characterized by a communication style that is open, warm, caring, and respectful. Positive feedback is open communication, that is, a two-way exchange of information. In health care, open communication relies on the expertise of each member of the healthcare team and the willingness to share that expertise. Reviewing basic communication skills and practicing listening and giving and

receiving feedback can enhance the professional's ability to communicate effectively. Giving and receiving feedback helps individuals acquire self-awareness and greater awareness and understanding of others, while assisting the collaborative team to develop an understanding and effective working relationship.

## Decision-Making

The decision-making process at the team level involves shared responsibility for the outcome. Obviously, to create a solution, the team must follow each step of the decision-making process, beginning with a clear definition of the problem. Team or collaborative decision-making must be directed toward the objectives of the specific effort; in health care, these are the agreed-upon desired outcomes. Factors that enhance collaborative decision-making include trust, mutual respect, and positive communication.

Decision-making at the team level or collaborative decision making requires full consideration and respect of various viewpoints based on the diverse experience and expertise of the team members. Team members must be able to verbalize their perspectives in a nonthreatening environment. Group members use effective communication skills and give and receive feedback in an exchange of information and expertise throughout the decision-making process. Group members realize an interdependent relationship as they work together sharing knowledge and expertise.

An important aspect of decision-making in the interprofessional team is focusing on the client's priority needs and organizing interventions accordingly. The discipline/profession best suited to address a specific client's need is given priority in planning and is responsible for providing its interventions in a timely manner. For example, a social worker may first direct attention to a client's social needs when these needs interfere with the client's ability to respond to therapy. By nature of their holistic practice and the greater amount of time spent with clients in relation to other health professions, nurses are often able to help the team identify priorities and areas requiring further attention.

## Conflict Management

Collaboration is about relationships, and conflict can often occur within these relationships. Conflict in health care can occur within interprofessional healthcare teams, and between individual healthcare providers, including nurses and physicians, nurses and other nurses, nurses and other healthcare professionals, and between healthcare providers and patients and families. Huber (2014, p. 294) suggests that "conflict is typically the result of an undeveloped or poor interpersonal relationship with a colleague." **Intrapersonal conflict** occurs within the person and relates to

internal stress or tension that results when that person feels threatened or is unable to meet his or her needs or achieve his or her goals. Intrapersonal conflict may result when the individual's expectations are not consistent with the expectations of the organization. **Interpersonal conflict** occurs between two or more people and arises when people are called on to carry out roles that have opposing or incompatible goals or expectations. In an interpersonal conflict, different people disagree or have different expectations about goals and/or roles. **Intergroup conflict** refers to "disagreements or differences between the members of two or more groups or their representatives over authority, territory, and resources" (Huber, 2014, p. 171). Workplace conflict can result in decreased quality of client care, decreased employee performance, poor employee morale, increased stress, increased employee turnover, and increased organizational costs.

It is important to remember that conflict is not always a negative phenomenon. When communication is strong among team members, discussion of different viewpoints (disagreements) can result in the development of a better plan of care. When conflict is constructive, creativity is stimulated, individual interest is encouraged, and the quality of decisions is improved. When team members work through a conflict to achieve a desired goal, group cohesiveness is increased, and individual and group performance is improved.

Developing constructive collaborative relationships in health care requires developing strong conflict management skills. When conflict gets out of control, the quality of care is compromised and the client suffers.

Organizational structure can contribute to the success of interprofessional collaboration. Structures that maintain a hierarchical authoritarian structure do not support interprofessional collaboration. The organization can be particularly effective in the promotion of collaboration between physicians and nurses by intervening where the tradition of the physician as the authority figure has been particularly strong. The relationship among health professionals must be one of trust and respect. The failure on anyone's part to either assume or yield power appropriately can block collaboration.

Conflict is inevitable in organizations, and that conflict can be functional, serving to generate positive changes, or dysfunctional, serving to choke the organization's efforts. There are five stages, or levels, of conflict. *Latent conflict* is always present when there is a complex organization or when roles are differentiated and may come into conflict. *Perceived conflict* is when awareness begins. The conflict may or may not progress beyond a latent or perceived level. When it does progress, *felt conflict* occurs, and hostilities, anxieties, and stress erupt. *Overt conflict* results when the conflict is acted out and battle lines are



drawn. *Conflict aftermath* comes about with a resolution, which may or may not be optimal. The results may range from full cooperation to active or passive resistance. Although the conflict is resolved, the behaviors may still be affected. There may be difficulty letting go of feelings once there is resolution.

The conflicts may be interpersonal between or among individuals, or the conflicts may involve groups. For example, intergroup conflicts may occur between nurses and laboratory personnel or between nurses and physicians. Intragroup conflicts may occur within a group, such as when nurses on a care unit disagree with each other about policies governing practice, for example, a plan or policy for floating to another unit.

Whatever the conflict, resolution strategies are important to success. *Problem solving*, or *confrontation*, can be applied through open discussion and a thorough investigation of the dimensions of the conflict. When the goal is a win-win outcome in which each side is satisfied with the outcome, success is more likely. *Negotiating*, or *bargaining*, entails identifying one's bottom line as well as one's optimal result and then making trade-offs to get a final agreement that is as close as possible to each party's optimal position. For this approach to be successful, both parties must be sincere in the desire to negotiate. Negotiation can be either cooperative or competitive; characteristics of each are found in Table 13–1. *Smoothing over* is a short-term resolution focused on minimizing the felt conflict without resolving it. With this approach, the felt conflict is likely to reemerge. *Avoidance* may be used when one side makes the decision to cease discussion and withdraw. *Forcing* uses power or influence to impose a preference: This often involves “going over someone’s head” and using a higher authority to enforce the resolution.

Reflect On . . .

- what barriers to collaborative care you experience in your practice setting.

- what characteristics support collaborative practice in your practice setting.
- how your values, beliefs, and work experiences influence your abilities to be an effective member of a collaborative healthcare team.

Interprofessional Health Care

Nurses often work independently based on their specialized knowledge and skill in providing care to their patients. Such actions include continuous assessment, providing physical care and comfort, providing emotional support, teaching and counseling, and making referrals to other healthcare providers. Nurses work dependently and collaboratively with physicians and collaboratively with other healthcare professionals such as social workers, dietitians and nutritionists, pharmacists, physical therapists, occupational therapists, and various technicians. Standard 13 of the ANA Standards of Professional Performance states that the nurse “partners with others to effect change and produce positive outcomes through the sharing of knowledge of the healthcare consumer and/or situation” (American Nurses Association, 2010b, p. 57). The advanced practice nurse and the nurse specialist partner “with other disciplines to enhance healthcare consumer outcomes through interprofessional activities, such as education, consultation, management, technological development, or research opportunities” (American Nurses Association, 2010b, p. 58). Thus, the goal of interprofessional care is to maximize the expertise of the different team members to promote positive client outcomes. This section discusses the roles of other healthcare professionals with whom the nurse works in providing care to clients and their families.

Physicians

The physician is often considered the leader of the healthcare team in the delivery of care to his or her patients; however, other team members may take the lead in relation to their specific areas of expertise. The physician may be the

TABLE 13–1 Characteristics of Negotiation

| Cooperative Negotiation                                                             | Competitive Negotiation                                                          |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| The tangible goals of the negotiation are seen as fair and reasonable to each side. | The tangible goals are for each side to get as much as possible.                 |
| There are sufficient resources for a win-win resolution.                            | There are insufficient resources for each side to attain the desired goal.       |
| Each side believes it can attain its desired goal.                                  | Each side believes it is not possible for both sides to attain the desired goal. |
| The sides work together to maximize joint outcomes.                                 | The goal is to win against the other side.                                       |

first point of contact for the patient and has the primary responsibility to determine the patient's medical diagnosis and plan the treatment regimen for the medical problem. Many physicians, especially those who work in primary care, include health promotion and disease/injury prevention counseling in their practice.

Nurses work with physicians to ensure that the treatment regimen is implemented, and in many cases the nurse carries out activities of the treatment plan, including medication administration, wound or incisional care, and so on. Nurses may also be involved in scheduling and preparing patients for diagnostic studies or surgery and scheduling physician-requested consultations with other health professionals. Based on their nursing assessments, nurses may recommend a specific course of therapy, a change in therapy, or consultations with other specialists. For example, during an assessment the patient may tell the nurse that he is experiencing uncomfortable side effects of a prescribed medication. The nurse may request a change in the medication order, either to a different effective dose or to a different medication that has a similar therapeutic effect without the side effects experienced by the patient.

Education to become a physician generally requires 4 years of baccalaureate education and 4 years of medical school. Additionally, physicians must complete post-medical-school internships. In order to specialize, a physician must complete an appropriate residency program. Internship and residency training can be from 3 to 8 years (U.S. Department of Labor, 2014a).

In 2012 there were approximately 691,400 physicians in the United States with a projected growth by 2022 to 814,700 (U.S. Department of Labor, 2014a). Physicians will be especially needed in rural and low-income areas. In response to the increasing numbers of elderly, there will be an increased need for physician specialists in gerontology. There are two types of physicians: MDs (doctor of medicine), also known as allopathic physicians, and DOs (doctor of osteopathy), or osteopathic physicians. DOs focus on the body's musculoskeletal system and emphasize preventive care and holistic medicine (U.S. Department of Labor, 2014b). They are more likely to practice in primary care settings but may specialize. Both MDs and DOs use all accepted methods of assessment and treatment, including diagnosing disease or injury, performing surgery, and prescribing medications and treatments.

Most physicians practice in one or more specialties and have received specialized training and certification in those specialties beyond their basic medical education. The major professional organization for physicians is the American Medical Association which cites its mission as the promotion of the art and science of medicine toward and along with the betterment of public health (AMA, 2014).

Shortages of physicians in specialties of general or family practice, internal medicine, gerontology, anesthesiology, and obstetrics and gynecology, and in rural or low-income areas, have created increased opportunities for advanced practice nurses such as nurse practitioners, nurse midwives, and nurse anesthetists.

## Pharmacists

Pharmacists prepare and dispense medications in both hospitals and community settings (e.g., clinics, drug-stores, skilled nursing facilities, grocery, and big box stores such as Walmart and Target). Pharmacists may also administer flu shots and immunizations in community settings, provide information about over-the-counter drugs, and provide information about wellness and healthy lifestyle choices.

Nurses work with pharmacists to ensure the safe administration of medications to patients. In preparing and dispensing medications for nurses to administer or for patient self-administration, pharmacists check for drug incompatibilities. Pharmacists also prepare intravenous infusions for patients living at home or in nursing homes, and for patients in some hospitals.

Some pharmacists specialize in areas such as oncology, nuclear pharmacy, intravenous nutrition support, geriatric pharmacy, or psychiatric pharmacy. These pharmacists may be active members of a unit-specific healthcare team interacting daily with physicians and nurses about the choices and effects of pharmacotherapeutics used for patients on the specialty unit.

Pharmacists are also a source of information about medications, such as expected actions, appropriate dosage, specific administration requirements (e.g., take with food, take before eating), and potential for adverse reactions, for both health professionals and consumers. Nurses should feel comfortable in contacting the hospital pharmacist or, in the case of home care, the patient's pharmacist for information about medications the nurse is responsible for administering.

Pharmacists earn a doctor of pharmacy degree (PharmD) from an accredited school of pharmacy. To enter a school of pharmacy, the applicant must have at least 2 years of postsecondary education with prerequisite courses in mathematics and natural sciences, such as chemistry, anatomy, and physiology. Pharmacists may also complete a residency training period as part of their experiential education (U.S. Department of Labor, 2014c).

In 2012, there were approximately 286,400 pharmacists in the United States, with a projected increase to 327,800 by 2022 (U.S. Department of Labor, 2014c). Pharmacists may also supervise pharmacy technicians and pharmacy aides in the processes related to dispensing medications.

The major professional organization for Pharmacists is the American Society of Health-System Pharmacists (ASHP), which advocates and supports “the professional practice of pharmacists in hospitals, health systems, ambulatory care clinics, and other settings spanning the full spectrum of medication use” (American Society of Health-System Pharmacists, 2014).

## Dietitians and Nutritionists

Dietitians and nutritionists are experts in food and nutrition and work in both community and institutional settings. They “counsel patients on nutrition issues and healthy eating habits; develop meal plans, taking both cost and clients’ preferences into account; evaluate the effects of meal plans; and promote better nutrition” through education (U.S. Department of Labor, 2014d).

When a therapeutic diet is ordered for a specific patient, the dietitian or nutritionist will ensure that meals served comply with the dietary requirements. The dietitian may also provide dietary teaching to patients and their families so that therapeutic diets can be followed in the home; for example, a dietitian may be an active member of the healthcare team that provides care and teaching for diabetic patients both in the hospital and in the home. Nurses may also consult dietitians when hospitalized patients or residents in a nursing home have a poor appetite or are dissatisfied with usual menu options. A discussion between the patient, dietitian, and nurse may identify food preferences (e.g., personal, cultural, spiritual) or timing of meals (e.g., preference for major meal at lunchtime with a light meal in the evening) that improves the patient’s nutrition and sense of well-being.

Whether hospitalized or at home, patients who are undergoing chemotherapy may experience poor appetite as a side effect of treatment. The nurse may consult the dietitian to assist the patient with nutritional support. In some cases, such as patients with severe burns, nutritional support may be determined during a team conference between the physician, nurse, dietitian, and pharmacist, each having a role in ensuring adequate nutrition for healing to occur.

Community dietitians and nutritionists “develop programs and counsel the public on topics related to food and nutrition” (U.S. Department of Labor, 2014d). Dietitians may also supervise dietary aides and other food service workers in the preparation and service of meals.

A baccalaureate degree in dietetics, foods and nutrition, food service systems management, clinical nutrition, or a related area is required to become a dietitian or nutritionist. Courses in chemistry, biochemistry, biology, microbiology, physiology, food science, nutrition, and institution management are required for students who wish to become a dietitian or nutritionist. Many dietitians

and nutritionists have graduate degrees in dietetics and nutrition, especially those who teach, manage dietary departments, or conduct research (U.S. Department of Labor, 2014d).

In 2012, there were 67,400 dietitians and nutritionists in the United States, with a projected increase to 81,600 by 2022 (U.S. Department of Labor, 2014d). The major professional organization for dietitians and nutritionists is the Academy of Nutrition and Dietetics, formerly called the American Dietetics Association. The mission of the academy is to “empower members to be the nation’s food and nutrition leaders,” and the vision is to optimize “the nation’s health through food and nutrition” (Academy of Nutrition and Dietetics, 2014).

## Social Workers

Social workers provide counseling and support for clients and their families regarding social problems. “Social workers help people solve and cope with problems in their everyday lives” (U.S. Department of Labor, 2014e). In hospital settings, social workers may assist patients and families with planning for home care after discharge, arranging services such as Meals on Wheels or transportation for doctor appointments. Social workers may be liaisons with organizations such as Medicaid or workers’ compensation to provide financial support. They may also help families make decisions about appropriate placement of their elder relative, whether in the home, an assisted living facility, or a nursing home. Social workers may also provide psychological counseling as mental health therapists for patients with mental health problems.

Nurses and social workers work together to determine patient self-care abilities and potential needs to establish appropriate placement after discharge. For example, an elderly patient may not be able to return to her home following discharge after hip replacement surgery because she has no one to assist her. The social worker may arrange placement in a rehabilitation facility until the patient is sufficiently independent to perform self-care at home, or the social worker may arrange for a home health aide to visit the home every day to provide physical care (e.g., bathing and dressing) and prepare meals until the patient can do these things independently.

Usually the minimum requirement to work as a social worker is a baccalaureate degree in social work (BSW). Although a baccalaureate degree is sufficient for entry into the field, an advanced degree has become the standard for many positions, especially positions in healthcare settings. A master’s degree in social work (MSW), including a supervised practicum or internship, is generally required for positions in health settings and is required to be a clinical social worker. (U.S. Department of Labor, 2014e).

In the United States in 2012 there were 146,200 social workers employed in health care and 114,200 employed in mental health and substance abuse programs. The projected need in 2022 is 185,500 healthcare social workers and 140,200 mental health and substance abuse social workers (U.S. Department of Labor, 2014e).

The major professional organization for social workers is the National Association of Social Workers (NASW), whose mission is to “enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies” (National Association of Social Workers, 2014).

## Physical Therapists

Physical therapists assist patients with acute or chronic injury or disease to improve their movement and manage their pain. Physical therapists work in hospitals, rehabilitation facilities, nursing homes, and in home care. Physical therapists diagnose dysfunctional movements; use exercise, stretching maneuvers, hands-on therapy, and equipment to ease patient’s pain, to help increase mobility, to prevent further pain or injury, and to facilitate health and wellness (U.S. Department of Labor, 2014f).

Physical therapists assess musculoskeletal function, strength, and mobility and develop a treatment plan to promote function and increase strength and mobility. Treatment may include exercise, electrical stimulation, hot or cold compresses, ultrasound, traction, and massage to achieve the treatment goals. Physical therapists also teach patients how to use assistive and adaptive devices such as crutches, prostheses, and wheelchairs. They also teach patients how to continue exercise programs independently.

Nurses may determine the need for physical therapy when caring for a patient following an injury and may suggest a physician order for physical therapy. Nurses may also reinforce the physical therapy plan in the hospital and home settings to further promote patient independence and self-care.

To become a physical therapist, one must earn a doctoral degree in physical therapy (DPT). Physical therapy education is built upon undergraduate preparation that includes anatomy, physiology, biology, chemistry, and physics. Physical therapy studies include courses in biomechanics, anatomy, physiology, neuroscience, and pharmacology. Additionally, students complete a supervised clinical internship in various physical therapy settings (U.S. Department of Labor, 2014f).

In 2012, there were approximately 204,200 physical therapists in the United States with a projected increase to 277,700 in 2022 (U.S. Department of Labor, 2014f). Physical therapists may supervise physical therapy aides in providing care.

The major professional organization for physical therapists is the American Physical Therapy Association (APTA), which “seeks to improve the health and quality of life of individuals in society by advancing physical therapist practice, education and research, and by increasing the awareness and understanding of physical therapy’s role in the nation’s health care system” (American Physical Therapy Association, 2014).

## Occupational Therapists

Occupational therapists help patients improve their ability to perform activities of daily living, specifically those tasks needed to function in living and working environments (U.S. Department of Labor, 2014g). Occupational therapists work in hospitals, rehabilitation facilities, nursing homes, and in home care. They consult with employers to create supportive work environments for employees with disabilities. According to the American Occupational Therapy Association (2014), occupational therapy helps “people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations).”

Occupational therapists help clients perform various activities, including work-related skills such as using a computer and self-care-related skills such as bathing, dressing, cooking, and eating. Patients who have had a stroke and have decreased strength and dexterity in their arms and hands may be taught exercises to improve those functions so that they can write again or hold a fork or spoon to feed themselves. Occupational therapists also teach patients how to use assistive devices, including eating and dressing aids and how to navigate their environments safely to prevent injury. Clients who have short-term memory loss may be taught to make lists to aid in remembering, and clients who have coordination problems may be taught exercises to improve hand-eye coordination.

Occupational therapists also help patients improve decision-making, abstract-reasoning, problem solving, and perceptual skills through computer programs that help patients develop and improve these skills. For clients who wish to return to work, the occupational therapist may work with the client and his or her employer to modify the work environment so that the client can successfully perform work requirements.

Occupational therapists may work with special populations such as children with disability, the elderly, or people with neurological impairments such as Parkinson’s disease, cerebrovascular accident (stroke), or spinal cord injury. In such cases, the occupational therapist may be a permanent member of the healthcare team, assessing patients’ needs for therapy and designing a therapy plan in consultation with the physician, nurse, physical therapist,



and other team members. The nurse reinforces the therapy plan when the patient is on the nursing unit. For example, if the patient has been taught how to use an assistive device for eating, the nurse will ensure that the patient uses the device properly when eating meals. Or in the situation in which a family member wants to help by feeding the patient, the nurse will explain the importance of allowing the patient to feed himself or herself in promoting self-esteem.

To become an occupational therapist, one must earn a master's or doctoral degree in occupational therapy. Occupational therapy education is built upon undergraduate preparation that includes biology and physiology. Education to become an occupational therapist includes classroom, laboratory, and supervised clinical instruction in occupational therapy settings (U.S. Department of Labor, 2014g).

In 2012, there were 113,200 occupational therapists in the United States with a projected increase to 146,100 by 2022 (U.S. Department of Labor, 2014g). Occupational therapists may supervise occupational therapy assistants/aides in providing care. The major professional organization for occupational therapists is the American Occupational Therapy Association.

## Speech-Language Pathologists

Speech-language pathologists, also called *speech therapists*, “assess, diagnose, treat, and help to prevent communication and swallowing disorders in patients (U.S. Department of Labor, 2014h). Speech-language pathologists work in schools, hospitals, rehabilitation facilities, and nursing homes. Patients who require speech-language therapy include those who have had cerebrovascular accident (stroke), brain injury, hearing loss, developmental delay, cerebral palsy, cleft palate, neuromuscular degenerative disorders, or emotional problems.

Speech-language pathologists assess clients to determine their levels of speech, language, or swallowing difficulty and then identify treatment options and implement a treatment plan. Treatment plans may include ways to make sound or improve the voice, alternative communication methods, developing and strengthening muscles used to swallow, and counseling patients and families about how to cope with communication disorders. Nurses can work with speech-language pathologists by reinforcing treatment plans with patients and providing feedback on the effectiveness of a particular treatment plan.

To become a speech-language pathologist, one must earn a master's or doctoral degree in speech-language pathology. Speech-language pathology education is built upon undergraduate preparation. Education to become a speech-language pathologist includes classroom courses in

age-specific speech disorders, alternative communication methods, and swallowing disorders. Supervised clinical internships in speech-language pathology settings may be required (U.S. Department of Labor, 2014h).

In 2012, there were 134,100 speech-language pathologists in the United States with a projected increase to 160,100 by 2022 (U.S. Department of Labor, 2014h). The major professional organization for speech-language pathologists is the American Speech-Language-Hearing Association (ASHA), whose vision is to make “effective communication, a human right, accessible and achievable for all” (American Speech-Language-Hearing Association, 2014).

## Respiratory Therapists

Respiratory therapists implement physician-prescribed respiratory diagnostic and therapy procedures for patients with respiratory disorders. Respiratory therapists consult with physicians and nurses to develop and modify treatment plans. They perform complex respiratory assessment and treatment procedures such as working with patients on ventilators or providing respiratory treatments to patients with acute or chronic pulmonary diseases such as asthma and emphysema. Often, respiratory therapists are part of the permanent staff of an intensive care unit, and some respiratory therapists specialize, working in neonatal intensive care units, pediatric intensive care units, or adult intensive care units. Respiratory therapists may also supervise respiratory therapy technicians.

Side by side, nurses and respiratory therapists work to ensure effective ventilation and to prevent respiratory infection in their patients. For patients with complex respiratory problems, the care team is the physician, nurse, and respiratory therapist. In some specialized care units, the nurse is also a respiratory therapist who combines the knowledge and skill of both professions in managing patient care.

Respiratory therapists are educated in both associate and baccalaureate degree programs. Students must take courses in human anatomy and physiology, pathophysiology, chemistry, physics, microbiology, pharmacology, and mathematics. Specific courses related to respiratory therapy include the following: therapeutic and diagnostic procedures and tests, respiratory equipment, patient/client assessment, and cardiopulmonary resuscitation (U.S. Department of Labor, 2014i).

In 2012, there were 119,300 respiratory therapists in the United States with a projected increase to 142,100 by 2022 (U.S. Department of Labor, 2014i).

The major professional organization for respiratory therapists is the American Association for Respiratory Care (AARC), whose mission to “encourage and promote

professional excellence, advance the science and practice of respiratory care, and serve as an advocate for patients, their families, the public, the profession and the respiratory therapist” (American Association for Respiratory Care, 2014).

The interprofessional healthcare team may also include audiologists, chiropractors, dentists, home health aides, medical assistants, medical records and health information technicians, optometrists, personal care aides, podiatrists, psychologists, recreational therapists, and others who share the commitment to ensuring quality client care. As one expands the scope of interprofessional healthcare teams to policy decision making, the team can also include healthcare administrators, local and national government, and politicians.

## Interprofessional Focus

Interprofessional conferences may take place routinely, intermittently, or be part of a grand rounds practice. Such conferences afford the opportunity for each health professional to contribute from his or her area of expertise to create a more coordinated plan of care to improve patient outcomes. Nurses offer their expertise in developing a schedule that affords the patients opportunities for rest between medical procedures and therapy sessions. Nurses can let team members know whether the patient or his or her family has voiced any special consideration to the nurse but not to other care providers. Interprofessional team members can reinforce each other’s instruction to the patient and family. Interprofessional team members can also participate in research activities designed to promote the effective care of patients with specific types of health problems.

Many professional organizations invite healthcare providers from various disciplines to be members, to attend and present at national and international conferences. For example, the American Geriatrics Society includes members who are physicians, nurses, social workers, and others

who have an interest in care of the elderly. Another example is amfAR, the Foundation for AIDS Research, an organization “dedicated to the support of AIDS research, HIV prevention, treatment education, and the advocacy of sound AIDS-related public policy” (amfAR, 2014). National and international meetings of these groups are interprofessional and presenters discuss their research and practice with these special populations.



**InfoQuest:** Search the Internet for an organization or conference that has an interprofessional focus for research and education in your area of interest or practice. What other professions are included in the organization? When and where are the next organization conferences? How might you network with other health professionals through such an organization to improve your own practice?

## Global Collaboration

Worldwide, there are a number of significant influences on health and health care that will require international collaboration. The World Health Organization (WHO, 2014) set an objective to achieve “greater coherence in global health, with WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples.” Nurses can participate in global collaboration through participation in international nursing organizations such as the International Council of Nurses and Sigma Theta Tau International. Nurses can also participate in governmental and nongovernmental organizations along with other healthcare partners, especially in the areas of public health. Nurses can provide expertise in various fields of nursing care, including child health, women’s health, care for people with HIV/AIDS, and care for the elderly.

## Chapter Highlights

- Collaborative health care is a concept that addresses many existing problems in the healthcare system.
- Collaboration is a multidisciplinary, integrated, and participative approach that focuses on client-centered and client-directed care.
- Factors associated with the increasing demand for collaborative health care include (1) consumers of health care, who are insisting on comprehensive, holistic, compassionate and affordable health care that includes services related to health promotion and illness/injury

- prevention; (2) changing demographics, such as an increase in vulnerable populations including older adults, homeless, and the poor; (3) economic issues related to increasing healthcare costs; (4) healthcare inequities; (5) global and national demands for more effective healthcare delivery; (6) professional standards of collaboration requiring nurses to collaborate with healthcare consumers, their families, and other healthcare professionals in the delivery of care; and (7) technological advances.
- Collaborative care involves mutual goal setting and care planning between the client, physicians, nurses, and other involved healthcare professionals.
- Key competencies necessary for collaborative practice include effective communication skills, mutual respect

and trust, giving and receiving feedback, decision-making abilities, and conflict management.

- Each team member needs to be familiar with the knowledge, skills, perspectives, and unique contributions of other health professionals on the care team.
- Interprofessional teams may include nurses, physicians, pharmacists, physical therapists, occupational therapists, dietitians and nutritionists, social workers, and respiratory therapists, as well as others who contribute to achieving the health goals of clients and their families.
- The client is a key member of the interprofessional team providing his or her input to the team regarding his or her health goals.

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# 14

## UNIT III

### Processes Guiding Professional Practice

# Communicating Effectively

## Chapter Outline

### Challenges and Opportunities

### Definitions of Communication

### The Communication Process

- Sender
- Message
- Channel
- Receiver
- Response

### Factors Influencing the Communication Process

- Developmental Stage
- Gender
- Roles and Relationships
- Sociocultural Characteristics
- Values and Perceptions
- Space and Territoriality
- Environment
- Congruence
- Interpersonal Attitudes

### Types of Communication

- Oral/Verbal Communication
- Nonverbal Communication
- Therapeutic Communication
- Written Communication

### Barriers to Communication

### Nursing Documentation

- Methods of Documentation

### Communicating Through Technology

### Chapter Highlights

## Objectives

1. Define communication.
2. Describe the five components of the communication process.
3. Analyze factors influencing the communication process.
4. Discuss the types of communication and their characteristics.
5. Differentiate between therapeutic and nontherapeutic communication.
6. Identify barriers to effective communication.
7. Differentiate between nursing documentation and other forms of written communication.
8. Discuss technology as a form of communication.

Nursing is an interaction between nurses and clients and their families, nurses and other health professionals, and nurses and the community. The process of human interaction occurs through communication: verbal and nonverbal, written and unwritten, planned and unplanned. Communication between people conveys thoughts, ideas, feelings, and information. For nurses to be effective in their interactions, they must have effective communication skills. They must be aware of what their words and body language are communicating to others. As nurses assume leadership roles, they must be effective in both verbal and written communication skills. Nurses must have effective electronic communication skills as these modalities are increasingly used in providing information about health promotion, disease/injury prevention, and patient care in both acute and community settings.

In 2014, The Joint Commission listed as one of its National Patient Safety Goals (NPSG) to “improve the effectiveness of communication among caregivers.” The U.S. Department of Health and Human Services (USDHHS) reports that in 2010, 60.6% of persons 18 years of age or older reported that their healthcare providers always explained things so they could understand them (U.S. Department of Health and Human Services, 2014). That means that 39.4% of persons did not receive adequate health communication. *Healthy People 2020* (U.S. Department of Health and Human Services, 2014) identifies health communication as a major topic area with the goal “to use health communication strategies and health information technology (IT) to improve

population health outcomes and healthcare quality, and to achieve health equity.” A major objective under this topic area is “to increase the proportion of persons who report that their health care providers have satisfactory communication skills.” Effective use of health communication and health information technology has “the potential to improve health care quality and safety, increase the efficiency of health care and public health service delivery, . . . support care in the community and at home, facilitate clinical and consumer decision-making, and build health skills and knowledge.” In 2010, the Plain Language Act was signed into law requiring all agencies of the federal government to write documents in simple easy-to-understand language. Since then, the Department of Health and Human Services (DHHS), the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) have implemented plain language in all their written communications, including publications and websites.

## Challenges and Opportunities

Clear and appropriate verbal and nonverbal communication is essential for providing effective nursing care, and this is a unique challenge in the healthcare environment. Overcoming barriers to communication is necessary in a society in which many languages are spoken and the population is multicultural. Individual nurses cannot be fluent in each language that will be encountered, nor can they be fully informed of the cultural contexts of words and phrases that may have multiple meanings even in the same language. There are also variations in the meaning of non-verbal communication in different cultures. Not only is this a challenge in providing care to clients, it is also a challenge in working with colleagues of different cultures and languages. Clear communication about care and about client information is equally important, whether it is in the form of oral/verbal or written communications with coworkers or other members of the healthcare team, or publications in professional journals. A challenge for nurses today is to become proficient in communicating via technology, including telephone communication such as telephone triage and consultation, using computers for nursing documentation systems and email, and using handheld electronic devices such as smartphones and notebook computers to retrieve information, to document client care, send and receive messages through email and texting, and to participate in face-to-face distant communication through Skype and FaceTime.

Finding effective ways to overcome communication barriers provides the opportunity for nurses to bridge communication gaps in delivering health care. Nurses who can

use available resources and solve problems when there are communication difficulties will be better able to assist clients and families to access care and benefit from healthcare services. Clear communication will help the healthcare team provide effective care. It is essential in interprofessional teams. When nurses are able to communicate well in verbal and written form, the quality of care improves as nurses are able to provide better resources to the professional and public communities. Nurses can use technology to enhance communication with clients and other healthcare providers, to improve access to care for people in remote communities, and to increase their own knowledge using information resources available on the Internet.

## Definitions of Communication

In nursing, communication is defined as the giving or exchanging of information through oral, written, or non-verbal means. Berman and Snyder (2012, p. 463) expand on this definition of communication to include “any means of exchanging information or feelings between two or more people.” This suggests a broader concept of communication that goes beyond the simple transfer of information to the establishment of a relationship between people. Such relationships are founded upon effective communication skills. Commercial dictionaries provide additional definitions. The Merriam-Webster Dictionary (2014) defines communication as (1) “an act or instance of transmitting, (2a) information transmitted or conveyed, (2b) a verbal or written message, (3a) a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior, and (3b) personal rapport.” An exchange of information can occur verbally through oral or written language, or it may occur through gestures, signs, or behaviors, for example, American Sign Language. The message may be spoken or written; the act of communicating enables the exchange of information. *Rapport*, an interesting defining word, suggests the importance of mutual understanding and trust as a component of effective communication. Through effective communication people connect to each other to share questions, information, thoughts, ideas, and feelings.

Health communication is the study and use of communication strategies to inform and influence individual and community decisions that affect health (Centers for Disease Control and Prevention, 2014; health.gov, 2014, Schiavo, 2014). Health communication includes health promotion, disease/injury prevention, healthcare policy, and the business of health care. The goal of health communication is to engage and support the various sectors of society—individuals and their families, communities,

health professionals, special groups, policy makers, and the general public—to adopt and sustain practices that will ultimately improve overall health outcomes.

Most definitions of communication indicate that it is a process between two or more individuals, or interpersonal communication. However, people can communicate within themselves—intrapersonal communication—as they reflect upon their own knowledge, ideas, and feelings.

Nurses who communicate effectively are better able to establish successful relationships between themselves and others, including clients and their families, other nurses and healthcare professionals, healthcare administrators, legislators, and the lay public. Effective communication can also prevent many of the errors that lead to legal incidents associated with nursing practice.



**InfoQuest:** Search the Internet for sites that provide medical/health information for consumers (e.g., WebMD, organizational sites such as the American Heart Association, governmental sites such as [healthypeople.gov](http://healthypeople.gov)). Evaluate the information provided using the attributes of effective health communication listed in the accompanying box.



**InfoQuest:** Go to [healthypeople.gov](http://healthypeople.gov) and review the topic “Health Communication and Health Information Technology” and the specific objectives related to health communication. What are the targets that have been established for each objective for 2020? To what extent are the targets being met? What strategies would you suggest to improve the probability of achieving or exceeding the targets? What specific actions will you make as a registered nurse to assist in achieving the targets?

## The Communication Process

The communication process involves a sender, message, channel, receiver, and response, or feedback. (See Figure 14–1.)

In its simplest form, communication involves the sending and receiving of a message between two people. The sender defines the original message and transmits it to the receiver through a selected channel. The receiver then interprets the message and provides a response to the sender. This enables the sender to determine whether the receiver understood or interpreted the message correctly. If

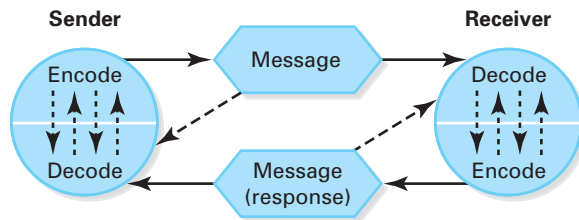
### Attributes of Effective Health Communication

- **Accuracy**—The content is valid and without errors of fact, interpretation, or judgment.
- **Availability/accessibility**—The content is delivered or placed where the audience can access it. Placement varies according to audience, message complexity, and purpose, ranging from interpersonal and social networks to billboards and mass transit signs to prime-time TV or radio, to public kiosks, and to the Internet.
- **Balance**—Where appropriate, the content presents the benefits and risks of potential actions or recognizes different and valid perspectives on the issue.
- **Consistency**—The content remains internally consistent over time and also is consistent with information from other sources.
- **Cultural and linguistic competence**—The design, implementation, and evaluation process that accounts for special issues for select population groups (for example, ethnic, racial, and linguistic) and also education levels and disability.
- **Evidence base**—Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice guidelines, performance measures, review criteria, and technology assessments for telehealth applications.
- **Reach**—The content gets to, or is available to, the largest possible number of people in the target population.
- **Referral/reference**—Additional reliable resources are provided for persons who want additional information.
- **Reliability**—The source of the content is credible and the content itself is kept up to date.
- **Repetition**—The delivery of/access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generations.
- **Timeliness**—The content is provided or available when the audience is most receptive to, or in need of, the specific information.
- **Understandability**—The language level and format (including multimedia) are appropriate for the specific audience.

Source: Adapted from “With Understanding and Improving Health and Objectives for Improving Health, Health Communication,” by the U.S. Department of Health and Human Services, 2000, in *Healthy People 2010* (Vol. 1, pp. 11–14), Washington, DC: U.S. Government Printing Office.

FIGURE 14-1

The Communication Process



Source: "Communicating," by J. Berman and A. Snyder, 2012, in *Kozier and Erb's Fundamentals of Nursing: Concepts Process and Practice* (9th ed.), Upper Saddle River, NJ: Pearson, p. 463.

the message was not interpreted correctly or if additional information is needed, the process starts again. Therefore, communication is an ongoing process, in which the roles of sender and receiver interchange as each transmits new information or understandings to the other.

Communication also can be an exchange of information between an individual and a group of people (e.g., by giving a lecture or teaching a class) or an exchange of information between several people (e.g., a change-of-shift report or group meeting). The components of the communication process are sender, message, channel, receiver, and feedback.

## Sender

The **sender** is the person or group who wishes to transmit a message to another. Another term for sender is *source encoder*. This means that the originator of the message, or source, has a purpose for the message and determines its content. The content of the message must be put in a form that is understandable to the receiver, called *encoding*. Encoding involves "the selection of specific signs or symbols (codes) to transmit the message" (Berman & Snyder, 2012, p. 464). Encoding includes the choice of specific words and the language of the message. It also includes the speech inflection and body language used to accompany the message. For example, when nurses are communicating with other nurses and health professionals, they may use medical terminology (e.g., *hypertension*); however, when they are talking with the client or family, they may use lay terminology (e.g., *high blood pressure*).

## Message

The second part of the communication process is the encoded **message** itself, the content of the message, that is, the thoughts, ideas, information, or feelings to be transmitted and the context of the message. Messages may be oral or written. They may be directed toward individuals or

groups. They may be face-to-face or through another channel. Messages between nurses and clients include verbal and written discharge instructions, interactions of support and caring, and information gathering. Messages between nurses and other nurses, physicians, and other health professionals include oral and written information about the client's status. Messages between nurses and healthcare administrators, community leaders, and policy makers include oral and written statements about health issues in the organization or community.

## Channel

The **channel** is the method selected to convey the message, including whether the message is spoken or written, the choice of words or language, and the choice of accompanying body language. For example, a change-of-shift report between nurses may be oral in a face-to-face interaction, or it may be recorded on audiotape. Client discharge instructions usually are both written and oral. Copies of written discharge instructions are included in the medical record in accordance with institutional policy. Communications with physicians and other health professionals may be face-to-face, via telephone or other electronic means, or through the client medical record. The channel can be visual (written text or images), auditory (oral language or other sound device), or through touch (feelings, comfort, demonstration/return demonstration). Some of the most effective communication interactions use more than one sensory channel.

## Receiver

The **receiver**, also called the *decoder*, is the one who receives the message, interprets (decodes) it, and makes a decision about how to respond. If the message is oral, the receiver must be able to hear or attend to the message and the sender. If the message is written or visual, the receiver must be able to see and read. The receiver decodes or interprets the message in relation to his or her past experiences, knowledge, and personal characteristics. If the receiver interprets the message congruently with the intent of the sender, then communication has been effective. Ineffective communication occurs when the message is not understood or is interpreted inaccurately. For example, a nurse may instruct the client to take his medication three times a day with meals. The client, however, eats only twice a day. This difference could result in the client not taking the medication as required.

## Response

The receiver's **response** is the *feedback* that enables the sender to know whether the message was received and interpreted correctly. Feedback is the message that the



## RESEARCH CURRENT

## Bedside Nurse-to-Nurse Handoff Promotes Patient Safety

The purpose of this study by Maxson, Derby, Wroblewski, and Foss, was to determine if “bedside nurse-to-nurse handoff increases patient satisfaction” with care and “increases patient perception of teamwork.” Additionally, the investigators sought to determine if “bedside nurse-to-nurse handoff increases staff satisfaction with communication and accountability.” The study was conducted on a surgical unit with 18 staff members and 60 patients (30 before implementation of change in shift report and 30 one month after implementation of shift change report) participating through an investigator-developed survey questionnaire. Each survey questionnaire consisted of five questions using a Likert scale format. Analysis of the patient surveys found a significant difference in responses to the question regarding being “informed of my plan of care for the day,” with a significant increase in strongly agree/agree responses following the implementation of bedside nurse-to-nurse report. Patient comments reflected the satisfaction with the changed practice. An example of patients’ comments is “I would strongly encourage you to continue the practice of coordinating the shift change in front of the patient. It gave me a sense of involvement in the process and confidence

that the incoming staff knew of the concerns that I had.” Analysis of the nurse surveys found a significant difference in responses to all five questions following implementation of the bedside nurse-to-nurse report. Nurse participants strongly agreed/agreed that nurse-to-nurse shift report (1) “makes people accountable,” (2) “provides adequate communication between nursing staff at change of shift,” (3) “helps me prioritize my workload,” (4) “allows me to perform shift change medication reconciliation,” and (5) “immediately after nurse-to-nurse shift report, I am able to communicate with physicians regarding patient care.” Nurses commented that there was a reduction in call lights during the shift change after implementation of the practice, and that it allowed patients “to feel they have an active voice in their care and recovery.” The investigators stated that bedside nurse-to-nurse change of shift report “has the potential to decrease medication errors, enhance communication among nurses, physicians, patient/family, and other members of the health care team.”

*Source:* “Bedside Nurse-to-Nurse Handoff Promotes Patient Safety,” by P. M. Maxson, K. M. Derby, D. M. Wroblewski, and D. M. Foss, 2012, *MEDSURG Nursing*, 21(3), 140–145.

receiver returns to the sender. Failure to obtain a response, or feedback, can result in ineffective communication. Feedback also can be verbal or nonverbal. Feedback may be verbal clarification or acceptance or rejection of the information or feelings. It may also be nonverbal. Examples of nonverbal feedback are nodding of the head, facial expressions of confusion or understanding, or signs of boredom, such as yawning. It is important to use verbal feedback to be sure that nonverbal language has not been misinterpreted. For example, clients might nod their head indicating understanding or as a sign of respect, but further questioning might show that they misunderstood the message. Feedback or response from the client is essential to validate interpretation and understanding of the message, and to evaluate the client’s response to information or care provided.

The response is the message back to the sender. The receiver has changed roles and becomes the sender. And so the process continues until the communication is ended.

## Factors Influencing the Communication Process

Many factors influence the communication process. These include developmental stage, gender, roles and relationships, sociocultural characteristics, values and perceptions,

space and territoriality, environment, congruence, and interpersonal attitudes.

## Developmental Stage

As individuals grow and develop, language and communication skills develop through various stages. It is important for a nurse to understand the developmental processes related to speech, language, and communication skills. Knowledge of the client’s developmental stage enables the nurse to select appropriate communication strategies. For example, when communicating with infants and toddlers whose language skills are not well developed, the nurse may rely more on the child’s nonverbal communications to assess for comfort and pain. The nurse may hold the child and use touch to provide comfort and demonstrate caring. For older children, the nurse may use pictures as an adjunct to verbal language to communicate. For adolescents and adults, nurses are more able to rely on verbal language for communication. With older adults, physical changes associated with the aging process may affect communication. For example, it may be more effective to use visual communication methods for clients who are hearing-impaired or oral communication methods for clients who are visually impaired. Also, intellectual processes develop across the life span as people acquire knowledge and experience.

The knowledge and experiences that people have influence their understanding and acceptance of transmitted information and feelings.

## Gender

Kneisl and Trigoboff (2013, p. 186) state that “men tend to require more space around them than women and are more likely to use gestures while women smile more often than men. Women also use their voices to communicate a wider range of emotions than do men.” Communication, gender, and culture and religion are interconnected. In cultures where women are expected to be passive and have little power, women may not be assertive in their communication and defer to male members of their family to make decisions. They may be passive in communication, refrain from asking questions, lower their eyes, and avoid touch when communicating with men or others who are believed to be superior to them. Men may assume more assertive/aggressive communication behaviors with both men and women. In other cultures, where women are seen as more equal to men, women may be more assertive and direct in their communication. They make eye contact, ask questions, expect answers, and make decisions for themselves.

Communication styles between men and women may also be associated with roles and the extent of relationship. When the relationship is close or of long duration, communication may be more open. When communication is with someone in authority (power) or senior (age, position), often regardless of gender, the communication may be more closed.

## Roles and Relationships

The roles and relationships between the sender and the receiver can influence communication. Roles such as nurse and client, nurse and colleague, nurse and physician, and nurse and administrator/supervisor can affect the content and the response in communication. Roles may influence choice of message content, communication vehicle, tone of voice, and body language. For example, nurses may choose fact-to-face communication for interaction with clients or healthcare providers on the nursing unit, whereas they may use telephones or emails to communicate with physicians or administrators. Nurses may choose a more informal or comfortable stance when communicating with clients or colleagues and a more formal stance when communicating with physicians or administrators. The length of the relationship may also affect communication. For example, nurses may use more formal language and a more formal stance when meeting clients or colleagues for the first time but use a more relaxed stance when interacting with clients or colleagues with whom they have an established relationship.

## Sociocultural Characteristics

Sociocultural characteristics such as culture, religion, education, and economic level can influence communication. Nonverbal communication characteristics such as body language, eye contact, and touch are influenced by cultural and religious beliefs about appropriate communication behavior. Some cultures may believe direct eye contact is disrespectful, whereas other cultures believe that direct eye contact shows trustworthiness. In certain cultures, touch would be appropriate to communicate caring and concern, but in other cultures physical touch would be offensive. Verbal communication may be difficult for the receiver whose primary language is not that of the sender.

People’s level of education may affect the extent of their vocabulary or their ability to read written communication. The National Coalition on Literacy (2014) reports that in the United States in 2009, 88% of adults age 16 years and older did not have proficient health literacy. Factors consistent with below-average health literacy included age (e.g., adults age 65 years and older) and educational level; 49% of adults who never attended or did not complete high school had below basic health literacy. Economic level may affect a person’s ability to access written communication. Today, when many people are using email to communicate or the Internet to obtain health information, those who cannot afford a computer or who do not have access to one will not be able to communicate using that means.

## Values and Perceptions

Communication is influenced by the values people hold about themselves, others, and the world in which they live. Because all people have values and perceptions based on their own experiences and characteristics, people who hold different values may send, receive, and interpret messages differently. For example, a client who values stoicism in managing his or her pain may not tell the nurse about the pain and may be offended when the nurse inquires about pain or offers pain medication. It is important that the nurse validate perceptions and their meanings with those who are part of the communication exchange.

## Space and Territoriality

Proxemics is the study of spatial separation or distance maintained by people in personal and social interactions; culture and environmental factors may affect the nature and degree of this spatial distancing. Proxemics includes both space and territoriality. Space involves the distance at which an interaction(s) takes place. Territoriality involves the space and contents of the space that the individual considers belonging to him or her.

Hall (1969) describes four distances at which interactions take place: intimate distance, personal distance, social distance, and public distance. *Intimate distance* ranges from physical contact to 1½ feet. Nurses interact with clients within the intimate range when they assess and provide some direct care activities for clients. Taking the blood pressure, listening to body sounds (breath sounds, intestinal sounds) with a stethoscope, assessing the pulse rate, changing a dressing, starting an intravenous drip, or giving an injection are all performed with physical contact. The manner in which the tasks are performed and the conversation that takes place during these activities communicate to the client in various ways. If the nurse is brusque when changing a dressing, the client may interpret the nurse's behavior as uncaring. If the nurse is gentle and shows concern, the client may perceive that the nurse is caring and feels comforted. Clients may feel uncomfortable when others enter their intimate space, especially if a trusting relationship has not been established. Nurses can alleviate this discomfort by telling the client before moving into the intimate distance range.

*Personal distance* ranges from 1½ to 4 feet. Most one-to-one communication takes place within this range. Nurses interact with clients in the personal distance range when they sit with a client to obtain a health history or when they teach clients self-care. Nurses also interact with colleagues in the range of personal distance when they exchange information face-to-face with a nursing colleague, physician, or other health professional.

*Social distance* ranges from 4 to 12 feet. Interactions with clients and family members or groups of clients are more likely to occur in the range of social distance. This is also the range of distance within which nurses interact with groups of colleagues, such as during a group change-of-shift report. It is important to note that usually the voice is louder when communicating in this range; therefore, a nurse must be aware of issues of client confidentiality. Communication with a client who is in a semiprivate room may be compromised if the nurse asks personal questions at this range while in the presence of other clients, their visitors, or caregivers.

*Public distance* starts at 12 feet and extends beyond that distance. This is the distance at which interactions with larger groups take place. There is less individual interaction or awareness of individual needs when communicating at this distance. Nurses communicate in public distance when they conduct community health education classes.

It is human nature to establish a boundary or territory that is considered to be one's own. Whether clients are being cared for in their own home, their own room in a long-term-care facility, or in a hospital room, they create a

personal environment that gives them comfort. They may have photographs, religious materials, or other personal items on a nearby table or bed tray. If the nurse attempts to change or rearrange furniture or objects in the client's environment, the client may perceive this as uncaring or devaluing. Similarly, nurses who have their own desk or locker often have personal objects that create their personal work territory or environment.

## Environment

The nature of the environment can also affect communication. Communication occurs best in an environment that supports the exchange of information, ideas, or feelings. Loud noises, poor lighting, noxious odors, or an uncomfortable temperature can all interfere with effective communication. The arrangement of furniture can affect communication. For example, communicating across a desk conveys a more formal interaction than when the nurse sits in a chair next to the client. A lack of privacy can also affect communication, especially when difficult or sensitive topics are being discussed. When interacting with clients, their families, or others, nurses should try to create an environment that is conducive to effective communication and minimizes environmental distractions.

## Congruence

When communication is congruent, the nonverbal behaviors match the verbal message. Nurses may state that they want clients to call if they have any questions or need anything. However, if the nurse appears to be rushed or distracted, a client may think the nurse is too busy and be unsure about calling the nurse when he or she has a question, needs assistance, or is experiencing pain or discomfort. Conversely, a client may state verbally that he does not have any pain, but his nonverbal behaviors—irritability, splinting of a body part, facial grimacing, and so on—may suggest otherwise. In order to provide quality patient care, the nurse needs to anticipate situations where clients may experience pain and should be knowledgeable about nonverbal indications of discomfort.

## Interpersonal Attitudes

Positive attitudes of respect, acceptance, trust, and caring facilitate communication, whereas negative attitudes of mistrust, rejection, and condescension inhibit effective communication. When one person is interacting with another, attitudes are conveyed by facial expression, tone of voice, the choice of words, and other body language. It is important to convey a nonjudgmental attitude during interactions. If the client feels that the nurse disapproves of some aspect of his or her lifestyle (e.g., smoking,

promiscuity, sexual orientation, addiction to drugs or alcohol), the client may not share the information needed to provide quality care.

## Types of Communication

There are two types of communication, verbal and nonverbal. Verbal communication may be spoken or written and involves words. Verbal communication is mainly conscious because people choose the words they use.

Verbal communication depends on language mastery. Language mastery includes vocabulary and grammar and is dependent on one's culture, educational level, socioeconomic background, and age and developmental level. Because of these factors, information can be given, ideas discussed, and feelings exchanged using many different words and word configurations. Nonverbal communication uses other forms such as facial expressions, gestures, touch, or other types of body language. Nonverbal communication also includes the use of pictures, signs, and symbols to communicate. Verbal and nonverbal communications occur simultaneously, so congruence between verbal and nonverbal communication behaviors is important for the receiver to understand the message.

### Oral/Verbal Communication

Oral communication is a spoken exchange of information, ideas, or feelings using words. Words can have different meanings for different people. Kneisl and Trigoboff (2013) describe four concepts related to word meanings: (1) denotative meaning, (2) connotative meaning, (3) private meaning, and (4) shared meaning. *Denotative meaning* is the way in which the word is generally used by people who share a common language. *Connotative meaning* is the meaning of a word that derives from one's personal experiences; for example, the word *love* may have different meanings when used with a parent, a child, a spouse, or a lover, or to describe one's favorite flavor of ice cream. *Private meanings* are those held by the individual. *Shared meanings* are the mutual understanding of the word or words between people who are trying to communicate effectively.

Berman and Snyder (2012) state that when choosing words for oral communication, nurses must consider (1) pace and intonation, (2) simplicity, (3) clarity and brevity, (4) timing and relevance, (5) adaptability, (6) credibility, and (7) humor.

1. **Pace and intonation.** Pace is the speed or rapidity of speech. Intonation is the tone, accent, or inflection used when speaking. Pace and intonation can express a variety of states, including interest, happiness,

excitement, anxiety, boredom, anger, fear, or depression. For example, when people speak in a monotone, not changing the pace or tone of their speech, they may be expressing boredom or apathy.

2. **Simplicity.** Simplicity in communication is the choice of commonly understood words. Nurses must remember to use language that is clearly understood when communicating with clients. This may mean avoiding complex medical terminology when discussing a client's illness or injury. It also means that the nurse must clarify that the client understands the word meanings in the same way that the nurse does.
3. **Clarity and brevity.** Clarity means choosing words that say unmistakably what is meant. Brevity is using the fewest words necessary to convey a message. It is important to communicate clearly so that the message is understood.
4. **Timing and relevance.** Timing is an important aspect of effective communication. If the client is experiencing pain or is otherwise distracted, it is not an appropriate time to give complex instructions in self-care. Communication must also be relevant to the receiver. If the receiver is not interested in the information at the time it is being given, he or she may be less attentive.
5. **Adaptability.** When speaking with clients and others, nurses must be cognizant of verbal and nonverbal cues from the receiver and adapt their communication accordingly. If the receiver appears confused after instructions have been given, the nurse must clarify understanding by restating or rephrasing the instructions.
6. **Credibility.** Credibility means being believable and trustworthy. To be credible when communicating, nurses must be consistent, dependable, and honest. Nurses must give accurate information and be willing to say when they don't know something or don't have information. It is more credible to state, "I don't know, but I'll find out for you," than to give inaccurate information that must be corrected later. Consistency is important when communicating to avoid confusion or misunderstanding. When a nurse is consistent and accurate in communicating, she or he is more believable or credible.
7. **Humor.** Humor can be effective in communication when used appropriately. It can help people adjust to difficult situations and decrease tension. Laughter can release endorphins that promote a sense of well-being. However, one must be careful in using humor, especially when communicating with people whose primary language is different or who are from a different culture. For example, jokes may seem funny only when used within a particular culture; they may



be offensive to or not be understood by people of a different culture.

Paralanguage or paralinguistic sounds are the sounds that accompany verbal language and add to the message being given by the spoken word. Paralanguage includes the tone, pitch, and volume of the voice; the speed or tempo of speech; hesitation before or during speech; and the emotions expressed that accompany speech. Emotions that accompany speech may include excitement, happiness, concern, agitation, anger, laughter, crying, fear, anxiety, or nervousness. Because these sounds accompany speech, they influence the message that is received by the listener so that the same words accompanied by different paralinguistic cues may be interpreted differently. It is important, however, to consider these sounds in the context of the culture of the client because they may have different meanings in different cultures.

## Nonverbal Communication

Nonverbal communication is also referred to as *body language*. It is the way in which one uses one's body to reinforce or contradict verbal, specifically oral, communication. Nonverbal communication includes (1) eye contact, (2) facial expressions, (3) body movements, (4) gestures, (5) touch, and (6) physical appearance.

1. **Eye contact.** Eye contact may initiate interaction and communication. Often when a person is trying to get another's attention, he or she does so by trying to make eye contact. However, before making judgments about the importance of eye contact, the nurse must know the meaning of eye contact within the client's culture. In many Western cultures, eye contact is interpreted as attentiveness, interest, understanding, or trustworthiness. In some cultures, however, direct eye contact is considered disrespectful. Knowing the cultural meaning of eye contact can help a nurse assess its meaning in a specific interaction.
2. **Facial expressions.** Facial expressions provide the emotion or feeling underlying the verbal communication. The face can express feelings of surprise, fear, concern, disgust, happiness, anger, confusion, and sadness. As with eye contact, facial expression can have a cultural meaning. Some cultures are more expressive than others. It is important that one's facial expression is congruent with the verbal message. An expression of concern when inquiring about a client's pain would be congruent, whereas an expression of boredom or anger would be incongruent and could lead the client to believe that the nurse does not care. Lack of facial expression can also convey meaning, for example, apathy, boredom, or depression.
3. **Body movements.** The way in which people stand, sit, or move their body also communicates to others. Posture and gait can communicate one's feelings about oneself, one's mood, and one's current state of health. When interacting with a client, a nurse demonstrates interest and concern by leaning toward the client or by reaching out his or her hands and arms toward the client. Leaning away from the client or crossing her or his arms and legs may indicate distance or withdrawal. Standing over a client during interaction may be intimidating to the client. When persons have agitated movements they may be fearful or anxious. Lack of or avoidance of movement may indicate pain, discomfort, or depression. Sitting or standing at the same level as a person and maintaining eye contact can convey confidence or respect. Standing over someone may suggest a difference in authority or power.
4. **Gestures.** Hand and body movements may emphasize or clarify verbal communication, such as when separating fingers or hands to indicate the size of something or to point to a part of the body where one has pain. When the client is asked to describe chest pain, a different meaning could be attributed to the gesture of a clenched fist in the center of the chest in contrast to an open hand waved vaguely in front of the chest. Some people use their hands as part of their verbal speech and may find difficulty in expressing themselves if they are unable to use their hands. For people who are hearing-impaired or unable to speak, sign language may be their primary means of communicating.
5. **Touch.** Physical touch can convey concern, comfort, and caring, or it can convey anger or agitation. Like eye contact, touch has cultural meaning. In some cultures and religions, touch is inappropriate between people of the opposite gender or between people of different classes. It is important that the nurse determine the meaning of touch in the client's culture or religion. When touch is inappropriate, clients may withdraw if a nurse reaches out toward them.
6. **Appearance.** How people present themselves, their dress, and their grooming can convey information about them. People who are physically or mentally ill may not be as attentive to their dress and grooming. Dress may indicate a person's position or status. For example, physicians, some nurses, and therapists may wear lab coats over business clothes; administrators may wear suits; and nursing assistants and dietary personnel may wear required uniforms or smocks. Jewelry may provide information about a person. Religious jewelry provides important information about a client or colleague. Nurses often wear pins or

other insignia that indicate their position or accomplishments, such as their school of nursing pin or a pin indicating they are a member of the nursing honor society, Sigma Theta Tau.

It is important that nurses be aware of their verbal and nonverbal communication patterns and characteristics. How they speak, their mannerisms, and their gestures may be effective tools for communication or they may impede communication.

### Reflect On . . .

- your speech patterns when communicating verbally with others, such as colleagues, clients, and friends. What feedback do you receive? Based on the usual feedback, do you believe you should make changes in your verbal communication behaviors?

- mannerisms and gestures you use when communicating nonverbally with others. What feedback do you receive? Based on the usual feedback, do you believe you should make changes in your nonverbal communication behaviors?

### Therapeutic Communication

Therapeutic communication is an interaction between the nurse or other healthcare provider and the client (or his or her family) with the planned purposes of establishing a trusting relationship, and assisting the client to overcome stress/anxiety, gain personal insight, control symptoms of physical or psychological disease, and promote healing. Therapeutic communication differs from social communication in that there is always a specific purpose or direction to the communication; therefore, therapeutic communication is planned communication. Communication is most

## RESEARCH CURRENT

### Use of Augmentative and Alternative Communication Strategies by Family Members in the Intensive Care Unit

The purpose of Broyles, Tate, and Happ's qualitative study was to identify "which augmentative and alternative communication (AAC) tools families use" when interacting with intensive care unit patients who are unable to speak and what nurses and family members of intensive care unit patients who cannot speak say about communication. The specific study was a secondary analysis of data (field notes, intervention logs, and nurse interviews) from a clinical trial that tested interventions to improve communication between nurses and patients in the intensive care unit.

The sample consisted of 41 patients where there was evidence of family involvement using AAC tools, and additional observations/comments about family/patient communication identified in the documents of 52 additional patients enrolled in the parent study. The most frequent family members communicating with the patients were spouses or significant others ( $n=22$ ) followed by adult children ( $n=10$ ). Other family members ( $n=4$ ) using AAC were parents, siblings, a grandchild, aunt, niece, and caretaker. More than one family member was involved with six patients.

AAC strategies used were writing (pen and paper;  $n=26$ ), electronic speech-generating devices ( $n=10$ ), eye blinking systems ( $n=3$ ), homemade flashcards or message boards ( $n=2$ ), toys (e.g., Etch-a-Sketch, Magna Doodle,  $n=2$ ). Eleven patient/families used two or more strategies.

There were five main themes identified that described use of AAC tools in patient/family communication:

- Families being unprepared and unaware. Families were unprepared for the patients' inability to

communicate or did not recognize the patients' capabilities for communication.

- Families' perceptions of communication effectiveness. Families were frustrated with their limited success in communication and were also aware of their patient's frustration.
- Nurses deferring to or guiding patient/family communication. Nurses deferred to families when planning communication strategies and in interpreting nonverbal messages from the patient.
- Patients' prior communication characteristics. Family reports of prior communication style and personality, literacy levels, and sensory deficits (e.g., vision, hearing).
- Families' experience with and interest in AAC tools. Families may have had limited knowledge or experience with AAC tools but were interested in using them and were creative in identifying solutions for communicating with their family member.

The investigators conclude that "assessment by skilled bedside clinicians can reveal patients' communication potential and facilitate useful augmentative and alternative communication tools and strategies for patients and their families."

*Source:* "Use of Augmentative and Alternative Communication Strategies by Family Members in the Intensive Care Unit," by L. M. Broyles, J. A. Tate, and M. B. Happ, 2012, *American Journal of Critical Care*, 21(2), e21–e32.

therapeutic when the nurse demonstrates an attitude of trust and caring for the client. There are specific verbal and nonverbal techniques of communication that express such an attitude.

**Presence**, or an attitude of being wholly there for the client, is part of therapeutic communication. A nurse cannot appear to be distracted; rather, a client must feel that he or she is the primary focus of the nurse during the interaction. Being present for a client is conveyed by exhibiting an open and relaxed posture and leaning toward the client. The nurse faces the client directly and maintains eye contact.

**Active listening**, sometimes referred to as *attentive* or *mindful listening*, is one of the most important communication techniques. Active listening requires the nurse to pay undivided attention to what the client says, does, and feels. With active listening, the nurse puts aside personal biases, judgments, and ideas long enough to really hear what the client is trying to communicate. To be therapeutic, listening must be active and involve all the senses rather than passively involving only the ear. Active listening hears what the client is saying and sees how the client is behaving to determine what the client is trying to communicate.

**Silence** is a part of attentive listening. Nurses need to become comfortable with silence. Silence allows clients to think about or reflect upon what has been said. Sometimes silence can communicate more than words; it can enable the expression of feelings or emotions.

Therapeutic communication techniques facilitate effective communication and enhance the nurse-client interaction. This communication focuses on the client's thoughts and concerns. Therapeutic communication techniques are described in Table 14–1.

## Written Communication

Nurses are required to be proficient in written communication. The most common form of written communication in nursing are the notes made in the medical record about a client's status, whether they be in handwriting or written using electronic charting formats. Nurses also write discharge instructions for clients and their families, memos to nursing colleagues and other health professionals, and client educational materials. Nurse-managers write employee evaluations, policies and procedures, and other communications to administrators, colleagues, and nursing staff. Nurse-educators write educational handouts and course syllabi. An important consideration in written communication is that decoding often occurs when the writer is not present and may occur long after the document is written. Therefore, clarity is important because it may not be possible to ask questions or clarify areas of confusion.

## Characteristics of Effective Written Communication

In addition to simplicity, brevity, clarity, relevance, credibility, and humor (characteristics of effective oral communication), written communication must contain (1) appropriate language and terminology; (2) correct grammar, spelling, and punctuation; (3) logical organization; and (4) appropriate use and citation of resources.

1. **Appropriate language and terminology.** Language and terminology must be appropriate for the age, education and reading level, and culture of the reader. Health education materials written for children should be different from materials written for adults. For people whose primary language is other than English, it may be more effective to have written materials translated into their primary language by a professional translator. To ensure understanding, appropriate lay terminology may be substituted for medical terminology; for example, *high blood pressure* may be used instead of *hypertension*. Online dictionaries and thesauruses help writers to choose the word(s) that best conveys the intended meaning.
2. **Correct grammar, spelling, and punctuation.** Using correct grammar, spelling, and punctuation provides clarity for the reader. Misspelled words, misplaced punctuation, or incorrect grammar can change the intended meaning and lead to confusion on the part of the reader. Most computer word-processing programs have spelling- and grammar-checking features that assist writers in improving their writing.
3. **Logical organization.** Written materials are well organized when they are logical and easy for readers to follow. Consider what the reader needs to know first. Simple and foundational information is usually provided first, followed by more complex information. Using examples can also assist readers in understanding of the material. Providing an outline of the material to be presented helps the reader focus on major themes and subthemes.
4. **Appropriate use and citation of resources.** Information taken from other sources must always be credited to the original source. Failure to reference work taken from another writer is called **plagiarism**, is considered unethical, and may violate copyright laws. There are various styles of referencing, including the Modern Language Association (MLA) and the American Psychological Association (APA). Another benefit of citing references is that readers who want additional information have other references to read.

**TABLE 14–1 Therapeutic Communication Techniques**

| Technique                                            | Description                                                                                                                                                                                                                                                                                                                                                                                              | Examples                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Using silence                                        | Accepting pauses or silences that may extend for several seconds or minutes without interjecting any verbal response.                                                                                                                                                                                                                                                                                    | Sitting quietly (or walking with the client) and waiting attentively until the client is able to put thoughts and feelings into words.                                                                                                                                                                                                             |
| Providing general leads                              | Using statements or questions that<br>a. encourage the client to verbalize,<br>b. choose a topic of conversation, and<br>c. facilitate continued verbalization.                                                                                                                                                                                                                                          | “Perhaps you would like to talk about . . .”<br>“Would it help to discuss your feelings?”<br>“Where would you like to begin?”<br>“And then what?”                                                                                                                                                                                                  |
| Being specific and tentative                         | Making statements that are specific rather than general, and tentative rather than absolute.                                                                                                                                                                                                                                                                                                             | “Rate your pain on a scale of 1 to 10.” (specific statement)<br>“Are you having pain?” (general statement)<br>“You seem unconcerned about your diagnosis.” (tentative statement)<br>“You are obviously not concerned about your diagnosis.” (absolute statement)                                                                                   |
| Using open-ended questions                           | Asking broad questions that lead or invite the client to explore (elaborate, clarify, describe, compare, or illustrate) thoughts or feelings. Open-ended questions specify only the topic to be discussed and invite answers that are longer than one or two words. Open-ended questions cannot be answered with yes or no.                                                                              | “I’d like to hear more about that.”<br>“Tell me about . . .”<br>“How have you been feeling lately?”<br>“What brought you to the hospital?”<br>“What is your opinion?”<br>“You said you were frightened yesterday. How do you feel now?”                                                                                                            |
| Using touch                                          | Providing appropriate forms of touch to reinforce caring feelings. Because tactile contacts vary considerably among individuals, families, and cultures, the nurse must be sensitive to the differences in attitudes and practices of clients and herself or himself.                                                                                                                                    | Putting an arm over the client’s shoulder.<br>Placing your hand over the client’s hand.                                                                                                                                                                                                                                                            |
| Restating or paraphrasing                            | Actively listening for the client’s basic message and then repeating those thoughts and/or feelings in similar words. This conveys that the nurse has listened and understood the client’s basic message and also offers the client a clearer idea of what he or she has said.                                                                                                                           | <i>Client:</i> “I couldn’t manage to eat any dinner last night—not even the dessert.”<br><i>Nurse:</i> “You had difficulty eating yesterday?”<br><i>Client:</i> “Yes, I was very upset after my family left.”<br><i>Client:</i> “I have trouble talking to strangers.”<br><i>Nurse:</i> “You find it difficult talking to people you do not know?” |
| Seeking clarification                                | A method of making the client’s <i>broad overall</i> meaning of the message more understandable. It is used when paraphrasing is difficult or when the communication is rambling or garbled. To clarify the message, the nurse can restate the basic message or confess confusion and ask the client to repeat or restate the message.<br><br>Nurses can also clarify their own message with statements. | “I’m puzzled.”<br>“I’m not sure I understand that.”<br>“Would you please say that again?”<br>“Would you tell me more?”<br><br>“I meant this rather than that.”<br>“I guess I didn’t make that clear—let me go over it again.”                                                                                                                      |
| Perception checking or seeking consensual validation | A method similar to clarifying that verifies the meaning of specific words rather than the overall meaning of a message.                                                                                                                                                                                                                                                                                 | <i>Client:</i> “My husband <i>never</i> gives me any presents.”<br><i>Nurse:</i> “You mean he has <i>never</i> given you a present for your birthday or Christmas?”<br><i>Client:</i> “Well—not <i>never</i> . He does get me something for my birthday and Christmas, but he never thinks of giving me anything at any other time.”               |

(Continued)



TABLE 14–1 Therapeutic Communication Techniques (Cont.)

| Technique                   | Description                                                                                                                                                                                                                                                                                                                                | Examples                                                                                                                                                                                                                                                                                                             |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Offering oneself            | Suggesting one's presence, interest, or wish to understand the client without making any demands or attaching conditions that the client must comply with to receive the nurse's attention.                                                                                                                                                | <p>"I'll stay with you until your daughter arrives."</p> <p>"We can sit here quietly for a while; we don't need to talk unless you would like to."</p> <p>"I'll help you to dress to go home."</p>                                                                                                                   |
| Giving information          | Providing, in a simple and direct manner, specific factual information the client may or may not request. When information is not known, the nurse states this and indicates who has it or when the nurse will obtain it.                                                                                                                  | <p>"Your surgery is scheduled for 11 a.m. tomorrow."</p> <p>"You will feel a pulling sensation when the tube is removed from your abdomen."</p> <p>"I do not know the answer to that, but I will find out from the nurse in charge."</p>                                                                             |
| Acknowledging               | Giving recognition, in a nonjudgmental way, of a change in behavior, an effort the client has made, or a contribution to a communication. Acknowledgment may be with or without understanding, verbal or nonverbal.                                                                                                                        | <p>"You trimmed your beard and mustache and washed your hair."</p> <p>"I notice you keep squinting your eyes. Are you having difficulty seeing?"</p> <p>"You walked twice as far today with your walker."</p>                                                                                                        |
| Clarifying time or sequence | Helping the client clarify an event, situation, or happening in relationship to time.                                                                                                                                                                                                                                                      | <p><i>Client:</i> "I vomited this morning."</p> <p><i>Nurse:</i> "Was that after breakfast?"</p> <p><i>Client:</i> "I feel that I have been asleep for weeks."</p> <p><i>Nurse:</i> "You had your operation Monday, and today is Tuesday."</p>                                                                       |
| Presenting reality          | Helping the client to differentiate the real from the unreal.                                                                                                                                                                                                                                                                              | <p>"That telephone ring came from the program on television."</p> <p>"That's not a dead mouse in the corner; it is a discarded washcloth."</p> <p>"Your magazine is here in the drawer. It has not been stolen."</p>                                                                                                 |
| Focusing                    | Helping the client expand on and develop a topic of importance. It is important for the nurse to wait until the client finishes stating the main concerns before attempting to focus. The focus may be an idea or a feeling; however, the nurse often emphasizes a feeling to help the client recognize an emotion disguised behind words. | <p><i>Client:</i> "My wife says she will look after me, but I don't think she can, what with the children to take care of, and they're always after her about something—clothes, homework, what's for dinner that night."</p> <p><i>Nurse:</i> "It sounds like you are concerned about how well she can manage."</p> |
| Reflecting                  | Directing ideas, feelings, questions, or content back to clients to enable them to explore their own ideas and feelings about a situation.                                                                                                                                                                                                 | <p><i>Client:</i> "What can I do?"</p> <p><i>Nurse:</i> "What do you think would be helpful?"</p> <p><i>Client:</i> "Do you think I should tell my husband?"</p> <p><i>Nurse:</i> "You seem unsure about telling your husband."</p>                                                                                  |
| Summarizing and planning    | Stating the main points of a discussion to clarify the relevant points discussed. This technique is useful at the end of an interview or to review a health teaching session. It often acts as an introduction to future care planning.                                                                                                    | <p>"During the past half hour we have talked about . . ."</p> <p>"Tomorrow afternoon we can explore this further."</p> <p>"In a few days I'll review what you have learned about the actions and effects of your insulin."</p>                                                                                       |

Source: Communicating. In *Kozier and Erb's Fundamentals of Nursing* (9th ed.), by A. J. Berman and S. Snyder, 2012. Electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

**CRITICAL THINKING EXERCISE**

Videotape an interaction with a colleague or client. (You must first obtain permission to videotape.) Analyze the videotape to identify inconsistencies between your verbal and nonverbal communication. Are there behaviors

or mannerisms that detract from your communication? In what ways would you improve your verbal and nonverbal communication behaviors?

**Reflect On . . .**

- your professional activities other than charting on client records that require written communication. What professional activities of you and your colleagues require written communication?
- your own comfort with and ability at written communication. What strategies would you implement to improve your ability at written communication? How would you assist your colleagues to improve their written communication?



**Infoquest:** Search the Internet for resources on improving communication in health care. Use the search words “effective communication” and “effective health communication.” Consider Internet sources that provide resources for health professionals to improve their communication skills with patients and also those sources that advocate for patients in improving healthcare delivery and quality. Identify strategies that promote effective communication.

**Barriers to Communication**

Just as there are characteristics of effective communication, there are identified barriers to effective communication. Nurses need to be cognizant of these barriers and avoid them. Nurses also need to recognize them when they

occur so that they can change to more effective communication. Berman and Snyder (2012, p. 474) state that “failure to listen, improperly decoding the client’s intended message, and placing the nurse’s needs above the client’s needs are major barriers to communication.” Additional barriers to effective communication and examples of each are listed in Table 14–2.

**Nursing Documentation**

Documentation of clients’ care and their responses to that care is essential for effective communication of clients’ status between healthcare providers. When such documentation is complete, accurate, and clearly understood by all healthcare professionals involved in providing the care, the quality of clients’ care and the potential for positive health outcomes are improved. Although the primary purpose of documenting care in clients’ records is for communication between healthcare providers so that they can plan appropriate care, there are other uses of the information provided in clients’ records: (1) planning client care, (2) auditing for quality assurance, (3) research, (4) education, (5) reimbursement, (6) legal documentation, and (7) healthcare analysis (Berman & Snyder, 2012).

1. **Planning client care.** The client record is used by each health professional to plan care for that specific client. Laboratory and diagnostic data help the physician or nurse practitioner determine medical diagnoses and treatment plans. In conjunction with client/family interviews, social workers use the client record to identify social/financial needs and plan for

**CRITICAL THINKING EXERCISE**

Choose a nursing topic to discuss with one or more colleagues or classmates. After the discussion ask the participants to analyze your verbal and nonverbal communication using the information in Table 14–1, “Therapeutic Communication Techniques,” and Table 14–2, “Barriers to Communication.” Are there words or phrases that you use that

distract from your communication, for example, excessive use of the phrase “you know”? Are there nonverbal mannerisms that detract from the communication, for example, frequently looking at your watch, interrupting, not making eye contact? What strategies will you implement to improve your communication?

TABLE 14–2 Barriers to Communication

| Technique                    | Description                                                                                                                                                                                                                                                                                                                      | Examples                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Stereotyping                 | Offering generalized and oversimplified beliefs about groups of people that are based on experiences too limited to be valid. These responses categorize clients and negate their uniqueness as individuals.                                                                                                                     | <p>“Two-year-olds are brats.”</p> <p>“Women are complainers.”</p> <p>“Men don’t cry.”</p> <p>“Most people don’t have any pain after this type of surgery.”</p>                                                                                                                                                                                                                                    |
| Agreeing and disagreeing     | Similar to judgmental responses (discussed later in this table), agreeing and disagreeing imply that the client is either right or wrong and that the nurse is in a position to judge this. These responses deter clients from thinking through their position and may cause clients to become defensive.                        | <p><i>Client:</i> “I don’t think Dr. Smith is a very good doctor. He doesn’t seem interested in his patients.”</p> <p><i>Nurse:</i> “Dr. Smith is head of the department of surgery and is an excellent surgeon.”</p>                                                                                                                                                                             |
| Being defensive              | Attempting to protect a person or healthcare services from negative comments. These responses prevent the client from expressing true concerns. The nurse is saying, “You have no right to complain.” Defensive responses protect the nurse from admitting weaknesses in the healthcare services, including personal weaknesses. | <p><i>Client:</i> “Those night nurses must just sit around and talk all night. They didn’t answer my light for over an hour.”</p> <p><i>Nurse:</i> “I’ll have you know we literally run around on nights. You’re not the only client, you know.”</p>                                                                                                                                              |
| Challenging                  | Giving a response that makes clients feel that they must prove or defend their statement or point of view. These responses indicate that the nurse is failing to consider the client’s feelings.                                                                                                                                 | <p><i>Client:</i> “I felt nauseated after that red pill.”</p> <p><i>Nurse:</i> “Surely you don’t think I gave you the wrong pill?”</p> <p><i>Client:</i> “I feel as if I am dying.”</p> <p><i>Nurse:</i> “How can you feel that way when your pulse is 60?”</p> <p><i>Client:</i> “I believe my husband doesn’t love me.”</p> <p><i>Nurse:</i> “You can’t say that; he visits you every day.”</p> |
| Probing                      | Asking for information chiefly out of curiosity rather than with the intent to assist the client. These responses are considered prying and violate the client’s privacy. Asking “why” is often probing and places the client in a defensive position.                                                                           | <p><i>Client:</i> “I was speeding along the street and didn’t see the stop sign.”</p> <p><i>Nurse:</i> “Why were you speeding?”</p> <p><i>Client:</i> “I didn’t ask the doctor when he was here.”</p> <p><i>Nurse:</i> “Why didn’t you?”</p>                                                                                                                                                      |
| Testing                      | Asking questions that make the client admit to something. These responses permit the client only limited answers and often meet the nurse’s need rather than the client’s.                                                                                                                                                       | <p>“Who do you think you are?” (forces people to admit their status is only that of client)</p> <p>“Do you think I am not busy?” (forces the client to admit that the nurse really <i>is</i> busy)</p>                                                                                                                                                                                            |
| Rejecting                    | Refusing to discuss certain topics with the client. These responses often make clients feel that the nurse is rejecting not only their communication but also the clients themselves.                                                                                                                                            | <p>“I don’t want to discuss that. Let’s talk about . . .”</p> <p>“Let’s discuss other areas of interest to you rather than the two problems you keep mentioning.”</p>                                                                                                                                                                                                                             |
| Changing topics and subjects | Directing the communication into areas of self-interest rather than considering the client’s concerns is often a self-protective response to a topic that causes anxiety. These responses imply that what the nurse considers important will be discussed and that clients should not discuss certain topics.                    | <p><i>Client:</i> “I’m separated from my wife. Do you think I should have sexual relations with another woman?”</p> <p><i>Nurse:</i> “I see that you’re 36 and that you like gardening. This sunshine is good for my roses. I have a beautiful rose garden.”</p>                                                                                                                                  |

(Continued)

**TABLE 14–2 Barriers to Communication (Cont.)**

| Technique               | Description                                                                                                                                                                                           | Examples                                                                                                                                                               |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Unwarranted reassurance | Using clichés or comforting statements of advice as a means to reassure the client. These responses block the fears, feelings, and other thoughts of the client.                                      | “I’m sure everything will turn out all right.”<br>“Don’t worry.”                                                                                                       |
| Passing judgment        | Giving opinions and approving or disapproving responses, moralizing, or imposing one’s own values. These responses imply that the client must think as the nurse thinks, fostering client dependence. | “That’s good (bad).”<br>“You shouldn’t do that.”<br>“That’s not good enough.”<br>“What you did was wrong (right).”                                                     |
| Giving common advice    | Telling the client what to do. These responses deny the client’s right to be an equal partner. Note that giving expert rather than common advice is therapeutic.                                      | <i>Client:</i> “Should I move from my home to a nursing home?”<br><i>Nurse:</i> “If I were you, I’d go to a nursing home, where you’ll get your meals cooked for you.” |

Source: Communication. In *Kozier and Erb’s Fundamentals of Nursing* (9th ed.), 2012, by A. J. Berman and S. Snyder. Electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

transitional care needs such as placement in a rehabilitation or skilled nursing facility. Nurses use laboratory and diagnostic data, medical diagnoses, client baseline and ongoing data, and medical treatment plans to develop and evaluate the nursing plan of care.

- 2. Auditing for quality assurance.** The client record is used by accrediting organizations such as The Joint Commission to review and evaluate the quality of care given in healthcare institutions.
- 3. Research.** Information in a client record can be used as a source of data for healthcare research. Data gathered from the medical records of numerous clients with the same health problem may yield information about (a) the effectiveness of specific treatment methods, (b) the effectiveness of specific nursing interventions, or (c) specific client characteristics that enhance or impede the effectiveness of a specific treatment or intervention.
- 4. Education.** Client records are used by students in the health professions as educational tools. Although textbooks provide generalized information about pathophysiology, signs and symptoms, usual treatment, and outcomes of a specific health problem, client records provide a comprehensive view of specific clients, their health problems, their medical treatments and nursing interventions, and their responses to the treatment and interventions. A client record provides a case study of the unique experience of one client with a specific health problem or multiple complex health problems. This helps students understand the individual experience of the client with the health problem.
- 5. Reimbursement.** Documentation of care helps the healthcare organization receive reimbursement from third-party payers, including private insurance companies and governmental sources of reimbursement

such as Medicare and Medicaid. Medicare requires that the client record must contain the correct diagnosis-related group (DRG) codes and document that the appropriate care was given for the healthcare provider to receive payment.

- 6. Legal documentation.** The client’s record is considered a legal document that can be used as evidence in a legal action. Such a record is a major source of information about the care that a client received when there is an accusation of negligence or malpractice against a healthcare provider.
- 7. Healthcare analysis.** In addition to being used by accrediting organizations to review the quality of care in a healthcare agency, client records can also help the healthcare agency analyze and plan the agency’s needs. For example, analysis of client records can help the agency identify services that are underutilized or overutilized, such as specific diagnostic studies or medications. This analysis can help the agency determine which services generate revenue and which cost the agency money.

## Methods of Documentation

There are several methods of organizing the client record, including the traditional source-oriented narrative record; problem-oriented medical record (POMR), sometimes referred to as the problem-oriented record (POR); the problems, interventions, evaluation (PIE) model; focus charting; charting by exception (CBE); computerized documentation; and case management. Table 14–3 provides a brief description of the various methods of documentation and their advantages and disadvantages.

One must be cautious about the use of abbreviations in documentation. Abbreviations can result in medical errors;



TABLE 14–3 Methods of Documentation

| Method                                                                                                                                                                                                                                                      | Organization                                                                                                                                                                                                                                      | Advantages                                                                                                                                                                      | Disadvantages                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Source-oriented narrative record</b>                                                                                                                                                                                                                     | Each provider documents in a separate section or sections of the client’s record (e.g., progress notes, nurse’s notes).<br><br>Information is written in chronological order in the appropriate section.                                          | Each discipline can easily locate the forms on which to document its data.<br><br>Easy-to-follow information specific to one’s discipline.                                      | Information scattered throughout the record.<br><br>Difficult to find chronological information integrating various disciplines.                                                                                                                      |
| <b>Problem-oriented medical record (POMR), or problem-oriented record (POR)</b><br><b>S</b> —Subjective data<br><b>O</b> —Objective data<br><b>A</b> —Assessment<br><b>P</b> —Plan<br><b>I</b> —Interventions<br><b>E</b> —Evaluation<br><b>R</b> —Revision | Consists of baseline data, a problem list at the front of the record, a plan of care for each problem, and progress notes written in SOAP, SOAPIE, SOAPIER, or PIE format.<br><br>Data are organized according to the client problems identified. | Encourages collaboration between healthcare providers.<br><br>The problem list in front alerts caregivers to client’s needs.<br><br>Easier to track the status of each problem. | Caregivers differ in their ability to use the required format.<br><br>Requires constant vigilance to maintain up-to-date problem list.<br><br>Inefficient because assessments and interventions that apply to more than one problem must be repeated. |
| <b>PIE</b><br><b>P – Problems</b><br><b>I – Interventions</b><br><b>E – Evaluation</b>                                                                                                                                                                      | Uses flow sheets and progress notes<br><br>Time parameters for charting can vary (e.g. hourly in critical care, monthly in ambulatory care)                                                                                                       | Efficient—Uses flow sheets and progress notes<br><br>Eliminates traditional care plan<br><br>Incorporates ongoing care plan into progress notes                                 | Nurse must review all notes to determine which problems are current and which interventions were effective                                                                                                                                            |
| <b>Focus charting</b>                                                                                                                                                                                                                                       | Client concerns and strengths are the focus of care.<br><br>Data are organized according to data (D), nursing action (A), and client response (R); often uses flow sheets.                                                                        | Allows charting on any significant area, not just problems.<br><br>Flexible.                                                                                                    | Not multidisciplinary.<br><br>Difficult to identify chronological order.<br><br>Notes may not relate to care plan.                                                                                                                                    |
| <b>Charting by exception (CBE)</b>                                                                                                                                                                                                                          | Only significant findings or exceptions to norms are recorded.                                                                                                                                                                                    | Efficient—uses flow sheets.<br><br>Rapid detection of changes.<br><br>Can take place of plan of care.                                                                           | Expensive to institute.<br><br>Not prevention focused.                                                                                                                                                                                                |

Source: Adapted from Documenting and reporting. In *Kozier and Erb’s Fundamentals of Nursing: Concepts, Process, and Practice* (9th ed.), by A. J. Berman and S. Snyder, 2012, Upper Saddle River, NJ: Pearson.

for example, OD and QOD may be mistaken for each other. OD means daily and QOD means every other day. If the abbreviation is misused or misunderstood, the patient could receive either too much medication or too little. The Joint Commission issued a Sentinel Even Alert regarding medical abbreviations in 2001, which was followed in 2004, by the development of a “do-not-use” list. In 2014, the Joint Commission included “improve the effectiveness of communication among caregivers” as part of the National Patient Safety Goals (NPSG). To be accredited by The Joint

Commission, organizations are required to implement these goals. One requirement is for organizations to develop an organizational list of “do-not-use” abbreviations.

### Communicating Through Technology

Nurses are increasingly using computers to enhance their communication. Nurses use email with smartphones or electronic notebooks to communicate with other nurses,

other departments in their employment setting, and resources outside the employment setting. Nurses can use computers to access health information through websites and electronic literature databases.

Healthcare agencies are implementing electronic health record (EHR) systems. Computers may be found at nurses' stations, clients' bedsides, or as handheld models in nurses' pockets. Computers at the bedside enable nurses to input assessment data as they are obtained and check orders immediately before administering a treatment or medication. When documenting in the EHR at the bedside or in the examining room, position yourself so that you can see the client. Avoid placing your back to the client while looking at the computer screen. Data from bedside monitors can be incorporated readily into clients' EHRs through bedside computers. Home health nurses can use notebook or laptop computers to access client information and input assessment data, treatment administered, and client/caregiver teaching. Computerized client information can be transmitted rapidly from one healthcare setting to another to facilitate consultation with other healthcare providers. Electronic documentation systems decrease the time spent in charting and increase the legibility and accuracy of information.

It is important for people using electronic means of communication to remember that the receiver will see only the written message and not see facial expressions or body gestures or hear tone or quality of voice.

It is also important that nurses using electronic means communicate in a manner that exhibits professionalism. Consider an email communication as a letter that is being

sent electronically. The same rules of courtesy, spelling and grammar, structure and layout, and message delivery apply. Some strategies to ensure professional electronic communication can be seen in Table 14-4.

This table of recommended practices and practices to avoid presents some ways of avoiding misunderstandings of the communicated message. The use of capital letters can be interpreted as shouting or yelling and reflects more emphasis than may be intended. Some of the common abbreviations used in electronic communication may not be familiar to all readers, leaving questions in the minds of the readers about what was really intended.

Common courtesy is the basis of many of the recommended practices. Starting with a greeting and using proper spelling, grammar, and punctuation show that care was taken in the development of the message and are respectful to the reader. The overuse of "Reply all" can be annoying and clutters the inbox of those who do not need the reply message. Remember that email is public, so confidential information should not be sent by email, and permission is needed to send someone else's words. One should also use bcc (blind copy) rather than cc (copy all), as the latter provides email addresses of all recipients on the email. Principles of privacy dictate that information about another should not be shared without his or her permission. When using bcc, recipients do not see the names or email addresses of other recipients.

The use of computers and technology has not only made communication faster and easier but also has improved safety and accuracy in client care.

## RESEARCH CURRENT

### Determination of the Effectiveness of Electronic Health Records to Document Pressure Ulcers

The purpose of this retrospective study by Li and Korniewicz was to compare the documentation of pressure ulcers in patients' EHR with documentation in patients' written medical record. The study sample was comprised of 139 patients, 60 with medical diagnoses and 79 surgical patients, 81 female and 58 male. All patients were on pressure ulcer support mattresses during their hospital stay. The mean length of hospital stay was 5.5 days. Of this group, there were 15 patients with documented pressure ulcers. The investigators developed a chart audit form to review the documentation. Data collected from the patient records, both EHR and written medical record, included current score on the Braden Scale for Predicting Pressure Ulcer Risk and skin assessment and wound assessment documentation. There were eight EHRs and seven

written medical records that had nursing notes about pressure ulcers. Four pressure ulcers that were documented in the EHR were not identified in the written medical record, and three pressure ulcers that were documented in the written medical record were not documented in the EHR. Quality of the nursing documentation was poor in both EHR and written medical record and did not conform to hospital policy, with incomplete or inaccurate recordings. The investigators recommend increased education of nursing students and graduate nurses to reinforce organizational policies regarding documentation of pressure ulcers, specifically in EHRs.

*Source:* "Determination of the Effectiveness of Electronic Health Records to Document Pressure Ulcers," by D. Li and D. M. Korniewicz, 2013, *MEDSURG Nursing*, 22(1), 17–26.

TABLE 14–4 Strategies for Professional Electronic Communication

| Recommended Practices                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Practices to Avoid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• <b>Do</b>—Include a meaningful subject line that indicates content and/or purpose.</li><li>• <b>Do</b>—Use blind copy (bc) and courtesy copy (cc) appropriately.</li><li>• <b>Do</b>—Start your email with a greeting.</li><li>• <b>Do</b>—Be brief and to the point.</li><li>• <b>Do</b>—Use proper spelling, grammar, and punctuation.</li><li>• <b>Do</b>—Use sentence case or format.</li><li>• <b>Do</b>—Use proper formatting, structure, and layout.</li><li>• <b>Do</b>—Use active voice rather than passive voice.</li><li>• <b>Do</b>—Be pleasant and courteous.</li><li>• <b>Do</b>—Answer all questions.</li><li>• <b>Do</b>—Reply promptly to messages received.</li><li>• <b>Do</b>—Include threads of previous emails.</li><li>• <b>Do</b>—Use templates for frequently used responses.</li><li>• <b>Do</b>—Use a signature that includes your contact information.</li><li>• <b>Do</b>—Add disclaimers to your emails.</li><li>• <b>Do</b>—Read the email before you send it.</li><li>• <b>Do</b>—Take care with abbreviations.</li><li>• <b>Do</b>—Remember that email isn’t private.</li><li>• <b>Do</b>—Ensure that antivirus software is installed and updated routinely on your computer.</li></ul> | <ul style="list-style-type: none"><li>• <b>Avoid</b>—Using all capital letters; it is considered SHOUTING.</li><li>• <b>Avoid</b>—Using abbreviations and emoticons.</li><li>• <b>Avoid</b>—Leaving out the message thread; the time interval in between messages may cause confusion about the response.</li><li>• <b>Avoid</b>—Overusing “Reply to all”; everyone on the original message may not need to get your response.</li><li>• <b>Avoid</b>—Forwarding chain letters or virus hoaxes.</li><li>• <b>Avoid</b>—Forwarding messages containing libelous, offensive, or obscene remarks. Such action could lead to legal action against the sender and the forwarder.</li><li>• <b>Avoid</b>—Using email to complain about or conduct personal attacks on others. Such action could lead to legal action against the sender.</li><li>• <b>Avoid</b>—Copying a message or attachment without permission; this could be considered plagiarism.</li><li>• <b>Avoid</b>—Using email to discuss confidential information; remember, federal privacy acts cover email communication in addition to other forms of communication.</li><li>• <b>Avoid</b>—Using excessively long sentences.</li><li>• <b>Avoid</b>—Replying to spam; this increases your risk of receiving viruses and other unwanted messages.</li></ul> |

Sources: “Email Etiquette: 26 Rules to Follow,” by H. Tschabitscher, 2011, retrieved from [email.about.com/od/emailnetiquette/tp/core\\_netiquette.htm](http://email.about.com/od/emailnetiquette/tp/core_netiquette.htm); “Email Etiquette 101,” by M. Hyatt, 2007, retrieved from [michaelhyatt.com/e-mail-etiquette-101.html](http://michaelhyatt.com/e-mail-etiquette-101.html); “Email Etiquette,” by K. Stolley and A. Brizee, 2010, Copyright © 1995–2014 by The Writing Lab & The OWL at Purdue and Purdue University, retrieved from [owl.english.purdue.edu/owl/resource/636/01/](http://owl.english.purdue.edu/owl/resource/636/01/); “Email Etiquette 101,” by Net Manners, n.d., retrieved from [www.netmanners.com/750/email-etiquette-101/](http://www.netmanners.com/750/email-etiquette-101/); “Tips for Writing Professional Email,” by D. R. McKay, 2014, About.com Career Planning, retrieved from [careerplanning.about.com/od/communication/a/email\\_tips.htm](http://careerplanning.about.com/od/communication/a/email_tips.htm)

### Chapter Highlights

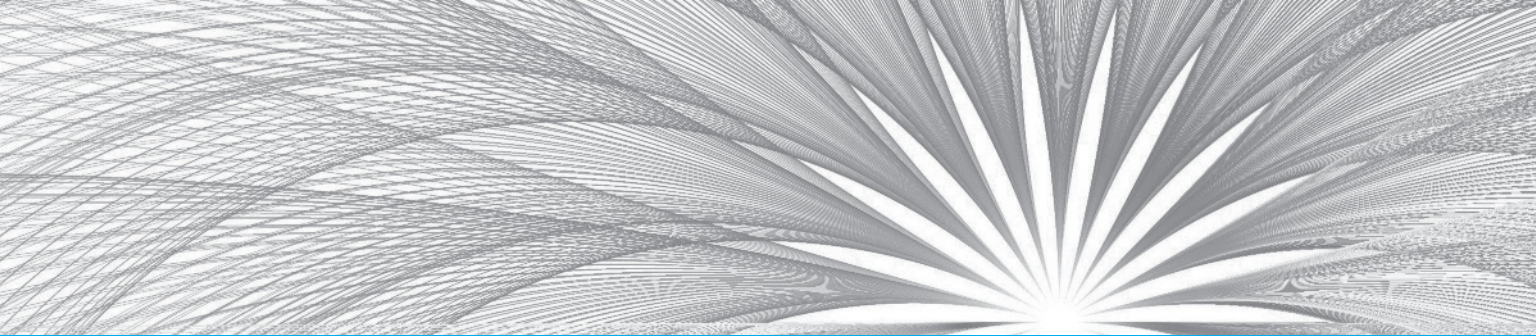
- Communication is the exchange of information or feelings between two or more people.
- Nurses must have excellent communication skills in order to communicate effectively with clients, their families, other nurses, and other health professionals.
- Professional nurses must be effective in both verbal and written and nonverbal communication.
- Proficiency in computer skills, including electronic charting of client care, word processing, and electronic communication is essential for nurses and other health-care professionals.
- *Healthy People 2020* identifies a major topic area and objectives for health communication and information technology.
- Communication involves the sending and receiving of messages and involves the sender, message, channel, receiver, and response or feedback. Factors influencing communication include developmental stage, gender, roles and relationships, sociocultural characteristics, values and perceptions, space and territoriality, environment, congruence, and interpersonal attitudes.

- Types of communication include verbal and nonverbal. Verbal communication includes both spoken and written words. Nonverbal communication uses facial expressions, gestures, touch, or other types of body language.
- Therapeutic communication is an interaction between the nurse or other healthcare provider and the client (or his or her family) with the planned purposes of establishing a trusting relationship and assisting the client to overcome stress/anxiety, gain personal insight, control symptoms of physical or psychological disease, and promote healing.
- Barriers to communication include stereotyping, agreeing/disagreeing, being defensive, challenging, probing, testing, rejecting, changing the topic, unwarranted reassurance, being judgmental (giving opinions, imposing one's own values), and telling the client what to do.
- Documentation of clients' care and their response to that care is essential for effective communication of the client's status between healthcare providers.
- Nursing documentation is not only used for communicating the client's status and care, but also for (1) planning client care, (2) auditing for quality assurance, (3) research, (4) education, (5) reimbursement, (6) legal documentation, and (7) healthcare analysis.
- Professional nurses are required to be proficient in the use of desktop, laptop, and notebook computers and other technology, such as smartphones, Skype, and FaceTime, for communication.
- Nurses use email to communicate with other nurses, other departments within their employment setting, and other health professionals. Nurses may use email or text messaging to communicate with clients and their families, such as to confirm appointments. When using electronic communication, nurses need to use proper etiquette and professionalism when communicating.

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# 15

## Managing Change

### Chapter Outline

#### Challenges and Opportunities

#### Meanings and Types of Change

- Spontaneous Change
- Developmental Change
- Planned Change

#### Change Theory

- Approaches to Planned Change
- Change Strategies
- Frameworks for Change

#### Managing Change

- Change Agent
- Steps in the Change Process
- Resistance to Change
- Examples of Change

#### Chapter Highlights

### Objectives

1. Differentiate spontaneous, developmental, and planned change.
2. Explain the empirical-rational, normative-reeducative, and power-coercive approaches to change.
3. Compare the change process models of Lewin, Lippitt, Havelock, and Rogers.
4. Discuss types and characteristics of change agents.
5. Identify ways to manage change by enhancing motivating forces and decreasing resistive forces.
6. Describe steps in the change process.

**T**o be effective and influential in today's world, nurses need to understand change theory and apply its precepts in the workplace, in government and professional organizations, and in the community. Change is a constant in the world around us. Change is a part of everyone's life; it is the way in which people grow, develop, and adapt. Change can be positive or negative, planned or unplanned. Change is rarely easy and can be painful. It can be desired or unwanted.

Even though change is inevitable, it is not always welcome because it produces anxiety and discomfort even when it is planned. There is a sense of loss of the familiar, and a grief reaction may occur. The intensity can be worse when the change is unplanned. In the words of Tiffany and Lutjens (1998), "Change is difficult. It helps. It hurts. It helps and hurts at the same time. Change is inevitable. We ignore change at our own peril" (p. 3).

The process of change is integral to many areas of nursing: clinical practice, including client care; health promotion and disease/injury prevention; education, both the education of nurses and other healthcare providers, and the education of clients, their families/caregivers, and the community; administration including the management within healthcare organizations, and in state, national, and global health organizations; research; and policy development at local, national, and global levels. It involves individual clients, families, communities, organizations, nursing as a profession, and the entire healthcare delivery system. Change can involve gaining knowledge, obtaining new skills, or adapting current knowledge in the light of new information. It can be particularly

difficult when presenting challenges to one's values and beliefs, ways of thinking, or ways of relating.

## Challenges and Opportunities

The experience of change always presents some level of challenge to the person who must adapt. The rapidity and amount of change experienced in recent decades in health care have been particularly challenging for the nursing profession. New administrative structures, new regulatory and accreditation mandates, new technology, new professional roles, and new ways of providing care have been added to and incorporated into practice. Assisting clients to make changes in lifestyle to enhance their health and well-being is likewise a challenge for nurses as well as for the clients and their families.

With these challenges come opportunities to adapt to the new demands in a positive way. There are opportunities to incorporate the demands of change into improved ways of providing care. Nursing can meet the challenges of changing times with resistance and hang on to what is familiar or with acceptance and help create improved environments of care and improved ways of delivering health care. There is an opportunity for nursing to be proactive and manage planned change, thus emerging as a more autonomous and recognized profession.

## Meanings and Types of Change

"Change is the process of making something different from what it was" (Sullivan, 2013, p. 56). Change disrupts equilibrium, and it involves endings, transitions, and new beginnings. People grieve when they lose something or are threatened with the loss of something, especially if that something is important to them. If they go through the steps of grieving, they may come to acceptance. Those who do not reach acceptance may experience disengagement or withdrawal, disidentification, with sadness and worry, disorientation and confusion, or disenchantment, accompanied by anger. Disengaged workers quit or retire in place doing only the bare minimum. People with disidentification, that is, they no longer feel identified as part of the organization, are vulnerable, and they tend to sulk and dwell in the past and resist new tasks. Disoriented workers no longer know where they fit in the organization and often do things incorrectly because they do not know or accept the new priorities. Employees who become disenchanted and disengaged can become angry and negative and may engage in undermining and destructive behavior.

Changes are disturbing to those affected, and resistance often develops. Change is most threatening in the presence of insecurity. Causes of resistance to change

include threats to self-interest, embarrassment, insecurity, habit, complacency, associated changes of power, and objective disagreement. Careful planning, appropriate timing of change related communications and implementation dates, adequate feedback, and employee confidence can reduce resistance to change. Informing personnel of reasons for change can help reduce resistance. Helping staff cope, individually and collectively, and recognizing their contributions also minimize resistance.

Change is not always the result of rational decision making. There are three types of change: (1) spontaneous, reactive, or unplanned; (2) developmental activities; and (3) consciously planned activities. Change can occur at all levels including individuals, groups, units, and organizations.

### Spontaneous Change

Spontaneous change is also referred to as reactive or unplanned change because it is not fully anticipated, it cannot be avoided, and there is little or no time to plan response strategies. Examples of spontaneous change affecting an individual include an acute viral infection, a spinal cord injury, or the unsolicited offer of a new position.

On a larger scale, spontaneous change can be either short term or long term. Examples of short-term spontaneous change include an earthquake or other natural disaster, a manmade disaster such as occurred in New York City on September 11, 2001, a major airplane crash that is near a small hospital, or a strike or sick out that affects the provision of care in a tertiary healthcare facility. The effects of the human immunodeficiency virus (HIV) and threats of bioterrorism on the policies and practices of healthcare facilities are examples of changes with long-term consequences.

Responses to spontaneous change can be either positive or negative. For example, the flu virus may create only minor inconveniences for one person but may lead to life-threatening illness in another. Likewise, an organization may respond successfully to the injuries resulting from a disaster event if a well-developed disaster plan is in place; conversely, without such a plan the organization may experience disorganization, confusion, and major difficulties. The result of spontaneous change can be unpredictable. To ensure a successful response, spontaneous change demands flexibility and cohesiveness.

### Developmental Change

Developmental change refers to physiopsychological changes that occur during an individual's life cycle or to the growth of an organization as it becomes more complex. Examples of developmental change of individuals include puberty in adolescents and the decreasing physical capability

of an older person. These changes are not consciously planned; they just happen. However, the individual may make plans for dealing with the changes. For example, an older person may make plans for dealing with the physical changes, such as moving to a smaller, one-floor residence that is easier to care for and in which it is easier to move around.

Organizations often grow and develop in unpredictable ways. A once-successful small health organization may no longer meet the increasing demands and needs of a community. As the organization evolves into a larger, more complex entity, it may undergo such unwanted change as overwork of employees, task and role changes of employees, less personalized service for clients and their families, and more formalized staff communication patterns. Such unavoidable changes necessitate development of organizational charts, revised job descriptions, and, often, formal staff meetings to meet the newly defined needs.

## Planned Change

According to Lippitt (1973), **planned change** is an intended, purposive attempt by an individual, group, organization, or larger social system to influence the status quo of itself, another organism, or a situation. Problem-solving skills, decision-making skills, and interpersonal skills are important factors in planned change. Organizations are continually involved in planned changes. In healthcare agencies, changes are made in policies, in methods of care delivery, in staffing practices, and so on. An example of a planned change in a healthcare organization is the implementation of an electronic health record system. An example of planned change at the level of the individual is the client who decides to improve his or her health status by attending a smoking-cessation program or participating in an exercise program. For the nurse, a planned change can be deciding to return to school for an advanced nursing degree. Being a part of and bringing about planned change is a major part of any nurse's role.

## Reflect On . . .

- unplanned or spontaneous changes that have occurred in your personal and professional life. How did those changes affect you or your organization? What personal or professional strategies helped you or your organization adjust to the spontaneous changes?
- planned changes that have occurred in your personal or professional life during the last year. Do planned professional changes result in planned personal changes? Is it possible that planned

professional changes might result in spontaneous personal changes? Have the planned changes been easier for you to manage than the unplanned changes? If no, what factors made it more difficult to change? If yes, what factors made it easier to change?

- developmental changes that might be identified in clients seen in your practice setting. Do the policies, procedures, and plans of care accommodate the developmental changes that are occurring in your clients?
- developmental changes that are occurring in your life? How are these developmental changes affecting your various roles, e.g. worker, student, spouse, parent, child, etc.?
- developmental changes that are occurring in your organization. What are the staff reactions to these changes? How might the professional nurse cope with or assist colleagues to cope with organizational change?

## Change Theory

### Approaches to Planned Change

Three broad strategies or approaches to planned change have been identified; they represent a continuum of least coercive (empirical-rational) through middle ground (normative-reeducative) to the most obtrusive (power-coercive). They are compared in Table 15–1. Each is appropriate in different situations and at different times. It is important to select the appropriate strategy carefully.

### Empirical-Rational

The *empirical-rational approach* is based on the beliefs that people are rational and that they will change if it is in their self-interest. Therefore, change will be adopted if the change can be rationally justified and shown to be advantageous to the people affected (Bennis, Benne, & Chinn, 1985; Tomey, 2009). An example of this would be convincing nurses that the implementation of the new electronic documentation system is needed not only because it has been mandated by federal legislation, but also because of the benefits for clients (e.g., accurate and legible information protects clients' safety and improves quality of care) and staff (e.g., more rapid access to laboratory and diagnostic data, increased legibility, more rapid input of treatment orders, etc.). The agency employees must be educated about the new procedures and related policies so that they become comfortable with it.

However, people do not always act rationally and

TABLE 15–1 Change Approaches

| Approach                      | Characteristics                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Power-coercive</b>         | <ul style="list-style-type: none"> <li>• Based on the application of power from a legitimate source.</li> <li>• Power is often economic or political.</li> <li>• Minimal participation by target members.</li> <li>• Resistance more likely to occur and morale may decrease.</li> <li>• Feelings and values of opposing forces are not a consideration.</li> <li>• Model is nonparticipative and undemocratic.</li> </ul>                |
| <b>Empirical-rational</b>     | <ul style="list-style-type: none"> <li>• Knowledge is power.</li> <li>• Influence moves from those with knowledge to those without.</li> <li>• Once members of the target group have knowledge, they will accept or reject the idea.</li> <li>• Is a noncoercive model.</li> <li>• Appropriate for new technology.</li> <li>• Works well when the target group is discontented.</li> <li>• Fully participative and democratic.</li> </ul> |
| <b>Normative-re-educative</b> | <ul style="list-style-type: none"> <li>• Recognizes that change must deal with feelings, values, and needs.</li> <li>• Recognizes that not all responses of people to change are rational.</li> <li>• Information and rational arguments are often insufficient to bring about change.</li> <li>• Model is partially participative and democratic.</li> </ul>                                                                             |

therein can be the difficulty. This strategy is most effective when there is little resistance to the change and the change is perceived as reasonable. Staff education about the purpose and expected benefits and preparation for implementation are essential in helping people accept the change. In the case of the implementation of an electronic documentation system, staff may need intensive education in computers and how to effectively use the system.

#### Normative-Reeducative

The *normative-reeducative approach* is based on the assumption that human motivation depends on the socio-cultural norms and the individual's commitment to these norms. The sociocultural norms are supported by the attitudes and value systems of the individuals. In this instance, change occurs if the people involved develop new attitudes and values by acquiring new information. In this approach, knowledge is the power for change, but it may be a lengthy process because attitudes and values are difficult to change. People's roles and relationships, perceptual orientations, attitudes, and feelings will influence their acceptance of change. In this approach, getting nurses to accept an electronic documentation system might center on showing the successful use of the electronic health record at a prestigious institution and convincing them that they are out of step by not using it.

The communication is participative and two-way. Staff development is through individual, small group and experiential means. People participate in their own reeducation. The change agents are usually members of the

organization, and their relationship to other personnel is important. The power ingredient is interpersonal relationships, and the change agent uses collaboration and cooperation. This approach can be effective in reducing resistance and stimulating creativity. It is well suited to nursing because nurses are well-versed in behavioral science and communication skills (Sullivan, 2013).

#### Power-Coercive

With the *power-coercive approach*, power lies with one or more persons of influence. The influence may come through political power, wealth, status, or ability. This approach does not deny the intelligence or rationality of people or the importance of their attitudes or values, but it recognizes the need to use power to attain change. It is a command and control approach in which positions of authority enforce the change. As a strategy, it can provoke resistance. The communication style is telling people what to do (Bennis, Benne, & Chinn, 1985). The new electronic documentation system would be presented to the staff, and they would be told that it is now policy for the institution and that they must use it.

This approach is sometimes appropriate in large-scale changes or when consensus is unlikely to be achieved, time is short, resistance is anticipated, and the change is critical for the organization's survival. Labor actions such as strikes, sit-ins, and sick outs may be used when employee resistance is great. Conflict resolution, collective bargaining, and negotiation may then be called for to resolve issues and move on with what needs to be done. The



## RESEARCH CURRENT

## Perceived Organizational Change and Its Connection to the Work-Related Empowerment

The purpose of this study was to obtain a longitudinal view of factors of organizational change and their relationship with experienced work empowerment. Specific research questions were (1) how did participants experience organizational change factors, (2) how were organizational change factors associated with experience work empowerment during the reorganization, and (3) how were the experienced organizational change factors associated with factors promoting or impeding work empowerment. The study hospital that provides care and treatment for patients with rheumatic conditions located in Finland implemented a change intervention called the Professional Career in Arthritis care project which consisted of a major organizational restructuring that included staff training, staff role/title changes, and opportunity for interaction through planned forums. Nursing staff were invited to respond to the survey. The Work Empowerment Questionnaire consisted of 22 items, the work-related empowerment promoting questionnaire consisted of 18 items, and the work-related empowerment impeding questionnaire consisted of 18 items. The survey was administered two times one year apart, immediately after implementation of the change and 1 year later. Responses to the survey in 2005 consisted of nurses ( $n=109$ ), physiotherapists (physical/

occupational therapists) ( $n=55$ ), practical nurse/masseurs/rehabilitation assistant (9), other including health fitness nurses, X-ray assistants, laboratory assistants and podiatrists ( $n=23$ ) who worked on multidisciplinary teams. Responses to the survey in 2006 consisted of nurses ( $n=103$ ), physiotherapists (physical/occupational therapists) ( $n=50$ ), practical nurse/masseurs/rehabilitation assistant (11), other including health fitness nurses, X-ray assistants, laboratory assistants, and podiatrists who worked on multidisciplinary teams ( $n=23$ ). The investigators reported that there were "no significant differences between the two measurements of empowerment immediately after the reorganization and one year later." Nurse participants reported the least satisfaction with the "adequacy of information received." Survey "statements regarding mutual support and a sense of confidence about the changeover process were found to be associated with most empowerment factors." The investigators recommend the importance of enabling staff to be part of decision-making processes to provide a sense of empowerment during organizational change.

*Source:* "Perceived Organizational Change and Its Connection to the Work-Related Empowerment," by T. Suominen, E. Harkonen, S. Rankinen, L. Kuokkanen, M. L. Kukkurainen, and D. Doran, 2011, *Nordic Journal of Nursing Research & Clinical Studies*, 99(3), pp. 4–9.

power-coercive approach should be avoided when there is a desire to foster openness within the organization. It tends to be better received when combined with the other two approaches.

## Change Strategies

Tiffany and Lutjens (1998) identified seven change strategies that fit on a continuum from most neutral to most coercive.

- 1. Educational.** This strategy provides a relatively unbiased presentation of fact that includes reasons for the planned change, timeline for implementation, individual roles for participation, and expected outcomes that is intended to serve as a rational justification for the planned action.
- 2. Facilitative.** This strategy provides resources critical to change. Resources may include time, money, space, and personnel that are essential for implementation of the change. It assumes that people are willing to change but need the resources to bring it about.
- 3. Technostructural.** This strategy alters the technology to access the social structure in groups or alters the social structure to get at technology. It assumes a relationship among technology, space, and structure. The use of space might be altered to affect the social structure. An example is the introduction of an electronic documentation system which may require changes in electrical wiring, introduction of computers in employee work stations, patient rooms, laboratories, and other places that will need to access the electronic documentation system for input or retrieval of information.
- 4. Data-based.** This strategy collects and uses data to make social change. Data are used to find the best innovation to solve the problems at hand. This strategy may seek input from various members/units of the organization related to the proposed change.
- 5. Communication.** Communication strategies spread information about the change over time through all available channels in a social system.
- 6. Persuasive.** The use of reasoning, arguing, and inducement are employed to bring about a change.
- 7. Coercive.** There is an obligatory relationship between planners and adopters. Power is used to bring about change. This is the least democratic or participatory of the strategies.

**TABLE 15–2 Comparison of Change Models**

| Lewin         | Lippitt                                                                                           | Havelock                                                                          | Rogers                                       | Prochaska & DiClemente                  |
|---------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------|
| 1. Unfreezing | 1. Diagnose problem<br>2. Assess motivation<br>3. Assess change agent's motivations and resources | 1. Building a relationship<br>2. Diagnosing the problem<br>3. Acquiring resources | 1. Knowledge<br>2. Persuasion<br>3. Decision | 1. Precontemplation<br>2. Contemplation |
| 2. Moving     | 4. Select progressive change objectives<br>5. Choose change agent role                            | 4. Choosing the solution<br>5. Gaining acceptance                                 | 4. Implementation<br>5. Confirmation         | 3. Preparation<br>4. Action             |
| 3. Refreezing | 6. Maintain change<br>7. Terminate helping relationship                                           | 6. Stabilization                                                                  |                                              | 5. Maintenance                          |

### Frameworks for Change

Frameworks such as those of Lewin, Lippitt, Havelock, Rogers, and Prochaska and DiClemente follow the normative-reeducative approach. They are compared in Table 15–2.

#### Lewin

Kurt Lewin (1948, 1951) originated change theory within the physical sciences based on his belief that change is a result of forces within a field or environment. He later expanded the theory to psychology and included all the psychological activity confronting a person. The result was his Force Field Analysis Model, in which two forces affect the change process: driving forces that attempt to move action and static or restraining forces that attempt to maintain the status quo. For change to be successful the driving forces must be stronger; this can come about by strengthening the driving forces or weakening the restraining forces. Lewin presented three basic steps or stages: unfreezing, moving, and refreezing. The process of change is shown in Figure 15–1.

During the *unfreezing* stage, the motivation to establish some sort of change occurs. The individual becomes aware of the need for change. This stage is a cognitive process in which the person becomes aware of a problem or of a better method of accomplishing a task and hence of the need for change. Having identified this need, the individual must also identify restraining and driving forces. For example, a nurse who is instructing an adolescent client

and his mother in dietary management of Type I diabetes may see the client's mother as a driving force and the client's father and siblings, who don't want to change their sugar-loaded diet, as restraining forces.

In the second stage, *moving*, the actual change is planned in detail and then started. Information is gathered from one or more sources. At this stage, it is important that the people involved agree that the status quo is undesirable. In this example, the nurse needs to help the family understand the importance of dietary management for diabetics and to enlist their support for the client. The status quo, or not implementing the dietary change for the adolescent with Type I diabetes, is not acceptable. Having the family accept and implement the dietary change for the entire family is preferable in meeting both the adolescent's health needs as well as providing a healthy diet for the family. The nurse could ask the dietitian to meet with the client and his family to demonstrate how a diabetic diet can be nutritious and tasty. The nurse might also provide printed food exchange lists, sample menus, and recipes, as well as resources for diabetic information. As a change agent, the nurse should work with the family to create an environment that is conducive to the change, including, perhaps, rewards to reinforce desired behaviors.

In the third stage, *refreezing*, the changes are integrated and stabilized. Those involved in the change integrate the idea into their own value system. Thus, in the example, the client and his family would come to value the importance of family involvement in dietary management of their diabetic son and sibling. The family members may develop their own strategies for assisting their loved one to comply with the plan. Indeed, the family may decide that the diabetic son's diet is healthful for the entire family, thereby resulting in a positive change for all family members.

These three stages are described in Lewin's *force field theory*. Lewin recommended that before a change is begun,

**FIGURE 15–1**

Process of Change

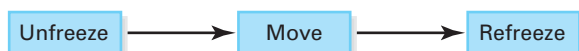
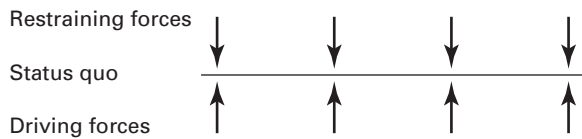


**FIGURE 15-2**

Effect of Driving and Restraining Forces on Status Quo



the forces operating for and against the change be analyzed. The forces for change are the *driving forces*, and the forces against change are *restraining forces* (see the accompanying box). When the driving forces predominate, change occurs; when restraining forces predominate, change does not occur or occurs more slowly and, perhaps, less effectively. It then becomes the responsibility of the change agent to use strategies to reduce the restraining forces and increase the driving forces. Reducing restraining forces usually is more effective than increasing the driving forces. This unfreezing is directed at the target system, that is, the individual, family, or group. See Figure 15-2.

### Lippitt

Lippitt, Watson, and Westley (1958) described planned change as having seven phases, as shown in Table 15-2. This approach extended Lewin's theory and focused more on what the change agent must do rather than on the evolution of the change. These seven phases begin with the recognized need for change. The manager can stimulate awareness and present the idea that a more desirable state is possible. Assessment can be made of the motivation and capacity to change as well as the resources for change. In Lewin's theory, this would be comparable to unfreezing.

For the process to move, a helping relationship must begin. The success or failure of the planned change will often depend upon the quality and workability of the client and change agent relationship. Problems must be identified and analyzed, alternative possibilities must be examined, and goals and objectives must be planned. Resources will

be examined and strategies developed. This stage corresponds to moving in Lewin's theory.

Generalization and stabilization correspond to Lewin's refreezing process. These are necessary to prevent slipping back into old ways. The change needs to spread and stabilize. A change in momentum, positive evaluation of outcomes of the change, rewards and benefits for change, and procedural and structural changes are each important factors in achieving success.

### Havelock

Ronald Havelock (1973) modified Lewin's theory regarding planned change by emphasizing planning the change process. He described the six-step process shown in Table 15-2. More attention is paid to the unfreezing stage, which he defines as building a relationship, diagnosing the problem, and acquiring resources. In the moving stage, the solution is chosen and acceptance is gained. Lewin's refreezing is referred to as stabilization and self-renewal.

### Rogers

Everett Rogers developed a *diffusion-innovation theory* rather than a planned-change theory. Rogers introduced the idea that an adopted change is not necessarily permanent. His framework, diffusion of innovation, emphasizes the reversible nature of change. Participants may initially adopt a proposal and later discontinue it, or they may initially reject it and adopt it at a later time. He defines *diffusion* as the process by which an innovation is communicated through certain channels over time among the members of a social system. Diffusion that involves innovation becomes social change when the diffusion of new ideas results in widespread consequences. Rogers's three phases in the diffusion of innovation follow (Dearing, 2008; Rogers, 1995; Rogers & Shoemaker, 1971):

1. **Invention.** Collecting information about the proposed change. Data are collected and analyzed. Data may include legislative or regulatory mandates for change; incidence of problems such as falls or nosocomial

## Common Driving and Restraining Forces

### Motivating Forces

- Perception that the change is challenging and achievable
- Economic gain
- Perception that the change will improve the situation
- Visualization of the future positive impact of change
- Potential for personal growth, recognition, achievement, and improved relationships

### Restraining Forces

- Fear that something of personal value will be lost (e.g., threat to job security or self-esteem)
- Misunderstanding of the change and its implications
- Low tolerance for change related to intellectual or emotional insecurity
- Perception that the change will not achieve goals; failure to see the big picture
- Lack of time or energy

infections, and factors related to these problems; and marketing factors.

2. **Diffusion.** Communicating information about the proposed change to others. It includes disseminating information and estimating the ease or difficulty of diffusing the new idea or information.
3. **Consequences.** The dissemination of information may result in the adoption or rejection of the change.

Rogers wrote that the factors associated with successful planned change are relative advantage, compatibility, complexity, divisibility, and communicability. These factors refer to the perception of the degree of advantage provided by the innovation and its fit with the prevailing values, experiences, and needs of the people involved, along with the degree of difficulty in implementing and the opportunity to test out/pilot or phase in the change. Willingness to adopt the innovation is also affected by the visibility to others of the benefits associated with the change.

Rogers's five steps to the diffusion of innovations, referred to as the *innovation-decision process*, are:

1. **Knowledge.** The individual, called the decision-making unit, is introduced to change and begins to comprehend it.
2. **Persuasion.** The individual develops a favorable or unfavorable attitude toward the change.
3. **Decision.** The person makes a choice to adopt or not to adopt the change.
4. **Implementation.** The person acts on the choice. At this time, alterations may take place.
5. **Confirmation.** The individual looks for confirmation that the choice was right. If the person encounters mixed messages, the choice may be changed.

Rogers (2003) describes five groups of adopters of innovation: innovators, early adopters, early majority, late majority, and laggards. They represent a continuum of enthusiasm for the change. *Innovators* are the most enthusiastic and introduce the new ideas. *Early adopters* are receptive to the new idea, and the *early majority* consider an idea for a while before supporting the change. The *late majority* tend to be skeptical and cautious; they accept a new idea only after their

uncertainty has been resolved. *Laggards* are last to accept innovation; they tend to have traditional values and look more to the past than the future. Rogers emphasized that, for change to succeed, the people involved must be interested in the change and committed to implementing it.

### Prochaska and DiClemente

Prochaska and DiClemente (1982, 1992) proposed five stages in the process of change: (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance. The five stages are cyclical, and people generally move through one stage before progressing to the next.

- **Precontemplation.** The person is not thinking about change nor is he or she interested in information about a proposed change.
- **Contemplation.** The person is willing to consider a change and obtains information about the proposed change. Belief in the value of the change and the person's confidence in his or her ability to change increases during this stage.
- **Preparation.** The person sees that advantages outweigh disadvantages of making the proposed change and makes specific plans for implementation of the change.
- **Action.** The change is implemented and new behaviors are adopted.
- **Maintenance.** The change is fully integrated into the system. Support systems are implemented to maintain the change, and problems associated with the change are discussed and resolved.



**InfoQuest:** Search the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PsychLit, and other electronic databases for articles and research on change theory. Which change theories are represented in the nursing literature? Select an article reporting on either organizational change or behavioral change. How is the theory helpful in guiding the change process? Are there change theories that you would choose to employ if you are the agent of change?

### CRITICAL THINKING EXERCISE

Identify a nursing situation from your practice in which a client is presented with the need to change a behavior in order to better manage a health problem, such as obesity, hypertension, or respiratory disease. Apply one of the frameworks discussed and identify how a nurse might assist with this change.

Identify a need for change that you have observed in your community, such as improved air or water quality. Apply one of these frameworks and identify steps you could take to facilitate this change.



## Managing Change

There are internal and external forces that affect change. Internal forces originate inside the organization, but they may be due to external forces. There may be an internal force for changing the organization of healthcare delivery related to low staffing levels, but these low staffing levels may be caused by external forces such as the shortage of nurses or changing healthcare economics.

The change manager must be able to identify the source of the problem, assess motivations and capacity for change, determine and examine alternatives, and then determine and implement a helping relationship. Havelock (1973) believes change agents facilitate planned change by being a catalyst, solution giver, process helper, and resource linker. In using Lewin's theory, change agents identify the restraining and driving forces and assess the relative strengths of each. Driving forces could include the desire to please authority figures or a desire to improve a situation. Restraining forces could include such things as conformity or threats to prestige. Strategies are then planned to reduce the restraining forces and strengthen the driving forces.

Cognitive dissonance is believed to be a powerful motivator for change. It assumes four concepts:

- People like consistency in their thoughts, beliefs, attitudes, values, and actions.
- Dissonance is a result of psychological inconsistency, which is experienced as discomfort.
- Dissonance drives people to action.
- Dissonance stimulates people to attain consistency and reduce inconsistency.

The degree of dissonance experienced is directly related to the importance of the issue and the meaning it has for the people involved in the proposed change. To reduce these feelings of imbalance, people often change attitudes or behavior to regain that feeling of consistency.

## Change Agent

"A **change agent** is one who works to bring about a change" (Sullivan, 2013, p. 56). The change agent is the person or group that initiates, motivates, and implements the change. Change agents are leaders. The nurse uses critical thinking and knowledge of change theory to act as an effective change agent in a variety of healthcare settings.

An effective change agent must be highly skilled. As the nurse moves through the process of change with clients, families, groups, communities, institutions, organizations, or policy makers, the nurse assumes a variety of roles, depending on the type of change and the needs of the individuals involved in the change. It is also important for the change agent to be accessible to all people involved in the change process. The change agent should be honest and straightforward about goals and problems. The accompanying box describes effective change agent skills.

A key element in the change process is trust. The change agent must trust the participants in the change, and they in turn must trust the change agent. One of the greatest risks of change is that it can disrupt the system or even render it nonfunctional. For example, changing the method of nurse assignments could result in gaps and missed care for some clients. To avoid this problem, the change agent must closely observe the situation during the change process.

A change agent may be formally or informally designated. A formally designated change agent is one who has the role and responsibility for change, such as a clinical nurse-specialist expected to make changes beneficial to specified clients, or a nurse manager charged with the implementation of the electronic documentation system on her or his nursing unit. This person has the authority to plan and implement change. An informally designated change agent does not have the authority to make change by virtue of a position but does have the leadership skills and respect of others and therefore can serve an important

## Change Agent Skills

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• The ability to combine ideas from unconnected sources</li> <li>• The ability to energize others by keeping the interest level up and demonstrating a high personal energy level</li> <li>• Skill in human relations; well-developed interpersonal communication, group management, and problem-solving skills</li> <li>• Integrative thinking; the ability to retain a big picture focus while dealing with each part of the system</li> <li>• Sufficient flexibility to modify ideas when modifications will improve the change, but persistent enough to resist nonproductive tampering with the planned change</li> </ul> | <ul style="list-style-type: none"> <li>• Confidence and the tendency not to be easily discouraged</li> <li>• Realistic thinking</li> <li>• Trustworthiness; a track record of integrity and success with other changes</li> <li>• Ability to articulate a vision through insights and versatile thinking</li> <li>• Ability to handle resistance</li> </ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Source: *Effective Leadership and Management in Nursing* (8th ed., p. 64), by E. J. Sullivan, 2013, Upper Saddle River, NJ: Prentice Hall. Reprinted with permission.

function in the change process. A change agent who has formal status carries authority, whereas an informal change agent can operate only through his or her own informal leadership style and persuasion.

Change agents may also be internal or external. An *internal change agent* is a person who is part of the situation or system, for example, a nurse manager on a hospital unit or a public health nurse providing school health services to a specific school or within a school system. Internal change agents are familiar with the situation and the organization. However, they may have vested interests in the present system as well as biases. An *external change agent* comes to the situation from outside the system or institution and may be considered an expert regarding the proposed change, for example, a nursing administrator from another hospital, a nurse-specialist from another healthcare facility, or a nurse-educator from another college. External change agents are able to view the problem and the situation objectively and usually have no biases; they are often viewed as experts and may be called consultants. However, they may not have personal knowledge of the situation and the problems. They may not be viewed openly as an insider would be; therefore, they must develop a cooperative working relationship with the people involved in the change. A third option is to pair the external agent with the internal person to serve together as change agents. There are advantages and disadvantages to each of these options, and it is important for any change agent to be aware of both in each situation.

## Steps in the Change Process

The pace of change has accelerated in the past decades because of factors such as the rapid changes in technology, communication, and the requirements of regulatory agencies. Individuals vary in their ability to tolerate change, yet today's work environment demands that people be able to manage change skillfully. Organizations also differ in their ability to absorb change.

Although change is inevitable and necessary for growth, it is not always welcomed and often produces anxiety. Even when change is well planned, it can be threatening because the process renders something different from the status quo. Change evokes emotional reactions, consumes considerable internal resources and energy, and often is associated with feelings of loss, grief, and pain.

Unfortunately, people are often called upon to deal with another change before they have reached full integration of a previous change. In today's rapidly changing healthcare environment, coping with change may be one of the biggest challenges. It calls for resilience, adaptability, and flexibility. Sullivan (2013) describes the 10 steps in the change process:

### Identify the Problem or Opportunity

Change may be required as a result of a policy change created by an accrediting body, a legislative mandate, or a problem identified by staff, administration, or quality and safety personnel. For example, the legislative mandate for the implementation of the electronic health record for public and private healthcare providers became effective in 2014. This mandate will require healthcare organizations to implement electronic documentation systems and healthcare professionals to become adept at electronic charting. In organizations, the quality and safety committee may note an increase in patient falls or nosocomial infections that requires changes in policy or practice. In both examples, maintaining the status quo is not acceptable and may result in financial penalties, legal actions, or other negative consequence.

### Collect Necessary Data and Information

Once the problem has been identified, it is important to know the background information and data that are necessary to establish goals and a plan of action. Legislative mandates, regulatory agencies, accrediting bodies, or others may provide detailed information about the required change and make resources available to assist with the change.

### Select and Analyze The Data

Once the problem has been identified, specific data can be identified and analyzed that provide information about the extent of the problem. For example, data regarding patient falls may be found in the quality and safety committee weekly/monthly reports. Such reports may identify if there are more incidents on a specific nursing unit or shift, or if specific types of patients/staff/visitors are affected.

### Develop a Plan for Change

The plan for change should include a detailed timeline including when and how the change will be communicated to people involved in the change, when the change will be implemented with dates/times of specific steps in the implementation plan, expected date of completion of implementation, and time intervals for evaluation of the change. The plan should identify resources needed and when they will be needed. Resources include personnel involved not only in planning the change but also those affected by the change, equipment needed, the costs associated with the change, and internal and external sources of information/experience that can assist through the various steps of the change.

### Identify Supporters and Opposers

Supporters can be a driving force to facilitate the change. Knowing who are the opposers or resisters can help you identify reasons for opposition, determine the validity of

the reasons, and provide answers to concerns or strategies for overcoming the opposition.

### **Build a Coalition of Supporters**

Supporters can be invited to actively participate and assist others in the change process. Supporters may also identify potential problems and come up with creative solutions to those problems.

### **Help People Prepare for Change**

An important part of the change process is to provide adequate information about the change. People want to know how the change will affect them, what will be required of them, when will the change occur, and how it will affect their normal work obligations. Sometimes resistance is emotional and more about letting go of the way things have always been done instead of embracing the anticipated benefits of the change.

### **Prepare to Handle Resistance**

Identify reasons for resistance from those opposed to the change and determine strategies to overcome resistance. Clarify information to be sure that those affected by the change have accurate information about the proposed change. Revise the change plan if appropriate, but be firm that the change outcome is required. Emphasize the positive outcomes of the proposed change, for example, how the change will benefit the individual or improve patient care. Discuss what will happen if they continue to resist; for example, the quality of care may suffer, organizational accreditation may be lost, or revenue will decrease.

### **Provide a Feedback Mechanism**

It is important to provide continuous updates to keep everyone informed on the progress of the change. This can be done by creating an organizational website that provides ongoing information about the change, sending emails to personnel on the status of the plan, and/or having routine meetings in which change leaders can report on the progress and respond to questions.

### **Evaluate Effectiveness of the Change**

Throughout the change, process evaluation should be done and documented about the status of the plan, and a summative evaluation should be conducted at the end of plan implementation. The goals and objectives of the planned change should be used to measure progress and effectiveness. For example, if the goal is to decrease patient/staff/visitor falls throughout the organization, evaluation would look at the incidence of falls following the change and compare that with the incidence prior to implementation of the plan. Detailed evaluation would look not only at the specific units identified where the problem occurred but

also throughout the organization to ensure that overall goals were achieved. If goals have been achieved—that is, if the change plan has been effective—then new procedures should be established within the organization’s policies and procedures documents. If goals are not achieved, the process starts again to determine what went wrong.

## **Resistance to Change**

Resistance to change is not merely the lack of acceptance but rather behavior intended to maintain the status quo, that is, to prevent the change from occurring. The change agent should anticipate some resistance to change, no matter how beneficial the change may seem. Resistance to change is often greatest when the idea is not concurrent with existing trends, such as trying to change from primary nursing to team nursing when primary nursing is the current trend. Resistance is also usually great when a proposed change would alter a situation with which people are comfortable.

Accepting change often takes time, particularly when it does not fit into a person’s attitudinal frame of reference; in such a case, change may not occur at all. For example, for a person who enjoys smoking and does not believe that it is harmful, stopping smoking may not be accepted as a desirable change. Optimally, this belief changes before the person tries to change the behavior.

A change agent should anticipate resistance to change. It is important to listen to what people are saying and under what circumstances. There are often nonverbal signs of resistance and perhaps passive aggressive behaviors, including poor work habits and lack of effort in assigned tasks. Open resisters are easier to deal with than the more passive resisters.

Resistance to a change is not always a bad thing; it can prevent the unexpected and provide a barrier to a change that may not be desirable for the institution. Some degree of resistance to change is a natural response. Resistance may help people adapt to the proposed change as they try to understand the meaning on a personal level, establish a thread of continuity, and then accept and grow with the change. It forces the change agent to be clear and convincing about the need and to provide motivation. On the other hand, persistent resistance can wear down supporters and use up energy that could be directed to implementation. Morale can suffer. It then becomes necessary for the change agent to minimize the resistance.

To manage resistance, the leader of the change or the change agent can analyze both the driving or motivating and the restraining forces that are operating in the change (see the discussion on Lewin). To achieve the change goal, the change agent must minimize the restraining forces and promote the driving forces. After the analysis, three kinds

**TABLE 15–3 Examples to Unfreeze a Change Target System**

|                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Creating discomfort with the status quo  | <ul style="list-style-type: none"> <li>• Meet with small groups of nurses and others affected by the change (target system) to discuss the inadequacies of the current system.</li> <li>• Explain new requirements from regulatory agencies (e.g., accreditation organizations, legal mandates) and how they are designed to improve client, staff, and organizational outcomes.</li> </ul>                                                                                            |
| Inducing guilt and anxiety               | <ul style="list-style-type: none"> <li>• Demonstrate how the current system is not meeting clients' needs for care.</li> <li>• Provide data about how the organization/unit is not meeting outcome measures/goals.</li> <li>• Provide examples of how the old system has endangered client safety or has otherwise had a negative effect on client outcomes.</li> <li>• Explain that the administration wants the new system.</li> </ul>                                               |
| Providing emotional/psychological safety | <ul style="list-style-type: none"> <li>• Assure nurses and others affected by the change (target system) that adequate numbers of staff will be provided during and after the change.</li> <li>• Express confidence in the nurses' abilities to implement the change.</li> <li>• Assure nurses that there will be regular meetings to discuss progress and that nurses will be active participants in the planning, implementation, and evaluation processes of the change.</li> </ul> |

of tactics can be used to “unfreeze” the system: (1) Create discomfort with the current status quo, (2) induce guilt or anxiety, and (3) provide emotional/psychological safety. See Table 15–3 for examples of how to unfreeze a change target system.

To create discomfort, the change agent can confront the target system with evidence that challenges the status quo. Often the change agent meets with defensive responses that attempt to protect the individuals. By inducing guilt—for example, by pointing out that the current accepted outcome measures or goals are not being met—the change agent often upsets the balance of the driving

and restraining forces. Then, by providing emotional comfort and psychological safety, the change agent can help the target system feel more comfortable and less threatened about the change. Other tips for managing resistance to change can be found in the accompanying box.

The change agent needs to be aware of the sources of power that can energize change. This often means the agent's being politically astute within an organization. The following four political strategies may be helpful:

1. Analyze the organizational chart and be aware of the formal and informal lines of authority.

### Suggestions for Managing Resistance

- Communicate with those who oppose the change. Get to the root of their reasons for resistance.
- Clarify information and provide accurate feedback.
- Be open to revisions but clear about what must remain.
- Present the negative consequences of resistance (threats to organizational survival, compromised client care, and so on).
- Emphasize the positive consequences of the change and how the individual or group will benefit. However, do not spend too much energy on rational analysis of why the change is good and why the arguments against it do not hold up. People's resistance frequently flows from feelings that are not rational.
- Keep resisters involved in face-to-face contact with supporters. Encourage proponents to empathize with

opponents, recognize valid objections, and relieve unnecessary fears.

- Maintain a climate of trust, support, and confidence.
- Divert attention by creating a different “disturbance.” Energy can shift to a “more important” problem inside the system, thereby redirecting resistance. Alternatively, attention can be brought to an external threat to create a “bully phenomenon.” When members perceive a greater environmental threat (such as competition or restrictive governmental policies), they tend to unify internally.

*Source: Effective Leadership and Management in Nursing (8th ed.), by E. Sullivan, 2013, Upper Saddle River, NJ: Pearson, pp. 63–64. Reprinted with permission.*



2. Identify the key people affected by the change. In an organizational hierarchy, the people immediately above and below those directly affected should be given attention.
3. Find out as much as possible about what makes these key people tick. It is important to know their likes and dislikes and with whom they usually align on decisions.
4. Begin to build a coalition of support before the change begins by identifying those individuals who are most likely to support the effort and those most likely to be persuaded easily. Their counsel on costs and benefits and objections can be used to make modifications that make the innovation more appealing. (Sullivan, 2013, pp. 64–65)

## Examples of Change

It is exciting to realize how effective nurses can be when they determine the need for change and plan strategies to bring it about. The following examples outline changes initiated by nurses who have identified a need to do something in each of four spheres of influence: the workplace, organizations, the government, and the community.

### The Workplace

At each of three staff meetings, Jane Hawkins, nurse-manager, listened to nurses complain about problems with getting clients' laboratory work done and reported to the unit in a timely manner. She conferred with other nurse-managers and with the attending and resident physicians on her unit. It appeared that similar complaints were widespread.

At the next management meeting, Jane described the problem. The group appointed a task force, with Nurse Hawkins as chair, and asked it to present a plan to solve the

problem at the next meeting. After gathering more data, the task force members invited representatives from the attending and resident staff and the laboratory director to meet with them to review the data, consider alternative solutions, and select a plan to solve the problem.

By the next management meeting, a preliminary plan to alter the system of laboratory reporting had been devised, and all concerned were working cooperatively to implement the plan.

### The Professional Organization

Nurses on the education committee of a district nurses' association recognized the need to make a public policy statement concerning the care of homeless individuals. The board of directors had recently expressed interest in promulgating such policy statements, so the committee sensed the timing was right and that the board would welcome its draft despite the controversial subject matter.

Members of the committee researched and drafted a statement. The full committee offered a critique and selected an articulate spokesperson to present the statement to the association president and seek support before asking to have the statement presented to the board. Once the president had approved the statement, it was placed on the agenda for the next board meeting.

After making minor additions, the board approved it for distribution to the lay and nursing press and asked the education committee to suggest a nurse to present the statement at a local hearing of the city council health committee.

### The Government

Although the pressure to contain healthcare costs escalated through the first half of the 1980s, a coalition representing

## CRITICAL THINKING EXERCISE

In 2010, the Patient Protection and Affordable Care Act (PPACA) was enacted with the goal of creating a better healthcare system for citizens and residents of the United States. Many changes were mandated that affect not only consumers of health care, but also providers including nurses, physicians, other healthcare professionals, and healthcare organizations. Some mandates of the PPACA have already been implemented, such as not being rejected for insurance because of pre-existing illness and the ability to keep young people up to age 26 on their parents' health insurance plan. Implementation of additional mandates will continue over the ensuing years. Review the PPACA at [www.health.gov](http://www.health.gov). Consider

first your own reaction to the mandates of PPACA. What were your own thoughts about PPACA as a healthcare consumer when it was passed? As a nurse? What are your thoughts now about PPACA as a healthcare consumer? As a nurse? In what ways are nurses required to be change agents in the implementation of PPACA? What principles of change can nurses use to help consumers understand their benefits under PPACA and promote healthier behaviors?

There are many older Americans who say that the reaction to PPACA is similar to the public reaction to Social Security and Medicare when those programs were enacted. What are your thoughts about this statement?

## RESEARCH CURRENT

## An Action Research Approach to Practice, Service and Legislative Change

Sullivan, Hegney, and Francis describe the action research approach they took to “engage a multidisciplinary group of health professionals and managers from five [Australian] rural health services with government officers in redesigning their emergency care services and informing legislative change.” The multidisciplinary group consisted of 14 registered nurses, 3 visiting medical officers, 3 pharmacists, 4 chief executive officers, 4 directors of nursing, and 1 paramedic. All participants were asked to participate in a 2-day planning session and “three one-day action learning sets (ALS) held at regular intervals during the project.” Quantitative data collection was done on emergency patients for 4–6 weeks at the start of the project and again before the final ALS meeting. Data obtained included patient characteristics and “proportion of patients seen by the nurse” and “the number of presentations managed by nurses

without doctors.” Qualitative data consisted of semistructured interviews of project participants and data obtained during the planning meeting, the ALS meetings, and focus groups analyzed using convergent interview and thematic analysis. The change process reinforced collaborative practice between the nurses and doctors and resulted in a legislative change “enabling nurses to supply medicines without a doctor’s order under certain circumstances.” The investigators conclude that the action research model “was key to the success achieved by the participants in changing clinical practice, service delivery and the Victoria Drugs Poisons and Controlled Substances Act (1981) to authorize registered nurses to supply medicines.”

*Source:* “An Action Research Approach to Practice, Service and Legislative Change,” by E. Sullivan, D. G. Hegney, and K. Francis, 2013, *Nurse Researcher*, 21(2), pp. 8–13.

the shared interests of the American Nurses Association (ANA), the National League for Nursing (NLN), and the American Association of Colleges of Nursing (AACN) mounted a campaign to convince Congress of the cost-effectiveness of a center for nursing research within the National Institutes of Health (NIH). Despite incredible odds, including a presidential veto and opposition from the American Medical Association, the Association of American Medical Colleges, and the NIH administrations, the proposal was passed by Congress in the fall of 1985. In 1993, the Center for Nursing Research became the National Institute for Nursing Research on an equal standing with all other institutes of NIH. The success of this effort demonstrates the effectiveness of carefully planned change, including the collaboration of nursing organizations. It

also illustrates the clout organized nurses can wield on any level and in any sphere.

### The Community

Every nurse plays several roles besides that of registered nurse. Each resides in a community, and many are parents. Some serve on school boards, belong to the League of Women Voters, or participate in religious, club, or scouting activities. There are numerous opportunities for nurses to contribute to the health and welfare of the communities in which they live. A group of nursing students recognized a health problem within their community and developed a plan to intervene. Many of the students were parents of children in local elementary schools where a high percentage of children were being sent home daily with head lice.

## CRITICAL THINKING EXERCISE

In recent decades there has been a shift in healthcare policy in the United States from a focus on curing disease to a focus on health promotion and disease/injury prevention. What change strategies would you implement to assist healthcare consumers to change their own focus of waiting to seek treatment for disease or injury to an emphasis on health promotion, disease/injury prevention, and

healthier lifestyles? Create a health promotion plan with/for a friend or colleague. What is his or her reaction to the proposed change in focus? What are the driving and restraining forces encountered in planning and implementing the plan? How will you (you the nurse and the friend/colleague) use the driving forces and overcome the restraining forces in order to achieve success?

Because of previously enacted budget cuts, the district's school nurses were each responsible for between three and five schools. The students volunteered to work with the district nurses to provide screening and health teaching at each of the elementary schools, thereby helping to resolve the community's problem.

All nurses are affected by change; nobody can avoid it. Knowledgeable nurses make rational plans to deal with opportunities both to initiate and guide needed change and to respond to change that affects them in the workplace, organizations, government, and the community. To recognize these opportunities for change and

respond to the factors that influence nursing from outside the profession, it is helpful to consider the history of nursing, current trends in nursing, and present political, social, technological, and economic issues.

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### Reflect On . . .

- what changes are needed in your professional skills and abilities to help you to become a more effective change agent. How will you approach the goal of developing these changes?
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## Chapter Highlights

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- To be effective and influential in current and future healthcare delivery systems, nurses need to understand and apply change theory and be able to apply its precepts in the workplace, governmental and professional organizations, and in the community.
- There are three types of change: spontaneous (also called reactive or unplanned change); developmental change; and planned or purposive change.
- There are three approaches to planned change: power-coercive, empirical-rational, and normative-reeducative. The least coercive is the empirical-rational approach.
- Strategies that can be useful in planning and implementing change include educational, facilitative, technostructural, data-based, communication, persuasive, and coercive.
- The literature describes several frameworks for change based on the work of Lewin, Lippitt, Havelock, Rogers, and Prochaska and DiClemente. Each has three or more stages that describe the change process and suggests strategies for managing change.
- Lewin's theory of change has three stages: unfreezing, moving, and refreezing. His force field analysis is a means of examining the driving forces for change and the restraining forces that would limit change.
- Lippitt proposed a seven-stage process beginning with diagnosing the problem and ending with terminating the helping relationship.
- Havelock modified Lewin's theory to emphasize the planning stage of the change process.
- Rogers introduced the idea that adopted change is not necessarily permanent. He developed a five-step diffusion-innovation process.
- Prochaska and DiClemente proposed five stages in the process of change, beginning with precontemplation and ending with maintenance.
- A change agent is one who works to bring about a change. Nurses are change agents as they work with clients/patients to promote healthier lifestyles; with colleagues and organizations as they work to implement changes in policy and procedures; with community leaders and policy makers to build healthier communities.
- In order to be effective in planning and implementing change, the nurse needs to know the driving or motivating and the restraining factors that influence the proposed change.
- There are many change skills that nurses must possess to be effective change agents: confidence, trustworthiness, integrative thinking, human relations skills, communication skills, the ability to energize others, the ability to articulate a "vision," and the ability to manage resistance.
- Change is stressful, and the individuals experiencing change need to be supported and empowered.
- Facilitating change is most effective when those affected by the change are active participants in the change process.

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# 16

## Technology and Informatics

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### Chapter Outline

#### Challenges and Opportunities

#### Nursing Informatics, Healthcare Informatics, and Technology

Nursing Roles and Education  
Technology and Informatics  
Informatics Frameworks

#### Issues Related to Information Technology

Ethical Concerns  
Confidentiality of Medical Records and Data  
Data Integrity  
Caring in a High-Tech Environment

#### The Technology Explosion

Evolution of Technology  
Computer Technology in Practice, Education,  
Research, and Administration

#### Current Applications of Information Technology in Practice

Physician Order Entry  
Clinical Information Systems  
Wireless and Portable Devices  
Electronic Health Record  
Evidence-Based Practice  
Telehealth

#### Chapter Highlights

### Objectives

1. Define nursing informatics and technology assessment.
2. Describe current issues related to technology and informatics.
3. Identify applications of information technology in health care.
4. Discuss the role of nursing and healthcare informatics.

Healthcare technologies and information management are two very important, closely related topics for professional nursing practice. For example, when a hospital installed point-of-care computers, nurses and other providers were given access to electronic patient records from any area in the facility. This was particularly important for error-free orders, capture and display of all current food and drug allergies, and documentation of medications to each electronic patient record. Acute care and outpatient services were subsequently linked, and departments such as physical therapy and respiratory therapy became paperless (Mastrian & McGonigle, 2012).

With the availability of the World Wide Web, nurses can instantly draw upon current research, industry experiences, and publications for all aspects of health care and nursing. Healthcare consumers likewise have greater access to information. The use of computers in nursing and health care and the nurse's responsibility in using technological advances in the delivery of care are the focus of this chapter. Several nursing and healthcare technology frameworks guide the presentation of three current issues: ethics, confidentiality of patient records, and caring for clients in an increasingly technical environment.

### Challenges and Opportunities

Nurses are continuously challenged to provide safe, timely, effective, efficient, accessible patient-centered care in a range of environments. New technologies, particularly information systems, are changing and improving nursing practice, education, research, and administration. Computers in health care have dramatically changed nursing practice and care outcomes over the past several decades. Indeed, they have become important and essential tools

that facilitate caring for individuals, families, and groups. There are, however, several challenges to address whenever adopting new technologies and information systems. Nurses who design and use information technologies must be aware of confidentiality and security concerns. In addition, nurses are challenged to manage information technologies in a manner that supports quality nursing care and provides the mechanisms for the measurement of care outcomes.

The opportunities provided by information technology are vast. Applications can change the face of practice, education, research, and administration by providing powerful tools for facilitating the care of patients, educating student nurses, offering continuing education, informing nurses about outcome management, storing and accessing patient records, teaching patients about wellness, and educating the public. Healthcare information systems continue to evolve and are providing effective and efficient means to support nursing and health care.

Many new applications will be developed in the near future, and nursing should be instrumental in the design and application of systems for every aspect of patient care. Examples of four important applications are considered in this chapter: physician order entries, clinical information systems, wireless and portable devices, and computer-based patient records.

## Nursing Informatics, Healthcare Informatics, and Technology

The term **informatics** is used to describe all aspects of computers and information systems; it is interdisciplinary and integrates the science of the discipline with computer science, cognitive science, and information science. Thus, informatics is applied to the management and communication of data, information, knowledge, and wisdom in practice (Mastrian & McGonigle, 2012). **Nursing informatics** is defined as the “science and practice (that) integrates nursing, its information and knowledge, with management of information and communication technologies to promote the health of people, families, and communities worldwide” (International Medical Informatics Association Nursing Informatics Special Interest Group, 2009). Nursing informatics as a nursing specialty focuses specifically on how to improve patient care and safety and on how to improve the workflow and work processes of nurses and other healthcare workers (Mastrian & McGonigle, 2012). Data, information, and knowledge are the core of informatics, and while computers are used to

store, manipulate, and manage them, computers are not the focus of information science. The computer is simply a tool.

Since the introduction of information systems to acute care in 1965, a blend of consumer informatics and patient-centered information systems has evolved through the current wide use of the Internet (Nelson & Staggers, 2012). Nursing information systems are now modules within larger integrated healthcare information systems. For example, the nursing documentation features for perioperative care may be part of a larger surgical information system that includes patient registration, orders management, inventory control, scheduling, billing, and postoperative patient-discharge instruction.

## Nursing Roles and Education

A discussion of the role and educational preparation for nursing informatics will help apply these definitions. The informatics nurse, a specialty that requires baccalaureate preparation, will generally find career opportunities in acute and ambulatory settings, academic institutions, application companies (vendors), and consulting firms. A recruiting advertisement for an informatics nurse might include the need for skills and experience to outline nursing functions to be automated, write technical manuals, manage projects, or train users. Informatics nurses design, develop, test, and evaluate new clinical applications and adapt existing systems to fit patient and provider requirements. Competencies vary and may include complex problem solving, database development, and application design and testing (Kenney & Androwich, 2012; Staggers, Gassert & Curran, 2002). In all cases, the prerequisite is clinical experience.

Nursing informatics is one of the newest specialties in professional nursing, first recognized by the American Nurses Association (ANA) in 1992. Nurses who wish to specialize in nursing informatics can pursue certification through the American Nurses Credentialing Center (ANCC). Scope of practice and standards documents were developed under the direction of the American Nurses Association (ANA) in 1995 and were revised in 2001 and most recently in 2008.

A wide variety of educational preparation is available for the nursing informatics role. Educational opportunities for the nursing informatics specialization can be found at many universities in graduate nursing programs (MS and PhD) and postmaster’s certification programs. The first two graduate programs in nursing informatics were established at the University of Maryland and the University of Utah in 1988 and 1990, respectively.

Undergraduate courses at many colleges and universities are often available as electives for nursing students. Conferences and weekend immersion programs are widely available to provide professional development and continuing education (Mastrian & McGonigle, 2012).



**InfoQuest:** Go to the American Nurses Credentialing Center web site and look up the eligibility requirements for taking the certification exam in Informatics Nursing. <http://www.nursecredentialing.org/Informatics-Eligibility.aspx>

Nursing roles in informatics are continually evolving: “The work of an informatics nurse can involve any aspect of information systems, including theory formulation, design, development, marketing, testing, implementation, training, maintenance, evaluation, and enhancement. Informatics nurses are engaged in clinical practice, education, consultation, research, administration, and pure informatics” (American Nurses Association, 2008). Informatics nurses may be entrepreneurs within start-up companies developing web-based products or have their own business as health database designers. According to a recent workforce survey conducted by the Healthcare Information and Management Systems Society (2014), the top job responsibility identified was systems implementation (includes preparing users, training, and support). This is a notable change from the 2011 survey in which the respondents identified systems implementation and systems development as the most frequent job responsibilities. System optimization/utilization was a new option in the 2014 survey and was the second most frequently selected job responsibility. These findings suggest that the job responsibilities may be moving beyond simply implementing systems toward leveraging their value. Other responsibilities identified in this recent survey were systems development, with the least frequent job responsibilities being professional billing and coding and sales/marketing (Healthcare Information and Management Systems Society, 2014).

All nurses need informatics competencies, whether or not they are specialists in that area. All nurses must be information- and computer-literate. These competencies may be categorized as computer skills, information literacy skills, or overall informatics competencies. Basic computer skills include such things as using a word pro-

cessor, being able to communicate by email, and using applications to document patient care. Information literacy skills include the ability to retrieve bibliographic information from the Internet and the ability to evaluate and use the information appropriately. Overall informatics competencies include implementing policies to protect privacy, confidentiality, and security of information and recording data relevant to the nursing care of patients. These skills are basic to the entry-level nursing role. Experienced nurses should have even greater proficiency in a particular area, such as administration, education, or public health.

### Reflect On . . .

- how the role of informatics for nurses might be implemented in your work setting. How might informatics assist the practicing nurse? The patient? Administration and management?

## Technology and Informatics

The leap in the development and use of information technologies calls for close examination of all aspects as they relate to quality of care. Part of the role of informatics nurses is to understand, apply, and disseminate the principles of healthcare technology evaluation. The purpose of this role is to improve the safety of patient care through a comprehensive evaluation of the fit between individuals, tasks, and technology. The FITT framework (Fit between Individuals, Task and Technology) was developed by Ammenwerth, Iller, and Mahler (2006), building on the work of DeLone and McLean’s Information Success Model (1992); Davis’s Technology Acceptance Model (1993); and Goodhue and Thompson’s Task Technology Fit Model (1995). The FITT model encourages the evaluator to examine the fit between each pair of the major model components: user and technology, task and technology, and user and task.

Telehealth technologies, a part of communication and information system technologies, are beginning to play a major role in delivering quality health care to patients at a distance. The common communication technologies used in telehealth are the telephone, videophone, and computer (Mastrian & McGonigle, 2012). These technologies assist nurses in delivering quality care to remote patients in underserved areas or in prisons. The Health Resources and Services Administration (2014) provides the following definition of telehealth:

## RESEARCH CURRENT

## 2014 Nursing Informatics Workforce Survey

The Healthcare Information and Management Systems Society (HIMSS) conducted this survey with the nursing informatics workforce to gain a better understanding of the background of informatics nurses and issues that they address on a daily basis along with the tools used in the conduct of their jobs. This current survey builds on previous HIMSS research from 2004, 2007, and 2011. A non-probability sample recruited through the snowball technique using websites, listservs, emails, and private referrals totaled 1,047. The majority of the respondents reported working either at a hospital (58%) or at the corporate offices of a healthcare system (13%). Additionally, 41% of the respondents reported that they worked at a Magnet-designated hospital. For a second survey in a row, there was a decrease in the number of nurses reporting that they worked for vendors.

Of this sample, 60% responded that they had a postgraduate degree (includes either a master's degree or a PhD in nursing or other field/specialty). Of note, 43% responded that they had a master's degree in nursing or a PhD in nursing, representing an increase from 36% who indicated such in 2011. Slightly fewer respondents indicated more than 16 years of experience from 2011 (46%) to 2014 (41%). Conversely, there was an increase in the number of respondents reporting 1–5 years of clinical bedside experience from 2011 (12%) to 2014 (20%), suggesting that the nursing informatics field continues to grow as a specialty and that there is increasing demand for the role, drawing nurses from the bedside. The average salary

reported by the respondents in 2014 was \$100,717; up from \$98,703 in 2011 and \$83,675 in 2007.

Applications of informatics in which these nurses participated most frequently were nursing clinical documentation and clinical information systems to include systems implementation and development as well as systems utilization and optimization. The largest barrier to success as a nurse informaticist during the 2004 and 2007 surveys was the lack of financial resources. For the 2011 survey the top identified barrier to success identified was the lack of integration and interoperability. For 2014 the top barrier identified was a lack of administrative support and a lack of staffing resources. Sources of information needed to complete the job responsibilities were identified as networking with peers, websites, and electronic journals.

Future trends were identified by the respondents as leadership roles in organizations; leadership in development, selection, and implementation of systems; interoperability and integration to reduce “stand alones” or independent systems; systems to support patient-centered care; and more education and training.

The survey concluded that nurse informaticists are recognized for their broad base of knowledge and their key roles are system design, selection, and implementation. The roles will see even greater involvement in the future.

*Source:* “2014 Nursing Informatics Workforce Survey,” by the Healthcare Information and Management Systems Society, 2014. Retrieved from [www.himss.org](http://www.himss.org)

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

Technology is affecting the way education and meetings are being conducted, and this will certainly increase in the future. Web conferences, web meetings, and web seminars (also referred to as *webinars*) allow quick dissemination of information reaching more people without associated travel time and costs. This technology enables collaboration across geographically dispersed areas with greater convenience and real-time sharing of information. Although the terms are often used interchangeably, web

seminars and web meetings have a few distinctions. Web seminars (webinars) most often use one-way communication from speaker to the audience with more limited interaction, while web meetings generally use the same technology but are more participatory, with a smaller audience. Both may be recorded for later viewing by audience members who were unable to attend in real time (Mastrian & McGonigle, 2012).

### Informatics Frameworks

Several nursing and healthcare informatics models exist. Models or frameworks help clinicians understand how concepts are structured and operationalized. Four



metastructures, or overarching concepts, are used in informatics theories and sciences:

- Data, information, and knowledge
- Sciences underpinning nursing informatics
- Concepts and tools from information science and computer science
- Phenomena of nursing

**Data** are discrete entities that are described objectively without interpretation. Information is data that have been interpreted, organized, or structured, and knowledge is synthesized information, whereby relationships are identified and formalized. As data are transformed into information and information into knowledge, increasing complexity requires greater application of human intelligence. Nurses are processors of information. They use informatics to manage and communicate data, information, and knowledge to support patients, nurses, and other providers in making decisions. Informatics assists them in storing clinical data, translating clinical data into information, linking clinical data and knowledge, and aggregating clinical data (see Figure 16–1).

Data are of concern to all nurses regardless of area of practice. Data can be derived from the care of one patient as the nurse assesses the patient, implements care, and evaluates outcomes. Data from the care of

many patients are compiled and become **information** used as a basis for decision making with additional patients. Further aggregation may address communities and populations or become the basis for nursing research to generate **knowledge**. Englehardt and Nelson (2002) built upon the model of Graves and Corcoran (1989) by adding wisdom. **Wisdom** is the appropriate use of knowledge in managing and solving human problems. The movement from data up to wisdom reflects greater complexity and greater application of the human intellect.

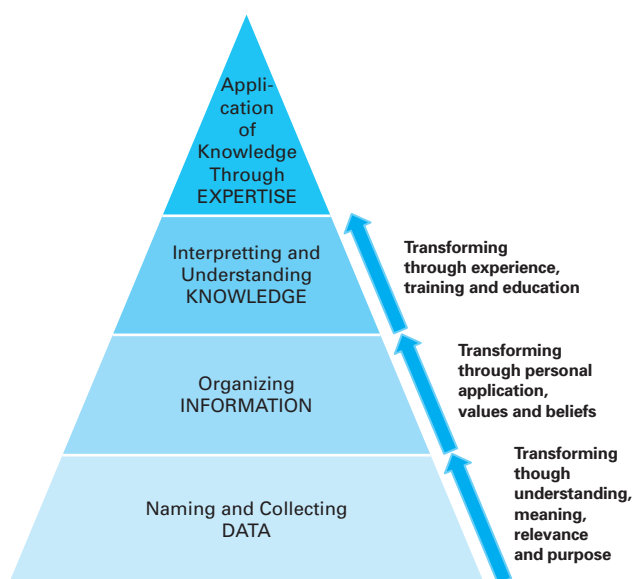
The sciences underpinning nursing informatics are nursing science, information science, and computer science (Mastrian & McGonigle, 2012). They are used to manage and process nursing data, information, and knowledge to facilitate the delivery of health care. This combination of sciences creates a unique blend that can be used to solve information management issues of concern to the discipline. Informatics nurse specialists often collaborate with other informaticists and may borrow concepts from many sources, including linguistics, cognitive science, engineering, and a variety of others as needed.

The tools and methods derived from computer and information sciences include information technology, structures, management, and communication (Kaminski, 2012). Information technology includes computer hardware, software, communication, and network technologies. Human-computer interaction and ergonomics concepts are fundamental to the informatics nurse specialist. Ergonomics focuses on the design and implementation of the equipment related to human use (Nelson & Staggers, 2012). The goal is optimal task completion.

The metaconcepts of nursing are nurse, person, health, and environment. Decision making involves these four concepts, and nurses must make numerous decisions with important implications for the quality of life and well-being of individuals, families, and communities. Nurses depend on data that have been transformed into information to determine interventions.

**FIGURE 16–1**

Transformation of Data to Knowledge



## Issues Related to Information Technology

As information technologies become basic tools for nurses, four issues need to be addressed: ethics, confidentiality, data integrity, and caring in a highly technical environment.

## Ethical Concerns

The American Nurses Association code of ethics for nurses (2001) applies to the issues and dilemmas in informatics. Confidentiality, security, and privacy are of great concern. When medical data are stored electronically, special precautions are needed to be certain that unauthorized access is prevented.

Mastrian, McGonigle, and Farcus (2012) elaborated on the basic principles that apply nursing ethics to the use of information technologies in health care. The concepts of autonomy, empowerment, accountability, and respect for the individual hold true for the practice of nursing informatics. Nurses have an ethical duty to protect patient confidentiality. All healthcare providers have a moral code that requires balancing the privacy of patients with the requirements for care, including access to patient records.

The expansion of guidelines for the ethical development of Internet sites has been ongoing since 1996, when Health on the Net Foundation (HON) became one of the first websites to guide both patients and medical professionals to reliable sources of healthcare information on the Internet. The HON Code of Conduct for medical and health websites addresses the reliability and credibility of information on the World Wide Web. It does not rate the quality of information but defines rules to hold website developers to ethical standards in the information presented, and to assist readers in knowing the source and purpose of the information presented (Health on the Net Foundation, 2013).



**InfoQuest:** Visit the website of the Health on the Net Foundation. Read the HON code of conduct for medical and health websites, and identify the standards and rules for the development of information for websites. How would these help the consumer to identify credible information?

## Confidentiality of Medical Records and Data

An example of a blatant breach of the confidentiality of medical records and potential patient impact was reported in the *New York Times* issue of September 8, 2011 (Sack, 2011). Data for 20,000 Stanford Hospital emergency room patients were posted inadvertently on the Internet in a spreadsheet with identifying information (names, diagnosis codes, account numbers, admission and discharge dates, and billing charges). That major medical privacy breaches occur generally through stolen laptops, hacked networks, unencrypted records, misdirected mailings, missing files,

and wayward emails (U.S. Department of Health and Human Services, 2014) is one of the perils of automation.

There are many laws addressing confidentiality and patient privacy. The Health Insurance Portability and Accountability Act (HIPAA) established policies and procedures that protect confidentiality. HIPAA requires improved efficiency of healthcare delivery by standardizing electronic data interchange and protecting confidentiality and security of health data through setting and enforcing standards. Unique health identifiers for all providers and health plans and security standards to protect the individual's identifiable health information, past, present, and future, for all health organizations—physicians' offices, health plans, employers, public health groups, life insurance companies, and information systems vendors—are required. Another important law, the Gramm-Leach-Bliley Act, required by most states as of July 1, 2001, calls for health plans and insurers to handle member and subscriber data in special electronic formats. It provides for protection of personal financial information.

## Data Integrity

Healthcare providers should have confidence in the accuracy and quality of the data that they access. Data integrity procedures instill trust, with controls that prevent incomplete or inaccurate entry of data. Although the term *data integrity* is often linked to databases, it also refers to ensuring that data are entered correctly and that there are data quality-management procedures in place. The correctness of patient information is always essential. The quality of the data input into the computer is critical to ensuring quality output. Without processes and procedures in place, computers can replicate and speed up the communication of erroneous data. An example of a procedure to ensure the accuracy of data is when input fields are designed to check for correct data type. For example, if an alphabet character is entered and a numeric character should have been entered, an error message appears on the screen.

## Caring in a High-Tech Environment

The information and knowledge informing the 21st century of nursing care delivery have been growing at an unprecedented pace. Nursing practice enabled by technology has begun to create a professional culture of reflection, critical inquiry, and interprofessional collaboration (Nagle, 2012). Nurses are now using technology at the point of care across all care settings (e.g., primary care, acute care, community care, and long-term care). The sophistication and amount of technology used vary from one care setting

to another. A few of the most common examples of technology used in the healthcare environment are computers, clinical information systems (e.g., electronic documentation applications), physiological monitoring devices (e.g., heart rate monitors), and use of the Internet for access to clinical research findings and decision support tools (Staggers & Thompson 2002).

The integration of technology in the care environment has impacted nursing care (Nagle, 2012). The evidence that technology actually improves the outcomes of patient care has been inconclusive. Depending on the setting, studies have identified that nurses spend between 25% and 50% of their day managing and recording clinical information and seeking knowledge to inform their practice (Gugerty et al., 2007). Some studies have found that although the quality of documentation of care may improve, there is an increase in the time associated in completing computer-related tasks (DesRoches, Donelan, Buerhaus, & Zhonghe, 2008; Kossman & Scheidenhelm, 2008). Of note, a survey of nurses ( $n = 1,760$ ) conducted by the Health Information Management Systems Society revealed that most nurses believe that computer information systems, specifically electronic documentation systems, improve patient safety (86%) and facilitate interdisciplinary collaboration (69%) and independent decision making (72%) (Dykes et al., 2006). These findings are promising. However, more research is needed to understand the full extent of the impact that the current and future healthcare technologies will have on nursing practice.

The title of the book *Nursing Informatics: Where Caring and Technology Meet* (Ball, et al., 2011) illustrates the related roles of nursing and informatics. Caring is an essential part of the provision of health care. When technologies are introduced, informatics nurses may be the architects and bridges to improved patient outcomes. Ethics, confidentiality, and caring are important in a high-tech environment as the expansion of information technologies continues at a rapid pace. Informatics nurses are challenged to continue to research and apply the appropriate codes and laws to protect patients and to use information tools to improve the quality of patient care.

## The Technology Explosion

### Evolution of Technology

The growth of the Internet and information systems has been exponential. Internet access and use are found in households around the world, and searching for health-related information is commonplace.

Nurses are often asked to verify information found on the Internet, and informatics nurses may be asked to explain and support research for more complex topics. Patients have come to expect healthcare information systems to provide the same level and standards of services set by other industries.

Patient registration and billing should be as easy as the global ability to instantly authenticate accounts and access money online. Unfortunately, this may not always be the case. The evolution of new healthcare information technologies has not followed this pattern of revolutionary design and availability. Rather, traditional text-based healthcare records have been difficult to automate.

The healthcare system in the United States faces an enormous challenge to improve the quality of care and simultaneously control costs. Electronic health records (EHRs) have been proposed as one solution to achieve this goal (Institute of Medicine, 2003). In 2009 the American Recovery and Reinvestment Act (ARRA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) were passed to specifically incentivize health organizations and providers to become meaningful users of EHRs. The incentives are expected to come from increased reimbursement rates from the Centers for Medicaid and Medicare Services (CMS) and resulted in a payment penalty to the healthcare organization if adoption of an EHR was not attained by January 2015 (Barey, 2012).

When the administration of a healthcare organization predicts physician and patient-care requirements, a study may be conducted and the system requirement may be added to the strategic plan. For example, when bedside computers were to be installed in a community hospital, a feasibility study was conducted and the system was tested on one unit. In addition, a cost-benefit study was undertaken. The board of trustees reviewed the new technology in light of the hospital strategic plan and recommended a phased approach, with careful analysis of patient outcomes and staff satisfaction.

The design of new patient care systems has affected staff in regard to workflow, efficiency, and effectiveness. Development of information systems is not simply automating a paper system. It involves studying and improving the care processes. From intensive care to hospice and assisted living, the venue for automation initiatives continues to expand and improve health care.

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### Reflect On . . .

- how the implementation of information technology has affected confidentiality in your work setting. Think of some ways that confidentiality could be enhanced.

- what ethical concerns you have about the inclusion of information systems in health care. How might nurses address these ethical concerns?
- whether increased uses of technology have affected the level of caring that nurses in your work setting have been able to deliver. What are some things nurses can do to increase caring in a highly technological care environment?

### Computer Technology in Practice, Education, Research, and Administration

New technologies have significantly changed the way nurses practice, conduct research, manage and administer, and advance their education. Automation in health care has assisted in defining a standardized nomenclature

for all disciplines. Standardization of terminologies for nursing is essential for delivering appropriate care and managing outcomes.

Nursing practice in an organization with an integrated clinical information system may include using an online Kardex, care protocols, bedside computers, barcode technology for medication administration, or a personal digital assistant (PDA) for patient care. Orders, procedures, and appointments are automatically updated, and an online Kardex may be used as a primary communications tool. The automated Kardex shows allergies, interventions, specimens to be collected, current medications, diet, and patient weight. An automated rounds report allows providers to quickly view patient information, vital signs, intake and output, lab results, radiology reports, and patient care notes. This increases accuracy and decreases redundancy and thus improves the efficiency and effectiveness of individual providers.

## RESEARCH CURRENT

### Judging Nursing Information on the World Wide Web

Health information on the World Wide Web (WWW) exists at varying levels of quality, validity, and reliability. The study by Cader (2013) was done to understand how qualified nurses in the United Kingdom judge the quality of WWW nursing information.

Experienced nurses participated in semistructured face-to-face interviews about their frequency of Internet usage, purposes for using the Internet, favorite websites, quality of information on the WWW, and ways by which they assessed practice-related information on the WWW. This qualitative study used a grounded theory approach to identify the process for assessing the information and the criteria for evaluating the information.

The process consisted of six evaluative tasks. They were identified as (1) assessing user-friendliness, (2) assessing outlook, (3) assessing authority, (4) assessing relationship to nursing practice, (5) appraising the nature of the evidence, and (6) applying cross-checking strategies.

The evaluative subtasks for evaluating nursing information on the WWW were identified as:

- User-friendliness, clarity and functionality of layout, ease of use (navigation), and logical presentation
- Outlook: Level of readability and appearance of site
- Author's background: Judging trustworthiness of web information and evaluating authority of sources
- Relationship to nursing practice: Judging currency of information, practice relevance, cultural origin, and safety
- Implication of information
- Nature of evidence: Methodology and references
- Cross-checking strategies: Online checking, cross-checking with printed materials, and checking with peers

The author concluded that a reliable set of evaluative criteria is essential if the WWW is to become an effective information source for nurses.

*Source:* "Judging Nursing Information on the World Wide Web," by R. Cader, 2013, *CIN: Computers, Informatics, Nursing*, 31(2), 66–73.

## CRITICAL THINKING EXERCISE

Find a website with information on some aspect of nursing practice. Evaluate the information on that website using the process and criteria found in the Research

Current box titled "Judging Nursing Information on the World Wide Web."



Orders management systems streamline the entry, receipt, and monitoring of orders throughout the enterprise. Wireless bedside computers for patient documentation allow appropriate providers to enter and access patient records from anywhere at any time. Some institutions have been using wireless terminals successfully for several years.

Automated medication administration records that are integrated with orders management, billing, and pharmacy systems proved effective and provided error-free access to drugs. When multiple medications are ordered, automated medication systems are programmed to scan for drug-drug interactions or other potential medication-related problems; the result is safer delivery of medications to the patient. Training for new applications and diverse equipment has become shorter and easier as nurses see the benefits and apply computer knowledge and skills from their everyday lives.

An informatics nurse's role in these new technologies is very important. It may involve examination and design of new workflow, development of an implementation plan, and training in and evaluation of the new technologies. Although patient access to the Internet may change the patient's level of knowledge about a health problem, patient education and counseling must be augmented and mediated by trained nurses for full understanding and compliance and subsequent improved patient outcomes. Overall, new information systems improve the efficiency, productivity, safety, and quality of care in an organization, but this is not always the case. Investment in information systems must be tied to an organization's strategic plan, sufficient resources must be in place, and a plan for managing the change must be implemented to see the full benefits.

The influence of new technologies on nursing education is changing the basic philosophies about the tools and methods for pedagogy. From online courses to virtual-reality intravenous training systems to patient simulators that react to student actions (physiologically with changes in vital signs and pupillary reaction, and emotionally with simulators vocalizing pain and other verbal responses) students have benefited from improvements in educational information technologies. At this time, you may be at a computer accessing an Internet-based course with a virtual instructor or working hands-on with an intravenous simulator.

Automated research tools and the Internet facilitate nursing research. Research databases such as the Cumulative Index for Nursing and Allied Health Literature (CINAHL) and MEDLINE provide nurses with effective methods to quickly find current relevant literature and access appropriate psychometric tools from the

computer desktop. Statistical tools like the Statistical Package for the Social Sciences (SPSS) help nurse researchers organize and analyze data when conducting research.

Nurse administrators use information technologies to guide their management when they are uncertain about something, to satisfy multiple stakeholders, and to build and retain passionate workforces. Two elements moved nursing administration to embrace computers for decision making: the speed and accuracy needed and the financial constraints of managed care. Information systems enable nursing administration to manage budgets, collect and evaluate staff and patient data to track and forecast resource needs, and anticipate quality management interventions. Data from clinical and financial information systems allow nurse administrators to analyze data for trends in patient problems and reimbursement gaps. The availability of appropriate data minimizes risk taking. For instance, recruitment programs can be developed to improve staffing ratios when the seasonal influx of patients is higher than expected.

The introduction of information technologies continues to enhance nursing practice and to provide tools for research, administration, and nursing education. A survey of nursing informatics researchers identified 10 priorities for research (Brennan, Zielstorff, Ozbolt, & Strombom, 1998):

- Standardized language/vocabularies
- Technology development to support practice and patient care
- Database issues
- Patient use of information technologies
- Use of telecommunications technology for nursing practice
- Putting technology into practice
- System evaluation issues
- Information needs of nurses and other clinicians
- Nursing intervention innovations for professional practice
- Professional practice issues

The research priorities identified above from the previous survey of nursing informatics researchers conducted by Brennan et al. (1998) continue to be relevant. However, the most recent survey conducted by Bakken, Stone, and Larson (2008) suggests that in addition to the 10 research priorities listed, a nursing informatics agenda for the immediate future must also include:

- Expanding users of interest to include interdisciplinary researchers

- Building upon the knowledge gained in nursing concept representation to address genomic and environmental data
- Guiding the reengineering of nursing practice
- Harnessing new technologies to empower patients and their caregivers for collaborative knowledge development
- Developing user-configurable software approaches that support complex data visualization, analysis, and predictive modeling
- Facilitating the development of middle-range nursing informatics theories
- Encouraging innovative evaluation methodologies that attend to human-computer interface factors and organizational context

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### Reflect On . . .

- how technology has changed nursing education since you were first introduced to nursing. What new skills do students need today compared to 5, 10, and 15 years ago?
- 

## Current Applications of Information Technology in Practice

Four applications of information technology are of great importance to nursing: physician order entries, clinical information systems, wireless and portable devices, and the electronic health record.

### Physician Order Entry

The Institute of Medicine (1999) report estimated that the number of deaths per year from medical errors is between 44,000 and 98,000. As part of the patient safety strategy, strong consideration is being made for purchase and implementation of automated physician order entry systems. These systems enable appropriate providers (physicians and, in some states, nurse practitioners) to enter, edit, schedule, track, and discontinue treatment and diagnostic services electronically. In this way, orders can be checked against patient allergies, interactions with other medications or tests, dosage levels, and standards of practice for the institution. With computerized physician order entry, adverse events and costs may be reduced, and length of patient stay may be shortened.

Automated physician order entry is generally part of an integrated system that allows direct entry by the physician and reduces the likelihood of transcription errors. It is

a complex system interfaced with many other systems; in the past it has not been available because of the cost and complexity of development. There is a current sense of urgency to purchase this application for patient safety, and companies are now developing such products.

### Clinical Information Systems

Another publication from the Institute of Medicine and National Academies Press (Committee on Quality of Health Care in America, 2001) highlighted the need for implementation of improved clinical information systems. The authors recommended a fundamental change and redesign of the healthcare system to promote evidence-based practice, strengthen clinical information systems, and lead to the elimination of most handwritten clinical data by the end of 2010.

Clinical information and financial and administrative systems are found in most healthcare entities and are generally integrated to serve patients and providers. Clinical systems may include patient registration, orders, and departmental systems such as nursing, dietary, radiology, pharmacy, cardiology, laboratory, and physical therapy. Although there are many independent systems, integration helps to ensure coordination of care across patient conditions, services, and settings over time.

### Wireless and Portable Devices

Wireless and portable devices are bringing patient records and provider services to the point of care. When bedside computers emerged in the early 1990s, advances enabled access to patient information anywhere and at any time. The location of patient care at home, in an office, in a church, in a community center, or in a hospital makes wireless and portable devices an attractive vehicle for documentation and record access.

One type of device is the PDA. Two PDA functions allow nurses wireless access to patient records and reference databases such as MedCalc and ePocrates. Wireless PDAs are being used to access medical records in some institutions. Many schools of nursing require their students to have PDAs that are preloaded with resource information such as laboratory and diagnostic information, information about medications (including classification, normal dosage, side effects), a medical dictionary, and nursing care plan information. The information on the PDA may be more current than textbooks, as PDAs can be updated electronically routinely and the cost may be less than the purchase of multiple textbooks. The PDA provides a more convenient and rapid way for nursing students to access information during their clinical experiences.

## Electronic Health Record

Interest in EHRs or electronically maintained information about an individual's lifetime health status and health began more than 20 years ago when the Institute of Medicine, Steen, & Dick (1997) conducted an important study on the value of a complete and accurate patient record. The text was updated in 1997 (Dick, Steen, & Detmer, 1997) and remains the seminal study for computer-based patient records or electronic health records. The American Recovery and Reinvestment Act (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act were passed in 2009. Both acts specifically incentivize health organizations and providers to become meaningful users of EHRs. The incentives are in the form of increased reimbursement rates from the CMS and results in a payment penalty to the healthcare organization if adoption of an EHR was not attained by January 2015 (Barey, 2012).

The ideal electronic health record will support users with reminders and alerts, clinical decision support systems, and links to medical knowledge. The intent of an EHR is to capture quality measurements and clinical outcome data to support the analysis of patient problems. The EHR effects quality improvements in patient care through effective documentation and monitoring.

An excellent example of an EHR is the system used by the Department of Veterans Affairs (VA). By leveraging the best parts of an older system and integrating commercial software applications, the VA has developed an advanced system that captures patient data in a provider-friendly way. Clinical documentation is standardized, accurate, always available, and very reliable throughout the inpatient areas and clinics in the VA system.

Implementations of EHRs will become more commonplace in the near future as the ARRA and HITECH Act put pressure on healthcare organizations to move more quickly toward adoption. As more organizations adopt EHRs, the dissemination of implementation of best practices will be greater and broader.

These four applications of information technology in health care are but a few of the many important developments to support providers and patients. New applications are developed and become cost-effective as demand grows and system requirements are defined.

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### Reflect On . . .

- the needs for changes in the technological environment of patient care in the future. What supports will nurses need to keep current with new technology applications? Are the current approaches to continuing education sufficient?
- 

## Evidence-Based Practice

Evidence-based practice (EBP) integrates nursing experience, patient preferences, and current research to achieve the best patient outcomes. (Refer to chapter 10.) The success of EBP depends upon being able to access the current professional literature both in print and online. Nurses therefore need to have literature-searching skills and familiarity with the software for searching relevant databases such as MEDLINE, CINAHL, and PsycINFO.

Information technology tools are necessary and must be available at the point of care when they are needed. Database searches of professional journals and credible websites can reduce the time and energy spent in retrieving information needed for care. PDAs are portable and convenient to use at the bedside for information retrieval.

Common computer applications that can support EBP include:

- Collaboration on topics needing research
- Online literature and database searches
- Full-text retrieval of articles
- Development of resource files
- Selection of data collection tools
- Data collection and storage
- Database utilization
- Electronic dissemination of information (Hebda & Czar, 2012)

Digital libraries extend the capabilities of physical libraries through information technology. They comprise electronic resources with the capability to create, store, organize, search, and retrieve information and provide open sharing of information among a community of users. They help transform data into information and knowledge. Access to information that might otherwise be a challenge to locate and use is made easier and faster.

## Telehealth

Telehealth refers to a wide range of health services that are delivered by telecommunications-ready tools such as the telephone, videophone, and computer (Mastrian & McGonigle, 2012). Telehealth differs from telemedicine in that it is a broader term that includes interdisciplinary applications. It provides education and information to providers as well as consumers in addition to the actual delivery of healthcare services. The use of communication technology to deliver nursing care is called *telenursing*. This is often done with videoconferencing and allows the delivery of information and care to people at a distance. It has been used extensively in Alaska, where clinics are connected through communication technology and has

## RESEARCH CURRENT

## Evidence-Based Staffing: Potential Roles for Informatics

The purposes of this article by Hyun, Bakken, Douglas, and Stone are to review evidence related to nurse staffing and patient outcomes and to discuss potential informatics solutions that could support evidence-based decisions related to staffing. An integrative literature review of 11 relevant studies was conducted to assess nurse staffing and patient outcomes at the hospital level. Further analysis was done using meta-analysis pooling data from 28 studies. The pooled data revealed that higher levels of RN staffing were associated with lower hospital-related mortality in intensive care units (ICUs), in surgical patients, and in medical patients. An increase of one RN per patient day in an ICU was associated with a decreased likelihood of hospital-acquired pneumonia, unplanned extubation, respiratory failure, and cardiac arrest. An increase of one RN per patient day for surgical patients was associated with a lower rate of failure to rescue.

Access to these comprehensive data is necessary in order for staffing policies to be based upon evidence. Informatics solutions can support decision making that is evidence-based. Four processes were identified to enhance the informatics approach: (1) data acquisition from multiple data sources, (2) representation of data in a way they can be used for multiple purposes, (3) sophisticated data-processing and data-mining techniques, and (4) presentation of data in a standardized way that can be user-configured.

The authors concluded that technology offers the opportunity to facilitate the availability of data from multiple sources to drive evidence-based decisions. The opportunity is there to provide better patient outcomes through informed decision making that uses effective evidence.

*Source:* "Evidence-Based Staffing: Potential Roles for Informatics," by S. Hyun, S. Bakken, K. Douglas, and P. W. Stone, 2008, *Nursing Economics*, 26(3), 151–158, 173.

improved quality and access to care in more rural and isolated locations.

Telehealth began with telephone consultation and has grown and become more sophisticated with the advances in technology. Driving forces have been cost containment, managed care, disease management, the shortage of providers, uneven access to care, and an aging population (Hebda & Czar, 2012). Telehealth allows access to experts that might have otherwise not been available, and it saves travel time and costs. It can improve continuity of care and follow-up by removing access barriers.

Home telehealth allows the provider to supervise patients at their homes and away from the office. Without the need to provide care on a face-to-face appointment basis, a nurse or physician can be more available, and this often reduces the need for urgent care or emergency department visits. Telemonitoring can be done at home, thus providing more timely information. This has been particularly helpful in managing patients with chronic conditions and providing care for those who are home bound. In addition to the health benefits, there are economic benefits to patients and families, who can eliminate travel costs and lost work time. The nurse is key to successful home management of the patient with telemonitoring. The visiting nurse or clinic nurse often identifies patients who could benefit from home monitoring, and the nurse is usually involved in reviewing the data from the patient while collaborating with the physician

on the plan of care and development of follow-up. As technology improves, the provision of care in this way will likely become more and more commonplace.

Some of the issues related to telehealth are the lack of standards regulating interface among systems. The geographically isolated regions that would benefit the most from telehealth services likely have the poorest infrastructure to support the technology. Funding for technology support services is often a problem. Another concern may be patient safety when direct observation and supervision are not available.

Nurses have long used the telephone for consultation with clients and for follow-up. Common uses are telephone triage, education, and checking biometric measurements. Continuing issues include reimbursement, liability, privacy and confidentiality, quality of care, and training. The American Nurses Association published *Core Principles on Telehealth* in 1999, which include guidelines on protection of client privacy. The American Academy of Ambulatory Care Nursing has updated and published *Scope and Standards of Practice for Professional Telehealth Nursing*, the most recent edition being 2011.

Both telehealth and telenursing are expected to continue their growth, but this will require the implementation of technical standards and overcoming barriers to reimbursement. Both telehealth and telenursing have the potential to bring about greater change in the delivery of health care, particularly in rural and underserved areas.



**RESEARCH CURRENT****Cost-Effective Care a Phone Call Away: A Nurse-Managed Telephonic Program for Patients With Chronic Heart Failure**

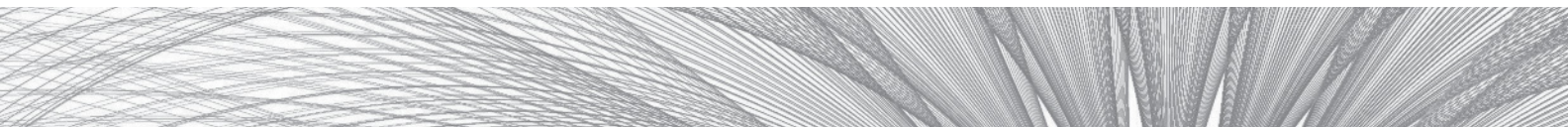
The article by Slater, Phillips, and Woodard reports the outcomes of a nurse-administered 24-hour health information telephonic program for patients with congestive heart failure (CHF). The goal of the program was to serve as a resource to the patients and their families by providing education that would empower them to take an active role in managing their condition. The objectives were to reduce readmissions, to decrease the cost of care, and reduce the length of stay (LOS) for patients who were readmitted to the hospital. The program was 3 months in length, and patients were called twice a week for the first month postdischarge and once a week for the remaining 2 months. During the initial phone call, an assessment was done of the patient's understanding of CHF, socioeconomic resources, and support systems. Based upon this assessment, an individualized plan of care was developed and updated with each subsequent phone call. The

decision to discharge the patient from the program was made by the RN even though the program was considered complete at 3 months.

The reduction in frequency of admission for 612 patients compared to admissions prior to the start of the program went from 854 to 200. For the same comparison groups, the length of stay was reduced from 5.96 days to 4.95 days, and the average cost per admission went from \$11,993 to \$6,553. Emergency department visits were also reduced by a total of 379 visits.

The authors conclude that the CHF telephonic program managed by nurses has shown excellent outcomes. These outcomes were achieved with limited but expert resources; there were two RN case managers and a telephone.

*Source:* "Cost-Effective Care a Phone Call Away: A Nurse-Managed Telephonic Program for Patients With Chronic Heart Failure," by M. R. Slater, D. M. Phillips, and E. K. Woodard, 2008, *Nursing Economics*, 26(1), 41–44.



## Chapter Highlights

- Nursing informatics is the combination of computer and information science with nursing science. It is part of the larger healthcare informatics.
- Nurses are being prepared as specialists in this area, but every practicing nurse needs some level of expertise.
- Four current applications of information technology that are important for nursing are physician order entries, clinical information systems, wireless and portable devices, and electronic health records.
- Several issues related to the increased use of technology in nursing include ethics, confidentiality, data integrity, and caring.
- Nurses are concerned with the ethical practices used in information access, storage, and retrieval.
- Ethical practices have a direct effect on confidentiality.
- The changes in technology of care also raise concerns about the caring practices that nurses implement.
- Advocacy is needed on the part of the nurse to see that patients, rather than equipment, remain the focus of care.
- The application of computer technology has changed practice, education, and research. The skills required to interface with information systems at the point of care, to participate in educational programs that further one's career, and to manage research data have changed and will continue to change.
- Web seminars and web meetings are becoming increasingly common as a convenient and cost-effective way of collaborating and disseminating information.
- Informatics and information technology support evidence-based practice by providing fast and convenient access to data needed to develop information and knowledge for the discipline and practice of nursing.
- Telehealth, home telehealth, and telenursing use telecommunication technology to deliver education and direct care to clients at a distance.
- The ability of nurses to manage and use information systems is critical in improving outcomes, decreasing costs, and improving access to care.
- The 21st century will bring more and better technologies to challenge and enhance professional nursing.

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# 17

## UNIT IV

### Professional Nursing in a Changing Health Care Environment

# Nursing in an Evolving Health Care Delivery System

## Chapter Outline

### Challenges and Opportunities

#### Changes in Health Care in the United States

#### Healthcare Cost Issues

- Demand Versus Supply of Health Care
- Paying for Health Care
- Cost Containment Strategies
- Access to Health Care

#### Concepts of Health, Wellness, and Well-Being

- Health
- Wellness and Well-Being

#### Case Management

#### Health Care Economics

- Billing Methods
- The International Perspectives

#### Nursing Economics

#### Financial Management

- Profit Versus Not-for-Profit Organizations
- Costs and Budgeting

#### Chapter Highlights

## Objectives

1. Identify changes in health care that affect nursing in the United States.
2. Examine the issues of cost containment and access to health care as they affect nursing.
3. Differentiate health, wellness, and well-being.
4. Identify selected issues related to nursing and healthcare economics.
5. Define common terms used in discussing healthcare financing.
6. Discuss international perspectives on the financing of health care.
7. Discuss cost containment strategies implemented in health care.
8. Examine the economics of providing healthcare services.
9. Apply economics to nursing.
10. Describe approaches to financial management in health care.

Changes in the healthcare delivery system have had a dramatic impact on the practice of nursing. In the early 1900s nurses made home visits and focused on personal care of sick individuals. As hospitals became the workplace where physicians provided medical and surgical care, nurses were employed to provide nursing care, and nursing followed common organizational patterns by establishing specialty areas of practice such as psychiatric, pediatric, obstetrical, medical, and surgical nursing. As nursing education evolved and nurses began to understand more about what constituted the practice of nursing, the boundaries expanded. During the 1970s and 1980s nurses began to seek more autonomy in the practice of nursing, particularly with regard to physicians and hospital administration.

Simultaneously, healthcare costs were rising at an alarming rate, resulting in a congressional demand for cost containment related to the government-funded Medicare program. This began with a demand for prospective payment through diagnosis-related groups (DRGs). Private insurance companies followed suit, and hospital administrators were forced to cut costs in order to survive. Care became focused on costs and profit, with less concern about quality. Healthcare providers were forced to do more with fewer



resources, resulting in stress, burnout, and nurses leaving the profession. With the Patient Protection and Affordable Care Act (PPACA) of 2010, the coverage of healthcare costs became the focus, and mandatory insurance coverage was legislated. Changes in insurance coverage regulations continue to evolve and affect nursing.

## Challenges and Opportunities

A commitment to high-quality care challenges nurses as never before to find ways of providing care with fewer resources. New and creative ways of doing more with less while avoiding undue stress and burnout are needed. Meanwhile traditional values are at stake in the new health-care arena, including advocacy for the individual client, holistic care, and meeting the healthcare needs of individuals and populations.

Nursing is in a position to create new roles and redefine nursing in a way that can have a positive impact upon health care. The continued evolution of nursing and its place in healthcare delivery provides a wide range of opportunities for the future.

## Changes in Health Care in the United States

Health care in the United States is facing challenges related to changing demographics of the population and to the economic realities of providing accessible and affordable care. The demographics show an increase in life

expectancy for the general population and includes the aging of the baby boom generation (representing a postwar period, between 1946 and 1964, when record numbers of babies were born) and thus the creation of a large segment of older citizens. An additional impact on health care is the increase in chronic illness; heart disease, cancer, stroke, and chronic lower respiratory tract disease are reported as the four leading causes of death. The growing population of older adults and the increase in chronic illness will place greater demands on the healthcare industry to meet health-care needs.

This increased demand is occurring at a time when the U.S. economy is recovering from the 2007 economic downturn. Unemployment and underemployment impact coverage of healthcare expenses. While the United States has maintained private health insurance as its preferred method of coverage, the government and taxpayers have gradually assumed greater segments of healthcare coverage. In 1965 Medicare and Medicaid were created as part of the Social Security Act, with Medicare covering costs for the elderly and those with disabilities and Medicaid covering costs for low-income/low-resource families and individuals. Over time, costs and coverage have expanded. Today, about 47% of healthcare costs are covered by these two programs (National Center for Health Statistics, 2013). The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides coverage for workers and their families when the worker loses or changes jobs, and it protects privacy of medical information. The PPACA requires U.S. citizens to have health insurance and expands

### Selected Changes Mandated by the PPACA

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- All individuals will be required to have health insurance, with some exceptions, or pay a penalty.
  - Children can stay on their parents' health insurance plans until the age of 26.
  - Insurance companies must spend at least 80% of premiums on medical care.
  - Healthcare plans can no longer set a lifetime dollar limit on an enrollee's essential health benefits.
  - New health plans must cover certain preventive services, such as mammograms, colonoscopies, and blood pressure and cholesterol screening, without charging a deductible, co-payment, or coinsurance.
  - Value-based purchasing initiatives allow reimbursements based on patient outcomes.
  - The Center for Medicare and Medicaid Services (CMS) reduces payments to hospitals for excessive readmission rates.
  - Insurance companies are required to offer coverage to adults regardless of preexisting conditions.
  - Insurance companies can no longer charge higher rates based on gender or health status.
  - Individuals and small groups can purchase insurance through a PPACA-mandated marketplace.
  - Essential health benefits offered through health plans include:
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including dental and vision care
-

**CRITICAL THINKING EXERCISE**

The accompanying box lists some of the major changes created by the PPACA. Discuss the implications for nursing.

government programs. It limits the insurer's ability to deny coverage and raise premiums. This bill has been controversial and has faced political and legal challenges since being signed into law by President Obama in 2010. Changes due to the law are shown in the accompanying box.

Health insurance shifts the risk of financial loss from the purchaser to a third party, usually an insurance company. Some will pay in more than they use while others will receive more in payouts than they have spent. This plan only works when large numbers of people are involved to help cover the heavy payouts to those who have major expenses. This rationale has been used for mandatory car insurance, mortgage company requirements for home owner's insurance, and now for healthcare insurance. This arrangement pools the risk of payouts by the insurance companies.

The government's payment for services is administered primarily through Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Veterans Administration benefits. SCHIP covers low-income children whose parents do not qualify for Medicaid. These government programs have suffered from waste, fraud, and abuse resulting in a need for compliance programs to ensure appropriate documentation for charges.

## Healthcare Cost Issues

### Demand Versus Supply of Health Care

During the 1980s, the cost of medical care was increasing faster than the gross national product. Coupled with the increased expense of care was the consumer's expectation that any and all services should be available and paid for by third-party payers regardless of cost. The demand for expensive care was outstripping the ability of payers to pay and was spiraling out of control, as consumers demanded a total continuum of care and unlimited access.

Further imbalance in supply and demand was created by the resulting increased cost of insurance coverage in the private sector. Many employers believed they could not afford to provide coverage to employees at the levels previously provided. Individuals who must provide their own insurance could no longer afford the premiums to maintain coverage. These increases in costs have resulted in a diminished ability of consumers to afford care, yet many continue to expect care on demand.

When there is an imbalance of supply and demand, an outcome may be rationing of health care. No country can afford to provide unlimited amounts of medical services to everyone, and each must decide on a mechanism to ration, or limit access to, healthcare services. This can happen in two ways. The first is by having the government set limits. In this approach, the cost of services is kept low and people wait for availability. This type of rationing has been used in industrialized countries, such as Great Britain and Canada. Scarce services are kept at a reasonable cost, but they are allocated according to particular criteria, such as age or a waiting list. In the United States, only Oregon has suggested such an approach. The Oregon legislature enacted a program to limit access to expensive procedures such as transplants and then to increase Medicaid eligibility to a larger number of low-income people. The second rationing approach is to ration by ability to pay. This limits demand for more expensive procedures by offering them only to those who are willing and able to pay out of pocket or who have sufficient health insurance coverage.

There are important differences between these rationing methods. One is the freedom of the individual to choose the amount and type of health care used and to select who should deliver it. This has been a traditional value of healthcare consumers in the United States. Under a system of strict government rationing, a patient will not be able to purchase a service unless it has been made available to everyone by the government. Under a method using ability to pay, a consumer can spend as much as he or she can afford. For those who cannot afford it, that service is not an option. To decide on the rationing technique, decisions must be made regarding how much health care will be provided to whom and at what cost.

### Paying for Health Care

In the past, private insurers, for the most part, have paid for U.S. health care. In 1965 the federal government entered into healthcare financing with the passage of Medicare, followed by Medicaid. These programs have grown and expanded until nearly half of the cost of health care is covered by at least one of them. The dilemma in healthcare reform is whether the federal programs should continue to expand until there is a national health care payment structure or whether private insurance should continue. The debate about national health care versus private insurance

## Insurance Benefits in the United States

- Employer-sponsored insurance is the leading source of health insurance for the nonelderly.
- Fifty-seven per cent of firms offer health benefits to their workers. The likelihood of offering health benefits differs significantly by size of the firm, with only 45% of employers with three to nine employees offering coverage.
- Over half of workers at small firms (3–199 workers) have a deductible of at least \$1,000.
- The average annual premiums for employer-sponsored health insurance in 2013 are about \$6,000 for single coverage and over \$16,000 for family coverage.
- The average annual premium paid by covered workers in 2013 was \$999 for single coverage and \$4,565 for family coverage.

- Almost three fourths of workers must pay a copayment for office visits with a primary care physician or a specialist.
- Only 28% of firms with 200 or more workers offer retirees health benefits.
- Nearly three quarters of employers that offer health benefits offer at least one wellness program, such as a weight loss program, a smoking-cessation program, or on-site exercise facilities.

Source: "Employer Health Benefits Survey," by the Kaiser Family Foundation and Health Research and Education Trust, 2013, Washington, DC: Author. Retrieved from [kff.org/private-insurance/report/2013-employer-health-benefits/](http://kff.org/private-insurance/report/2013-employer-health-benefits/)

has been vigorous, with significant support on each side of the issue.

Most industrialized nations outside the United States have a national health policy. Although the specific details of coverage and the availability of certain services vary by country, those governments provide financing for health care. Information about insurance coverage in the United States is shown in the accompanying box.

### Reflect On . . .

- whether health care is a right? Why or why not? If you believe health care is a right, who should pay for it?

## Cost Containment Strategies

Many cost containment strategies in health care have emerged in response to pressures from consumers and third-party payers. Some of the strategies used by nurses in an attempt to control costs and maintain quality include resource management and the utilization of assistive personnel.

Resource management is an important skill for successful, clinically competent nurses. It is of great importance that nurses be aware of limited resources and the consequences for healthcare delivery. Resource management uses cost-effective approaches to high-quality health care. The basic resources include financial, physical, and human, but others are organizational systems, information systems, and technical capabilities. Effective time management is an important resource utilization skill consisting of the planned and organized assessment of when and how long it will take to complete an activity; consequently, priority is then set regarding the problems to be addressed and

the responses to be made. Responding to downsizing, or the reduction in personnel, has been a major challenge in resource allocation.

The use of clinical nursing assistants (CNAs), also called *certified nursing assistants* or *nurse aides*, has been one attempt at resource utilization. The intent of using these individuals in providing care has been to relieve the professional nurse of tasks that can safely and effectively be delegated to someone with less educational preparation who can provide that level of care more cost-effectively. Concerns about this approach are the skill mix and whether CNAs are placed in situations of care that go beyond their limited preparation and thereby jeopardize quality. Delegation and supervision are a concern to the nurse in planning and providing safe and effective care. Debate is likely to continue about expanding the practice of these unlicensed assistive personnel. (Milstead, 2013).

### Reflect On . . .

- what the wasted resources and wasted efforts found in health care are today.
- what nurses can do to increase cost-effective, quality health care.

## Access to Health Care

The issue of access to health care has been a major factor in shaping the changes in nursing. The Centers for Medicare and Medicaid Services reports that the U.S. expenditure for health care was 2.9 trillion dollars in year 2013. Medicare and Medicaid totaled just over a trillion dollars, and costs are projected to increase as more people become eligible for Medicare. This will cause an increase to the tax

subsidies for the new healthcare exchanges. Medicare and Medicaid represented 35% of national health spending. Per capita spending increased due to new medical technologies and services, increases in provider salaries, and the expanded scope of healthcare coverage. The costs have expanded more rapidly than the economy. In the future there will likely be a sharp increase in benefits and continued increase in healthcare costs.

In addition to economic constraints, many people experience barriers to healthcare access due to inability to locate services, the location of services, and the availability of transportation. The American Nurses Association (ANA) published *Nursing's Agenda for Health Care Reform* in 1991. This document represented the efforts of the ANA, the National League for Nursing (NLN), the American Association of Colleges of Nursing (AACN), and the American Organization of Nurse Executives (AONE). It called for cost-effective, community-based delivery of care in a restructured healthcare system. Fifteen years later ANA reaffirmed its support of the document and released *ANA's Health Care Agenda—2005*, stating the belief that access to health care is a basic human right and calling for a redirection “away from the overuse of expensive, technology-driven, acute, hospital-based services to a new model in which a balance is struck between high-tech treatment and community-based services that focus primarily on prevention.” (American Nurses Association, 2005). The document was again updated in 2008 and published as the *ANA's Health System Reform Agenda*. It calls for a restructured system of health care ensuring universal access to a standard package of essential healthcare services for all citizens and residents. This access should be affordable, available, and acceptable.

## Concepts of Health, Wellness, and Well-Being

The escalating cost of providing care for illness has led to a change in focus from treatment and cure to prevention. There is a shift in perspective from cure and treatment of illness in large institutions to promotion of health, wellness, and well-being provided in settings that are easily accessible within the community.

Nurses need to be clear in their understanding of health and wellness because it will largely determine the scope and nature of nursing practice. Some people think of health and wellness (or well-being) as the same thing or, at the very least, as accompanying one another. However, health may not always accompany well-being: A person who has a terminal illness may have a sense of well-being; conversely, another person may lack a sense of well-being yet be in a state of good health.

For many years, the concept of disease was the yardstick by which health was measured. In the late 19th century, the *how* of disease (pathogenesis) was the major concern of health professionals. Currently, the emphasis on health and wellness (salutogenesis) is increasing and the focus is shifting to prevention.

## Health

Traditionally, **health** has been defined in terms of the presence or absence of disease. Nightingale (1860/1969) defined health as a state of “being well and using every power the individual possesses to the fullest extent” (p. 334). At an international conference on global health issues in 1947, the World Health Organization (1947) defined health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (p. 1). This definition does the following:

- Reflects concern for the individual as a total person functioning physically, psychologically, and socially. Mental processes determine people's relationship with their physical and social surroundings, their attitudes about life, and their interaction with others.
- Places health in the context of environment. People's lives, and therefore their health, are affected by everything they interact with—not only environmental influences such as climate and the availability of nutritious food, comfortable shelter, clean air to breathe, and pure water to drink but also other people, including family, significant others, employers, coworkers, friends, and associates of various kinds.
- Equates health with productive and creative living. It focuses on the living state rather than on categories of disease that may cause illness or death.

In recent years, the idea of health has come to include a more holistic approach and to encompass quality of life. Elements such as environmental, spiritual, emotional, and intellectual aspects have been included, and the term *wellness* has become more commonplace.



**InfoQuest:** The website [www.health.gov](http://www.health.gov) is designed to make health information easy to access and use. It is a portal to websites of a number of health initiatives and activities in the U.S. Department of Health and Human Services, coordinated by the Office of Disease Prevention and Health Promotion. *Healthy People 2020* provides topics and includes data and evidence-based resources. Browse the listings and select two topics that are of interest to you. Review the information available on those topics.



## Concepts of Wellness

- Wellness is a choice—a decision you make to move toward optimal health.
- Wellness is a way of life—a lifestyle you design to achieve your highest potential for well-being.
- Wellness is a process—a developing awareness that there is no end point, but that health and happiness are possible in each moment, here and now.
- Wellness is a balanced channeling of energy—energy received from the environment, transformed within you, and returned to affect the world around you.
- Wellness is the integration of body, mind, and spirit—the appreciation that everything you do, and think, and feel, and believe has an impact on your state of health and the health of the world.
- Wellness is the loving acceptance of yourself.

Source: From *Wellness Workbook* (3rd ed.), by W. Travis, and R. S. Ryan, 2004, Berkeley, CA: Celestial Arts. . Reprinted with permission. © 1981, 1988, 2004 by John W. Travis. [www.wellnessworkbook.com](http://www.wellnessworkbook.com)

## Wellness and Well-Being

**Wellness** is a process of identifying needs for improvement and making choices that facilitate a higher level of health. Basic concepts of wellness include self-responsibility; an ultimate goal; a dynamic, growing process; daily decision making in the areas of nutrition, stress management, physical fitness, preventive health care, emotional health, and other aspects of health; and, most importantly, the whole being of the individual. See the accompanying box.

Many health insurers offer a variety of wellness programs for large employers, to decrease their medical costs. In a survey of employers with an average of 8,000 employees, 80% responded that a wellness program was important to them. One of these employers indicated that there had been a 2-to-1 return on its investment in the wellness program, including a 10% reduction in hospital stays. The employers in the survey were mostly interested in helping their employees lose weight, eat better, and reduce stress (Vesely, 2008).

Some question the real impact of disease prevention on economics. Prevention accounts for only about 2%–3% of healthcare expenditures; disease care is the main driver of health spending. Several factors work against establishing the cost-effectiveness of preventive services; among them are that personal behaviors take time to change and health outcomes take time to document. While data are not abundant about the economic value of prevention, there are some conclusions that are clear. A core set of preventive services is effective. This set would include smoking cessation, weight loss, regular exercise, health screening, and healthy diet, and it is estimated that this core set would save thousands of lives annually.

These evidence-based preventive services offer high economic value. For example, colonoscopy costs far less

than treating colon cancer. The literature also reports high net savings from childhood immunizations, smoking cessation, and aspirin prophylaxis among people at risk for cardiovascular disease (Woolf, 2009).



**InfoQuest:** The Case Management Society of America (CSMA) has developed Standards of Practice for case management and published them in booklet format. The booklet is downloadable from their web site. Review the standards discussed on pages 15-19 of the booklet.

<http://cmsa.org/Individual/MemberResources/StandardsOfPracticeForCaseManagement/tabid/69/Default.aspx>

## Case Management

**Case management** describes a model of integrating healthcare services for individuals or groups. Case managers provide coordination of care and resource utilization directed to cost-effective outcomes for the patient. “Stewardship of the healthcare dollars, safe transitions of care, evaluating patient adherence, and consistent stakeholder communication are critical interventions that case managers employ, while maintaining a primary and consistent focus on quality of care and patient self-determination” (Leonard & Miller, 2012, p. 21).

Case managers encompass multiple disciplines, but nursing is predominant. Social workers and other healthcare professionals may serve in the role. However, nursing, with its focus on the whole person and its skill set for working with assessment of patients’ needs and collaborative care, has been important in the role.

**RESEARCH CURRENT****Providers' Perspective on Diabetes Case Management: A Descriptive Study**

Ercan-Fang, Gujral, Greer, and Ishanim's survey of physicians to assess their perspectives on case management for diabetes was nested in a broader study of diabetic patients with blood pressure greater than or equal to 140/90, glycated hemoglobin less than or equal to 9%, or LDL less than 100. For 1 year, 278 patients received case management services, and 51 out of 72 primary care physicians participating in the broader study responded to the mailed survey that assessed their comfort in working with case managers.

Most of the physicians (91.5%) reported that they felt very comfortable working with case managers, and 93.3% felt the care given by the case manager was accurate, and 89.4% felt that it increased adherence to treatment regimens. Improved patient satisfaction was

reported by 93.5%. Of the participating physicians, 74% believed that working with case managers increased the number of patients able to achieve their therapeutic goals. Nearly all the physicians (99.7%) said they will likely consult case managers for management of patients with poorly controlled diabetes.

Conclusions from the study were that comanagement of diabetes patients by a nurse case manager and a physician did not undermine the physician's perceived professional role. In fact the outcomes were enhanced among patients with diabetes and cardiovascular risk factors.

*Source:* "Providers' Perspective on Diabetes Case Management: A Descriptive Study," by N. Ercan-Fang, K. Gujral, N. Greer, and A. Ishanim, 2013, *American Journal of Managed Care*, 19(1), 29–32.

Various case management models exist that strive to provide cost-effective care and ensure quality outcomes. The case manager's intervention helps link people to appropriate resources and evaluates outcomes. The intervention is designed to prevent complications that are costly and may compromise future health status for the individual. Case managers suggest and assist with the initiation of services and link people to community resources. They assist with cost-efficiency by avoiding duplication of services, preventing gaps or delays in service, and facilitating movement through the healthcare system. In many healthcare settings, case managers use the title *case manager* and may be certified by their professional organization.

Certification for nursing case managers is available through the American Nurses Credentialing Center. Standards of Practice have been set by the Case Management Society of America.

## Health Care Economics

Because health care is an exceedingly expensive entity in contemporary society, many approaches have been developed to finance it and, at the same time, maintain quality.

### Billing Methods

There are three main types of billing for healthcare services: fee-for-service, capitation, and fee-for-diagnosis.

#### Fee-For-Service

In the fee-for-service method, clients pay the practitioner for each health service they receive. Physicians are not fiscally responsible for whatever they prescribe or for any resulting hospital costs. Ideally, clients choose the service they need and pay for this service. In reality, not all clients

**CRITICAL THINKING EXERCISE**

Mrs. Helen Whitehead is a 70-year-old widow who recently retired from a job as a checkout clerk for a large supermarket chain. Before her retirement, she had group health insurance coverage through her employer. She no longer has her own coverage; she needs cataract surgery and has just been diagnosed with type II diabetes. She has no savings but she does collect Social Security benefits. Her two children live several hundred miles away

from her, and she sees them only about twice a year. She owns her own house and drives her own car. She is an active member of her church, which is also the source of her social group.

1. What options do you think she might have for health care?
2. How would case management benefit her?

are willing or able to choose the service they require, and not all healthcare providers are willing to relinquish their prescriptive power. Therefore, collaboration is required to select mutually acceptable health services in the fee-for-service billing.

### Capitation

With capitation funding, healthcare providers are paid a fixed dollar amount per person for providing an agreed-upon set of health services to a defined population for a specific period of time. If the costs of providing service are lower than the fixed amount, the provider organization makes a profit. If costs exceed payment, however, then the provider organization takes a financial loss.

Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and physician/hospital organizations are managed-care systems and thus subject to capitation. In other words, payers negotiate healthcare costs, and the providers take both the potential financial risks and benefits.

### Fee-For-Diagnosis

Fee-for-diagnosis is a type of prospective payment system (PPS) introduced in the 1990s. Agencies are provided with a fixed dollar amount for the care of a client based on the client's main and secondary diagnoses, demographic information (e.g., age and sex), and the usual treatment provided for the health problems. The diagnosis-related groups (DRG) system is an example of a fee-for-diagnosis system. Because a diagnosis is needed to establish a fee for the healthcare provider, the fee-for-diagnosis system does not provide incentives for reducing costs by providing preventive care.

### Pay-For-Performance

In an effort to provide high-quality health care, the Center for Medicare and Medicaid Services (CMS) began the trend of rewarding healthcare organizations for the provision of high-quality health care. This is accomplished by allowing patient outcome to influence payment rather than paying for what is done to a patient. The goal is to promote the "right care for every patient every time" (Center for Medicare and Medicaid Services, 2005). This creates incentives to improve quality by promoting safer, more effective, and more efficient care. Some patient outcomes are determined to improve with greater quantity and quality of nursing care, such as pressure ulcers and falls (Duncan, Montalvo, & Denton, 2011). Nursing-sensitive quality indicator definitions have been submitted to the National Quality Forum, a

not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting in the United States. This public-private partnership has broad participation from all levels of the healthcare system (National Quality Forum, 2008).

## International Perspectives

One thing that is fairly consistent around the world is that health care is in some level of crisis and countries are considering what would be appropriate healthcare reform and restructuring. Most countries, regardless of their level of funding for health care, have run out of ways to fund their expenditures through taxation or their existing channels. Most countries are exploring public-private strategies to meet the healthcare needs of their populations. All are realizing they must contain costs in the future. Further, there is concern in Western European nations, Canada, and Australia about the increased sophistication and resulting expectations of their middle classes.

Each country's healthcare system is unique, but four categories can be identified for the organization and financing of health care. Although countries can be separated into the predominant categories listed below, it is important to note that most countries are funding health care with varying degrees of public and private sector funds.

The first category is **socialized medicine**, in which the state owns and controls production. Examples are the United Kingdom, Sweden, and Denmark, where physicians derive virtually all their income from the government and have employment contracts with the state. The second category is **socialized insurance**, a system in which all medically necessary services are covered, including physician care, hospital services, and to some extent prescription drugs. Canada, France, and Australia have this form of healthcare payment. **Mandatory health insurance**, the third category, is found in Germany and Japan, where the large, nonprofit health insurance organizations are called *sickness funds*. These sickness funds are usually organized around large employers or work-based associations. Government-sponsored programs cover citizens who are not part of a sickness fund. Everyone belongs to one of these two types of plans, thus ensuring universality. The fourth category, **voluntary insurance**, provides no guarantee of universality. The United States and South Africa both provide this kind of coverage. They are the only two developed countries where significant proportions of the population are uninsured (Morrison, 2000).

## Nursing Economics

Few efforts have been made to determine the actual costs of nursing care. Traditionally, the cost of nursing services has been included in the average hospital bill within the general category termed *room rate*. Often, the number of patients determines the number of nurses needed, but the nurse-to-patient ratio assumes that every patient on a particular nursing unit has the same need for nursing care. It fails to take into consideration individual patient variability. In the early 1960s, a patient classification system (PCS), developed at Johns Hopkins Hospital, identified the needs for nursing care in quantitative terms. Since that time, various PCSs have been developed that assess the acuity of illness and the corresponding complexity and amount of nursing care required. This calculation is a complex task encompassing many variables. The accompanying Research Currents box discusses research that reflects the difficulty and complexity in such an endeavor.

Both consumers and healthcare professionals are expressing concerns about diminished quality of care resulting from cost constraints, early discharge, nursing shortages, and the increased use of unlicensed assistive personnel (UAPs). Determining the precise cost of nursing services is a major challenge for nursing. What are the exact costs of high-quality nursing care? How is the number of required nursing-care hours determined? What is the best skill mix—that is, ratio of registered nurses to licensed practical nurses and nursing assistants—on each hospital unit? Since 1983, many studies have been undertaken to

determine the actual costs of nursing care and the cost-effectiveness of nursing care. Researchers have investigated such topics as the impact of nurse-physician collaboration; new cost-effective interventions; cost benefits of primary nursing, nurse practitioners, and nurse midwives; cost-effectiveness of home care; and so on. The quality of the nursing care of the future will rely on ongoing research.

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### Reflect On . . .

- how cost containment programs have influenced nursing care.
  - measures that could be implemented to relieve nurses of nonnursing tasks.
  - the role nurses play in maintaining quality care.
  - what cost-effective care nurses could provide that may substitute for physicians' services in your community.
- 

## Financial Management

### Profit Versus Not-for-Profit Organizations

Hospitals in the United States have three forms of ownership: public, private for-profit, and private nonprofit. Federal, state, or local government agencies govern public

## RESEARCH CURRENT

### The Zebra Index: One Method for Comparing Units in Terms of Nursing Care

An index to show the intensity of nursing care given was developed by Levenstam and Bergbom, to compare nursing units in terms of patient needs for nursing care. This was done to enable nursing costs to be individualized. This was based on the Zebra method, which consists of four parts: (1) patient classification, (2) actual staffing monitoring and estimation, (3) quality monitoring, and (4) activity study. The patient classification has six components of care: hygiene, nutrition, observation, mobilization, uncontrolled output, and extra care needs. These components are combined to create categories of care: minimal, average, above average, and intensive. Activity studies looked at total time the nurses spent in direct care activities, indirect care activities, unit-related work, and personal time. A ratio between minutes of care by the nurse and the category of care was

calculated for each of the categories of care; the result is the index of care. This index factor was multiplied by the number of patients/category of care from the patient classification. The result is the total indexed patient days. The indexed patient days divided by the number of patient days provides the Zebra Index.

The Zebra Index can be used to monitor changes in the nursing care given over a period of time. Since RN-to-patient ratios do not take patient acuity into account, the use of the Zebra Index would lead to more accurate reimbursement for nursing services. It can explain the need to increase or decrease staffing levels.

*Source:* "The Zebra Index: One Method for Comparing Units in Terms of Nursing Care," by A-K. Levenstam and I. Bergbom, 2011, *Journal of Nursing Management*, 19, 260–268.



nonprofit hospitals, which provide care regardless of the client's ability to pay. Private for-profit hospitals are owned by private investors to make profits, and they primarily serve paying clients. They provide limited charitable care. Private not-for-profit hospitals are owned by a voluntary board of trustees to provide care for both paying clients and those who require charitable care.

Health care in the United States has been and continues to be mostly a nonprofit enterprise. The for-profit sector accounts for about 18% of hospital beds. For-profit organizations have shareholders who invest money and expect a return on the investment. They are often referred to as the private sector and are taxed by the government.

Not-for-profit organizations operate according to mission statements that usually refer to community service and are often referred to as the public sector; they receive tax exemptions based on their benefits to the community. Not-for-profit hospitals include nongovernment or community hospitals and state or local government hospitals. Nongovernment community hospitals account for about 50% of hospitals, while state and local government community hospitals account for about 18%. The remainder of hospitals are federal government, psychiatric hospitals, and long-term-care hospitals (American Hospital Association, 2014).

During the healthcare reform movement of the 1980s, the shift of hospitals and physician groups to the private sector was referred to as the corporatization of health care. The emphasis placed upon profits for shareholders led to the criticism that quality of care was no longer important; rather, the focus was on cost cutting and revenue production.

Increased attention has been paid to the for-profit sector because of its visibility in acquiring struggling hospitals and HMOs and creating corporate chains. The pattern has been for these chains to undergo turmoil as a result of low profits or even losses, with the divesting of struggling organizations and the buyout of other institutions. According to Morrison (2000, p. 64), "It is likely that when the accounting is all done, the net amount of capital brought into health care from shareholders exceeds the amount of capital that has gone out of the system in the form of profits." In other words, the for-profit organizations have not been profitable. There are inconsistencies in research to determine the financial differences between for-profit and not-for-profit hospitals that result in misleading information about financial outcomes (Shen, Eggleston, Schmid, & Lau, 2007).

The not-for-profit organizations operate in much the same way as the private sector in that their leaders use the language of business and pay attention to financial margins. They are also under pressure to show evidence of

community benefit, as required by their tax-exempt status. Because much of the cost cutting was generated by changes in healthcare financing by third-party payers rather than by a profit motive, public institutions have suffered the same impact of tightened financial resources.

## Costs and Budgeting

It is extremely important for nurses to understand the business of health care. Financial considerations and accounting drive many management decisions, and familiarity with the basic concepts can empower nurses.

Cost accounting is used by hospitals and other organizations; it is a method of accounting for total costs of the business and tracking and allocating those costs to the specific service. For instance, the cost of providing a service is calculated and then used to determine the charge for the service. In the mid-1980s this was applied to DRGs. This method is used when the organization negotiates capitated rates.

Total costs of care are a sum of fixed costs and variable costs. Fixed costs are those that do not fluctuate with census or volume. Examples are salaries of managers and salaries of the minimum number of nurses needed to staff a unit. Variable costs are a function of census or volume and are over and above the fixed costs. An example is medical supplies for a particular patient. The total costs are used to calculate the cost per unit of service, which in many hospitals is the cost per patient day.

Full costing includes direct and indirect costs. Direct costing compares a department's actual outflow with its inflow from the services it delivers. Indirect costs are necessary but not directly related to delivery of service; examples are administrative salaries or bed linens. Productivity measures also figure in determining costs. These measure how efficiently resources are utilized in providing the service. For nursing, productivity is often measured in hours per patient day and compares actual staffing with projected hours under some patient acuity classification system.

Costing and productivity measures are used to develop a budget for the unit of service. The budget is an educated guess or estimate of the expenses to be encountered in the next year. It operationalizes management functions of planning, ongoing activities, and spending control. There are different budgeting methods that may be used. The simplest method is the flat percentage increase that develops a budget based on year-to-date expenses and multiplies it by the inflation rate. Management by objectives supports programs and services that assist the organization to reach its predetermined goals and usually requires cost-benefit analysis. Zero-based budgeting requires analysis of services on three levels: minimum, current, and improvement levels. It requires ranking by priorities.

## CRITICAL THINKING EXERCISE

The National Quality Forum (2008) is a nonprofit organization based in Washington, DC, that is dedicated to improving the quality of health care in the United States. Its members include physicians, nurses, hospitals, and others. The following statement can be found on its website:

*The U.S. healthcare system is one of the most innovative and talented systems in the world. Yet it is*

*fragmented and uncoordinated. Our system delivers compassionate care and healing, but also generates preventable harm and costs without better patient outcomes (retrieved from [www.qualityforum.org/story/About\\_Us.aspx](http://www.qualityforum.org/story/About_Us.aspx)).*

Accept or reject the above statement and provide a rationale for your position.

Marketing concepts are applied to health care to maximize the potential utilization and satisfaction with a service. Four variables are involved in marketing:

1. *Product*—the service to be provided
2. *Place*—the agency where the service is to be provided
3. *Promotion*—advertising and publicity
4. *Price*—the charge for the service

The goals of marketing are to maximize marketplace consumption of a service and to maximize customer satisfaction to create more demand. Marketing of nursing's product or services may emphasize the quality of nursing provided in the organization compared to others. Many public relations campaigns emphasize care that is more family-centered, for example, so that the potential customer will want to receive care at that agency. Some marketing strategies may focus more on one variable than others, but healthcare marketing tends to focus

more on the product or quality of a particular service (Turner, 1999).

## Reflect On . . .

- how nursing can work toward achieving a seamless healthcare delivery system.
- marketing strategies that could be used to promote nursing.



**InfoQuest:** Search the Internet to compare how hospitals and other healthcare organizations in your area perform on nursing-sensitive quality measures and other quality indicators. One place to start would be to go to the website of the U.S. Department of Health and Human Services.

## Chapter Highlights

- Changes in the delivery of health care have resulted in changes in the practice of nursing.
- Two influences on these changes are cost containment measures mandated by third-party payers and the use of assistive personnel.
- Cost containment has resulted in more focus on resource management and created the need for nurses to become skillful in the utilization of scarce resources and to provide accountability for outcomes.
- Concerns about the use of unlicensed assistive personnel relate to the skill mix needed for care.
- Focus of care has expanded from acute inpatient care to include primary and preventive care that is community focused.

- The changes in nursing require a new perspective on health as more than the absence of illness or disease, but as also involving a high level of wellness or the fulfillment of one's maximum potential for physical, psychosocial, and spiritual functioning.
- Wellness includes the physical, social, emotional, intellectual, and spiritual dimensions.
- Well-being is considered a subjective perception of balance, harmony, and vitality.
- Illness is usually associated with disease but may occur independently of it.
- Illness is a highly personal state in which the person feels unhealthy or ill.
- Disease alters body functions and results in a reduction of capacities or a shortened life span.
- Case management focuses on care coordination, financial management, and resource utilization to produce cost-effective quality outcomes for the patient.
- Payment for health care can include the following approaches: fee-for-service, capitation, fee-for-diagnosis, and pay for performance.
- Internationally, payment for health care occurs through socialized medicine, socialized insurance, mandatory health insurance, or voluntary insurance.
- The cost of nursing care has been difficult to establish but is important in establishing the value of nursing.
- Hospitals in the United States have three forms of ownership: public, private for-profit, and private nonprofit.
- Understanding costs and budgets can empower nurses in the business of health care.

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# 18

## Providing Care in Home and Community

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### Chapter Outline

#### Challenges and Opportunities

##### Community Health Nursing: An Integrated Approach

Definitions of Community and Community Nursing

##### Philosophical Paradigms of Community Nursing Practice

Community-Oriented Nursing Practice  
Community-Based Nursing Practice  
Public Health Nursing Practice

##### Settings for Community Nursing Practice

Public Sector Settings  
Public-Private Partnership Settings  
Private Sector Settings  
Nursing in Rural Communities

##### Home Health Nursing

Definitions of Home Health Nursing  
Perspectives of Home Health Nursing  
Differences Between Home Health Nursing and Hospital Nursing

##### Influencing Community Health Outcomes

Assessment and Community Engagement  
Diagnosing  
Planning and Implementation  
Evaluation

#### Chapter Highlights

### Objectives

1. Describe the roles of the community health, public health, and home health nurse.
2. Differentiate between providing nursing care in community and home settings and in the hospital setting.
3. Describe characteristics of a healthy community.
4. Differentiate between community-oriented nursing and community-based nursing.
5. Differentiate between community health and public health nursing.
6. Discuss various nursing practice settings in the community.
7. Describe the nursing and health needs of rural communities.
8. Apply nursing and public health processes to influence community health outcomes.
9. Discuss the interrelationship between the community health nurse, public health nurse, and home health nurse.

As a result of changing demographics, rising healthcare costs, and a growing emphasis on health promotion, disease and injury prevention, managing chronic disease and stress, and enhancing the quality of life, there has been an increase in the delivery of nursing services in home and community settings. Public health nurses focus on the care of communities and populations with the goal of preventing disease and protecting health. Important concepts related to community health, public health, and home health nursing include:

- *Healthy People 2020* (U.S. Department of Health and Human Services, 2014). The goals of *Healthy People 2020* are to (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages (U.S. Department of Health and Human Services, 2014). These goals can best be achieved by delivering services where people live, work, play, or attend school, in their homes and communities.



- For the community- and home-based nurse, nursing care generally focuses on the individual client and the persons who provide care and support for that client. For the community-oriented and public health nurse, the focus is on health promotion and disease/injury prevention for families, groups, and populations.
- Community health nursing focuses on health initiatives at the local community level. For the community health nurse, there are three clients: individuals, families, and groups. Groups may be communities as a whole, at-risk aggregates in the community (e.g., homeless, people living with or at risk of acquiring HIV, victims of violence), or persons with similar problems and needs within the community. Public health nursing focuses on health care for communities and populations at local, state, national, and international levels.
- People living in rural communities have particular difficulties in accessing and obtaining health services and nursing care. Approaches to resolving these difficulties include greater use of technology in providing communication between rural populations and healthcare providers as well as increasing the number of providers available to rural populations.
- The nurse in community, public health, and home health nursing has a higher degree of autonomy and independence than in hospital-based nursing because nurses work with patients/clients and groups who have greater control of their own healthcare decision making.

## Challenges and Opportunities

One of the greatest challenges is for nurses to work within the healthcare system to provide safe and effective nursing and health care for all segments of the population, regardless of race, religion, age, gender, sexual orientation, political belief, or other characteristics that often marginalize groups. In the United States, the goal of achieving health for all has been implemented through the Department of Health and Human Services' Healthy People initiatives, including the publication *Healthy People 2020*. Internationally, the goal of health for all is derived from the *Declaration of Alma-Ata* and is consistent with the belief that health is a fundamental human right (Allender, Rector, & Warner, 2014; World Health Organization and United Nations Children's Fund, 1978; World Health Organization, 2014b). Health for all emphasizes provision of health care that is affordable, culturally acceptable, appropriate, and delivered in collaboration between national health service systems and local communities (Allender et al., 2014). Nurses in the community provide an important link to

healthcare information and services for those who have limited access to health care, lack a primary healthcare provider, or live in a medically underserved urban or rural area. Rising healthcare costs have resulted in decreased lengths of hospital stays, and patients are discharged requiring nursing and rehabilitative care at home or in community settings. The Patient Protection and Affordable Care Act (PPACA; U.S. Code of Federal Regulations, 2010) fundamentally changes how health care is delivered in the United States. Nurses will need to work in community settings to provide support and information about nursing and other healthcare services as well as how to navigate the transformations that are occurring in the healthcare system.

Around the world and at home, people continue to struggle with poverty, hunger, unemployment, homelessness, illiteracy, racism, sexism, ageism, environmental pollution, and lack of access to health care. The interrelationships among these factors determine individual and population health. This range of personal, social, economic, and environmental factors that influence health status are known as *determinants of health*. Determinants of health (U.S. Department of Health and Human Services, 2012) can be broadly categorized into:

- policymaking, for example, clean air legislation
- social and physical determinants of health, for example, educational and job opportunities, discrimination, social support, natural and built environments, exposure to toxic substances
- health services, for example, access to and quality of healthcare services
- individual behavior, for example, diet, physical activity, substance misuse
- biology and genetics, for example, age, sex, HIV status

Factors that influence the health of a community and community health nursing in the 21st century include:

- healthcare reform initiatives with a goal to contain costs and decrease fragmentation
- demographic shifts in populations, for example, aging populations in North America and Western Europe
- increased globalization
- poverty and growing wealth inequities and health disparities
- changes in primary health care and a shift toward universal health coverage
- violence, injuries, and social disintegration
- biological and other forms of terrorism

The interconnectedness of people globally increases the challenges related to transmission of communicable diseases, fair distribution of health resources such as

HIV/AIDS medications and other pharmaceuticals, and responsiveness to violence including terrorism.

The opportunities for addressing these problems will increase. Technology will provide opportunities for instant communication in the most remote areas of the world. New and effective partnerships with communities will be developed. Nurses will increasingly work with local, national, and international healthcare agencies to improve health for individuals and families in their home communities as well as communities around the world. For example, implementation of the PPACA will expand the number of patient-centered medical homes (PCMHs) to provide comprehensive primary care services, including health promotion, disease prevention, injury prevention, and illness care. With the expansion of healthcare services, there is concern that patients who have historically received healthcare services from essential community providers may not be able to access services from providers with whom they have established solid patient-provider relationships (Sonfield, 2013). Nurses have responded to the needs of communities in the past and are an essential part of healthcare reform today. The expansion of healthcare coverage and services across America will provide nurses new opportunities in roles as navigators and assistants to their patients who may be accessing the healthcare system for the first time. Nurses will have the responsibility to be at the forefront of planning for the future of health care in the local community, the nation, and the world.

## Community Health Nursing: An Integrated Approach

The goal of many public and private efforts is to develop and maintain healthy communities. Characteristics of a healthy community are described in the accompanying

box. Nursing, as a caring profession, exists because individuals, families, and groups (and therefore communities) are not always healthy or self-sufficient. The focus in community nursing is the community: It is a practice that is comprehensive and continuous, takes place in a wide variety of settings, is directed toward all age groups, and commands the utilization of all professional nursing roles. Although definitions of community health nursing by the American Nurses Association; the American Public Health Association, Public Health Nursing Section; and the Association of Community Health Nursing Educators vary, they all agree that community health nurses focus on nursing service to the population as a whole. At the same time, providing care for individuals, families, and groups in the community enhances the health of the community as a whole.

Community health nursing practice occurs at multiple levels, with reciprocal and often simultaneous effects across contexts and system levels (Krieger, 2008; Phillips et al., 2013). Conceptualizing community and the health of community members as part of a dynamic system facilitates understanding the philosophical underpinnings, nursing care delivery settings, and roles of nurses within the community. For example, the integration of “essential community provider” services into “America’s post-reform health care system . . . would assure that millions of low income women and men who trust their . . . providers can continue to turn to them for the care they need” (Sonfield, 2013, p. 22). Essential community providers are providers that have historically served predominantly low-income, medically underserved people (U.S. Code of Federal Regulations, 2012).

Nurses who want to specialize in community and public health nursing are prepared in graduate programs in nursing and public health. These programs usually

### Characteristics of a Healthy Community

A healthy community:

- Has members who identify with and are aware they are part of the community.
- Provides for the progressive realization of the basic needs of all community members.
- Uses natural resources wisely and conserves them for future generations.
- Respects and supports the diverse beliefs and perspectives of its members.
- Has historical roots and cultural heritage that it promotes and celebrates.
- Encourages and supports community involvement in local government.
- Strives to provide accessible health and social services for all community members.
- Has a diverse and innovative economy that strives to provide for all its members.
- Is able to mobilize and effectively respond to crises and conflicts.
- Identifies, analyzes, and organizes its own needs to solve the community’s problems.
- Possesses open communication channels that allow information to flow among all subgroups of citizens across all system levels.

prepare the nurse for leadership and coordinating functions in the community. The many roles of the community health nurse can include care provider, client advocate, consultant, coordinator, manager, educator, collaborator, and researcher.

## Definitions of Community and Community Nursing

To understand community nursing one must first define the word *community* and other terms associated with community nursing. The World Health Organization (1974, p. 7) defined **community** as “a social group determined by geographic boundaries and/or common values and interests. Its members know and interact with one another. It functions within a particular social structure and exhibits and creates norms, values and social institutions.” Warner and Lightfoot (2014, p. 439) define community as “a group of people who have some characteristics in common, are bounded by time, interact with one another, and feel a connection to one another.” Communities can be formed based on geographic or geopolitical boundaries, or common interests, or among a group of people who come together to solve a problem that they all share. A *geographic community* is a community that is defined by geographic boundaries like rivers and mountains (Rector, 2014). A *geopolitical community* (e.g., town, city) is a community that is defined by geographic and jurisdictional boundaries (Clark, 2008). A *neighborhood* is smaller than a community, is often more homogeneous, and has geographic or geopolitical boundaries (Clark, 2008).

Groups (e.g., religious and ethnic groups) that constitute a community because of common member interests are often referred to as a *common interest community*.

Nurses working in community health often encounter a group of people who come together to solve a problem that affects them all. This type of community is called a *community of solution*. A community of solution varies in size, geographic area affected, and available resources. Problems that can be addressed by a community of solution include water pollution, HIV/AIDS, and obesity (Rector, 2014).

With the advent of the Internet and social media platforms, there are opportunities for common-interest communities to connect locally as well as globally. Through the use of technology, nurses and patients are able to interact in a multitude of ways to share health-related information. For example, community health nurses can provide HIV counseling and testing services through social media platforms to persons who are at high risk for acquiring HIV disease (Latkin, Weeks, Glasman, Galletly, & Albarracin, 2010).

A community also can be defined as a *social system* in which the members interact formally or informally and form networks that operate for the benefit of all people in the community. Five functions of a community are described in the accompanying box.

## Philosophical Paradigms of Community Nursing Practice

Community health practice is informed by diverse professional disciplines, including public health, nursing, and medicine. *Ecosocial theory* originated from epidemiology and is useful for understanding the complex factors and perspectives that shape the health of communities and the practices of nurses in the community. Ecosocial

### Five Functions of a Community

1. *Production, distribution, and consumption of goods and services.* These are the means by which the community provides for the economic needs of its members. This function includes not only the supplying of food and clothing but also the provision of water, electricity, police and fire protection, and the disposal of refuse.
2. *Socialization.* Socialization is the process of transmitting values, knowledge, culture, and skills to others. Communities usually contain a number of established institutions for socialization: families, places of religious worship, schools, media, voluntary and social organizations, and so on.
3. *Social control.* Social control refers to the way in which order is maintained in a community. The police enforce laws; public health regulations are implemented to protect people from certain diseases. Social control is also exerted through the family, religious organizations, and schools.
4. *Social interparticipation.* Social interparticipation refers to community activities that are designed to meet people's needs for companionship. Families and places of worship have traditionally met this need; however, many public and private organizations also serve this function.
5. *Mutual support.* Mutual support refers to the ability to provide resources at a time of illness or disaster. Although the family is usually relied on to fulfill this function, health and social services may be necessary to augment the family's assistance if help is required over an extended period.

theory equally values the perspectives of all stakeholders (e.g., patients, family and social network members, nurses and other healthcare providers, public health and other government officials) across all environmental levels (e.g., individual, interpersonal, social, and structural levels) and is mindful of the simultaneous and reciprocal effects of actions and interactions across and between those levels (Krieger, 2008; Phillips, 2011). Additionally, ecosocial theory can help nurses in the community as they assess a community's health and explore the pathways and power dynamics that contribute to individual and population health outcomes (Phillips et al., 2013).

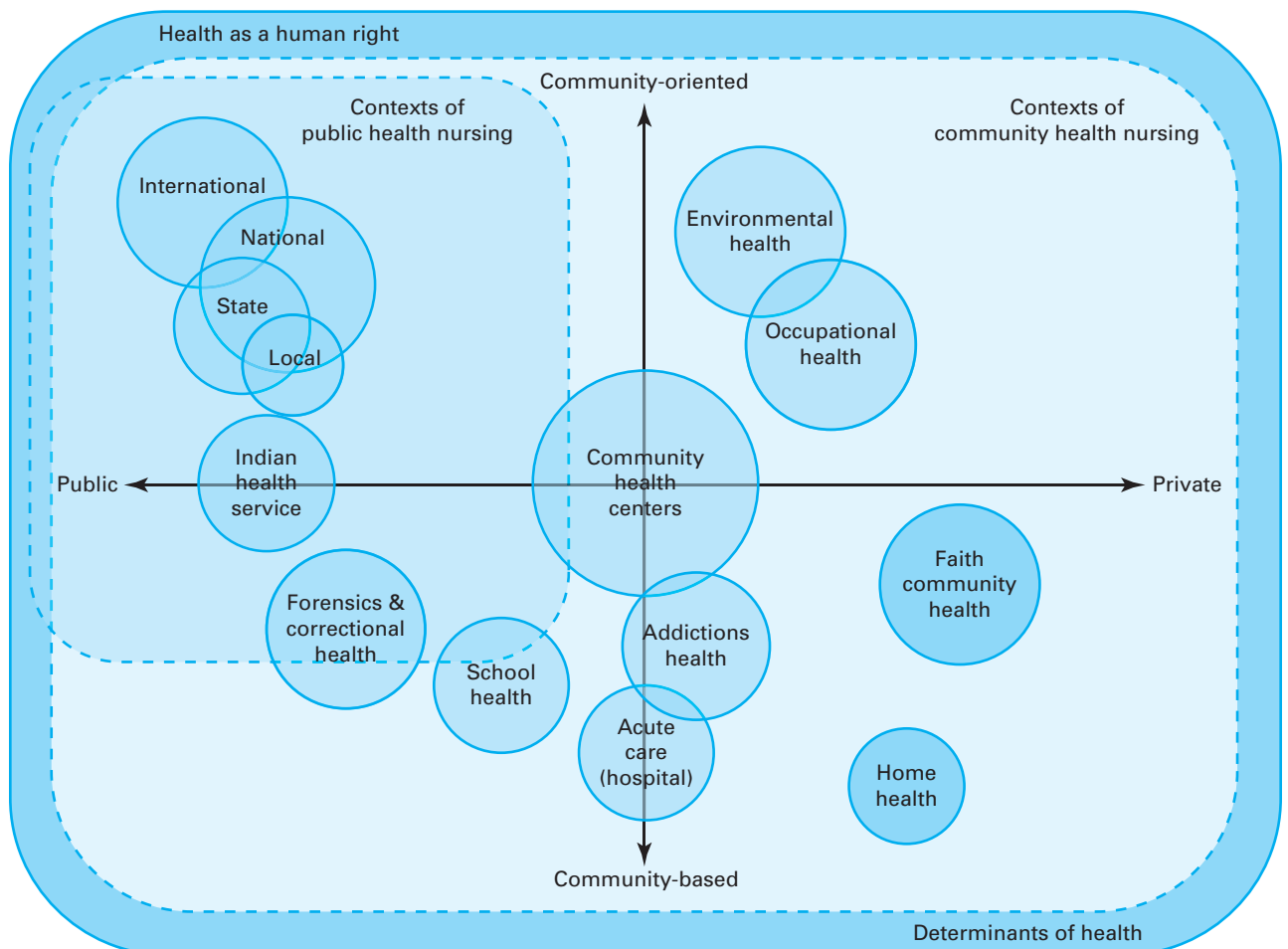
The ecosocial framework for community health and community health nursing are represented by a solid boundary that encompasses the concepts of health as a human right and the determinants of health (graphically represented in Figure 18–1). Within community health,

the contexts in which nurses practice can be separated into community health nursing, public health nursing, and home health nursing. The contexts of community and public health nursing are represented by broken lines to represent the dynamic interchange that is ongoing, simultaneous, and reciprocal between the multiple levels and practice settings (represented by circles) within communities. The double-headed arrows represent the community orientation continuum of community-oriented to community-based and the continuum from public to private sectors.

To more fully understand the complex nature of community healthcare delivery, one must differentiate between the philosophical paradigms that guide the delivery of nursing services with communities and those that guide community-oriented nursing and community-based nursing (Stanhope & Lancaster, 2014).

**FIGURE 18–1**

The Ecosocial Framework for Community Health





## Community-Oriented Nursing Practice

Community-oriented nursing practice is a philosophy of nursing service delivery through which generalist or specialist public health and community health nurses provide health care. Community-oriented nursing services are provided through community diagnosis and investigation of major health and environmental problems, health surveillance, and monitoring and evaluation of community and population health status. The purposes of providing these services are prevention of disease and disability and promotion, as well as protection, and maintenance of health to create conditions in which people can be healthy (Stanhope & Lancaster, 2014).

Community-oriented nursing encompasses care provided through a multitude of agencies that are designed to enhance the health of an entire community or population. Community-oriented care settings include public health agencies at all geopolitical levels (e.g., international, national, state, local). Examples of community-oriented health agencies include the World Health Organization, the U.S. Public Health Service, and state and local health departments. Schools and correctional facilities are also settings where healthcare services are provided with the goal of improving both population health and the health of individuals within the community.

## Community-Based Nursing Practice

*Community-based nursing practice* is defined as a “setting specific practice in which care is provided for ‘sick’ individuals and families where they live, work, and attend school” (Williams, 2014, p. 11). In contrast to community-oriented nursing practice, the emphasis is on managing acute and chronic conditions through the provision of comprehensive, coordinated, and continuous care. Nurses working in community-based settings may be generalists or specialists in maternal-infant, pediatric, adult, gerontological, or psychiatric mental health care. Community-based nursing settings include home health settings, hospitals, clinics, and other acute care settings located in communities. The scope of this chapter is limited to the

discussion of community-based nursing outside of acute care settings (e.g., hospitals). Settings where nurses provide care in communities can be separated into the public sector and the private sector.

Van Kalsbeek and Saunders (2011) identified *Healthy People 2020* as the roadmap to achieving health for all. It extends the goals of *Healthy People 2010*, which set the health promotion and disease/injury prevention agenda for the nation, its citizens, and its communities. These statements of national health objectives build upon the accomplishments of the Healthy People initiative that started with *Healthy People 2000*, which was designed to identify significant preventable threats to health and the establishment of goals to reduce those threats. Nurses in the community and home will have increasing responsibilities in assisting individuals, families, and groups in meeting the goals outlined in *Healthy People 2020*.

## Public Health Nursing Practice

*Public health nursing practice* is “the synthesis of nursing and public health theory applied to promoting and preserving the health of populations” (Williams, 2014, p. 11); “Public health nursing practice focuses on population health through continuous surveillance and assessment of the multiple determinants of health with the intent to promote health and wellness; prevent disease, disability, and premature death; and improve neighborhood quality of life” (American Nurses Association, 2013a, p. 2). Public health nurses address population health priorities through identification, implementation, and evaluation of universal and targeted evidence-based programs and services. Primary prevention with the goal of achieving health equity is the main objective of public health nurses.

The specialty of public health nursing is distinguished from nursing and other nursing specialties that practice in communities because it is population-focused, community-oriented, health-promotion-focused, and disease/injury-prevention-focused, and it produces interventions at the community and population levels. In population-focused practice, problems are defined (assessments/diagnoses) and

### CRITICAL THINKING EXERCISE

Interview a community health nurse, public health nurse, and home health nurse in your area. Consider the different roles of the professional nurse: care provider, health promoter, educator and learner, leader, manager, researcher, advocate, and collaborator. Describe how the roles of the nurses you interview differ from each other

and from your practice or the practice of the hospital nurse. What new knowledge does the nurse need to transition from acute care nursing (e.g., hospital-based nursing) to community health, public health, and/or home health nursing?

## RESEARCH CURRENT

## Cultivating Constituencies: The Story of the East Harlem Nursing and Health Services, 1928–1941

The purpose of D’Antonio’s historical research study was to examine the history of the East Harlem Nursing and Health Services from its beginnings as a demonstration project in 1928 to its closing in 1941. In this article, the researcher explores the goals, needs, and ambitions of the many different constituents that paid for, delivered, and received healthcare services. The author sets the contextual stage for this article with the backdrop of the signing of the Patient Protection and Affordable Care Act in 2010 and highlighting that it set in motion demonstration projects to increase access to high-quality, cost-effective, coordinated health care for beneficiaries of Medicare, Medicaid, and the Children’s Health Insurance Program. The East Harlem Nursing and Health Services began as a highly successful nurse-led demonstration project during the years between World War I

and World War II. Throughout its history, the East Harlem Nursing and Health Services became internationally recognized for its innovative and independent nursing practice and teaching. It was heralded as a leader in the provision of interprofessional health care because it disregarded the barriers that existed between professional groups and brought together multiple disciplines to provide optimal services to the people of the community. Despite this level of innovation and interprofessionalism, the service failed because it was more focused on educational advancement of public health nurses than on addressing the real healthcare needs of the East Harlem Community.

*Source:* “Cultivating Constituencies: The Story of the East Harlem Nursing and Health Services, 1928–1941,” by P. D’Antonio, 2013, *American Journal of Public Health*, 103(6), pp. 988–996.

solutions (interventions) are implemented for or with a defined population or subpopulation (Williams, 2014).

Population-focused interventions may include the provision of preventive services or the development of specific policies. The predominant focus of intervention is on health promotion, health maintenance, and disease/injury prevention, and therefore, it is health- and prevention-focused. Nurses in public health practice intervene at the community and population levels by using political processes to affect public policy change to achieve health for all members of the community or population, especially vulnerable subpopulations (Williams, 2014). The terms *community health nurse* and *public health nurse* are often used interchangeably (Williams, 2014).



**InfoQuest:** Search the Internet for information about community and public health nursing opportunities throughout the United States. What are the roles and responsibilities of public health nurses as described by the various state agencies?

## Settings for Community Nursing Practice

Community-based nursing is practiced in diverse settings that may be publicly funded, privately funded, or both. Within each setting, nurses provide care to patients based on the philosophical underpinnings of the agency they

work for and the scope and standards that guide their specialized practice. In the following sections, settings for community nursing practice are separated based on the primary sector in which services are delivered, public versus private. This separation based on sectors is loosely related to how services are funded. There is considerable overlap and some settings and specialties span the full spectrum of public to private services.

### Public Sector Settings

#### Public Health Nursing

Public health nurses provide community-oriented care and work to promote and protect the health of an entire population (American Nurses Association, 2013a). See the accompanying interview box. Public health nurses provide care to populations at local, state, national, and international levels. In addition to working in public health agencies at all levels of government, public health nurses also work in the Indian Health Services and Uniformed Public Health Nursing. Indian Health Services’ nurses provide care to Native Americans in a variety of urban and rural settings. The main goal of the Indian Health Service is to improve the health status of all Native American Peoples, including American Indians and Alaska Natives. These nurses work and oversee care in Indian Health Services clinics that focus on primary care and general practice, providing health education, health promotion, and disease and injury prevention services. They may provide immunizations, perform well-child assessments, or conduct HIV/AIDS screenings. Some of the unique characteristics of Indian Health Services nursing arise from the fact that

## Interview ► Kevin Myers, RN, BSN, ACRN—Public Health Nurse

1. **Why did you choose to become a public health nurse?** I chose to pursue a career in public health nursing because I was intrigued with the notion of a population or community serving as the “patient.” In the field of public health, nurses are able to combine a variety of skills (interviewing, assessment, epidemiological analysis, research design, policy development, client education, etc.) to influence larger groups and create healthy change.
2. **What qualities do you think are necessary to be a public health nurse?** Public health nurses must work well in groups and be open to collaboration. They must have awareness around cultural issues and be aware of their own limitations, seeking guidance and clarification from subject matter experts or community leaders when appropriate. Most of all, public health nurses must have an investment in the area they live and work, and the drive to improve the health of their community.
3. **What has been your most gratifying moment as a public health nurse?** While I appreciate the

impact of public health nurses on the larger community, some of my most gratifying moments as a public health nurse have been working with individuals affected by infectious diseases, answering questions about their condition, and offering support. Whether I am investigating the cause of an outbreak, teaching patients about food safety practices, or discussing tuberculosis treatment in the hospital, I value the opportunity to connect with community members and participate in their health care.

4. **What encouragement would you give a nurse considering practice in your setting?** I would recommend that someone interested in pursuing a career in public health not be afraid to ask questions, and seize every possible learning opportunity—conferences, webinars, case studies, conversations with an experienced nurse or patient, etc. Nurses must be committed to their professional development to stay up-to-date and relevant in a world that is constantly changing.

services are often provided in rural and remote areas with limited access to urban healthcare settings. Additional challenges encountered may be related to inadequate housing, lack of telephone lines, and inconsistent electricity (Maughan, 2014).

Uniformed Public Health Nurses in the United States serve in “the Department of Defense (e.g., Army, Navy, Marine, Air Force), Department of Homeland Security (Coast Guard), Department of Commerce (National Oceanic and Atmospheric Administration [NOAA] Commissioned Corps), and Public Health Service Commissioned Corps (USPHSCC)” (Maughan, 2014, pp. 989–990). The Public Health Commissioned Corps was established in 1798 to provide care for sick seamen in Marine hospitals. The corps has expanded to oversee the health of new immigrants entering the country, to assist in preventing/treating communicable disease outbreaks, and to respond to disasters such as the 2010 earthquake in Haiti. The corps is overseen by the U. S. Surgeon General and nurses are an integral part of the services provided. (Maughan, 2014). Military nurses are commissioned officers and provide services to members of the military community and communities where military actions occur. These nurses are often educated to deliver highly specialized care in a variety of clinical settings. They may work in clinics or hospitals on military bases. They may also work in field hospitals in war zones. They may also be involved in humanitarian

missions, education, and administration. Military nurses exercise leadership skills and are involved in preventive, occupational, and environmental healthcare services in areas where they are stationed (Warren, Heale, Battle Haugh, & Yiu, 2012).

### Schools

Community schools reflect the greater community of which they are a part. Today, schools are encountering increasingly complex health-related problems in students, including substance abuse and teen pregnancies; dealing with major environmental risks, such as violence and poverty; and accommodating children with significant physical and psychosocial impairments. School nurses are responsible for providing nursing care to the students and staff of the school. They help children who have disabilities or complex medical regimens to stay in school. In their role as health educator, school nurses provide individual health counseling for students and teach health education classes. They consult with teachers regarding student learning and behavioral problems to assess health-related factors.

“School nurses facilitate positive student responses to normal development; promote health and safety, including a healthy environment; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build

student and family capacity for adaptation, self-management, self-advocacy, and learning” (American Nurses Association, 2013b, p. 3). School nurses also provide service in other settings where children are found, such as in juvenile detention centers, preschools, and day-care centers; during field trips; at sporting events; and in children’s homes (American Nurses Association, 2013b). The core components of a **school health** program are health services, health education, and a healthy environment. Nursing services are an integral part of the school health program. School nurses provide direct care in school clinics, manage immunization programs, provide health education in classrooms, offer health-related expertise during student conferences, coordinate student health services, promote safety, and advocate for student health programs at the local and state levels. Many school systems recognize that providing health services is an investment in children’s future, and they directly or indirectly support health services at school sites by maintaining primary care clinics that provide care for both students and their families. Nurses who wish to pursue a specialty in school nursing will find a variety of graduate programs that provide advanced degrees leading to certification in this field.

### Addictions Nursing

Community health nurses also provide specialized care to communities that are struggling with the challenge of addictions. Addictions nurses “are in prime positions to lead change in the delivery of health care for individuals, families, communities, and populations affected by substance use and maladaptive behaviors” (American Nurses Association, 2013c, p. 5). These nurses serve their communities as advocates for their individual patients and for the implementation of policies and programs to reduce the harm associated with substance use and maladaptive behavior. In the past, addictions nurses practiced primarily in specialized drug and alcohol treatment facilities. In recent years, there has been an increased appreciation that nurses in many diverse clinical settings encounter persons living with addictions across the continuum of health and illness states and settings (American Nurses Association, 2013c). Settings where there is high potential for addictions “include, but are not limited to, maternal-child health and neonatal care, pediatrics, primary care, family practice, geriatrics, emergency and urgent care, trauma, oncology, and pain management (American Nurses Association, 2013c).

## RESEARCH CURRENT

### Risk Taking in First and Second Generation Afro-Caribbean Adolescents: An Emerging Challenge for School Nurses

The purpose of this mixed methods exploratory study by Jolly, Archibald, and Liehr was to explore risk-taking behaviors of Afro-Caribbean adolescents living in the United States. The study explored effects of migration on adolescents and compared risk taking behaviors between first- and second-generation adolescents. First-generation adolescents were born in the Caribbean and at least one of their parents was Caribbean-born. Second-generation adolescents were born in the United States with at least one parent being Caribbean-born. The adolescent risk-taking behavior instrument (ARTI) was used to study the following three research questions: (1) what are the differences in risk-taking attitudes for first- and second-generation Afro-Caribbean adolescents? (2) What percentages of first- and second-generation Afro-Caribbean adolescents report sexual activity, substance use, and violent behaviors? And (3) what do Afro-Caribbean adolescents describe as the riskiest activity they have ever undertaken? Data were collected from Afro-Caribbean students ( $n = 106$ ) from the 7th to 12th grades. Participants received a \$5 gift card as an incentive for completing the study.

The researchers observed no significant difference ( $p = .06$ ) in risk taking attitudes between first- and second-generation adolescents. However, second generation adolescents reported higher percentages of all risk-taking behaviors (sexual activity, substance use, violence) compared to first-generation adolescents. In qualitative theme analysis, second-generation adolescents reported more risk-taking behaviors across all themes (i.e. sexual activity, substance use, aggression, exposure to threatening environment, thrill seeking, stealing/lying) except “challenging authority.”

Afro-Caribbean adolescents have a number of behavioral health risks that can have significant and lasting health consequences. The researchers recommended implementing culturally sensitive healthcare and education programs in school settings to increase access to care for this population. School nurses are best positioned to provide culturally appropriate guidance that will empower these youth to achieve optimal health and well-being.

*Source:* “Risk Taking in First and Second Generation Afro-Caribbean Adolescents: An Emerging Challenge for School Nurses,” by K. Jolly, C. Archibald, and P. Liehr, 2013, *Journal of School Nursing*, 29(5), pp. 353–360.



### Correctional Nursing

“Correctional nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human response; advocacy for and delivery of health care to individuals, families, communities, and populations under the jurisdiction of the criminal justice system” (American Nurses Association, 2013d, p. 1). Corrections nurses work in on-site medical units within criminal justice facilities and their primary responsibility is to restore and maintain health of inmates entrusted to their care. Correctional health nurses use public health, community, and school nursing skills to manage the health of inmate populations. They also use skills acquired in emergency rooms, occupational health, mental health, orthopedics, and ambulatory care specialties to provide for the healthcare needs of individual inmates and inmate populations. Correctional health nurses are challenged with health concerns related to mental health, drug abuse and communicable diseases (Maughan, 2014).

### Forensic Nursing

“Forensic nursing is a multifaceted and complex practice specialty characterized by responsibilities, functions, roles, and skills that have been derived from general nursing practice, yet also developed in accordance with the distinctive practice environments and populations of forensic nursing” (International Association of Forensic Nurses and American Nurses Association, 2009, p. 2). “Forensic nursing is the practice of nursing globally when health and legal systems intersect” (International Association of Forensic Nurses and American Nurses Association, 2009, p. 3). Forensic nurses provide direct services to individuals, families, communities, and populations; consultative services to nursing, medical, social, and other healthcare and legal disciplines and practice environments; and provide factual and expert court testimony related to both intentional and unintentional injury to the living and/or deceased. Forensic nurses work in a variety of settings, including criminal justice settings, medical examiner’s offices, and community-based or hospital-based sexual assault treatment centers (International Association of Forensic Nurses and American Nurses Association, 2009).

## Public–Private Partnership Settings

### Community Health Centers

In community health centers, nurses and advanced nurse practitioners provide services to clients who are usually a group of individuals with common needs or interests. Community health centers include a broad array of service delivery models and receive funding from across the continuum from public to private sectors. *Nurse-managed*

*health centers* and *community nursing centers* have emerged, where care is provided by center nurses and advanced nurse practitioners (Miller, Utley, & Lukes, 2014). Community nursing centers may be outreach clinics provided by large hospital organizations. They may be based in colleges/universities or schools to provide family health services or health services for students or employees, or they may be freestanding. Advanced nurse practitioners may diagnose and treat common health problems in community nursing centers or refer clients for more complex care by physicians or in acute-care facilities such as hospitals.

Community nurses may provide services through organized community healthcare programs in various settings in the community. Nursing services may include activities such as health-related education and influenza and pneumonia immunizations for older adults in an adult day-care center, blood pressure screenings and nutritional counseling at a community health fair, stress management group discussion at a local church, or a cardiopulmonary resuscitation (CPR) class in a school. Nurses and advanced nurse practitioners also staff stationary or mobile clinics that provide primary care and health screening services for the medically indigent or disadvantaged. Providing care through community health centers or clinics increases access and convenience for the consumer while increasing nurse efficiency. Nurses and advanced nurse practitioners in the community also collaborate with other health and community professionals, such as social workers, nutritionists, or environmental engineers.

### Patient-Centered Medical Homes

The patient-centered medical home was envisioned to be a comprehensive approach to provide continuity of patient care across all practice settings based on the healthcare needs of the patient. The patient-care medical home was woven into the Patient Protection and Affordable Care Act, and is an alternative practice model designed to reduce costs, coordinate care efforts, and utilize health information technology to facilitate the attainment of higher quality health care and better health outcomes for patients (Klein, Laugesen, & Liu, 2013; U.S. Code of Federal Regulations, 2010). The aims of the patient-centered medical home is to engage patients and their providers in a collaborative partnership with the patient and his or her healthcare needs and outcomes as the focal point. Patient-centered medical homes are envisioned to use interdisciplinary and interprofessional care plans that integrate clinical and community preventive and health promotion services for patients. Patient-centered medical homes have been broadly defined in the legislation to provide the flexibility needed to meet the diverse community healthcare needs

and encourage their adoption. An essential distinction between traditional primary care and patient-centered medical homes is the inclusion of “teams of providers from a diverse array of professional backgrounds utilizing health information technology to manage a defined panel of patients for both acute and chronic conditions in a proactive, patient centered manner (Klein et al., 2013, p. 83). In addition to the inclusion of health information technology to facilitate the more effective and efficient exchange of information to improve healthcare services delivery, patient engagement in care is emphasized. Patient engagement in care is intended to build long-term relationships with patients where practices adapt to patient needs and focus on access to care, including strategies toward disease self-management (Klein et al., 2013; U.S. Code of Federal Regulations, 2010).

### Navigators, Assistors, and Application Counselors

A major component of the PPACA is the health insurance exchanges or marketplaces. These marketplaces are run by either states or the federal government and allow people to shop for insurance, determine whether they qualify for federal subsidies, and enroll in a health plan (Ten Nepal & Eckel, 2013). A primary goal of the PPACA is to simplify the purchase of health insurance and make the process more transparent. To accomplish this goal, there are three levels of professionals who are able to help people navigate the process of obtaining a health plan.

*Navigators* have the following five duties that are outlined in the legislation (Health Affairs, 2013):

- perform public education and outreach activities
- distribute fair and impartial enrollment information on health plans and the availability of federal subsidies
- facilitate enrollment in qualified health plans
- provide referrals to appropriate agencies for grievances or complaints
- provide all information in a manner that is linguistically and culturally appropriate for the consumer

Navigators must have existing relationships with likely marketplace consumers, including uninsured and underinsured persons, self-employed persons, and small businesses. Because of this requirement, Navigators will most likely be individuals in community-based organizations (Health Affairs, 2013; Ten Nepal & Eckel, 2013).

*In-Person Assistors* are similar to Navigators but are not part of the PPACA. They were established under the regulatory authority of the Department of Health and Human Services and are required to meet the same education, training, and conflict-of-interest requirements as Navigators. In-Person Assistors can be funded by establishment grants.

The final category of professionals who can assist consumers in navigating the marketplace are Certified Application Counselors. *Certified Application Counselors* help consumers complete the application and enrollment process. Like Navigators, Certified Application Counselors cannot be funded out of the marketplace establishment grants. They are usually community-based organizations, such as community health centers or hospitals (Health Affairs, 2013). Nurses are uniquely positioned to serve in these roles, because they are trusted members of the health-care system. Nurses or other persons interested in becoming Navigators, In-Person Assistors, or Certified Application Counselors are required to complete an online certification process (Health Affairs, 2013; U.S. Code of Federal Regulations, 2010; Ten Nepal & Eckel, 2013).



**InfoQuest:** Search the Internet for objective information about the PPACA. Many people are not familiar with the specifics of the act and believe what they hear in the media or from political pundits. What are the specific benefits provided by the PPACA? How does the PPACA affect the clients that you serve in your nursing practice? How does it affect you?

## Private Sector Settings

### Faith Communities

Faith community nursing, also called *parish nursing*, is practiced in faith communities, such as churches, synagogues, temples, and other places of worship. Faith community nursing has its historical foundations in the religious foundations of nursing, starting with the early Roman deaconesses who provided care based on Christian values and continuing through the Middle Ages, when men and women of faith provided care to those who were in need. Although faith community nursing is associated with the Christian faith, faith community nursing is also practiced in Jewish and Muslim faith communities. In contemporary society, faith community nursing began in the United States in the late 1960s, when churches used nurses to provide health care to their congregations. *Faith community nursing* is defined by the American Nurses Association (2013e, p. 5) as “the specialized practice of professional nursing that focuses on the intentional care of the spirit as part of the process of promoting wholistic health and preventing or minimizing illness in a faith community.” Ryan (1997) describes the intent of faith community nursing (formerly called *parish nursing*) as creating an atmosphere founded on the principles of their faith practice within which the parish nurse and the client

(which would include patient, family, and congregation) can engage, and exchange support and care. The relationships encompass God, the individuals, as well as the congregation and the whole community.

Faith community nursing is nondenominational and includes nurses of all religious faiths. Faith community nurses are found in nations around the world, including Canada, Australia, New Zealand, Russia, and Jamaica.

### Occupational and Environmental Health

Both **occupational health nurses** (see the accompanying interview box) and environmental health nurses focus on preventive health care, health promotion, and health restoration within the context of a safe and healthy environment. Their practice is evidence-informed and includes the prevention of adverse health effects from occupational and environmental hazards and health promotion in general (American Association of Occupational Health Nurses, 2012). Occupational health nurses work in private industry and governmental agencies and have responsibilities not only for providing healthcare services directly to employees but also for ensuring a safe work environment.

The primary functions of the occupational health nurse are to provide emergency treatment and promote worker health and safety; however, rapid changes in technology, the healthcare system, and societal expectations have expanded the nurse's role and made it increasingly complex. Occupational health nurses may now develop and carry out health promotion, health maintenance, and risk management programs and consult with their employers in reducing health-related costs. They may offer direct care to employees, manage program evaluation, and analyze work-related injuries and illnesses. In companies in which management positions have been reduced, the occupational health nurse may assume expanded responsibilities in job analysis, safety, and benefits management. Specialization in the field is often a requirement for additional responsibilities. Nurses who wish to pursue specialization and certification in occupational health will find a number of graduate programs that offer advanced education in this field.

In contrast, **environmental health** encompasses the physical, chemical, and biological factors external to a person and includes all behaviors that result from the

### Interview ► Ken Storen, BSc (CE), BScN, RN, COHN (C), DOHN—Occupational Health Services Manager

- 1. Why did you choose occupational health nursing?** There was never a plan from day 1 to become an occupational health nurse (OHN) as the profession has a low visibility outside of most workplaces. I would say it was more a journey trying on career possibilities until I found a match. Once I became an OHN I knew it was what I like to do as it allows independence, collaboration with other groups, and a sense of accomplishment as you get to see your efforts rewarded. You are highly regarded within your organization and are sought out for advice on a frequent basis.
- 2. What qualities do you think are necessary to be an occupational health nurse?** An occupational health nurse has to be a critical thinker and have very good people skills. The OHN must be self-directed and have the ability to stay updated on all the latest developments. At all times an OHN must be independent, confident, an educator, and an advocate for both employee and employer. An OHN is also considered a generalist who is knowledgeable in areas of business, law, and human resources because many of the issues encountered by OHNs require input/knowledge from all of these areas. In addition, the OHN must be culturally sensitive and able to delegate effectively.
- 3. What has been your most gratifying moment as an occupational health nurse?** I think the most gratifying moment has to be when you are able to return an employee back to work who has suffered an occupational or nonoccupational illness or injury. There is a lot of critical thinking required to look at the problems, find solutions, and then follow through to the end. Your patients are your work, and in many cases you could be with them for 20 or 30 years. You realize that everyone has a need to contribute and the sense of relief employees feel when they realize they are back to work and making a positive contribution to their employer or society.
- 4. What encouragement would you give a nurse considering practice in your setting?** Research all the branches of occupational health nursing and conduct an Internet search (e.g., Google) to find local occupational health nurses' associations to make contacts. Because it is an area that is not well known, the opportunities are great for someone starting off and someone who is looking to become a leader in the specialty.

person interacting with environmental factors. Environmental health is concerned with the assessment and control of environmental factors that influence health and contributes to the development of strategies to prevent disease/injury and create health-supportive environments (World Health Organization, 2014a). “The mission of health professionals in environmental health is to prevent, anticipate, recognize, evaluate, and control for those environmental exposures that could bring harm to a population” (Kiryuchuk & Koehncke, 2012). Occupational and environmental health nurses work in a variety of settings across the continuum from public to private sectors.

### Reflect On . . .

- organizations within your community where health care is currently delivered or where health and nursing services could be delivered. What are the advantages to delivering health care in these various settings?
- whether nursing and health services are better provided to the traditionally underserved (e.g., the poor, older adults, minorities) by providing that care in the community and in the home.
- which nursing services can be effectively delivered in the home and community. Are there any nursing services that can be delivered only in the hospital? If yes, which services and why? Are there nursing services that are more effectively delivered in the home or community? If yes, which services and why?



**InfoQuest:** Search the Internet for additional information about opportunities, specialty organizations, roles, and practice of school nursing, faith community nursing, hospice and palliative care nursing, corrections and forensic nursing, and environmental and occupational nursing.

### Nursing in Rural Communities

Defining *rural* is difficult. The Merriam-Webster OnLine dictionary (2014) defines **rural** as “relating to the country, country people or life, or agriculture.” Government definitions of rural vary according to purpose, and many of these definitions tend to focus on what is not urban/metropolitan rather than what is rural (U.S. Department of Agriculture, 2013b). Approximately 20%–25% of the U.S. population

lives in rural areas (U.S. Census Bureau, 2014). The variance relates to the multiple definitions of rural: (1) the Department of Commerce’s Census Bureau looks at population density; (2) the White House Office of Management and Budget looks at where people live and work (e.g., does a person live in a suburban or rural area but commute to an urban/metropolitan area to work?); and (3) the Department of Agriculture’s Economic Research Service combines Census Bureau information with commuting information (White House Office of Management and Budget, 2009; U.S. Census Bureau, 2014; U.S. Department of Agriculture, 2013a). Rector, Avila, and Strand (2014) define rural as “communities with fewer than 10,000 residents and a county population density of less than 1,000 persons per square mile” (p. 924). Additionally, definitions of rural may relate to land use, such as land used for ranching, farming, and agricultural purposes, or areas with significant natural resources in or under the land.

People who live in rural areas are often older, because young people tend to leave to go to urban/metropolitan areas for college and work opportunities. Families that live in rural areas tend to be poorer than their urban counterparts (U. S. Department of Agriculture, 2014). Adults living in rural areas tend to have less formal schooling than those living in urban areas, because they may have limited access to community colleges or universities in their community. “However, the [education attainment] gap is beginning to close for high school completion” in rural areas (Rector et al., 2014, p. 927). Many community colleges and universities offer courses and degree programs over the Internet, which should help to increase the rates of education in rural areas in the future. Rural areas often have some transitory population because migrant laborers and their families follow the harvesting seasons across the country.

Barriers to health care in rural areas include significant distances to healthcare providers, clinics, and hospitals; lack of public transportation to get to healthcare providers; difficult travel conditions; inability to pay for care; and language barriers for migrant laborers. There is a lack of primary health providers serving the people living in rural communities, as well as a lack of outreach or home health services to provide nursing services and other professional therapies.

In comparison to nonrural persons, “rural Americans experience higher rates of chronic disease, disability and mortality” (U.S. Department of Health and Human Services, 2013, ¶ 1). Approximately 20% of uninsured Americans live in a rural area. Compared to urban residents, a greater proportion of rural residents are uninsured or underinsured. The Patient Protection and Affordable Care Act continues to implement changes that will help to



reduce health inequities for all Americans. It is estimated that more than 7.8 million uninsured rural Americans under age 65 will have opportunities to enroll in affordable health care (U.S. Department of Health and Human Services, 2013).

Nurses who live and work in rural communities are often the primary source of health information and care. Rural health nurses need to be generalists who have a broad diversity of knowledge and experience as they address health concerns of people across the life span, the very young to the very old. Rural health nurses have greater autonomy in practice, and their activities often overlap those of other health professionals when providing nutritional counseling or physical and occupational therapies. Because of the isolation of rural communities, nurses do not always have rapid access to new health information and technology, although in recent years, new technologies, such as Internet communication, telemedicine, and telehealth, have brought specialized health care to some rural areas. Rural health nurses need to establish links to health centers to obtain information about specific patient care and to provide referral for clients with problems that cannot be resolved without medical intervention.

Because rural health nurses live and work in the community they serve, the relationship with their clients is often both personal and professional. Nurses who work in a small town or community may encounter challenges from a lack of anonymity and informal social encounters. They may feel that they are permanently on call. There is also the concern that because of the small population, “everyone knows everything about everyone else,” which can lead to problems of confidentiality. At the same time, residents of rural communities are accustomed to helping each other out as neighbors and friends when an individual or family experiences trouble: They may bring food, share their personal resources, help care for farm/ranch animals, or help harvest the crop. As the only healthcare provider in a rural community, a nurse is often highly regarded as a source of health information and referral.

## Home Health Nursing

Historically, nurses who provided direct services in the home were strong generalists who focused on long-term preventive, educational, remedial, and rehabilitative outcomes. Today, community-based **home health** services center on individualized, episodic care with curative, short-term outcomes. Many home healthcare nurses are generalists or specialists possessing high-technology skills that were formerly used only in acute-care settings. For example, nurses provide a variety of intravenous therapies in the home setting and monitor clients who are dependent on

technologically complex medical equipment, such as ventilators and central lines. These nurses collaborate with physicians and other healthcare professionals in providing care; usually, third-party payers pay for their services.

Several factors contributed to the growth of home health care in the 1980s and early 1990s, including (1) the increase in the older population, who are frequent recipients of home care; (2) third-party payers who favor home care to control costs; (3) the ability of agencies and institutions to successfully deliver high-technology services in the home; and (4) consumers who prefer to receive care in the home rather than an institution (Stulginsky, 1993a, b).

## Definitions of Home Health Nursing

The delivery of nursing services in the home has been called by a variety of terms, including *home health nursing*, *home care nursing*, and *visiting nursing*. Home care encompasses “a wide range of health services delivered at home and throughout the community to recovering, disabled, chronically, or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essentials of daily living” (Health Canada, 2013). See the interview box on page 341. Similar to other nurses in community settings, home health nurses are concerned with disease/injury prevention and health promotion, with an emphasis on care provided in the patient’s place of residence. Home health nursing services are provided not only in private residences such as homes, apartments, trailers, and cars but also in long-term care facilities, residential hospices, residential shelters for abused women and children and the homeless, and adult congregate living facilities (ACLFs) or any other place where a person lives. Zerwekh and Warner (2014) further define home health nursing as providing nursing care “to acute, chronic, and terminally ill clients of all ages in their homes, while integrating public health nursing principles that focus on the environmental, psychosocial, economic, cultural, and personal health factors affecting the client’s and family’s health status and well-being” (p. 1047).

Today, home health nurses work primarily with ill clients, collaborating with a multidisciplinary team that includes the primary physician and may include respiratory therapists, physical therapists, occupational therapists, social workers, and home health aides. Although home health nurses provide physical care, they must also incorporate their knowledge of social, economic, and environmental influences on health when planning care. Home health nursing is family-centered with the primary focus on the individual, and the family being defined by the individual (Martin & Bowles, 2014).

## Interview ► Janice Waskin, RN, MSN—*Home Health Nurse and Supervisor*

1. **Why did you choose this practice setting?** I had taken an extended leave of absence from work to care for my critically ill mother. After she expired I decided to change work settings. I had worked in ob/gyn for 16 years and thought a drastic change to geriatrics would be stimulating. I found a job in home care and realized that teaching a patient and his or her family in their home setting was so important, necessary, and rewarding.
2. **What qualities do you think are necessary to be a nurse in this setting?** From the perspective of both home care nurse and supervisor, the nurse in the field must possess several qualities to be successful. The nurse needs to have a strong med/surg background, be an independent practitioner and have excellent assessment and problem-solving skills. Dealing with the elderly in their own home also requires considerable patience, compassion, understanding, flexibility, and good teaching skills.
3. **What has been your most gratifying moment as a nurse in this setting?** The most gratifying moments were experienced when I started working with patients and families who were hesitant to provide needed care such as colostomy care, PEG tube feedings, or complicated wound care procedures. Then one day there was the acceptance and realization that they could do the care and they became proficient at it. It gave me a great deal of satisfaction to see them change and become so independent.
4. **What encouragement would you give a nurse considering practice in your setting?** Believe that patients and families desire to be independent and self-sufficient in their homes for as long as possible. Continue to develop your skills at listening and teaching them how to accomplish this during your home visits.

## Perspectives of Home Health Nursing

Stulginsky (1993a, b) interviewed home healthcare nurses who identified their practice as “meeting the acute and chronic care needs of patients and their families in the home environment.” These nurses maintained that care focuses on the client and that the nurse’s role is to advocate for the client despite possible conflict in the opinions and needs of various care providers. Because the home is the family’s territory, power and control issues in delivering nursing care differ from those in the institution. For example, entry into a home is granted, not assumed; the nurse must therefore establish trust and rapport with the client and family. Families also may feel freer to question advice, ignore directions, do things differently, and set their own priorities and schedules.

Advantages of home health care include convenience, access, information, relationship, cost, and outcomes. Care is provided in the home, convenient and accessible for clients who are immobile or have difficulty with transportation to a clinic, doctor’s office, or hospital. The home setting is intimate, enabling nurses to develop a better relationship with the client and the client’s family or caregivers. This intimacy fosters familiarity, information sharing, connections, and caring among clients, families, and their nurse. Behaviors are more natural, cultural and spiritual beliefs and practices are more visible, and multigenerational interactions tend to be displayed. Home healthcare nurses become realistic about what they can remedy and

learn how to provide various supports and use creative interventions for what they cannot remedy.

Home health nurses have also identified issues that negatively affect care in the home. More than any other care providers, these nurses have firsthand knowledge about and experience with the burden of caregiving. In the interest of cutting healthcare costs, policy makers, third-party payers, and medical providers are placing increasingly complex responsibilities on clients’ families and significant other(s). Caregiving demands may go on for months or years, placing the caregivers themselves (many of whom are older adults) at risk for physiological and psychosocial problems. This is especially so for parents who have the responsibility of caring for a disabled child or the spouse who has the responsibility of caring for a spouse with Alzheimer’s disease. This may also be true for adult children, sometimes referred to as the “sandwich generation,” who have responsibility for their own children while also providing care for elderly parents. Additionally, nurses enter homes where the living conditions and support systems may be inadequate. When this occurs, home health nurses and the individuals and families they care for face difficult decisions.

Because home healthcare nurses must function independently in a variety of home settings and situations, employers generally prefer that the nurse be prepared at the baccalaureate level or above. Many nurses choose to leave the stresses of acute-care nursing to provide more autonomous care for individuals and families in their homes.

## RESEARCH CURRENT

## The Relationship Between Social Roles and Self-Management Behavior in Women Living With HIV/AIDS

The purpose of the qualitative description study by Webel and Higgins was to identify and examine the main social roles of women living with HIV ( $n = 48$ ) and how these social roles influence self-management of HIV/AIDS. The study analyzed data collected from 12 digitally recorded focus group sessions with women who were recruited from HIV clinics and AIDS service organizations in North-eastern Ohio. Data analysis identified the following six social roles experienced by these women that influenced their HIV self-management: (1) mother/grandmother, (2) faith believer, (3) advocate, (4) stigmatized patient, (5) pet owner, and (6) employee. Social roles had both positive and negative effects on women's HIV self-management abilities. Variability in the influences of the social roles were

observed among the women based on age and length of time since diagnosis with HIV. The authors suggest that women living with HIV struggle to navigate their social roles and the demands of managing the many daily tasks required to live well with HIV disease. The authors argued that nurses and other healthcare providers working with women living with HIV must become aware of the multitude of social roles women experience in order to tailor the most effective plans of care to facilitate optimal health outcomes in partnership with these women.

*Source:* "The Relationship Between Social Roles and Self-Management Behavior in Women Living With HIV/AIDS," by A. R. Webel and P. A. Higgins, 2012, *Women's Health Issues*, 22(1), pp. e27–e33.

Hospice and palliative care nursing is often considered a subspecialty of home health nursing because hospice services are frequently delivered to terminally ill clients in their home. Hospice and palliative care is defined as "the provision of care for the client with life-limiting illness and their family with the emphasis on their physical, psychosocial, emotional and spiritual needs" (National Board for Certification of Hospice and Palliative Nurses, 2014, p. 1). Hospice and palliative care nurses provide pain and symptom management and support for family and significant others.

Financing home health care is complicated and standardized. Medicare and Medicaid are the primary funders of home healthcare services. Third-party health insurance companies are another major source of home health services funding. Preventive home care visits to clients of public health agencies (e.g., well baby visits) are provided for in public health budgets and are funded by taxes. Home care services such as health education, risk reduction, case management, and primary care may be reimbursed from federal, state, or local program funds; grants; contracts; or third-party billing (Martin & Bowles, 2014).

### Differences Between Home Health Nursing and Hospital Nursing

The role of the home care nurse is different from the role of the nurse in acute care. Some of the major differences between home health and hospital nursing include:

- The home health nurse is a guest who works within the client's home environment. In hospital environments, there is often the perception that the client is a guest and nurses and doctors own the hospital.
- The need for clear and complete communication is essential in home health nursing because other health team members are usually not present with the nurse.
- Knowledge of reimbursement systems is essential. Nurses and clients must know what services are available, because most people do not pay directly for services.
- The home health nurse works alone in the home. However, with the advent of portable computers and Internet enabled smartphones and tablets, the nurse is increasingly more connected with other healthcare professionals. These devices expedite care, facilitate communication and documentation, and provide real-time opportunities for enabling more effective communication between members of the healthcare team. As a result, clients with more complex healthcare needs can be managed effectively in the home.
- The nurse in the hospital setting has a large variety of supplies and equipment readily available. The home health nurse often must create or adapt equipment to fit the home.
- The home health nurse is at risk for malpractice claims related to the complexity of care needed and actual or alleged negligence that can arise from time constraints for each visit or when nurses fail to adhere to practice standards (Whittier, 2009).
- Knowledge of community resources is important. Community resources can often bring a great deal of improvement to the client's quality of life. Home health nurses should have a resource file to share with the client and the client's family. Internet-enabled

computers, smartphones, and tablets are useful for accessing and sharing information about community resources with clients.

### Reflect On . . .

- the differences in professional autonomy between the home healthcare nurse and the hospital nurse. What are the legal and ethical implications of the independence experienced by the home healthcare nurse?
- how the availability of computer technology assists the home healthcare nurse in providing and documenting better nursing care.

## Influencing Community Health Outcomes

### Assessment and Community Engagement

In developing an understanding of a community, the nurse uses a systematic approach in identifying community needs, defining problems, and determining community resources. Nurses assess community health by using epidemiological studies and by using an established community assessment framework or tool.

#### Epidemiological Studies

*Epidemiology* is “the study of the distribution and determinants of disease in populations” (Hilfinger Messias, McKeown, & Adams, 2014, p. 151). Friis and Sellers (2014) further elaborate the definition of epidemiology as including the factors that determine the population’s health status and the use of the knowledge generated to control the development of health problems. Epidemiological studies provide health professionals with information about the health and illness patterns of a specified population, the people involved, and any causal factors. Most health problems are currently thought to be the result of multiple causes. For example, multiple factors interact to result in illnesses such as coronary heart disease, injuries such as those experienced in motor vehicle accidents, and other health problems, including teenage pregnancy.

Epidemiologists use three types of studies: analytic, descriptive, and experimental. In *analytic studies*, the epidemiologist uses prospective (forward-looking) and retrospective (backward-looking) and/or experimental studies to test hypotheses about health and illness. A *prospective study* starts with an event and then goes forward in time to look at outcomes such as follow-up studies.

For example, a nurse researcher may implement an educational intervention with ninth-grade students to prevent teenage pregnancy in a specific high school. The researcher then gathers data about the incidence of pregnancy among those students through their graduation. The researcher can then make judgments about the effectiveness of the educational intervention. In a *retrospective study* the investigator starts with an event, such as an outbreak of food poisoning, and then looks at past records to determine the possible causes.

In addition to these classical epidemiological studies, the use of social epidemiology methods is useful in community assessment. Social epidemiology studies the social distribution and social determinants of health and is interested in understanding both specific features of, and pathways by which, societal conditions affect health (Berkman & Kawachi, 2000; Krieger, 2012).

A *descriptive study* relies primarily on existing data. The epidemiologist describes the people most likely to be affected by a disease, the geographic region in which it will occur, when it will occur, and its overall effect.

An *experimental study* is conducted to determine the effectiveness of a particular therapeutic modality. Subjects are assigned to one of two or more groups: a control group and one or more experimental groups. People in the experimental group(s) may be, for example, exposed to one or more conditions thought to improve health, to prevent disease, or to influence a person’s health status in some manner, such as implementing a specific exercise program. The members of the control group are not exposed to the experimental condition(s). Any subsequent differences in the health patterns between the groups are then attributed to the manipulated factor(s).

Two types of rates are commonly used when describing health patterns in a population: the incidence rate and the prevalence rate. The **incidence rate** reflects the number of people with a particular health problem or characteristic over a given unit of time, such as a year. The **prevalence rate** describes a situation at a given point in time. For example, if 63 students in a school of 1,000 students have chicken pox, the number of students who have the disease is divided by the number of students in the school, resulting in a prevalence rate of 0.063, or 6.3%.

#### Community Assessment Framework

There are many sources of data for community assessment (see the accompanying box). Using a systematic approach and analyzing the interrelationships between determinants of health and engaging all members of a community in the process of addressing health concerns is essential to the development of effective community health interventions. The integrated model for community



## Sources of Community Assessment Data

- City maps to locate community boundaries, roads, churches, schools, parks, hospitals, and so on
- State or provincial census data for population composition and characteristics
- Chamber of commerce for employment statistics, major industries, and primary occupations
- Municipal, state, or provincial health departments for location of health facilities, occupational health programs, numbers of health professionals, numbers of welfare recipients, and so on
- City or regional health planning boards for health needs and practices
- Telephone book for location of social, recreational, and health organizations, committees, and facilities, and individual healthcare providers
- Public and university libraries for district social and cultural research reports
- Health facility administrators for information about employee caseloads, prevalent types of problems, and dominant needs
- Recreational directors for programs provided and participation levels
- Police department for incidence of crime, vandalism, domestic violence, and drug addiction
- Teachers and school nurses for incidence of children's health problems and information on facilities and services to maintain and promote health
- Local newspapers for community activities related to health and wellness, such as health lectures or health fairs
- Online computer services that may provide access to public documents related to community health and census data

assessment (Figure 18–2) is a conceptual model of essential components that must be addressed at each ecosocial level (i.e., individual, social, and structural) in the process of influencing community health outcomes. Community health nurses in partnership with community

members who are affected by or interested in addressing community health concerns actively engage in the process to design health-promoting and injury-preventing strategies. The process of influencing community health outcomes includes five essential tasks: assessment,

## RESEARCH CURRENT

### Changing Health Outcomes of Vulnerable Populations Through Nursing's Influence on Neighborhood Built Environment: A Framework for Nursing Research

The purpose of this article by DeGuzman and Kulbok was to present a framework for nurses to study the impact of built environment on health outcomes among vulnerable populations. The authors adapted a framework of the social determinants of health and environmental health promotion that described how physical and social environments interact and influence individual and population health outcomes across multiple contextual levels (e.g., macro, community-level, and interpersonal factors). Nursing research that evaluated built environments and health outcomes was supplemented with Nightingale's theory of nursing to adapt the framework for public health nursing. The integration of global information systems (GIS) technology facilitated objective comparisons of built environments across large and diverse geographic areas at multiple levels of analysis. Built environment factors that affect health were observed at regional, neighborhood, and individual levels. Regional-level factors that influenced health included material wealth, employment, educational opportunities, and political influence. Neighborhood-level factors that influenced health included neighborhood income,

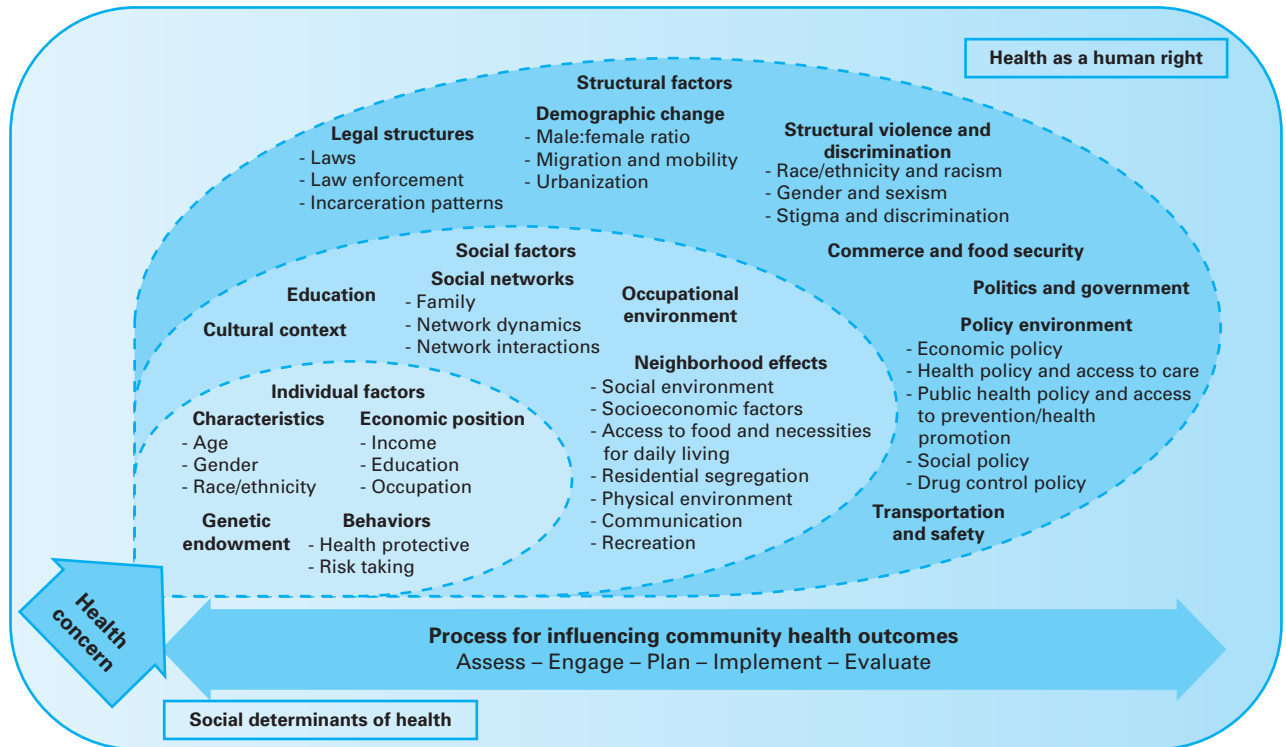
neighborhood education, and collective efficacy (a measure of informal social control, mutual trust, and social cohesion). Individual-level factors that influenced health included specific health behaviors of walking and dietary practices. Additional social network factors observed to influence health at the individual level included social network factors that increase an individual's access to jobs or political activity. The authors described that GIS is a useful tool to study the effect of the neighborhood built environment on health outcomes of populations.

The authors reported that public health nurses and other public health clinicians can use their framework to understand the pathways by which built environments influence the health of their patients. The information gained by using this framework can guide researchers and clinicians in the development, implementation, and evaluation of interventions to improve population health.

*Source:* "Changing Health Outcomes of Vulnerable Populations Through Nursing's Influence on Neighborhood Built Environment: A Framework for Nursing Research," by P. B. DeGuzman and P. A. Kulbok, 2012, *Journal of Nursing Scholarship*, 44(4), pp. 341–348.

FIGURE 18-2

Integrated Model for Community Assessment



engagement, planning, implementation, and evaluation. The first two tasks must occur nearly simultaneously to be most effective and inclusive of all perspectives about what is the best approach to positively influence community health outcomes. When a community health nurse works with an engaged community, the planning, implementation, and evaluation tasks are facilitated because community members are more likely to believe that they have a vested interest in improving their community.

**Assessment/Engagement** Assessment of the community includes an examination of the community's history, its demographics, and its values and beliefs conducted with the engagement of community members and leaders, both formal and informal. Key informant interviews and community stakeholder forums may be used to solicit community involvement in the assessment process. In examining the history of the community, the nurse might seek to find out whether this is an older, established community, with little population shift, or a new community. Is it a community where a large percentage of the population moves in and out in a more transient way? What are the members of the community proud of, for example, its programs for children, for the elderly, for other specific populations?

In assessing the demographics of the community, the observer would collect data about population size, rate of growth, density, and composition; life expectancy; overall health status of individuals; the types of people and families living in the community and their age, ethnicity, languages spoken, marital status; and other demographic characteristics that might indicate the health needs of the community. The analysis of demographic characteristics entails evaluation of individual factors that contribute to health, including age, gender, race/ethnicity; genetic endowment; economic position (e.g., income, education, occupation); and behaviors that are health protective or risk taking. Consider that a specific community might provide comfort and a home to population groups that are sometimes marginalized by general society, such as homeless communities or gay and lesbian communities.

The values and beliefs of the community are assessed by noting signs of culture and community heritage, cleanliness, green spaces, and the numbers and types of houses of faith, including churches, temples, synagogues, and mosques. To gain a full understanding of the values and beliefs that underpin a community, the community health nurse must analyze the interrelationships between social and

structural factors and how they influence the health outcomes of community members individually and collectively. Social factors that can contribute to the health of individuals and communities include (1) education; (2) cultural context; (3) social networks (e.g., family, friends, network dynamics, network interactions); (4) occupational environment; and (5) neighborhood effects (e.g., social environment, socioeconomic factors, residential segregation, physical environment, communication, recreation, and access to food and necessities for daily living). Structural factors that influence community health outcomes include:

- Legal structures, for example, laws, law enforcement, incarceration patterns
- Demographic change, for example, male:female ratio, urbanization, migration, and mobility
- Structural violence and discrimination, for example, race/ethnicity and racism, gender and sexism, stigma and discrimination
- Commerce and food security
- Politics and government
- Policy environment, for example, economic policy, health policy and access to care, public health policy and access to disease/injury prevention and health promotion, social policy, drug control policy
- Transportation and safety

Completion of an integrated community health assessment, often referred to as a *windshield survey*, facilitates community engagement and establishes a solid foundation for the planning, implementation, and evaluation phases of community health intervention. This integrated assessment approach helps the community to achieve the goal of health as a human right for all community members. The windshield survey is derived from an ethnographic research strategy that provides community health nurses with an overall perspective of a community and can provide clues about its health and the well-being of its members (Polit & Beck, 2012). An integrated community health assessment is used to assess each of the community's domains of individual factors including genetic endowment, economic positions, and behavior; social factors including education, social networks, cultural context, occupational environment,

and neighborhood effects; and structural factors including, legal structures, demographic change, structural violence and discrimination, commerce and food security, politics and government, policy environment, and transportation and safety (see Table 18–1).



**InfoQuest** Using the keywords windshield survey and community assessment, conduct an Internet search. What are the major sources of information from this search? What are the major differences between the tools you are able to identify with this search?

The final component of assessing the community addresses the perceptions of the residents of the community based on their life experience within the community and the perceptions of the observer. Residents reflecting the diversity of the community (age, gender, and ethnicity) can be asked how they feel about their community and what the community's strengths and weaknesses are. Finally, the observer can validate his or her own perceptions with various residents and leaders of the community. To achieve the goals set forth in *Healthy People 2020*, it is essential for nurses to meaningfully engage with community residents and leaders in all aspects of addressing community health issues. Community engagement is “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people” (Centers for Disease Control and Prevention, 2014).

## Diagnosing

After gathering and analyzing the community assessment data, the nurse identifies community diagnoses that describe the health situation in the community and the etiology, or reason, for health problems that exist. Nursing diagnoses are those actual or potential health problems that

## CRITICAL THINKING EXERCISE

Select a community of interest in your area. Using the integrated model for community assessment shown in Figure 18–2 and a community assessment tool, assess your community. What are your findings? What are the

strengths of the community? What are the weaknesses? As a registered nurse in your community, what strategies would you propose to improve on the weaknesses you identified?

**TABLE 18–1 Integrated Community Health Assessment****Community Engagement and Preliminary Data-Gathering Activities**

- Identify key informants and community stakeholders.
- Begin to establish rapport with community members and leaders (formal and informal).
- Identify social determinants of health that influence the community.
- Explore data sources to determine the community's preliminary health concerns.

| Domain                    | Subdomain                   | Assessment Questions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Individual Factors</b> |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Characteristics           | <i>Age</i>                  | <ul style="list-style-type: none"> <li>• What is the average age of the community?</li> <li>• What is the age distribution of the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                  |
|                           | <i>Gender</i>               | <ul style="list-style-type: none"> <li>• How many males and females are in the community?</li> <li>• Are there sexual minority (lesbian, gay, bisexual, transgender, Two Spirit, queer, intersex) persons in the community?</li> </ul>                                                                                                                                                                                                                                                                                   |
|                           | <i>Race/ethnicity</i>       | <ul style="list-style-type: none"> <li>• What racial/ethnic groups are part of the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Genetic Endowment         |                             | <ul style="list-style-type: none"> <li>• What are the rates of congenital defects in the community?</li> <li>• Is there reason to suspect genetic anomalies among some or all community members?</li> </ul>                                                                                                                                                                                                                                                                                                              |
| Economic Position         | <i>Income</i>               | <ul style="list-style-type: none"> <li>• What is the average income of the community?</li> <li>• What is the wealth distribution in the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                                            |
|                           | <i>Education</i>            | <ul style="list-style-type: none"> <li>• What is the level of education in the community? Are educational opportunities equitably distributed within the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                           |
|                           | <i>Occupations</i>          | <ul style="list-style-type: none"> <li>• What types of occupations are prevalent in the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                            |
| Behaviors                 | <i>Health protective</i>    | <ul style="list-style-type: none"> <li>• What health protective measures do the community, its members, and its leaders engage in?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                            |
|                           | <i>Risk taking</i>          | <ul style="list-style-type: none"> <li>• What risk-taking behaviors are practiced in the community?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Social Factors</b>     |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Education                 |                             | <ul style="list-style-type: none"> <li>• Are there schools in the community?</li> <li>• How do the schools look?</li> <li>• What is the reputation of the schools?</li> <li>• What are the dropout and completion rates for the community's schools?</li> <li>• Are extracurricular activities available? Are they used?</li> <li>• Is there a local board of education? How does it function?</li> <li>• Are there libraries in the community?</li> <li>• What are the community's major educational issues?</li> </ul> |
| Social Networks           | <i>Family</i>               | <ul style="list-style-type: none"> <li>• How is family defined by members of the community? Are families made up of blood relations or are they defined differently?</li> </ul>                                                                                                                                                                                                                                                                                                                                          |
|                           | <i>Network dynamics</i>     | <ul style="list-style-type: none"> <li>• Are community networks stable or in flux?</li> <li>• What is the level of network functioning? Are leaders formal or informal?</li> </ul>                                                                                                                                                                                                                                                                                                                                       |
|                           | <i>Network interactions</i> | <ul style="list-style-type: none"> <li>• Is there communication within and between networks? What form(s) of communication exist within and between networks (e.g., open forums for dialogue about concerns/issues, violence within and/or between groups)?</li> </ul>                                                                                                                                                                                                                                                   |
| Cultural Context          |                             | <ul style="list-style-type: none"> <li>• Are there museums, amphitheatres, historical markers, historical sites, or other gathering places of cultural significance in the community? Are they used?</li> </ul>                                                                                                                                                                                                                                                                                                          |
| Occupational Environment  |                             | <ul style="list-style-type: none"> <li>• Are there places of employment, industries?</li> <li>• What are working conditions like?</li> <li>• What is the unemployment rate?</li> </ul>                                                                                                                                                                                                                                                                                                                                   |

(Continued)



**TABLE 18–1 Integrated Community Health Assessment (Cont.)**

| Domain                                 | Subdomain                                                                     | Assessment Questions                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Social Factors</b>                  |                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Neighborhood Effects                   | <i>Social environment</i>                                                     | <ul style="list-style-type: none"> <li>• Are there common areas where people gather?</li> <li>• Is the community conducive to social interactions?</li> <li>• What religious/philosophical beliefs do the community members ascribe to?</li> <li>• Are there religious/philosophical differences in the community?</li> </ul>                                                                                                                        |
|                                        | <i>Socioeconomic factors, access to food and necessities for daily living</i> | <ul style="list-style-type: none"> <li>• Are there stores? What types of stores are available? What is the average distance traveled to reach stores?</li> <li>• Where do people shop for food and other necessities for daily living? Is there evidence that social subsidies are used to purchase food?</li> </ul>                                                                                                                                 |
|                                        | <i>Residential segregation</i>                                                | <ul style="list-style-type: none"> <li>• Is there diversity of housing and residential opportunities?</li> <li>• Does there appear to be residential segregation based on race/ethnicity, socioeconomic status, or other characteristics?</li> </ul>                                                                                                                                                                                                 |
|                                        | <i>Physical environment</i>                                                   | <ul style="list-style-type: none"> <li>• How does the physical environment look?</li> <li>• What are the geographic and physical boundaries of the community? Is there a map of the community?</li> <li>• What is the size of the community? What is the population size? What is the size of the geographic territory (e.g., square miles)?</li> </ul>                                                                                              |
|                                        | <i>Communication</i>                                                          | <ul style="list-style-type: none"> <li>• What modes of communication (e.g., telephone, computers, newspapers, radio, television, word of mouth) exist? Which modes of communication do people use?</li> <li>• What are the formal and informal methods of communication?</li> <li>• What communication strategies are used for conveying health and social services information? Are there public service announcements/messages visible?</li> </ul> |
|                                        | <i>Recreation</i>                                                             | <ul style="list-style-type: none"> <li>• Where do children play? Where do families and/or adults play?</li> <li>• What are the major forms of recreation? Who participates?</li> <li>• What facilities for recreation do you see (e.g., sports fields, parks, entertainment venues)?</li> </ul>                                                                                                                                                      |
| <b>Structural Factors</b>              |                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Legal Structures                       | <i>Laws</i>                                                                   | <ul style="list-style-type: none"> <li>• Are the laws generally accepted and followed?</li> <li>• Are there concerns about crime? What types of crime? What crime statistics are available?</li> </ul>                                                                                                                                                                                                                                               |
|                                        | <i>Law enforcement</i>                                                        | <ul style="list-style-type: none"> <li>• Are there police services available?</li> <li>• What is the community's perception of the police? Are they perceived as beneficial/helpful?</li> </ul>                                                                                                                                                                                                                                                      |
|                                        | <i>Incarceration patterns</i>                                                 | <ul style="list-style-type: none"> <li>• What are the incarceration patterns? Are specific members of the community disproportionately incarcerated?</li> </ul>                                                                                                                                                                                                                                                                                      |
|                                        | <i>Male/female ratio</i>                                                      | <ul style="list-style-type: none"> <li>• What is the male to female ratio?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                |
|                                        | <i>Age</i>                                                                    | <ul style="list-style-type: none"> <li>• What is the age distribution?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                    |
| Demographic Change                     | <i>Migration/mobility</i>                                                     | <ul style="list-style-type: none"> <li>• What are the patterns of migration and mobility? Are people moving in or out of the community? Where are they coming from? Where are they going?</li> </ul>                                                                                                                                                                                                                                                 |
|                                        | <i>Urbanization</i>                                                           | <ul style="list-style-type: none"> <li>• What is the level of urbanization? Is the community urban, suburban, rural, or remote?</li> </ul>                                                                                                                                                                                                                                                                                                           |
| Structural Violence and Discrimination | <i>Race, ethnicity, and racism</i>                                            | <ul style="list-style-type: none"> <li>• Are there current or historical race/ethnic tensions?</li> <li>• Are specific race/ethnic groups viewed differently from other members of the community?</li> </ul>                                                                                                                                                                                                                                         |
|                                        | <i>Gender and sexism</i>                                                      | <ul style="list-style-type: none"> <li>• Are there gender- or sex-based tensions in the community? Are women and men equally valued in the community? Are sexual minority persons in the community treated differently from other community members?</li> </ul>                                                                                                                                                                                      |

(Continued)

**TABLE 18–1 Integrated Community Health Assessment (Cont.)**

| Domain                     | Subdomain                                             | Assessment Questions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Commerce and Food Security | <i>Stigma and discrimination</i>                      | <ul style="list-style-type: none"> <li>• Are specific groups stigmatized? What groups? What are the experiences and perceptions of stigma from the stigmatized group members and other community members?</li> <li>• Is there evidence of discrimination? Are specific groups discriminated against?</li> </ul>                                                                                                                                                                                                                                                                                                                               |
|                            |                                                       | <ul style="list-style-type: none"> <li>• Are conditions favorable for food production (e.g., farms, community or family/individual gardens)?</li> <li>• Are there food production, processing, or distribution concerns?</li> <li>• What is the trade environment like?</li> </ul>                                                                                                                                                                                                                                                                                                                                                            |
|                            |                                                       | <ul style="list-style-type: none"> <li>• What form of government predominates in the community (e.g., elected mayor and city council)?</li> <li>• Are there signs of political activity (e.g., posters, meetings)?</li> <li>• What political party(ies) are present in the community? Which one(s) predominate?</li> <li>• Are community members involved in decision making in their local government?</li> </ul>                                                                                                                                                                                                                            |
|                            |                                                       | <ul style="list-style-type: none"> <li>• Is there free and/or fair trade? Are there incentives or tariffs on food or consumer goods?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Policy Environment         | <i>Economic policy</i>                                | <ul style="list-style-type: none"> <li>• Is there evidence of acute or chronic health problems?</li> <li>• Is there evidence of traditional healers (botanicas, <i>curandero[a]</i>s, etc.)?</li> <li>• Are there healthcare settings present (clinics, hospitals, healthcare providers' offices, public health services, home health agencies, emergency/urgent care centers, nursing homes, mental health services, etc.)?</li> <li>• If not available in the community, are they accessible to community members?</li> <li>• Is there evidence of public health initiatives for disease/injury prevention and health promotion?</li> </ul> |
|                            | <i>Health/public health policy and access to care</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                            | <i>Social policy</i>                                  | <ul style="list-style-type: none"> <li>• Are there shelters (e.g., homeless shelters, shelters for victims of domestic violence)?</li> <li>• Are there social services agencies?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                            | <i>Drug control policy</i>                            | <ul style="list-style-type: none"> <li>• Is there evidence of drug use, abuse, and misuse?</li> <li>• Is there drug abuse prevention information available?</li> <li>• Are drug detoxification, treatment, and rehabilitation services available?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                  |
| Transportation and Safety  |                                                       | <ul style="list-style-type: none"> <li>• Are there protective services (e.g., fire, sanitation) available?</li> <li>• Are air and water quality monitored?</li> <li>• Do people feel safe?</li> <li>• How do people get around?</li> <li>• What types of public and private transportation are available?</li> <li>• Are there automobiles, buses, bicycles, taxis, trains, or other modes of transportation?</li> </ul>                                                                                                                                                                                                                      |

the nurse is qualified to treat based on scope of practice and licensure. Community nursing diagnoses focus on a community or an aggregate of people rather than individuals, for example, high infant mortality rate, high rate of sexually transmitted diseases (STDs) or HIV/AIDS among teenagers and young adults, or high rate of morbidity/mortality related to motor vehicle accidents (MVs) among the elderly.

A community nursing diagnosis not only states the problem but also includes the etiology of the problem and the signs and symptoms or characteristics of the problem.

For the examples given above, the etiology statements could be:

- High infant mortality rate related to lack of prenatal care, as evidenced by
  - insufficient public prenatal clinics
  - inaccessibility of available prenatal clinics
- High rate of STDs and HIV/AIDS related to lack of school-based health education programs, as evidenced by
  - insufficient or inaccurate sexual health knowledge of teenagers and young adults in the community

- unavailability of sexual health education programs in community schools
- unavailability of sexual health education programs in community faith communities
- High rate of morbidity/mortality related to motor vehicle accidents among the elderly, as evidenced by
  - insufficient public transportation resources
  - lack of safe driving education programs for older adults

It is important to note that although the community nursing diagnoses are related to health problems in the community, the data supporting the diagnosis may come from any of the subsystems of the community. In the examples given, the subsystems of education, safety and transportation, and health and social services are all involved in the problems cited. Therefore, the solutions need to focus on the appropriate subsystems of the community if they are to be successful. Furthermore, collaborating with community members through the community engagement process will facilitate more accurate diagnoses that can lead to interventions that are more acceptable to members of the community, which increases the likelihood of sustainability and improved community health outcomes.

## Planning and Implementation

Planning community health may be oriented toward improved crisis management, disease prevention, health maintenance, and/or health promotion. The responsibility for planning at the community level is usually broadly

based. The exact resources and skills of members of the community will often depend on the size of the community. A broadly based planning group that includes leaders from the community is most likely to create a plan that is acceptable to members of the community and is essential for effective engagement. Also, people who are involved in planning become educated about the problems, the resources, and the interrelationships within the subsystem relative to health problems.

When setting priorities, health planners must work with consumers, interest groups, or other involved persons to prioritize health problems. The priority areas established in *Healthy People 2020* can be used as a guide during this stage (U.S. Department of Health and Human Services, 2014). It is important to take into consideration the values and interests of community members, the severity of the problems, and the resources available to identify and act on the problems. The inclusion of community members is an essential component of community engagement that builds community capacity and increases the likelihood of sustainability of interventions designed to improve community and/or population health.

Establishing goals also requires consumer participation. The goals should reflect a desirable state, for example, to reduce infant mortality by 15%. National statistics and/or *Healthy People 2020* topics and objectives may be helpful in keeping goals realistic. Among the many other factors that must be considered are the traditions of people in the community, the community's self-identified needs and priorities, vested interests, current organizations, and resources, all of which may be barriers to change. An example of a goal for a

## RESEARCH CURRENT

### The Development of a Community and Home-Based Chronic Care Management Program for Older Adults

The purpose of Cooper and McCarter's project was to evaluate a chronic care management program piloted by a visiting nurses association. The desired program evaluation outcomes were increased nurses' knowledge of chronic condition self-management and improvement in patient self-efficacy and clinical measures. Results from the nurses' educational development component of the study included 17 home care and community health nurses completing the Chronic Care Professional certification program. All of the home care and community health nurses were successful in completing the certification program, and the agency became a fully accredited Chronic Care Professional organization. Faith community nurses ( $n = 38$ ) completed a half-day continuing education program and posttest on the care of aging persons and

persons living with chronic conditions. Patient improvement in self-management was measured with pre- and postintervention self-efficacy scores; clinical outcome measures including blood pressure, weight, pulse, blood glucose; and the type(s) of chronic disease(s) and demographic characteristics for each patient. A total of 13 patients were included in the pilot project. Of these, 3 patients were observed to have self-efficacy scores improve and 8 had improvement in clinical measures. Cooper and McCarter determined that the educational development of community nurses prepared those nurses to provide more effective care to older adults with chronic conditions.

*Source:* "The Development of a Community and Home-Based Chronic Care Management Program for Older Adults," by J. Cooper and K. A. McCarter, 2013, *Public Health Nursing*, 31(1), pp. 36–43.

### CRITICAL THINKING EXERCISE

Using the American Nurses Credentialing Center (ANCC) guidelines, what academic and experiential qualifications should a nurse have to practice in the community or home setting? What are the differences in knowledge and

skill required to become certified as a community health nurse or a home care nurse? How do your nursing experiences prepare you to function in the community as either a community health nurse or a home health nurse?

community would be to reduce the incidence of motor vehicle accidents among older adult drivers.

Outcome criteria or objectives are specific, measurable targets. An example of such an objective is an increase in immunization levels by 20%, to be achieved by September 2018.

Implementing nursing strategies in community health is generally a collaborative action. Nurses are also frequently catalysts and facilitators in the implementation of plans.

### Evaluation

In community health, evaluation determines whether the planned interventions have led to the achievement of the established goals and objectives, for example, whether the rate of STDs and HIV/AIDS in teenagers and young adults decreased. Because community health is usually a collaborative process between health providers (including nurses), community leaders, politicians, and consumers, all may be involved in the evaluation process. Often the community health/public health nurse is the agent of evaluation in collecting evaluation data that determine the effectiveness of implemented programs. Evaluation data may include community statistics related to changes in disease incidence rates, mortality and morbidity rates, the costs to provide programs and the availability of required financial and other resources, and citizen program utilization and satisfaction rates. Leaders must decide whether the benefits of a program merit the costs in money, time,

and other resources. Based on such evaluation, effective programs may be continued, ineffective programs may be discontinued, existing programs may be modified, or new programs may be implemented.

### Reflect On . . .

- the responsibility and role of the hospital-based nurse in promoting community health. What activities can you pursue to promote community health in your various communities?
- the value of collaboration among various health professionals in promoting community health. How can you, as a nurse, influence legislators and policy makers who have little or no knowledge and experience related to health care to make wise and effective decisions regarding community health?
- your thoughts about differences in autonomy in decision making and practice between the hospital nurse, the community nurse, and the home care nurse. Do you believe that one type of nurse has greater autonomy than another, or are there simply differences in the types of independent decision making and practice? What is your level of autonomy in your current area of practice? How does it compare to the autonomy experienced by community nurses or home health nurses?

## Chapter Highlights

- Achieving health care for all is a major national and international goal integrated into *Healthy People 2020* and the Patient Protection and Affordable Care Act.
- Community health nurses are concerned with addressing the determinants of health to facilitate the achievement of optimal health functioning in communities.



- The expansion of health insurance to all Americans provides both challenges and opportunities for community health nurses.
- Definitions of community include geographic community, common interest community, and community of solution.
- Ecosocial theory provides a mechanism for viewing all aspects of the environment that influence community health nursing outcomes.
- The primary philosophical paradigms of community health nursing include community-based nursing practice, community-oriented nursing practice, public health nursing practice, and home health nursing practice.
- Community-based nursing settings can be categorized as public and private sector settings. There is tremendous overlap between these sectors, and some settings can be viewed as existing in both sectors.
- Public sector settings include public health, Indian Health Services, Uniformed Public Health Services, schools, addictions, corrections, and forensic settings.
- Private sector settings include community centers, essential community providers, and patient-centered medical homes.
- The complexity of the Patient Protection and Affordable Care Act has necessitated the creation of consumer advocates—Navigators and In-Person Assistors—to help patients navigate the healthcare exchanges set up to enroll Americans into health plans.
- Persons living in rural communities have unique needs that community health nurses are able to provide for.
- Home health nursing is individual-based care that is provided in the community.
- Home health nursing requires modifications of how nursing services are delivered because the nurse is the outsider or guest in the patient's home.
- Community health assessment entails a systematic approach to assessment and community engagement to diagnose, plan, implement, and evaluate interventions.
- Epidemiology and epidemiological evidence are essential components of community health assessment. Both community health nurses and home health nurses are essential components of a healthcare delivery system that ensures access to quality health care at an affordable cost that is acceptable to patients and communities.

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# 19

## Global Health

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### Chapter Outline

#### Challenges and Opportunities

##### Understanding Global Health

- Goals of Global Health
- Principles of Global Health
- Human Rights and Ethical Considerations

##### Global Health Concerns

- Demographic and Epidemic Shifts
- Communicable Disease
- Noncommunicable Disease
- Environment and Health

##### Health Systems in a Global Environment

- Governmental and Intergovernmental Systems
- Community Development Assistance Agencies
- Nongovernmental Systems

##### Health Delivery Systems Around the World

- Health System Models

##### Nursing and Global Health

- Nursing Roles in Global Health
- Nursing and Health Professions Organizations
- Nursing Opportunities in Global Health
- Nurse Migration

#### Chapter Highlights

### Objectives

1. Consider the importance of individual nurses having knowledge of global health.
2. Describe the interrelationship between determinants of health and international efforts to achieve health for all, including the strengths and limitations of health as a human right.
3. Explain elements of the global health policy agenda and nursing's role in achieving health for all.
4. Examine global demographics and their relationship to the major health conditions currently affecting the world's populations.
5. Describe the influence of selected global, national, regional, and local (area or group) organizational structures and describe their influence on global health outcomes.
6. Compare and contrast selected national healthcare systems.
7. Discuss nursing's role in addressing global health challenges.

**P**peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity are the fundamental conditions and resources necessary for health (World Health Organization, 1986). Nursing is intimately involved in all aspects of global health, including health promotion, disease/injury prevention, disease/injury management, and health care. Nurses in every country are entrusted to have an essential role in finding local solutions to health problems. Collectively, nurses possess the knowledge, skills, and human potential to be leaders in identifying solutions to global health problems. According to Glasgow, Dunphy, and Mainous (2010), there is a need for increased emphasis on global health in nursing education curricula.

It is important for nurses to study global health in order to identify the relevance of global health concepts to nurses' practice in their local communities, to gain a better understanding of progress that has already been made in addressing global health problems, and to identify the global health challenges that remain to be addressed and how to address them most effectively. The expansion of communication technologies and the ease of international travel have resulted in the world shrinking. Therefore all people must be concerned about the health of others. Nurses, as

the largest group of health providers, have an ethical imperative to bring their knowledge and skill to bear in finding solutions to these global health concerns. There are significant worldwide disparities in health outcomes that result in ethical and humanitarian questions related to assessing and addressing these issues.

### Reflect On . . .

- your own travel experiences. Have you avoided travel to certain countries because of health conditions? If you have traveled to countries where infectious disease is endemic, what precautions did you take to avoid becoming ill? Have you returned from international travel feeling unwell, for example, experiencing gastrointestinal upset or diarrhea? What are your thoughts/feelings about those experiences?
- your professional clinical experiences. Have you cared for a patient who acquired disease or injury while traveling to another country? Have you cared for military veterans who acquired malaria, hepatitis, or other disease during military duty in another country? Consider that some elderly veterans of World War II, the Korean Conflict, and the Vietnam Conflict may still experience exacerbations of diseases acquired during military service. What additional knowledge and skills do you need to care for patients with these diseases?

This chapter discusses global health concepts, health status indicators, strategies to address health and human development concerns, and nursing's roles and responsibilities in achieving the goal of health for all. The concept of human development, which involves the study of the human condition, includes all dimensions of personhood and is closely linked to health and the achievement of optimal health outcomes. In this chapter, **human development** is defined as the process of expanding people's freedoms and opportunities to improve their well-being. It is about the real freedom ordinary people should have to decide who to be, what to do, and how to live (Social Science Research Council, 2014). Human development is a process that is concerned with advancing the richness of human life, rather than the richness of the economy in which human beings live (Sen, 2004). Human development defined in this way encompasses both individual and collective development potential. Countries with major health problems encounter difficulties attracting economic development opportunities that would facilitate overcoming health and development challenges.

## Challenges and Opportunities

Current worldwide concerns across many healthcare systems have resulted in unique challenges that confront nurses in practice, research, and academic environments. Various geopolitical and economic constraints, as well as jurisdictional limitations may restrict nurses' ability to carry out their professional obligations and to practice in an ethical and socially just manner. Nearly 20 million people die each year because of global health inequities, most of them among the world's poor (Gostin & Friedman, 2013). There have been concerted international efforts to address global health challenges—among them, the enactment of the Millennium Development Goals (MDG) by the United Nations—by governments and societies as well as disease-specific initiatives and efforts to strengthen health systems globally. These efforts strive to integrate perspectives from all sectors of society to influence health outcomes for individuals and populations, directly and indirectly. Global health challenges include addressing major causes of morbidity and mortality, from communicable and infectious diseases, noncommunicable diseases, traumatic injuries, and violence, to climate changes. Nurses and other health and human rights leaders must be empowered to influence all aspects of society that contribute to global health and human development.

A final challenge is the global demand for competent, skilled healthcare workers. This demand has resulted in nurse migration, which creates challenges for the health systems they are leaving, for the health systems they are entering, and for the nurses themselves.

Nursing has a historical imperative for engaging in and leading activities of social justice that has resulted in an expectation for nurses to be active citizens of the world (Crigger, Brannigan, & Baird, 2006). In an ever more globalized world, it is important for nurses to understand our historical imperative to be leaders in addressing global health challenges. Nurses' understanding of the field of global health and increasing their ability to effectively communicate with others about global health challenges requires knowledge of the determinants of health, health equity, social justice, and human rights. Integral to this understanding is knowledge of community and human development processes and their interrelationship with human health and global health outcomes. Additionally, nurses must understand their nursing roles and the social responsibility they have to facilitate the achievement of health for all.

## Understanding Global Health

Nurses around the world have an ability to influence global health through their knowledge, skills, and values as nurses. An essential part of understanding what is meant



by global health includes defining it in relation to international health and public health. **Global health** refers to the optimal well-being of all persons from individual and collective perspectives. The good health of individuals benefits the health of those around them and therefore has a synergistic effect on the health of the broader society. Global health (Koplan et al., 2009):

- Addresses health issues that transcend national boundaries, such as highly pathogenic avian influenza (HPAI).
- Requires global cooperation and multilateral approaches to manage health issues, including planning and implementation of strategies to combat the spread of emerging or reemerging infectious diseases like Ebola, malaria and measles.
- Focuses on population health issues through interventions and initiatives focused on disease/injury prevention and the delivery of clinical care services, such as diagnostic and treatment strategies for more efficient approaches to tuberculosis care and control.
- Is based on the principles of health equity across and within nations with a goal of achieving health for all, such as essential medicines programs that ensure the availability of medications to address the health needs of vulnerable populations around the world.
- Requires interdisciplinary and interprofessional approaches designed to improve population health outcomes by positively influencing the determinants of health.

Global health emerged from the fields of international health and public health. Conceptually the focus and purpose of global health are more expansive than either of these and encompass broader goals for the achievement of health for all. **International health** addresses health issues that occur in another country, with bilateral (usually between two countries) cooperation with the goal of helping other nations. International health embraces a few disciplines with the goal of providing health care to populations in another country (Koplan et al., 2009).

**Public health**, in contrast, addresses health issues of access and equity within one country and focuses on specific communities, being only occasionally concerned with health issues in other countries.

## Goals of Global Health

The goals of global health have been formulated in several international agreements, including the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion. These international documents provide foundations upon which current conceptualizations of health-care systems and health system reforms are built. In the United States, the U.S. Department of Health and Human Services (2015)

identified three goals for global health engagement that reflect the agency's mission to protect the health and security of Americans and contribute the agency's unique assets to improve health around the world. The department's three goals are (1) to protect and promote the health and well-being of Americans through global health action; (2) to provide leadership and technical expertise in science, policy, programs, and practice to improve global health; and (3) to advance the interests of the United States in international diplomacy, development, and security through global health action (U.S. Department of Health and Human Services, 2015). These goals are consistent with international goals of achieving health for all.



**InfoQuest:** Explore the [globalhealth.gov](http://globalhealth.gov) website. What are the key priorities for each of the global strategy objectives identified by the U.S. Department of Health and Human Services? What activities can registered nurses engage in to facilitate achievement of these key priorities?

## Primary Health Care

Primary health care is an approach to health that includes a spectrum of services extending beyond the traditional health-care system. It encompasses all services that influence the determinants of health, such as income, housing, education, and the environment. Embedded within primary health care is primary care, which focuses on healthcare services and is a major component of nursing student studies, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. The five domains of primary health care articulated in the Declaration of Alma-Ata are accessibility and equitable distribution, community participation, health promotion, appropriate technology, and intersectoral collaboration (World Health Organization, 2015d). Each of these domains is an essential and integral part of achieving health for all.

*Accessibility* and *equitable distribution* mean that health care is universally available regardless of geographic location and sociodemographic characteristics. *Community participation* means that efforts are made to engage the community in decision making about its state of health, its health needs, and solutions to its health challenges. *Health promotion* includes education on a variety of topics such as maternal and child health, immunizations, nutrition, sanitation, and endemic disease control. *Appropriate technology* includes the use of technologies that are evidence-informed, cost-effective, and feasible for

use in the community. The rational use of essential medicines and health products for the treatment and control of endemic diseases also falls within this domain. *Intersectoral collaboration* integrates all the sectors involved in addressing the determinants of health, such as agriculture, education, housing, and water and sanitation resources (World Health Organization, 2015d). The research and data analysis processes are integrated in each of the five domains.

## Principles of Global Health

The principles of global health have been described in various national and international documents, including the Global Health Strategy of the U.S. Department of Health and Human Services Strategic Plan 2010–2015 (2011). The underlying principles of global health include:

- Using evidence-based knowledge to inform decisions
- Leveraging strengths through partnership and coordination
- Responding to local needs
- Building local capacities
- Ensuring a lasting, measurable impact
- Emphasizing prevention
- Improving health equity

## Determinants of Health

Human health is contingent upon biological and social characteristics that contribute to an individual's physical, psychosocial, developmental, and cultural/spiritual well-being. These characteristics are referred to as *determinants of health*.

**Biological Determinants** Biological determinants of health are typically innate individual characteristics that are less amenable to change by an individual's actions. Examples of biological determinants of health include genetics, ethnicity, sex at birth, and age. Although some biological characteristics can be changed, their influence on an individual's well-being and how they are perceived by other members of society typically requires societal change for acceptance. In order for individual members of a group with similar characteristics to be accepted by a society, they may be required to adapt to the social norms of that society.

**Social Determinants** Social determinants of health include a wide range of factors such as income, employment and working conditions, housing, education, nutrition, social support, social exclusion, stress, and violence. Social determinants of health are believed to explain both the causation of ill health in individuals and the social distribution or patterns of ill health. This duality of influence

contributes to moral concern for social inequalities in health achievements as well as the evolving hypotheses that social determinants are responsible for patterns of ill health (Venkatapuram & Marmot, 2009).

When considering determinants of health, it is important to understand that both biological and social determinants can be altered by changing societal perceptions.

## Reflect On . . .

- the determinants of health as they relate to your health. What social factors in your environment positively or negatively contribute to your health?
- the determinants of health as they relate to your community. What effect do these factors have on the health of your community?
- ways you and your nursing colleagues can advocate for change to improve the social conditions affecting the health of your community. Your nation. Your world.

## Health Equity

**Health equity** means universal access to an effective and sustainable health system that incorporates attention to health care and the underlying determinants of health. Health equity and how to distribute health-care services and other public resources among members of society have posed challenges throughout much of human history. As members of society, nurses have taken an integral role in meeting these challenges. The discipline of nursing has been actively engaged in advocacy for the equitable distribution of health resources. Many nursing leaders have contributed to the discipline's knowledge base. As early as 1907, E. A. Stevenson, a British public health nurse, articulated three reasons why the poor ought to have equal advantages to the rich with regard to nursing: "Rich and poor alike are liable to sickness, sickness is to a great extent entirely beyond the power of the individual to avert, and the ravages of sickness among the poor and working classes are disastrous to our prosperity" (p. 430). This was further emphasized by Lavinia Dock, an American nursing educator and leader, in her presentation on urgent social concerns to the American Nurses Association in 1907. Exploration of wider societal conceptualizations of health equity strengthens our understanding of health equity and its influence on human health and well-being.

The words *equity* and *equality* are often erroneously used interchangeably in health-related literature. **Equality** implies entitlement to equal access to all healthcare resources. Equal distribution of health resources may contribute to

“avoidable, unnecessary, and unfair/unjust” health outcomes among vulnerable populations (Venkatapuram & Marmot, 2009, p. 86). Equity is a complex concept shaped by different values. At its most basic level, **equity** means just or fair treatment of individuals within their own social context. Equity is considered a prerequisite for good health. Equity in health refers to “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is different positions in the social hierarchy” (Braveman & Gruskin, 2003, p. 254). To achieve health equity there must be equal distribution of resources and services to balance the required (unequal) need, equal opportunity to access services, equally high standards of service for everyone, and equity reflected in health outcomes bringing health differentials down to the lowest possible denominator (Almond, 2002; Eaves, 1998).

There have been initiatives designed to address global health. The World Health Organization (WHO) has recognized that underlying differences in life circumstances have caused a large proportion of the differences in health status between regions, between urban and rural areas, and between socioeconomic classes and other social categories.

One of the most notable and ambitious global initiatives to address health equity was delineated in the Millennium Declaration (United Nations, 2000). The declaration represents consensus and agreement by leaders from all member nations to address and overcome the challenges that impede human development for the majority of the earth’s population. The Millennium Development Goals (MDG) were selected at the time of the Millennium Declaration and served as benchmarks to measure international progress. Eight goals were set with a target achievement date by 2015:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health

6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

### Reflect On . . .

- the MDG. What is the level of achievement of these goals within your own country? Your own community?
- the MDG. What are the roles and responsibilities of you and your nursing colleagues to work toward the achievement of sustainable improvements in MDG health indicators beyond 2015?

### Social Justice and Social Responsibility

**Social justice** is “scholarship and professional action designed to change societal values, structures, policies, and practices, such that disadvantaged or marginalized groups gain increased access to these tools of self-determination” (Goodman et al., 2004, p. 795). Challenges for nurses addressing issues of social justice arise in all professional roles (practice, teaching, scholarship, administration, research). Social justice requires:

- Ongoing personal and professional self-reflection
- Acknowledgment of systematic injustices inherent in modern society
- Awareness of power dynamics and socioeconomic structures that perpetuate oppression

This definition of social justice and its core elements challenges long-accepted assumptions about expert-driven interventions delivered to oppressed and/or vulnerable people. Instead, the focus is on opportunities for collaboration between oppressed peoples and the various healthcare providers to create new alternatives (Smith, Chambers, & Bratini, 2009).

### Social Responsibility

The constructs of social conscience, social consciousness, and social responsibility contribute to a person’s ability to engage in socially just practices. **Social conscience**

### CRITICAL THINKING EXERCISE

The target date for achieving the MDG was 2015. Explore the development and health literature and identify initiatives that have been proposed to sustain progress toward realizing further improvements in human health for each health-related MDG. For each health-related

MDG determine how the United States compares in progress toward achieving these goals with other countries from each World Health Organization region. As a nurse, what activities can you engage in to facilitate achievement of these goals?

and **social consciousness** imply that an individual recognizes being part of a larger social group and an awareness that his or her actions or inactions may influence others (Kagan, Smith, Cowling, & Chinn, 2009; Tyer-Viola et al., 2009).

Social responsibility can be viewed as directly linked to the work of nurses. Social responsibility includes enhanced awareness, expansion of knowledge, and actions that emphasize individual and collective values of equity, access, and justice (Tyer-Viola et al., 2009). Social responsibility can be observed in individual and collective engagement in environmentally sustainable activities that respect diversity, freedom of expression, and the needs of human societies collectively (Tyer-Viola et al., 2009).

### Reflect On . . .

- the statement “A nurse must support the clients as well as the society against the health and treatment

system which sometimes considers patients as instruments” (Fasaleh-Jahromi et al., 2014, p. 294). What are your thoughts about this statement? What strategies would you, as a nurse, use within the limitations of your national healthcare system to address the needs of patients who are treated unjustly? What resources would you mobilize to respond to this type of situation?

- the statement “It makes no difference whether a patient is rich or poor. I think all of them are sick and I care for a poor patient the same way I do for a rich one” (Fasaleh-Jahromi et al., 2014, p. 292). Do you think it is possible to care for the poor in the same way one cares for the rich? Explain your answer. Which of the professional nursing roles could be enlisted to address health disparities? As a nurse, what action would you take for each of the professional roles you identified?

## RESEARCH CURRENT

### Iranian Nurses' Perceptions of Social Responsibility: A Qualitative Study

The purpose of Fasaleh-Jahromi, Moattari, and Peyrovi's qualitative study was to explore Iranian nurses' perceptions about social responsibility and document dimensions of social responsibility as reported by these nurses. The researchers reported that the study was needed because of the cultural, social, and economic differences between Iranian and Western contexts. The study participants used a total of 10 nurses (4 staff nurses, 2 head nurses, 1 matron, and 3 nursing faculty members) as key informants from hospital and university settings in Shiraz and Jahrom, Iran. The study used purposive and theoretical sampling to enroll participants. Participants completed semistructured interviews that lasted about 1 hour. The constant comparative method of analysis was used, and five main categories emerged from the data.

The five categories used for describing a socially responsible nurse were (1) positive human characteristics, (2) professional competencies, (3) professional values, (4) clients and nursing care, and (5) deployment of professional performance. Positive human characteristics included subcategories of appropriate public relations and humanitarianism. A socially responsible nurse has a good relationship with patients and their visitors, is kind with patients, is honest, and instills hope. With respect to colleagues, this nurse maintains confidentiality, has humility, respects senior nurses, and is helpful. Humanitarian characteristics include compassion, fidelity, fairness, and not being

apathetic toward the problems of others. Professional competencies of a socially responsible nurse include both technical capacity and management capabilities. Management capabilities include abilities to manage care delivery as well as supervise and effectively collaborate with subordinates, peers, superiors, and other members of the healthcare team. Professional values include work-related and patient-related values. Examples of work-related values included honoring nursing and gaining people's trust in the nursing profession. A socially responsible nurse always considers the patient's rights and feels a sense of responsibility toward the patient. She or he pays attention to what the patients say and is respectful of the patients' interests, needs, and personalities. Socially responsible nurses provide solution-focused nursing care and pay attention to the patients' problems, focusing on the outcomes of the nursing care they provide.

The researchers reported that “Iranian nurses' views on social responsibility are somehow similar to” Western conceptualizations (Fasaleh-Jahromi et al., 2014, p. 296). They attributed differences they observed to limited involvement of nurses in community health care in Iran. They suggest that there is a need for a systematic change in the healthcare system that shifts care from hospitals to the community.

*Source:* “Iranian Nurses' Perceptions of Social Responsibility: A Qualitative Study,” by M. Fasaleh-Jahromi, M. Moattari, and H. Peyrovi, 2014, *Nursing Ethics*, 21(3), pp. 289–298.



## Core Elements of Human Rights

Human rights are:

- Universal and inalienable: Universality is the cornerstone.
- Interdependent and indivisible: Improvement of one right facilitates advancement of the others. Conversely,

deprivation of one right diminishes the effects of others.

- Equal and nondiscriminatory: The principle applies to everyone.
- Both rights and obligations.

## Human Rights and Ethical Considerations

Human rights and the ethical considerations that arise in relation to them are essential principles of global health. The international human rights framework was established to protect and respect human dignity. This framework intends to protect people from their government. Nations have legal obligations to protect and uphold the human rights of persons within their international boundaries. At the individual level, this framework allows individuals and groups to claim rights, but each right carries with it responsibilities and recognition of the limitations on a claimed right—the requirements of morality, public order, and the general welfare of society (United Nations, 1948). The core elements of human rights are listed in the accompanying box.

### Human Rights in Nursing Contexts

Nurses have a moral obligation and responsibility to address human rights in health care. They deal with human rights issues daily, in all aspects of their professional role. There are many situations where nurses may be pressured to apply their knowledge and skills in ways that are detrimental to patients and others (International Council of Nurses, 2009). Nurses must be vigilant and well informed to meet their human rights obligations and responsibilities. The ICN endorses the Universal Declaration of Human Rights and states that the organization carries out its activities in relation to human rights issues through advocacy, publication of policy statements and fact sheets, and other

forms of social and political activism. Article 25 of the Universal Declaration of Human Rights (United Nations, 1948) relates specifically to health and health care stating:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

### Human Rights Issues in Nursing

Nurses have specific human rights obligations and responsibilities arising from the following human rights domains within nursing: (1) nursing ethics, (2) nurses as victims of human rights violations, (3) imprisonment of nurses, (4) human rights of nurses in conflict, (5) nurses and the infliction of punishment, (6) nurses working in inadequate conditions, (7) forensic nurses, (8) refugee claimants, (9) reproductive rights, (10) health equity and access to care, (11) human subjects research, and (12) palliative care (Amnesty International, 1997; McHale & Gallagher, 2003). Examples of severe human rights violations that intersect with the discipline of nursing are listed in Table 19–1.

## CRITICAL THINKING EXERCISE

Using the human rights domains and nursing context examples presented in the accompanying box, investigate the details of a clinical situation (personal professional experience, professional journal article, or news story) under one or more of the nursing context

examples. Discuss with your peers what strategies you would use to prevent the potential harms that could arise from human rights violations of this type in your clinical environment.

**TABLE 19–1 Nurses and Human Rights**

| Human Rights Domain                                 | Nursing Context Example                                                                                                                                                                                                                                 |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Nursing ethics</i>                               | The nurse's role in safeguarding human rights<br>The nurse's role in the care of detainees and prisoners<br>Nurses and torture<br>Nurses and the death penalty<br>Consent to treatment<br>Mental health care<br>Right to privacy and health information |
| <i>Nurses as victims of human rights violations</i> | Torture of nurses<br>Assault of nurses                                                                                                                                                                                                                  |
| <i>Imprisonment of nurses</i>                       | Imprisonment of nurses: Vietnam, Cuba, East Timor, and Singapore                                                                                                                                                                                        |
| <i>Human rights of nurses in conflict</i>           | Nurses practicing in conflict environments: Afghanistan, Colombia, Iraq, Liberia, Libya, Peru, Syria, Turkey, and Zaire<br>Attacks on Red Cross nurses in Africa and Russia                                                                             |
| <i>Nurses and the infliction of punishment</i>      | Nurses' participation in the enactment of the death penalty in the United States<br>Nurses' participation in corporal punishment in Afghanistan                                                                                                         |
| <i>Nurses working in inadequate conditions</i>      | Prison conditions in the United States and Zambia<br>Remote single-nurse posts with limited resources or access to other healthcare providers in Australia and Canada                                                                                   |
| <i>Forensic nurses</i>                              | Death of a person in custody in Australia<br>Nurses' participation in death investigations without adequate training in Brazil                                                                                                                          |
| <i>Refugee claimants</i>                            | Nurses and the care of asylum seekers, refugees, and other immigrant groups<br>Nurses and the care of torture victims                                                                                                                                   |
| <i>Reproductive rights</i>                          | Nurses' role in reproductive rights                                                                                                                                                                                                                     |
| <i>Health equity and access to care</i>             | Individuals' rights to receive health care and the allocation of health-care resources                                                                                                                                                                  |
| <i>Human subjects research</i>                      | Nurses' role in the ethical conduct of research                                                                                                                                                                                                         |
| <i>Palliative care</i>                              | Individuals' right to life and end-of-life nursing considerations                                                                                                                                                                                       |

Source: Adapted from *Nurses and Human Rights*, by Amnesty International, 1997. Retrieved from [www.amnesty.org/en/library/info/ACT75/002/1997](http://www.amnesty.org/en/library/info/ACT75/002/1997)



**InfoQuest:** Explore the Internet, including news media and social media sites (e.g., Facebook, Twitter), to identify resources where nurses concerned about human rights violations can obtain additional information related to their obligations and responsibilities. What is the quality of the resources available? Are they from government agencies, nongovernmental organizations, or private corporations? What thoughts do you have about the information contained in these resources?

## Global Health Concerns

Historically, multiple classification systems have helped to measure and differentiate the health and development needs and differences among the nations of the world.

Each of these systems has its unique limitations and may contribute to misrepresentations and overgeneralizations about the health of all persons living in a country. The World Bank (2015a) classifies nations based on a nation's per capita gross national income (GNI) as low, middle, or high income. Another system classifies nations based on levels of development. In this system, countries are classified based on how developed civil society is within that nation. Under this system, nations are classified as developed, developing, or un/underdeveloped. Both of these classification systems have applications and are currently used in the global health literature.

Several indicators have been developed to enhance an understanding of the effects of global health conditions on populations, providing evidence of the morbidity and mortality of various diseases and injuries. **Healthy average life expectancy** (HALE) is the “average number of years that a person can expect to live in ‘full health’ by taking

## CRITICAL THINKING EXERCISE

Identify a country from each of the World Health Organization regions. Go to the United Nations Development Programme (UNDP) human development index (HDI) webpage and look up the HDI and its elements for each country. Compare and contrast the HDI elements for each country you selected. What are the similarities and

differences between each country and its HDI performance? What implications does this information have for addressing population health concerns in each country? What strategies would you, as a registered nurse, recommend to policy makers to improve the health outcomes for people in each country?

into account years lived in less than full health due to disease and/or injury” (World Health Organization, 2015c). A **disability-adjusted life-year** (DALY) is “one lost year of ‘healthy’ life. The sum of these DALYs across the population, or the burden of disease, is the measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability” (World Health Organization, 2015a). Simply stated, DALYs are the years of life lived with a disability adjusted for the severity of disability. Currently DALYs for health conditions or injuries are calculated by summing the **years of life lost** (YLL) due to premature mortality in the population and the **years lost to disability** (YLD) for people living with the condition or its consequences (World Health Organization, 2014a).

### Demographic and Epidemic Shifts

The global incidence and prevalence of diseases and injuries has changed over time. Changes in population characteristics, internal and external migration of people within and between countries, and the emergence and migration of diseases are all factors that contribute to shifts in disease profiles. Adverse health outcomes occur across socioeconomic strata and throughout the life span. The prevalence of diseases in countries is also influenced by the age distribution of the country. For example, in Western Europe and North America, the percentage of elderly is increasing, resulting in a corresponding increase in chronic disease, age-related injuries, and dementia leading to disability. In

contrast, in countries with younger populations, injuries and infectious disease are more likely to contribute to morbidity and mortality. Demographic changes also occur as the result of aging populations and migration of peoples from one area to another.

Demographic shifts are important to understand, because they influence the types of health policy interventions necessary to facilitate optimal health outcomes within each country. Addressing these factors requires global cooperation to effectively manage the burden of diseases and injuries. The top 10 rankings of broad categories for causes of death globally in 2011 are presented in the accompanying box, and projections for the top 20 ranked causes of death globally are presented in Table 19–2.

### Communicable Disease

Communicable diseases include diseases caused by both infectious agents (e.g., bacteria, viruses) and parasites (e.g., ticks, mosquitoes, mites, worms). Communicable diseases are more prevalent among people of lower socioeconomic strata. Whether people are from more impoverished countries or live in impoverished areas of wealthier countries, communicable diseases and the associated adverse health outcomes disproportionately affect the world’s poor. Communicable diseases have accounted for nearly half of the disease burden in low- and middle-income countries (World Health Organization, 2015a) and are important contributors to years of life lost to morbidity and mortality. As people migrate from rural to urban areas,

### Top-Ranked Broad Categories for Causes of Death Globally in 2011

- |                                                           |                                                                  |
|-----------------------------------------------------------|------------------------------------------------------------------|
| 1. Cardiovascular diseases                                | 6. Neonatal conditions                                           |
| 2. Infectious diseases (including respiratory infections) | 7. Digestive diseases                                            |
| 3. Cancers                                                | 8. Endocrine, blood, and immune disorders, and diabetes mellitus |
| 4. Injuries                                               | 9. Neurological and sensory organ conditions                     |
| 5. Respiratory diseases                                   | 10. Genitourinary diseases                                       |

**TABLE 19–2 Predictions of Top 20 Causes of Death Globally for 2015 and 2030**

| 2015 |                                       |                               | 2030 |                                         |                               |
|------|---------------------------------------|-------------------------------|------|-----------------------------------------|-------------------------------|
| Rank | Cause                                 | Deaths per 100,000 population | Rank | Cause                                   | Deaths per 100,000 population |
| 1    | Ischemic heart disease                | 105                           | 1    | Ischemic heart disease                  | 112                           |
| 2    | Stroke                                | 92                            | 2    | Stroke                                  | 104                           |
| 3    | Lower respiratory infections          | 44                            | 3    | Chronic obstructive pulmonary disease   | 55                            |
| 4    | Chronic obstructive pulmonary disease | 44                            | 4    | Lower respiratory infections            | 43                            |
| 5    | Diarrheal diseases                    | 25                            | 5    | Diabetes mellitus                       | 30                            |
| 6    | HIV/AIDS                              | 23                            | 6    | Trachea, bronchus, lung cancers         | 29                            |
| 7    | Trachea, bronchus, lung cancers       | 23                            | 7    | Road injury                             | 22                            |
| 8    | Diabetes mellitus                     | 21                            | 8    | HIV/AIDS                                | 22                            |
| 9    | Road injury                           | 20                            | 9    | Diarrheal diseases                      | 20                            |
| 10   | Hypertensive heart disease            | 16                            | 10   | Hypertensive heart disease              | 18                            |
| 11   | Preterm birth complications           | 16                            | 11   | Cirrhosis of the liver                  | 14                            |
| 12   | Cirrhosis of the liver                | 14                            | 12   | Liver cancer                            | 14                            |
| 13   | Tuberculosis                          | 12                            | 13   | Kidney diseases                         | 14                            |
| 14   | Kidney diseases                       | 12                            | 14   | Stomach cancer                          | 14                            |
| 15   | Self-harm                             | 12                            | 15   | Colon and rectum cancers                | 13                            |
| 16   | Liver cancer                          | 11                            | 16   | Self-harm                               | 12                            |
| 17   | Stomach cancer                        | 11                            | 17   | Falls                                   | 12                            |
| 18   | Birth asphyxia and birth trauma       | 11                            | 18   | Alzheimer's disease and other dementias | 12                            |
| 19   | Colon and rectum cancers              | 10                            | 19   | Preterm birth complications             | 11                            |
| 20   | Falls                                 | 10                            | 20   | Breast cancer                           | 10                            |

Source: *Global Health Estimates Summary Tables: Projection of Deaths by Cause, Age, and Sex, 2015 and 2030*, by the World Health Organization, 2013b. Retrieved from [www.who.int/healthinfo/global\\_burden\\_disease/en/](http://www.who.int/healthinfo/global_burden_disease/en/)

or from one country to another, there are commensurate changes in the population's disease profile. For example, tuberculosis is more prevalent in overcrowded urban areas. Another example relates to people who are seeking protection from civil unrest, terror and oppression in refugee centers around the world who are at risk for acquiring typhus or cholera.

Further global challenges persist with emerging and reemerging communicable diseases contributing to the demands on healthcare systems throughout the world. Economically disadvantaged communities are less able to prevent the spread of disease, because of unsafe water, overcrowded living conditions, and lack of access to vaccines or other communicable disease prevention strategies. More affluent people are less susceptible to

communicable diseases and their adverse effects, because they have the knowledge and income to protect themselves (Skolnik, 2012).

Communicable diseases can enter a population through one of the following modes of transmission:

- foodborne (e.g., salmonella, *E. coli*)
- waterborne (e.g., cholera, rotavirus)
- sexual or bloodborne (e.g., hepatitis, HIV)
- vectorborne (e.g., malaria, West Nile virus)
- inhalation (e.g., tuberculosis, influenza)
- nontraumatic contact (e.g., anthrax)
- traumatic contact (e.g., rabies)

In addition to understanding modes of transmission, it is essential to understand how communicable diseases can be



TABLE 19–3 Global Communicable Disease Deaths, 2011

|                                                                                                                                                                                        | Population | 6,938,255,000 |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------------|---------|
| Cause of Death                                                                                                                                                                         |            | Deaths (n)    | % Total |
| <b>All Causes</b>                                                                                                                                                                      |            | 54,591,000    | 100     |
| <b>All Infectious and Parasitic Diseases</b>                                                                                                                                           |            | 6,853,000     | 12.6    |
| Diarrheal diseases                                                                                                                                                                     |            | 1,894,000     | 3.5     |
| HIV/AIDS                                                                                                                                                                               |            | 1,591,000     | 2.9     |
| Tuberculosis                                                                                                                                                                           |            | 976,000       | 1.8     |
| Meningitis                                                                                                                                                                             |            | 408,000       | 0.7     |
| Childhood-cluster Diseases (i.e. whooping cough, diphtheria, measles, tetanus)                                                                                                         |            | 331,000       | 0.6     |
| Acute hepatitis B                                                                                                                                                                      |            | 141,000       | 0.3     |
| Parasitic and vector diseases (i.e. malaria, trypanosomiasis, chagas disease, schistosomiasis, leishmaniasis, lymphatic filariasis, onchocerciasis, leprosy, dengue, trachoma, rabies) |            | 759,000       | 1.4     |
| Other infectious diseases, including intestinal nematode infections (i.e. ascariasis, trichuriasis, hookworm disease)                                                                  |            | 529,000       | 1.0     |
| Sexually Transmitted Infections (STI) excluding HIV (i.e. syphilis, chlamydia, gonorrhea, trichomoniasis, other STIs)                                                                  |            | 94,000        | 0.2     |
| Encephalitis                                                                                                                                                                           |            | 92,000        | 0.2     |
| Acute hepatitis C                                                                                                                                                                      |            | 40,000        | 0.1     |

Source: Adapted from summary data worksheet of the World Health Organization. (2013a). *Global health estimates summary tables: Deaths by cause, age, and sex—2011 and 2000*. Retrieved on May 3, 2014, from [http://www.who.int/healthinfo/global\\_burden\\_disease/en/](http://www.who.int/healthinfo/global_burden_disease/en/)

controlled. The predominant communicable disease prevention strategies include:

- vaccination
- mass chemotherapy
- vector control
- improved water, sanitation, and hygiene
- improved case finding, care seeking, and disease recognition

- treatment/case management and improved caregiving
- case surveillance, reporting, and containment
- behavior change to prevent infection and transmission

Communicable diseases substantially affect the world's poor, low-, and middle-income countries. Table 19–3 summarizes the major causes of death from communicable diseases globally. Globally, the relative importance of communicable diseases in comparison to noncommunicable

### CRITICAL THINKING EXERCISE

During the Ebola outbreak of 2014, citizens from the United States and Western Europe who became infected with the virus while providing healthcare services to persons living in affected countries such as Guinea, Liberia, and Sierra Leone were airlifted to their home countries for medical treatment. Additionally, some of these infected healthcare providers received experimental treatments that were not made available to the persons affected by Ebola in the endemic areas. As a nurse, what are your thoughts about the transport of persons infected with a communicable disease that is not in your country? What capacity does your local hospital have to

manage patients with a communicable disease such as Ebola? How would your community respond to the knowledge of people infected with Ebola being transported there? What precautions would need to be in place for the safe transfer of a patient with a communicable disease like Ebola to be transported to your local hospital? What ethical considerations are inherent in the transfer of patients infected with a communicable disease such as Ebola? What ethical issues arise from the administration of experimental treatments to healthcare providers from nonendemic countries?

diseases and injuries varies by geographic region and demographic characteristics, such as age, ethnicity, and gender.

### Reflect On . . .

- how the responses to communicable diseases differ between your community and the country where you live and other countries around the globe. In what ways are the responses different? What strategies for prevention or control of communicable disease are the same or similar?
- the roles and responsibilities of nurses in response to communicable disease outbreaks in your local community, your nation, and the world. Do these roles differ based on national context? Explain your answer.

One group of communicable diseases, *neglected tropical diseases* (NTDs), is responsible for the morbidity and mortality of nearly one sixth of the world's population (World Health Organization, 2015f). These 17 diseases, resulting from four different causative pathogens (i.e., bacteria, helminth, protozoa, virus), are listed in the accompanying box. These diseases are the most common among the world's impoverished communities, have long-term effects, and may influence the health of people throughout the life span. They impede growth and development among children, harm pregnant women, and can cause long-term debilitating illnesses. These diseases contribute to stigma and discrimination because persons living with these conditions are often shunned by family and community members. Because of the lost productivity of infected persons, the economic effects of these diseases influence not only the health of the persons living with the disease, but also the societies in which they live (Skolnik, 2012). This group of diseases poses unique challenges for global health because limited resources have been allocated to managing them.

### Neglected Tropical Diseases

|                  |                                                   |
|------------------|---------------------------------------------------|
| <b>Bacteria</b>  | Buruli ulcer                                      |
|                  | Leprosy (Hansen disease)                          |
|                  | Trachoma                                          |
|                  | Yaws                                              |
| <b>Helminths</b> | Cysticercosis/taeniasis                           |
|                  | Dracunculiasis (guinea worm disease)              |
|                  | Echinococcosis                                    |
|                  | Foodborne trematodiasis                           |
|                  | Lymphatic filariasis                              |
|                  | Onchocerciasis (river blindness)                  |
| <b>Protozoa</b>  | Schistosomiasis                                   |
|                  | Soil-transmitted helminthiasis                    |
|                  | Chagas disease                                    |
|                  | Human African trypanosomiasis (sleeping sickness) |
|                  | Leishmaniasis                                     |
|                  | Dengue fever                                      |
| <b>Viruses</b>   | Rabies                                            |

Source: Adapted from *The 17 Neglected Tropical Diseases*, by the World Health Organization, 2015f, Geneva, Switzerland: Author. Retrieved from [www.who.int/neglected\\_diseases/diseases/en/](http://www.who.int/neglected_diseases/diseases/en/)

Additionally, pharmaceutical companies lack financial incentives for the development of new treatments because of the perception that the market for treatments of NTDs would not be profitable.



**InfoQuest:** Select one of the neglected tropical diseases. What countries are most likely to be affected by the disease? What are signs and symptoms of that disease? If a traveler infected with that disease returns from the affected country to your community and practice setting, what signs and symptoms and treatment would be initiated?

### CRITICAL THINKING EXERCISE

In 2000, it was believed that measles had been eradicated in Canada and the United States. In 2011, measles reemerged in the United States, and since then new cases have also been documented in Canada. In 2014, the reemergence of measles was identified as a major health concern by the U.S. Centers for Disease Control and Prevention and by Health Canada. What factors contributed

to the reemergence of measles? What can you, as a nurse, do to mitigate the effects of the reemergence of measles in your practice setting and community? What can we learn about the reemergence of communicable disease in general based on the experience with measles? What is the responsibility of the nurse in helping to eradicate communicable diseases?

### Reflect On . . .

- the list of neglected tropical diseases. Have any of these diseases emerged in your practice community? How would you obtain additional information about the signs and symptoms of specific neglected tropical diseases? What resources are available to diagnose and treat a person who comes to your clinical practice setting with the signs and symptoms of a specific neglected tropical disease?
- the roles and responsibilities of nurses in response to outbreaks of neglected tropical disease in your local community, your nation, and the world? Do these roles differ based on national context? Explain your answer.

### Noncommunicable Disease

Noncommunicable diseases are growing in prevalence and importance globally. The term *noncommunicable disease* is often used interchangeably with *chronic disease* and *degenerative disease*. The CDC's list of noncommunicable diseases includes (U.S. Centers for Disease Control and Prevention, 2014a):

- Arthritis/musculoskeletal diseases
- Cardiovascular disease, for example coronary artery disease, cerebrovascular disease
- Malignant neoplasms (cancers)
- Diabetes and other endocrine disorders, such as hypercholesterolemia
- Neuropsychiatric disorders, for example, mental disorders, epilepsy, dementia
- Sensory organ disorders, for example, hearing loss, glaucoma, cataracts
- Unintentional injuries, for example, from traffic crashes

The burden of noncommunicable disease is greater than the burden of communicable disease across all country income categories globally. Low-, middle-, and high-income countries encounter challenges related to the burden of noncommunicable diseases. On a global scale, noncommunicable diseases are expected to increase, and it is anticipated that by 2030, 6 of the top 10 causes of mortality worldwide will be noncommunicable diseases. See Table 19–2 (World Health Organization, 2013b).

### Chronic Disease and Disability

Cardiovascular disease caused 16.6 million deaths worldwide in 2011, accounting for more than 30% of all-cause

mortality. It remains the leading cause of death worldwide (World Health Organization, 2013a). Cardiovascular disease is now the leading cause of death in low- and middle-income countries, but high-income countries continue to have a higher incidence of cardiovascular disease when compared to low- and middle-income countries. The majority of deaths (83%) from cardiovascular disease are the result of three pathophysiological conditions: ischemic heart disease, stroke, and hypertensive heart disease (World Health Organization, 2013a). The prevalence of cardiovascular disease is higher in urban areas compared to rural areas. In low- and middle-income countries, limited access to prevention programs or appropriate treatments results in death related to cardiovascular disease occurring at an earlier age than in high-income countries (Skolnik, 2012). Cardiovascular disease also contributes to disability and may reduce the length of a person's life. Evaluating the years of life lost (YLL) and years lost to disability (YLD) provides an indicator of the burden that cardiovascular disease has on people and societies. The statistic of disability-adjusted life-years (DALY) provides a perspective on the functional decline of persons living with cardiovascular disease globally. In 2011, cardiovascular disease was the second leading cause of DALY globally (Table 19–4). In other words, because of cardiovascular disease, 378,875,000 years of life were lost to disability. For every 100,000 people, there was a loss of 5,461 years of healthy expected life.



**InfoQuest:** Search the World Health Organization's Global Health Observatory and Global Health Estimates databases to determine the incidence and prevalence, mortality rates, and years lost to disability (YLD) for each of the following (1) malignant neoplasms (cancers), (2) diabetes, (3) endocrine disorders (e.g., hypercholesterolemia), and (4) sensory organ disorders (e.g., hearing loss, visual impairment). Compare these rates between your own country and three other countries of your choosing. Do the rates for your country reflect your own practice community? As a nurse, what recommendations do you have for improving these rates in your community, your country, the world?

### Mental Health

Global health epidemiologists use the term *neuropsychiatric disorders* to encompass mental and behavioral disorders (e.g., depression, schizophrenia), substance use disorders

**TABLE 19–4 Leading Broad Causes of Disability-Adjusted Life-Years (DALYs), 2011**

| Rank | Broad Cause                                            | DALY        | % DALYs | DALYs per 100,000 Population |
|------|--------------------------------------------------------|-------------|---------|------------------------------|
| 1    | Infectious diseases (including respiratory infections) | 624,141,000 | 22.7    | 8,996                        |
| 2    | Cardiovascular diseases                                | 378,875,000 | 13.8    | 5,461                        |
| 3    | Injuries                                               | 296,836,000 | 10.8    | 4,278                        |
| 4    | Neonatal conditions                                    | 231,581,000 | 8.4     | 3,338                        |
| 5    | Cancers                                                | 223,539,000 | 8.1     | 3,222                        |
| 6    | Mental and behavioral disorders                        | 198,370,000 | 7.2     | 2,859                        |
| 7    | Respiratory diseases                                   | 134,246,000 | 4.9     | 1,935                        |
| 8    | Neurological and sensory organ conditions              | 128,613,000 | 4.7     | 1,854                        |
| 9    | Musculoskeletal diseases                               | 108,401,000 | 4.0     | 1,562                        |
| 10   | Endocrine, blood, immune disorders, diabetes mellitus  | 88,211,000  | 3.2     | 1,271                        |

Source: *Disease Burden*, by the World Health Organization, 2015a, Geneva, Switzerland: Author. Retrieved from [www.who.int/healthinfo/global\\_burden\\_disease/estimates/en/index2.html](http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.html)

(drug and alcohol misuse), and neurological conditions (e.g., Alzheimer’s disease, dementia, epilepsy, Parkinson’s disease). Worldwide, mental and behavioral disorders account for the most years of life lost to disability. In 2011, five mental health disorders (unipolar depression, anxiety disorders, pervasive developmental disorders, bipolar disorder, and schizophrenia) accounted for the majority of years lost to disability (YLD) globally (World Health Organization, 2015a). A major challenge to addressing mental and behavioral disorders is the lack of epidemiology data from low- and middle-income countries where there are insufficient mental health care resources, including mental health professionals, to address the needs of persons living with mental health disorders among their populations (Gostin & Friedman, 2013; Skolnik, 2012).

### Injuries, Trauma, and Violence

Millions of people each year seek health care for injuries that result from unintentional injuries and violence. Men are nearly twice as likely to experience unintentional injuries (accidents) as women, and men are more than three times as likely to experience intentional injuries (violence) as women (World Health Organization, 2015a). Accidents and violence are a major public health issue worldwide; related injuries result in approximately 5.8 million deaths each year from all age and economic groups (U.S. Centers for Disease Control and Prevention, 2014b). Road traffic incidents, suicides, and homicides are the three leading causes of injury- and violence-related deaths worldwide. The well-being of families and communities is adversely affected by violence when

perceptions of safety and security are eroded. Violence contributes to significant mental and physical health consequences, including depression and anxiety, pregnancy complications, and even chronic diseases such as diabetes and heart disease (U.S. Centers for Disease Control and Prevention, 2014b). Family-based violence in the forms of child maltreatment (e.g., abuse, neglect, female clitoridectomy [female genital mutilation]), elder abuse, and spousal abuse/intimate partner violence) remains a persistent challenge.

### Environment and Health

According to the World Health Organization (2014b) environmental health includes two broad conceptual definitions. *Environmental health* includes all the physical, chemical, and biological factors external to a person, along with all the related factors that influence humans’ behavior and their interactions with the environment. Environmental health also encompasses the assessment and control of environmental factors that have the potential to influence health. The primary goals of environmental health are to prevent disease/injury and to create health-supportive environments.

The World Bank (2015b) goal of alleviating poverty emphasizes the importance of environmental factors that influence health. These environmental factors result from development without environmental safeguards, including modern hazards such as ambient (outdoor) air pollution, and traditional hazards, such as diseases caused by inadequate water supply and sanitation, respiratory diseases caused by poor indoor air quality, and diseases such as



## Household Air Pollution

### Key facts

- Approximately 3 billion people cook and heat their homes using open fires and simple stoves burning biomass (e.g., wood, peat, animal dung, crop waste) and coal.
- Over 4 million people die prematurely from illness attributable to household air pollution.
- More than half of deaths among children under 5 are related to pneumonia from household air pollution.
- Each year 3.8 million premature deaths from noncommunicable diseases are attributed to household air pollution exposure.

### Health effects

- Disability and death from pneumonia, cerebrovascular disease, cardiovascular disease, chronic obstructive pulmonary disease, childhood asthma, lung cancer, and other health conditions can be attributed to household air pollution.
- Lack of access to electricity creates health risks resulting in burns, injuries, and poisonings.

Source: Adapted from *Household Air Pollution and Health*, Fact Sheet #292, by the World Health Organization, 2014, Geneva, Switzerland: Author. Retrieved from [www.who.int/mediacentre/factsheets/fs292/en/](http://www.who.int/mediacentre/factsheets/fs292/en/)

malaria that occur when irrigation and other systems are poorly designed (World Bank, 2015b). Since 2010, the World Health Organization (2015b) has published environmental health fact sheets on:

- Household air pollution
- Blinding trachoma
- Ambient (outdoor) air quality
- Climate change
- Mercury
- Lead poisoning
- Arsenic
- Ionizing radiation, healthcare waste management
- Electromagnetic fields (mobile phones)
- Environmental and occupational cancers
- Asbestos elimination
- Dioxins

Household air pollution and health considerations are described in the accompanying box.



**InfoQuest:** Search the websites of the World Bank, the World Health Organization, and the U.S. Centers for Disease Control and Prevention for fact sheets about environmental health issues. Choose one or more issues from among those described by these organizations. Identify what efforts have been taken to manage the issue. As a registered nurse, what activities would you engage in to address the issue? Do health effects related to the issue influence your own practice community? As a nurse, what recommendations do you have for improving health status in relation to the issue in your community, your country, the world?

## Health Systems in a Global Environment

Global health addresses both health and human development challenges. Several governmental, intergovernmental, and nongovernmental agencies have established major goals to respond to global health issues. Each agency has a unique mandate, and all of them strive to work in a coordinated and collaborative manner. National agencies from many countries have global health mandates, and there are many nongovernmental organizations working to achieve goals within the context of global health.

### Governmental and Intergovernmental Systems

The United Nations (UN) is an intergovernmental organization established after World War II to promote international cooperation. The UN is financed through assessed and voluntary contributions from its 193 current member states. Its objectives include maintaining international peace and security, promoting human rights, fostering social and economic development, protecting the environment, and providing humanitarian aid in cases of famine, natural disaster, and armed conflict (United Nations, 2014). The UN agencies with specific global health mandates (United Nations, 2014) are the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF), the United Nations High Commission for Refugees (UNHCR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office of the High Commissioner for Human Rights, and the World Health Organization (WHO).

In addition to governmental and intergovernmental agencies working to achieve global health goals, regional organizations such as the Pan American Health Organization

## RESEARCH CURRENT

## Aboriginal Women's Experiences of Accessing Health Care When State Apprehension of Children Is Being Threatened

The purpose of Denison, Varcoe, and Browne's qualitative study was to examine how the fear or threat of child apprehension influenced Canadian Aboriginal women's experiences accessing healthcare services. The study used exploratory qualitative methods that followed general ethnographic research principles. The study was conducted in two phases. Phase One was a secondary analysis of qualitative interviews with Aboriginal women ( $n = 3$ ), who spoke about experiences with child protective services, and healthcare providers ( $n = 4$ ), who described experiences of working with women involved with child protective services. Phase Two involved collecting primary data through in-depth face-to-face interviews and field notes from Aboriginal women ( $n = 9$ ) who had experienced the removal of a child or children by child protective services and healthcare providers ( $n = 8$ ) with extensive experience working with women who have had child protective service involvement.

The study's findings indicated that Aboriginal women whose children are involved with child protective services experience complex sociopolitical and economic challenges. Parenting possibilities and the way the women are perceived by social services are influenced by both sociopolitical and economic factors. Child protective services and the healthcare system converge in complex ways in the lives of the Aboriginal women and their children. Many of the women reported being lone parents or having unstable partnerships. Many of the women had experienced the

foster care system as children themselves. The women reported ongoing governmental disruption of Aboriginal families and communities, the influence of structural inequities, and the context of poverty as major factors influencing their lives and the lives of their children. All of the women reported that their lives had been affected by social, political, and economic factors, such as poverty, substance use, violence, abuse, and other forms of trauma. The women identified service gaps for men or partners who were trying to parent and were also navigating socioeconomic and political challenges related to violence, anger, and substance use. Women who were navigating complex life circumstances encountered extreme difficulty in providing for stable and secure home for their children and were often not able to provide sufficient evidence of stability to maintain guardianship of their child or children.

All of the women encountered racism, judgment, and discrimination when they sought access to healthcare services. The researchers argued that these issues, which perpetuate the trauma experienced by Aboriginal women, must be addressed. The researchers proposed educating healthcare providers about culturally safe approaches to care as a critical step in mitigating the ongoing impact of colonialism and its effects on the health of Aboriginal communities.

*Source:* "Aboriginal Women's Experiences of Accessing Health Care When State Apprehension of Children Is Being Threatened," by J. Denison, C. Varcoe, and A. J. Browne, 2014, *Journal of Advanced Nursing*, 70(5), 1105–1116.

(PAHO) are actively involved in addressing health issues within their region. PAHO serves as the WHO regional office for the Americas. Because PAHO was established earlier, it has a different mandate, with different goals and objectives than the WHO and the other WHO regional offices (ROs). The WHO has a total of six regional offices to facilitate achieving its goals and objectives: Africa (AFRO), Europe (EURO), South-East Asia (SEARO), Eastern Mediterranean (EMRO), Western Pacific (WPRO), and the Americas (AMRO, which is PAHO).

### Community Development Assistance Agencies

Community and human development are integral to the health and well-being of humans. Multinational and multilateral development assistance agencies that support global health initiatives include the World Bank Group and the International Monetary Fund. In addition to international and regional agencies with global health and human development mandates, many national agencies have similar mandates. National agencies with global health and/or human

development mandates include the Department of Foreign Affairs and Trade (Australia); the Foreign Affairs, Trade and Development (Canada); the United Kingdom Department for International Development; the U.S. Agency for International Development; the U.S. Centers for Disease Control and Prevention; and the U.S. National Institutes of Health's Global Health Initiatives and the Fogarty International Center.



**InfoQuest:** Australia, Canada, the United Kingdom, and the United States have agencies with global health and/or international development mandates. Identify the global health and international development priorities for each of these countries. Search for departments from other countries that have similar mandates. What are the similarities and differences between each of the agencies' mandates? Based on nursing roles and responsibilities, in what ways would you be able to contribute to or participate in the health initiatives of these agencies?

Nongovernmental Systems

Achieving health for all and improving the health of persons living in impoverished communities requires the committed efforts of governments, civil society, and nongovernmental organizations (NGOs). Many NGOs have established strong community ties and built relationships of trust with governments that allow them to carry out global health initiatives in some of the most remote areas, as well as areas where there are major conflicts and civil unrest.

International Federation of the Red Cross and Red Crescent

The International Committee of the Red Cross was founded in 1863 and is the largest and most prestigious of the world’s humanitarian NGOs. It has three components: the International Committee of the Red Cross (ICRC); the International Federation of Red Cross and Red Crescent Societies (IFRC); and approximately 160 national societies, such as the Jordan National Red Crescent Society and the American Red Cross. The IFRC provides humanitarian help worldwide for people affected by conflict and armed violence, and it promotes the laws that protect victims of war. It is an independent and neutral organization whose mandate stems essentially from the Geneva Conventions of 1949 (International Committee of the Red Cross, 2010). The ICRC is mandated by the Geneva Conventions to protect and assist prisoners of war and civilians in international armed conflicts and will only enter war-torn areas when it is invited by the recognized governing body where the response is needed. For example, the ICRC can only help refugees who escaped conflict in Syria, and who are living in refugee camps in Lebanon, if the IFRC was invited in by the Lebanese government. The IFRC and National Red Cross and Red Crescent Societies also provide humanitarian aid during natural and manmade

disasters, and they collaborate with the ICRC in its efforts to achieve its mission. For example, the American Red Cross responds to wildfires in California, to mudslides in the Pacific Northwest, and, as in monumental disasters, to help the victims of Hurricane Katrina when it hit New Orleans in 2005.

Doctors Without Borders

The French-founded Médecins Sans Frontières (MSF)/Doctors Without Borders, an international humanitarian-aid nongovernmental organization, provides health aid to victims of war and natural disasters. Its mandate is similar to the Red Cross. In contrast however, MSF does enter war-torn areas without the permission of authorities. Although MSF’s charter includes the same principles of impartiality and neutrality as the IFRC, MSF considers one of its functions to be speaking out on human rights abuses. MSF draws attention to cases of underreported human rights violations and occasionally will take a strong stand and denounce egregious violations. This approach to human rights issues can create dangerous conditions for the staff and volunteers of MSF (Médecins Sans Frontières, 2014). A partial listing of other NGOs with global health mandates is in the accompanying box.

Philanthropic and Public/Private Partnerships

Private philanthropic foundations and public/private partnerships provide substantial economic and human resources for global health initiatives. In many regions of the world these organizations can supplement governmental efforts and provide expanded technical capacity to deliver health programs designed to achieve global health goals and objectives. The accompanying box lists some of the major foundations that contribute to the achievement of global health goals. Examples of public/private partnerships include the Stop TB Partnership and Roll Back Malaria.

Global Health and Human Development NGOs

|                                                                                                                                     |                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• OxFam</li><li>• Physicians for Human Rights</li><li>• CARE</li><li>• World Vision</li></ul> | <ul style="list-style-type: none"><li>• Save the Children</li><li>• Catholic Relief</li><li>• Islamic Relief</li><li>• HOPE—Project HOPE</li></ul> |
|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|

Selected Philanthropic Foundations with Global Health Mandates

|                                                                                                                                                                                     |                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Aga Khan Foundation and the Aga Khan Development Network</li><li>• Bill and Melinda Gates Foundation</li><li>• Clinton Foundation</li></ul> | <ul style="list-style-type: none"><li>• Ford Foundation</li><li>• Merck Foundation</li><li>• Wellcome Trust</li></ul> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|



**InfoQuest:** Select one of the philanthropic foundations listed in the previous box. Search the Internet for information about the major mission of that foundation as it relates to global health. In what ways can nurses contribute to or participate in the mission of the selected foundation? In your Internet exploration, what other philanthropic foundations did you find that have a mission in global health?

## Health Delivery Systems Around the World

Nurses witness the effects of the social determinants of health in their day-to-day work with individuals, families, and communities. Currently, many healthcare systems are structured to address preventing and curing disease/injury, not toward health promotion and maintaining health. Addressing the social determinants of health requires a shift in the prevailing thinking about health and the role of the health system. Most social determinants of health are influenced by the global economic system and the power relations that underpin it. Implementing primary healthcare strategies will be constrained until power and resources are more equitably distributed globally (Sanders, Baum, Benos, & Legge, 2011).

Knowledge of what a health system is and how health systems function is essential to understanding how countries strive to meet obligations and facilitate the progressive realization of health for all. A **health system** is “the sum total of all the organizations, institutions and resources whose primary purpose is to improve health” (World Health Organization, 2005). A country’s government is responsible for the overall performance of that country’s health system. However, achieving optimal health system performance requires the participation of regional, state/province, municipal, and individual health organizations. Effective health systems improve not only individual people’s lives but also the society in which they live.

### Health System Models

All countries must navigate complex financial, historical, legal, and political challenges to deliver healthcare services to their populations. Each country and its national context are unique in shaping the health system. However, there are four basic models for delivering health services: the Beveridge, Bismarck, national health insurance, and out-of-pocket models (Reid, 2009; World Health Organization, 2015e). Characteristics and examples of each model are outlined here.

#### Beveridge Model

In the Beveridge model, healthcare services are financed and provided by the government through tax payments. This system is often referred to as a *national health system*. Under this health system, many hospitals and clinics are government owned and many nurses, physicians, and other healthcare providers are government employees. A hallmark of this type of healthcare system is that per capita health costs are usually low. Lower costs under this system are usually attributed to the fact that the government, as the single payer for healthcare services, controls what healthcare providers can do and what they charge for their services. The health systems of Cuba, Great Britain, New Zealand, and Spain are based on the Beveridge model (Reid, 2009; World Health Organization, 2015e).

#### Bismarck Model

Under the Bismarck model, healthcare services are usually jointly financed by employers and employees through a system of mandatory health insurance plans. These not-for-profit insurance plans are required to cover everyone. Hospitals and clinics are often privately owned and operated. Nurses, physicians, and other healthcare providers are usually employed by the hospital or clinic where they work. Under this system, healthcare costs are limited through governmental regulations that can achieve cost controls similar to single-payer Beveridge models. The health systems of Belgium, France, Germany, and Japan are based on the Bismarck model (Reid, 2009; World Health Organization, 2015e).

#### National Health Insurance Model

Countries with a national health insurance system include elements of the Beveridge and Bismarck models. These health systems use private-sector providers who receive payments from a government-run insurance program that everyone contributes to. National health insurance programs are less costly because there are no costs associated with marketing insurance products. Administrative costs are lower and simpler than in for-profit insurance plans such as those in the United States. A hallmark of this model is the bargaining power that single-payer insurance companies have to negotiate low prices for healthcare products and services. For example, Canada has been able to negotiate lower drug prices than the United States from pharmaceutical companies. The health systems of Canada, South Korea, and Taiwan are based on the national health insurance model. Health system reforms in the United States through the Patient Protection and Affordable Care Act of 2010 include elements of this model (Reid, 2009; World Health Organization, 2015e).



### Out-of-Pocket Model

Healthcare services in this model are often fragmented, and persons with economic resources access the highest quality and quantity of health services. Out-of-pocket health systems are based on the ability of the person seeking health care to pay for the services he or she receives. This health system often operates in low- and middle-income countries with poorly organized governmental structures that are not able to provide mass healthcare systems. The health systems of China, India, and South Africa are based on the out-of-pocket model. In out-of-pocket health systems, illness/injury can cause financial hardship, and catastrophic illness/injury can result in financial ruin for individuals and their families. Prepayment plans and pooling of resources have been suggested as strategies to overcome these financial challenges. Historically, the U.S. health system was based on an out-of-pocket model. Exceptions to the U.S. out-of-pocket model included:

- Veterans Administration health services are provided through a system that resembles a single-payer government-owned system like Great Britain.
- Persons over the age of 65 receive health care financed through a national insurance model (Medicare) like Canada.
- Americans who have insurance through their employers experience a health system similar to Germany's Bismarck model.
- Uninsured Americans access health services if they can pay for them, if they are sick enough to be admitted to the emergency department of a public hospital, or through a national insurance model (Medicaid) if they are extremely impoverished (Reid, 2009; World Health Organization, 2015e).

The goals of the Patient Protection and Affordable Care Act (PPACA) of 2010 are to increase access to affordable health insurance and to improve access to health care services. Since open enrolment began in 2013, an estimated 15–22 million previously uninsured or underinsured people were able to obtain affordable health insurance, including millions who have acquired health insurance through expansion of state Medicaid programs or through the provision that allows people under 26 years of age to be covered under their parents' healthcare plan (obamacarefacts.com, 2015). However, 5.7 million people are still uninsured because of states that chose not to expand Medicaid or to set up healthcare marketplaces under the PPACA (whitehouse.gov, 2014).

## Nursing and Global Health

Nursing has been and continues to be a leader in the field of global health. In the late 19th century, nurses trained by Florence Nightingale in London were recruited by nations around the world, including Australia, New Zealand, India, and Jamaica, to implement the Nightingale model of nursing practice and nursing education. Nursing was the first health profession to organize at the international level to address issues that are of concern to the profession and that transcend national boundaries. Throughout much of nursing's history, there is evidence of the profession's struggle with the global health concepts of social justice, health equity, and human rights. Early nursing theorists and scholars have provided a rich foundation for contemporary nurses to build upon. "Tracing the roots of nursing to Nightingale and even before—to the religious who took care of the sick—it is clear that nursing had at its core the

## RESEARCH CURRENT

### Nurse Staffing and Education and Hospital Mortality in Nine European Countries: A Retrospective Observational Study

The purpose of Aiken and colleagues' retrospective observational study was to determine whether differences in patient-to-nurse ratios and nurses' educational qualifications were associated with variation in hospital mortality after common surgical procedures. Data sources for the study included hospital discharge data for 422,730 patients from 300 hospitals, administrative data to estimate 30-day in-hospital mortality, and survey data from 26,516 nurses practicing in the study hospitals to determine nurse staffing ratios and nurse education.

The researchers observed that an increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission. The effect of

increased levels of nurse education, with higher percentages of nurses holding a bachelor's degree, was associated with a decreased likelihood of patient mortality. These findings highlight that nurse staffing cuts designed as cost-saving measures may adversely affect patient outcomes. The researchers argued that increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

*Source:* "Nurse Staffing and Education and Hospital Mortality in Nine European Countries: A Retrospective Observational Study," by L. H. Aiken, D. M. Sloane, L. Bruyneel, K. Van den Heede, P. Griffiths, R. Busse, M. Diomodous, J. Kinnunen, M. Kózka, E. Lesaffre, M. D. McHugh, M. T. Moreno-Casbas, A. M. Rafferty, R. Schwendimann, P. A. Scott, C. Tishelman, T. van Achterberg, and W. Sermeus, for the RN4CAST consortium, 2014, *The Lancet*, 383 (9931), 1824–1830.

principles of social justice and respect for the dignity of human life” (Fitzpatrick, 2003).

Conceptually, nurses have understood the importance of social justice and have debated topics emphasizing the importance of equality and equity throughout the profession’s history. Moving forward it is important to reflect on the past to inform nurses’ understanding of global health concepts and their centrality in addressing inequalities in health and health care (Pauly, MacKinnon, & Varcoe, 2009). Furthermore, the collective commitment of nurses as expressed in the Nursing Manifesto proclaims the profession’s intent to strive to achieve health for all; that is, “Our concern covers the world and we seek to embrace a global perspective” (Cowling, Chinn, & Hagedorn, 2000).

Providing nursing care in a global health context can be both rewarding and challenging for the nurse and the community or country where the care is provided. Nursing care delivered in global health contexts includes:

- Direct care provided to healthcare consumers, their families, and their communities in primary, secondary, or tertiary settings in urban, suburban, rural, and remote locations in the nurse’s home country or in short- or long-term assignments in countries around the world
- Education and training of care providers, healthcare consumers, their families, and their communities provided face-to-face in a country or via technology-based education platforms such as the Internet
- Program planning and implementation to address specific health needs such as tuberculosis, HIV/AIDS, malaria, or Ebola
- Policy advocacy to ensure healthcare services are provided in a manner that is economically feasible and based on principles of health equity

Nursing in a globalized world is influenced by geopolitical changes and societal challenges that influence individual and population health outcomes. Nurses working in global health settings work in collaboration with colleagues who represent different healthcare professions with varying levels of knowledge and clinical competence, attained from a variety of educational and training paradigms. It is essential to recognize that not all persons identified as nurses have the same training and competence. There are efforts to increase the skill level of nurses around the world to ensure the achievement of primary healthcare goals.

There have been efforts to provide more standardized frameworks for entry to practice and to establish minimal standards of care across multiple national boundaries. For example, the International Council of Nurses and the Association of Nurses in AIDS Care (ANAC) collaborated in the development of essential nursing competencies related to HIV/AIDS (Relf et al., 2011). This document outlines

the necessary training and competency validation needed to provide minimally safe care to persons living with HIV. It provides a general framework that can be adapted to the needs of local communities confronting HIV disease.

## Nursing Roles in Global Health

Global achievement of healthcare goals can be attained through the implementation of all the roles of the professional nurse. The nurse as health promoter can contribute to the management of communicable and noncommunicable disease through participation in disease and injury prevention initiatives such as the global response to the influenza pandemic in 2009. Nurses as care providers can administer care to improve health outcomes during disaster response, wars, or civil unrest; among internally displaced persons and persons in refugee camps; and to the impoverished and vulnerable populations within their own or other countries. The interprofessional nature of global health requires nurses to fulfill their roles as colleague and collaborator in order to coordinate and implement initiatives designed to ensure health equity and socially just responses to global health issues. For example, nurses in several sub-Saharan African nations have been trained to dispense and manage antiretroviral therapy medications for persons living with HIV/AIDS.

One of the most important roles of the nurse in global health is the role of educator. The nurse as educator can build capacity for healthy communities through improving the technical capacity of nurses in a particular country and by being part of initiatives to train nurses and other healthcare workers to address global health issues. Nurses can also be involved in training nurses in low- and middle-income countries to meet the needs of the population. Nurses in global health must be political advocates who can effectively communicate the essential healthcare needs of the communities where they work. In leadership and advocacy roles the nurse can actively promote just and equitable care to all, including women, children, the elderly, the impoverished, and other vulnerable or marginalized groups. Such healthcare activism must be respectful of and consistent with the community’s identified healthcare needs and the ethical norms of the nursing profession. The nurse as researcher in global health can contribute to the development of new prevention and treatment strategies and efficacy evaluations of global health initiatives and programs

## Nursing and Health Professions Organizations

Nursing and nurses have a rich history of advocating for health issues and continue to collaborate with other healthcare organizations, governments, and civic organizations to address global health issues.

### International Council of Nurses

The **International Council of Nurses (ICN)**, headquartered in Geneva, Switzerland, is a federation of more than 130 national nurses associations (NNAs), representing more than 16 million nurses worldwide. Founded in 1899, ICN is the world's first and widest reaching international organization for health professionals. Organized and managed by nurses, ICN (2015) works to ensure:

- Quality nursing care for all
- Sound health policies globally
- The advancement of nursing knowledge
- A competent and satisfied nursing workforce
- The presence of a respected nursing profession worldwide

### Sigma Theta Tau International

**Sigma Theta Tau International (STTI)**, the nursing honor society, continues to establish alliances with international healthcare organizations, support global nursing initiatives, and collaborate with nurses and members worldwide. STTI has alliances and partnerships to support global health work with the World Health Organization, the United Nations, the Pan American Health Organization, the Canadian Nurses Association, the International Council of Nurses, the Joanna Briggs Institute, the American International Health Alliance, and the Plexus Institute. Selected STTI (2014) global health initiatives include:

- Global Advisory Panel on the Future of Nursing
- Technology Informatics Guiding Education Reform
- Global Standards for the Initial Education of Professional Nurses and Midwives
- Essential Nursing Competencies and Curricula Guidelines for Genetics and Genomics

The ICN and the STTI collaborate with the World Medical Association and the World Health Professions Alliance to achieve goals of common interest to the organizations' members and to implement initiatives of relevance to all health professionals.

### World Medical Association

The **World Medical Association (WMA)** was founded in 1947 by physicians from 27 countries. It now includes 106 national medical associations with the purpose "to serve humanity by endeavoring to achieve the highest international standards in Medical Education, Medical Science, Medical Art and Medical Ethics, and Health Care for all people in the world" (World Medical Association, 2015).

### World Health Professions Alliance

Nurses, physicians, pharmacists, and other healthcare professionals collaborate to advocate and work for the highest possible standards of health care for all people through the

**World Health Professions Alliance (WHPA)**. The WHPA was formed in 1999 and represents more than 26 million healthcare professionals in more than 130 countries. The WHPA collaborates with more than 600 member organizations and "works to improve global health and the quality of patient care and facilitates collaboration among the health professions and major stakeholders" (World Health Professions Alliance, 2015).

Many national nursing organizations also have global health initiatives and mandates, including the American Nurses Association and the Canadian Nurses Association.

### American Nurses Association

The **American Nurses Association (ANA)** has been involved in an international panel on safe patient handling. The ANA collaborates with its affiliated nursing organizations to achieve global health goals. The ANA is involved in the following activities that are consistent with global health goals:

- Healthy work environments and environmental health
- Disaster preparedness and response
- Professional standards and nurse staffing
- Leadership to transform health care

### Canadian Nurses Association

The **Canadian Nurses Association (CNA)** strives to remain current with global health issues and has established partnerships with a number of international organizations. CNA (2014) is most active in the following global health areas:

- Maternal, newborn, and child health
- Social justice and equity
- Global health leadership
- Female genital mutilation
- Disaster response

Nursing specialty organizations that have global health initiatives include the Association of Nurses in AIDS Care, the Nightingale Initiative for Global Health, and Nurse Together.



**InfoQuest:** In the United States and around the world, there are a number of nursing professional and nursing specialty organizations. Conduct an Internet search to identify the global health activities and initiatives of one or more of these organizations. What information are you able to find out about the global health involvement of the specialty in which you currently practice or that you are most interested in pursuing?

## Nursing Opportunities in Global Health

There are many global health opportunities for nurses at home and abroad, including employment and volunteering for short-term and long-term postings with a number of different organizations.

Global health nursing employment opportunities are offered through agencies such as Médecins Sans Frontières/Doctors Without Borders, the World Health Organization and its regional offices, Health Volunteers Overseas, or Project Hope. Global health volunteer nursing opportunities are available through a number of governmental, nongovernmental, religiously affiliated, and private agencies. For example, Mercy Ships operates hospital ships that respond to the healthcare needs of residents in different countries. The ships can respond to natural and manmade disasters as well as providing needed surgical or other medical procedures and services that may not be available in that country (Geller, 2014). Health Volunteers Overseas provides healthcare professionals to developing countries for short- or long-term assignments to assist in building local capacity to meet the healthcare needs of the community being served.

Nurses considering working or volunteering in global health settings need to become informed about a number of issues to ensure they are safe and able to provide nursing care that is within their scope of practice and ethical, and that reduces the likelihood of causing harm in the host community. A partial list of these considerations includes:

- Exploring the reputation of the employer or volunteer agency or agencies
- Becoming knowledgeable about local and national security considerations in the host country
- Obtaining recommended/required immunizations and reviewing travel health advisories
- Obtaining contact information and knowing the location of the nearest embassy or consulate from their home country
- Knowing the scope and standards of nursing practice in the host country
- Seeking nursing registration in the host country

An additional consideration before working or volunteering in a global health setting is to determine if the nurse's home country has specific requirements or restrictions for practicing abroad.

Opportunities also arise for nurses interested in working with global health issues within their home country. In the United States, the Indian Health Service is the agency responsible for providing health care to Native American and Alaskan Native peoples. In Canada, Aboriginal Affairs

and Northern Development Canada (AANDC) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada provide healthcare services, and nurses are employed in these agencies. Additional global health nursing opportunities exist among vulnerable populations in urban areas and rural and remote communities in Canada and the United States.



**InfoQuest:** Explore the websites of agencies such as Aboriginal Affairs and Northern Development Canada, First Nations and Inuit Health Branch, and Indian Health Services. What are the mission and goals of these organizations? What career opportunities are available for nurses? What incentives do these agencies have for nurses and other healthcare workers employed in the agency?

## Reflect On . . .

- your own thoughts about using your knowledge and skills as a nurse to influence the health of impoverished or vulnerable people within your community, your nation, or another country. What knowledge and skills would you need to obtain to contribute to global health initiatives?
- your ability to provide care in the event of a local disaster, or a national disaster. What do you need to know in order to be available in the event of a disaster?

## Nurse Migration

The need for skilled and highly trained nurses and other healthcare workers throughout the world creates both challenges and opportunities. Kingma (2007) described international nurse migration as an exaggeration of the systemic problems that result in nurses leaving their jobs and often the profession. She argued that international nurse migration is only an issue when there are nursing shortages or when migrant nurses are exploited or abused. Nurse migration is shaped by a multitude of social forces, such as demographic and illness/injury profile changes, economic



conditions and economic policies, healthcare system and workforce issues, social change and civil unrest, and workplace safety.

There can be many motivators for nurse migration. These can include economic opportunity, desire to learn new skills and build professional skill sets, political forces, poverty, age of the migrant, past colonial and cultural ties between source and destination countries, a facilitated emigration process, employment/educational opportunities for family members, and an existing diaspora (transnational communities). Barriers to nurse migration include the process of requalification, costs of physical relocation, learning a new language and technical terminology, adapting to different clinical practices, and navigating the process of immigration (e.g., obtaining worker visas, residency, and/or citizenship) in the recipient country (Kingma, 2007).

Nurse migration poses challenges for the health systems and the nurses from developing nations because it contributes to brain drain when skilled nurses leaving their home country to practice in more developed nations or in countries where the economic opportunities and working conditions are better. Many nurses migrate for higher wages and more opportunities to practice to their full scope of practice and skill level. However, for individual nurses from developing nations, the regulatory requirements in the host country may limit their opportunities to obtain licensure to practice. They may not be able to practice and may seek to return to their home country. For example, in rural areas of some developing countries, nurses may be the only healthcare provider and have more autonomy to practice beyond the scope of nursing practice that is acceptable in more developed nations. In some cases, when the nurse returns to her or his home country, she or he has lost the skills and competence necessary to function within their home practice environment and may have missed out on opportunities for advancement within the ranks of the healthcare system in the home country. At a national level, the economic impact of nurse migration on the source countries can be devastating. The cost of training nurses and other healthcare workers who then migrate can strain health resources in countries with limited resources. Yet nurses in the diaspora (living and working outside their home country but with familial and cultural ties to the home country) often send part of their earnings home, which contribute to the economic welfare of family members. In the absence of effective policies that address recruitment and retention issues, including equal opportunity salary scales and substantial

improvements in working conditions, there will continue to be challenges in ensuring sufficient numbers of nurses in healthcare systems throughout the world (Kingma, 2007): “Injecting migrant nurses into dysfunctional health systems—ones that are not capable of attracting and retaining domestic-educated staff—is not likely to meet the growing health needs of national populations” (Kingma, 2007, p. 1294). Within the nursing profession and the health sector, there is much debate about the most effective strategies for addressing nurse migration.

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### Reflect On . . .

- your own thoughts about nurse migration. Have you worked with a healthcare provider who has migrated to your country? Is that person able to practice to her or his full capacity as a healthcare provider? How have you assisted that nurse in transitioning to nursing practice in your community/country? What have you learned from the migrant nurse that has influenced your practice?
  - your own experience if you have migrated from one country to another in order to practice nursing. What challenges have you encountered in your migration? How have you dealt with these challenges? What do you see as the advantages and disadvantages of your multinational nursing experience?
  - factors that contribute to your roles and responsibilities in relation to international nurse migration. What ethical and moral considerations can be found in nursing’s knowledge base to address the challenges that nurse migration poses?
- 

The field of global health offers the opportunity for the people of the world to come together to meet the challenges associated with achieving health for all. Nurses have the responsibility for addressing global health issues at local, national, and global levels. As a profession, nursing is uniquely positioned to participate in and lead global health initiatives. Nurses, as individuals, have opportunities to engage in global health issues at all levels of healthcare delivery at home and abroad.

## Chapter Highlights

- Health and the achievement of optimal health outcomes is closely linked to human development, which includes all aspects of personhood. Human development is defined as the process of expanding people's freedoms and opportunities to improve their well-being. Human development encompasses both individual and collective development potential.
- Global health means the optimal well-being of all humans from individual and collective perspectives. The focus and purpose of global health are more expansive and encompass broader goals for the achievement of health for all than the fields of international and public health from which it evolved.
- Goals of global health, including primary health care, have been articulated in several international agreements, including the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion.
- The five domains of primary health care are accessibility and equitable distribution, community participation, health promotion, appropriate technology, and intersectoral collaboration.
- The principles of global health have been described in various national and international documents and include using evidence-based knowledge to inform decisions, leveraging strengths through partnership and coordination, responding to local needs, building local capacities, ensuring a lasting and measurable impact, emphasizing prevention, and improving the equity of health.
- Determinants of health, health equity, social justice, and social responsibility are concepts that are integrated into global health, and nursing has been instrumental to understanding the effects of each of these concepts on health outcomes globally.
- Human rights and ethical considerations are important elements to addressing global health issues, and nursing has been integral to advancements in the protection of human rights and the provision of ethical global health care.
- Global health concerns include communicable disease; noncommunicable diseases; mental health issues; and injuries, trauma, and violence. They are influenced by demographic and epidemic shifts, economic and sociopolitical forces, and environmental changes.
- Several governmental, intergovernmental, and nongovernmental agencies, including philanthropic foundations, have major goals to respond to global health issues.
- Each country is responsible for the development and maintenance of its healthcare system. The main elements of healthcare systems can be separated into one of four basic models for delivering health services globally: the Beveridge model, the Bismarck model, the national health insurance model, and the out-of-pocket model.
- Nursing was the first health profession to organize at the international level to address issues that are of concern to the profession and transcend national boundaries. Global achievement of healthcare goals can be attained through the implementation of all of nursing's professional roles.
- Nursing and nurses have a rich history of advocating for health issues and continue to collaborate with other healthcare organizations, governments, and civic organizations to address global health issues.
- Global health opportunities for nurses exist at home and abroad and include employment and volunteer opportunities for short-term and long-term postings with a number of different organizations globally.
- Nurse migration is pushed, pulled, and shaped by a multitude of social forces that must be addressed in order to overcome the challenges inherent in the process. Within the nursing profession and the health sector, there is much debate about the most effective strategies for addressing nurse migration.

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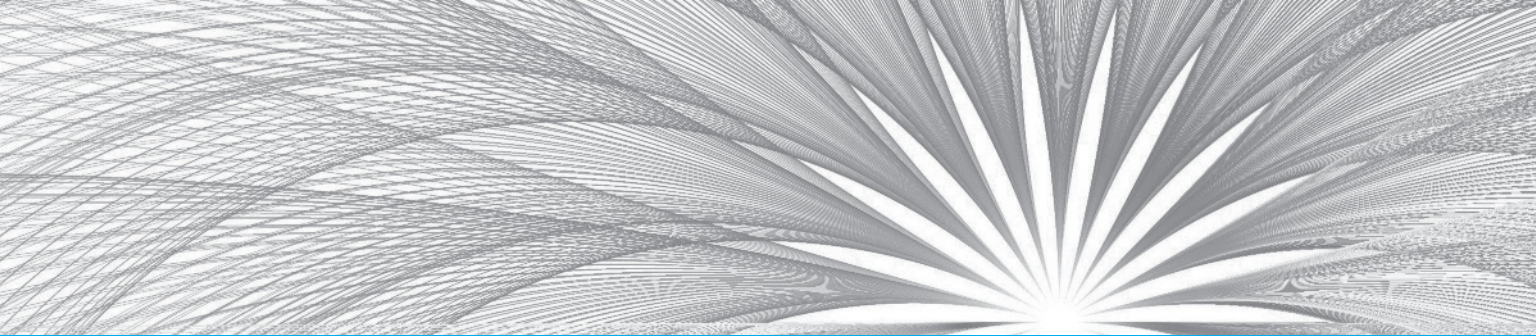
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# 20

## Dimensions of Holistic Health Care

### Chapter Outline

#### Challenges and Opportunities

##### The Expanding View of Health Care

- Complementary and Alternative Medicine
- Holistic Nursing
- Health Promotion and Healthy Lifestyles
- Primary, Secondary, and Tertiary Prevention

#### Transition to Integrative Health

##### Complementary Therapies

- Biologically Based Therapies
- Manipulative Body-Based Therapies
- Energy Therapies
- Mind-Body-Based Therapies

#### Chapter Highlights

### Objectives

1. Describe the change in the view of health care from one of biological focus on disease management to comprehensive health care.
2. Define holistic health and holistic nursing.
3. Differentiate primary, secondary, and tertiary health promotion.
4. Discuss integrative health in the context of nursing.
5. Compare biologically based, manipulative body-based, energy, and mind-body-based therapies

A client enters the healthcare system as a multidimensional human being. Traditional medicine has generally been concerned with focusing on only the physical dimension of a person. In the healthcare system, this is generally narrowed to the client's illness or disease. Each client is a person who comprises more than his or her physical illness/disease. Often, in the hectic world of health care, the client is reduced (by healthcare providers) to being referred to as their disease/illness. You may hear someone referring to "the type 2 diabetic in room 304" or "I sent your MI (myocardial infarction) patient down for the stress test." This type of labeling is common in health care but not respectful or acceptable from a humane or professional perspective. Clients are much more than their disease. They are a composite of their physical, emotional, psychological, and spiritual attributes. All these components contribute to the whole person and work in concert to contribute to health or disease.

A cohort of holistic nurses organized the American Holistic Nurses Association (AHNA) in 1981, declaring that their practice differed from mainstream nursing in that it was based on competencies that focused on facilitating mind-body-spirit and health, healing, and wellness. Through time holistic nurses have differentiated their worldview and practice and have said that the focus is on the clients as the experts on their own life experiences, who should be the primary source of information for planning care. Clients are considered an equal partner with the nurse (Erickson et al., 2013).

## Challenges and Opportunities

The traditional view of nursing and medicine is no longer adequate and must be expanded to include the various dimensions that encompass holistic health. Early nursing theorists, including Virginia Henderson and Hildegard Peplau, considered client dimensions beyond the physiological functioning as important in identifying and planning nursing care. Later, Madeleine Leininger focused on the culture of caring in developing her theory of culture care diversity and universality. We indeed are now part of a global village and work with an increasingly culturally diverse population of clients who are seeking health care from a variety of perspectives. The challenge of providing care for this diverse population must be met by expanding perspectives of health care. Health care is rapidly changing and incorporating both Eastern and Western philosophies.

Exciting opportunities are present for nursing to actively participate in expanding the focus of health care. Complementary and alternative medicine (CAM) is getting increased focus in research and practice in this country and is a common choice for many clients. In order to provide comprehensive, individualized care to clients, nurses must be knowledgeable about the modalities that clients are selecting to enhance their health and healing. Sometimes the choices that they make can actually have detrimental effects on their health, and the nurse who is knowledgeable about CAM becomes valuable to the client. Understanding that not all CAM therapies are safe for everyone is a challenge, but this understanding creates an opportunity for nurses to educate clients regarding the potential attributes and the potential dangers of certain modalities. Expanding assessments of clients to include the multiple dimensions of holistic health can be exciting and rewarding. Taking the time to assess the many attributes of each client can provide an enriching experience where both client and nurse experience positive growth as a result of the encounter.

## The Expanding View of Health Care

Western medicine has been through three eras, beginning in the 1860s when it was struggling to be recognized as scientific, and science itself was just becoming legitimized. Emerging was the idea that health and illness were physical in nature, and medicine focused on the use of drugs, treatment, technologies, and the combinations of these to produce a cure. In the 1950s therapies emerged that reflected a growing recognition of the effects of the mind or consciousness on the physical. During these first two eras, the view of consciousness was limited to location within the body at the present time. In the latest era,

consciousness has expanded time and space and is believed to be infinite. This belief allows the consciousness to create bridges between people, exemplified by distant healing, intercessory prayer, and shamanic healing (Dossey & Keegan, 2013).

## Complementary and Alternative Medicine

The National Center for Complementary and Alternative Medicine (NCCAM) has been established at the National Institutes of Health to be the lead federal government agency for scientific research on CAM. NCCAM defines CAM as “a group of diverse medical and health care interventions, practices, products, or disciplines that are not generally considered part of conventional Medicine” (National Center for Complementary and Alternative Medicine, 2011). *Complementary medicine* refers to the non-mainstream approach used in combination with or in addition to conventional medicine. *Alternative medicine* refers to using nonmainstream approaches in place of conventional medicine. The complementary approach is more commonly found in healthcare practice. The boundaries between complementary and conventional medicine often blur, and what was once considered complementary may become conventional; for instance, guided imagery and relaxation strategies that were once considered outside of the mainstream are now commonly used for pain and stress management.

CAM therapies can be described as those that involve doing and those that involve being. Doing therapies are those that involve active interventions such as medications, dietary changes, or spinal adjustment. Being therapies use states of consciousness such as meditation, imagery, or prayer that work with the power of the mind to effect the body. All these healing experiences can be placed on a continuum from paradoxical to rational healing. The degree of doing or being determines placement on that continuum. The rational healing experiences are those that are more easily explained or understood by the more traditional scientific world and include surgery, radiation, and pharmacotherapies. Paradoxical healing approaches are less traditional and are more difficult to explain scientifically, such as prayer, placebos, therapeutic touch, and energy fields.

Relationship-centered care as described by the Pew Health Professions Commission Report in 1994 put forth the tenet that relationships and interactions between and among people provide the foundation for therapeutic activities and healing. There are three types of relationships: patient-practitioner, community-practitioner, and practitioner-practitioner. Each of these is important to the model of care. The relationship with the patient is contingent upon the practitioner’s self-awareness, understanding of the

patient's experience, caring, and effective communication. The community-practitioner relationship must involve the practitioner's active collaboration with patients and families. Power inequalities are counterproductive. The practitioner must understand the community and contributors to health and illness within the community. In the practitioner-practitioner relationship, integrative care requires that care be interdependent among providers, requiring respect and understanding of the roles of others. All practitioners will need to remain open to the experiences of different providers and value the diversity.

Optimal healing environments integrate social, psychological, spiritual, physical, and behavioral aspects of care directed toward healing and wholeness for individuals. See Figure 20–1. Key concepts include awareness and intention. Practitioners achieve these through reflective practices such as mindfulness, dialogue, and journaling. This process begins with each individual, whether practitioner or patient.

The holistic healthcare movement has expanded the choices of treatment modalities for health and healing. Many of the unconventional or alternative treatment choices have been borrowed from Eastern medicine. The

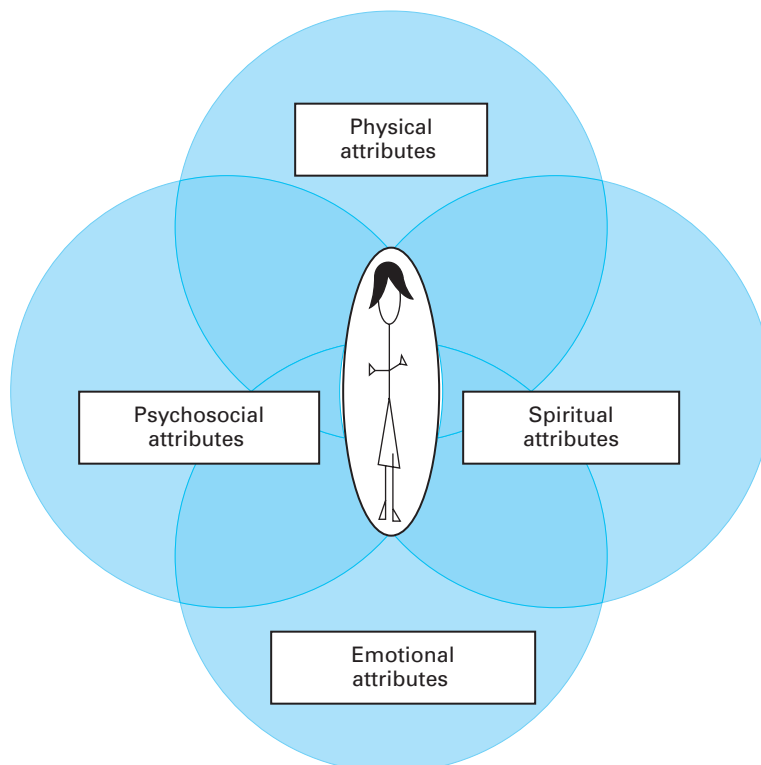
use of these alternative therapies began the transition away from only valuing the traditional Western philosophy of medicine. Although some proponents of the holistic health movement encouraged the use of only alternative therapies, many providers began to blend the use of Eastern and Western medicine. This blending of both Eastern and Western medicine has become known today as **integrated medicine**, or **integrative health**.

## Holistic Nursing

Holistic nursing has emerged with the rise of the focus on the whole person. The American Nurses Association recognizes holistic nursing as a nursing specialty with its own scope and standards of practice. The American Holistic Nurses Association (AHNA) developed standards of practice that define holistic nursing as a specialty practice that draws upon nursing knowledge, theories, expertise, and intuition to guide nurses in becoming therapeutic partners with clients to strengthen the client's ability to heal. Holistic nursing practice takes into account the interconnectedness of body, mind, emotion, spirit, social/cultural effects, relationships, context, and environment and its impact on health and healing. Holistic nursing recognizes the

**FIGURE 20–1**

Multiple Dimensions of a Person



## Phenomena of Concern to Holistic Nursing

- The caring-healing relationship
- The subjective experience of meanings ascribed to health, illness, wellness, healing, birth, growth and development, and dying
- The cultural values and beliefs and folk practices of health, illness, and healing
- Spirituality in nursing care
- The evaluation of complementary/alternative modalities used in nursing practice
- Comprehensive health promotion and disease prevention
- Self-care processes
- Physical, mental, emotional, and spiritual comfort, discomfort, and pain
- Empowerment, decision making, and the ability to make informed choices
- Social and economic policies and their effects on the health of individuals, families, and communities
- Diverse and alternative healthcare systems and their relationships with access and quality of health care
- The environment and the prevention of disease

Source: *Holistic Nursing: A Handbook for Practice* (6th ed.), by B. M. Dossey and L. Keegan, 2013, Burlington, MA: Jones & Bartlett, p. 65. Used by permission.

mind-body-spirit connection and therefore often incorporates the modalities of complementary and alternative medicine, such as therapeutic massage, imagery, meditation, and healing presence (Dossey & Keegan, 2013).

Certification as a holistic nurse is done through the American Holistic Nurses Credentialing Corporation; it may be done on the basic level as either holistic nurse, board-certified (HN-BC), or holistic baccalaureate nurse, board-certified (HNB-BC). It may also be done at the advanced level as either advanced holistic nurse, board-certified (AHN-BC) or advanced practice holistic nurse, board-certified (APHN-BC). Certification involves an application and examination and also requires a self-reflective self-assessment. Eligibility criteria include contact hour minimum, active practice requirement, licensure, and graduation specifications; these can be found on the American Holistic Nurses Credentialing Corporation's website.

Holistic nursing incorporates a theory of integral nursing that embraces both the art and science of nursing. In this theory, reality comes from four perspectives: individual interior (personal/intentional), individual exterior (physiology/behavioral), collective interior (share, cultural), and collective exterior (systems/structure). The "worldview examines values, beliefs, assumptions, meaning, purpose, and judgments related to how individuals perceive reality and relationships from the four perspectives" (Dossey & Keegan, 2013, p. 23). The theory of integral nursing has three aims: to embrace the whole person and the complexity of nursing and health care, to explore and apply the four perspectives of reality, and to expand the capacities of nurses toward integral health locally and globally. The building blocks of the theory are healing, the metaparadigm of nursing, patterns of knowing, and the four perspectives. The concept of healing accepts the person as an energy field connected to other energy fields of

all humanity and the world. Healing includes knowing, doing, and being. It brings one into harmony and stages of inner knowing that lead to integration. (See the accompanying box.)



**InfoQuest:** Visit the AHNA website and review the Scope and Standards of Practice. What interests you about this role?

In order to provide the best care possible, it is imperative that healthcare professionals take the time to comprehensively assess the multiple dimensions of a client. Nurses must commit to getting to know the client as a composite of his or her physical, emotional, psychosocial, and spiritual attributes. This comprehensive assessment offers the nurse the ability to meet the needs of each individual client in a more meaningful way.

## Health Promotion and Healthy Lifestyles

Another factor that has influenced the transition in the healthcare system to a more holistic view is a government-supported healthcare initiative. This initiative was originally known as *Healthy People 2000* and has now expanded to become *Healthy People 2020*; it has influenced a significant change in the U.S. healthcare system by moving away from an illness/disease-based framework to a more comprehensive approach to health care that has expanded to include health screening and health promotion strategies.

The World Health Organization (WHO) first proposed that health is more than the absence of disease in 1946. During the 1950s and 1960s wellness models emerged. Halbert Dunn was the first to use the term *wellness*, and



## CRITICAL THINKING EXERCISE

Mrs. L. Miccio is a 72 year old female hospitalized with a diagnosis of congestive heart failure. While reviewing her chart, you note the following statement by the emergency department physician: “Client is noncompliant with medication and diet regimen to manage her disease.” As you are providing care with Mrs. Miccio, you and she are chatting. She reveals to you that her husband of 50 years died 3 months ago. Mrs. Miccio becomes very tearful and tells you that she is feeling very sad and lonely since he died. She also states that her husband always did all of their grocery shopping and cooking due to her severe osteoarthritis of both knees. Mrs. Miccio tells you that she has had great difficulty getting to the

grocery store to buy groceries. As a consequence, she has become more reliant on canned soups and packaged food items for her meals. She also mentions that it is difficult for her to obtain her prescription medications because her husband always picked them up for her, since she does not have a driving license.

1. Besides the physical concerns, what other dimensions/attributes of Mrs. Miccio do you think must be considered? What problems have you identified in these dimensions?
2. How does your assessment of Mrs. Miccio now contribute to her care plan?

many other models were developed that were focused on the individual’s health and levels of functioning but did not address well-being. From these models have derived eight dimensions of health, wellness, and well-being: physical, psychological, emotional, intellectual/cognitive, spiritual, occupational, social, and environmental (Hunter, Marshall, Corcoran, Leeder, & Phelps, 2013).

Many CAM disciplines, systems of traditional medicine, and integrative medicine practices place a strong emphasis on preventive health strategies, including better dietary practices and regular physical exercise. In addition, CAM and integrative medicine practitioners often claim a high degree of success in supporting healthy behavior, using CAM-inclusive interventions and practices to facilitate behavior change and support sustained motivation.

Although limited in scope, an emerging body of interesting data suggests that users of CAM have a greater degree of health consciousness, in that they are more likely to engage in activities widely accepted as health promoting. For example, preliminary data suggest that CAM users are more likely to exercise regularly than non-CAM users. Other data suggest that individuals who see both CAM and conventional medical providers are more proactive about their health than are those who see only CAM or only conventional medicine providers.

These claims and preliminary findings are noteworthy because of the widely recognized need for better or more individualized strategies for promoting healthy behavior and positive health behavior change. They merit further investigation, initially aimed at verifying this preliminary evidence and exploring the observed associations. If confirmed, translational research toward subsequent intervention trials testing evidence-based hypotheses would be warranted. Going forward, NCCAM will work with its

stakeholder communities to develop initiatives for research exploring these associations and, if appropriate, designing the methods and translational tools needed to develop this area of investigation further.

### Primary, Secondary, and Tertiary Prevention

Clients generally come into the healthcare system seeking help to improve their health status. The most common setting where nurses would care for clients in the past was in the acute-care settings. Most often, clients were seeking care/treatment for an illness or disease that had already occurred. Many nurses were not involved in care for a client, unless the person had an illness, injury, or disease that had already occurred. Clients were hospitalized to be treated for an illness or disease, or to recover from surgery. This level of care is considered tertiary and is known as the **tertiary level of prevention**, which is defined as the care and restoration of a patient after an insult or injury (disease) has occurred. The tertiary level of prevention is the most expensive level of care in the healthcare system. It is well known that early diagnosis and aggressive management of diabetes for good control can prevent the long-term serious sequelae of renal failure, blindness, and peripheral vascular disease with possible amputation of the lower extremities. (See the accompanying box.)

The **secondary level of prevention** focuses on screening and early detection of disease with the goal of early intervention. This level of health promotion helps to identify clients who are at risk for certain diseases earlier so that intervention can be instituted earlier with the intent of averting the serious sequelae and more expensive outcome that may occur when a disease is identified later in its progression. The secondary level of prevention has become an

## Levels of Health Prevention

**Primary health prevention:** Immunizations, healthy diet, exercise, maintaining a healthy weight, skin protection, seat belts, violence prevention

**Secondary health prevention:** The following screenings: blood pressure, temperature, pulse, vision, hearing, lead, cardiac risk profile, chemistry labs and mammography

**Tertiary health prevention:** cardiac rehabilitation, orthopedic rehabilitation, hypertension management, diabetes management, arthritis management, and cancer treatment

important part of mainstream medicine today with age-related screening tests being done for clients of all ages. For example, guidelines for screening women for cervical, ovarian, and breast cancer have been implemented, and these screenings are very effective in decreasing morbidity and mortality. This type of intervention saves lives through early detection so that aggressive interventions can be implemented to prevent disability and mortality from delayed diagnosis. Often, early screening measures detect disease before the client has experienced any symptoms.

The first level of health promotion, known as the **primary level of prevention**, has become a major focus for health agendas concerned with health promotion and education; it is considered the optimal level of prevention as it engages health-promoting behaviors designed to avoid illness and disease. Primary prevention strategies have become more common in mainstream medicine. Many providers now spend time with clients educating them about health-promoting behaviors such as sun protection for skin cancer prevention, nutritional guidelines regarding the importance of fruit and vegetable consumption to enhance health, and the importance of regular exercise. The primary level of prevention may turn out to be the most cost-effective intervention to improve the health and well-being of everyone.

**Modifiable risk factors** are defined as those identified factors that are amendable to modification, such as weight, blood pressure, exercise patterns, and smoking. For example, risk factors such as obesity, sedentary lifestyle, elevated blood pressure, and smoking can have a negative influence on the progression of several common diseases, such as diabetes, hypertension, and heart disease. However, aggressive management of these risk factors, such as weight loss, regular exercise, and smoking cessation, can have a positive influence by delaying or preventing the onset of certain diseases. Nonmodifiable risk factors are defined as those identified risk factors that are not amendable to intervention. Examples of *nonmodifiable risk factors* include gender, age, and genetics.

## Transition to Integrative Health

In the 1990s, the American healthcare industry became aware of the magnitude of alternative medicine use in this country. Eisenberg et al. (1993) published the results of their landmark study on the use of unconventional medicine by consumers in the United States. The study results were based on a sample size of more than 1,500 consumers and revealed that 1 in 3 of those surveyed were currently utilizing at least one form of alternative medicine. Even

### CRITICAL THINKING EXERCISE

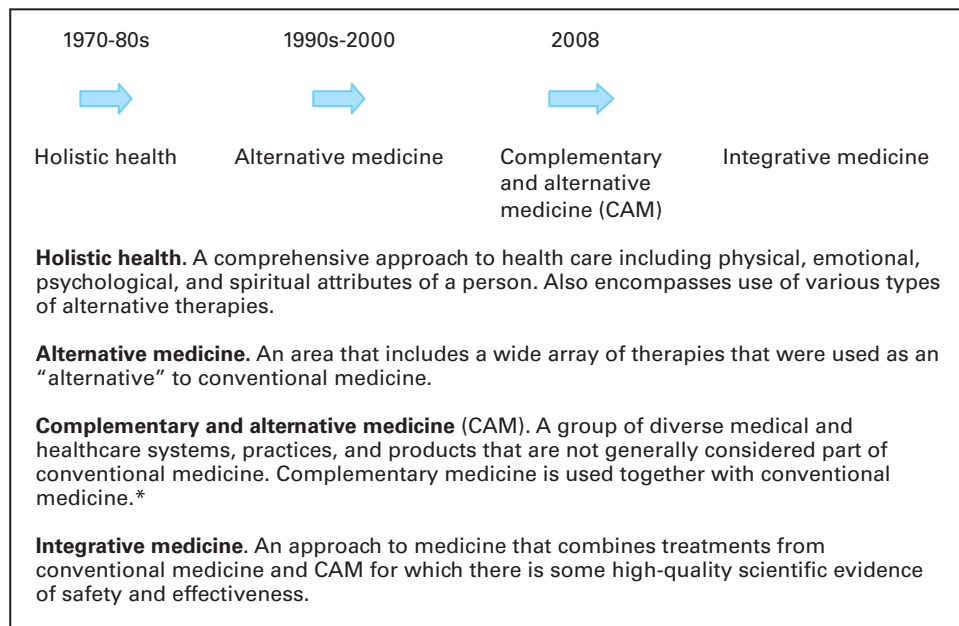
Mr. S. Carignan, a 62-year-old male, enters the emergency room for complaints of chest pain and nausea. His medical evaluation reveals elevated cardiac enzymes, indicating a diagnosis of acute anterior wall myocardial infarction (MI), and he is admitted to the cardiac care unit (CCU), where nurses and physicians work to stabilize Mr. Carignan's medical condition, following which he will be referred to a cardiac rehabilitation program. Mr. Carignan has now experienced permanent injury to his heart muscle and will need help to recover from this insult to his heart and body

and to recover and resume his daily life activities. The diagnosis of MI is at the tertiary level of prevention and is very costly to the healthcare system. If Mr. Carignan had sought health care earlier, had his risk factors identified and modified, prior to his MI, his heart damage might have been averted.

1. What are some examples of secondary prevention that might have helped Mr. Carignan?
2. What are some examples of primary prevention that might have helped Mr. Carignan?

FIGURE 20-2

What's in a Name? The Evolution of Nomenclature for Integrative Health



\*Retrieved from [www.nccam.nih.gov](http://www.nccam.nih.gov)  
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more compelling was the fact that the authors extrapolated that 325 million Americans were seeking some form of alternative medicine and spending over \$10 million for these therapies in out-of-pocket expenses. This study highlighted the use of 15 different types of alternative medicine by consumers, including herbal therapies, mind-body therapies, acupuncture, and energy healing therapies. By 1997, when the Eisenberg et al. repeated their telephone survey, they found the number of visits to alternative providers had risen by over 200 million visits to a total of 625 million visits. In addition, out-of-pocket expenses had increased dramatically to \$27 million dollars (estimate based on a sample of over 2,000 participants). Based on the outcomes of these data, it became clear that alternative medicine was becoming a common choice for American consumers.

In 1997, the National Institutes of Health (NIH) established an Office of Alternative Medicine (OAM) to further explore unconventional medicine. At this time, the title began to transition from “alternative medicine” to “complementary and alternative medicine” (CAM), and it continued to grow. Congress responded by advancing the mission of the OAM and designated it as a center, which became known as the National Center for Complementary and Alternative Medicine (NCCAM). In 2008, NCCAM expanded to include the provision of a national information clearinghouse on CAM that would support research

efforts to determine the effects/efficacy of biologically based products, and it supported 12 centers of excellence focusing on CAM research. NCCAM’s mission is to:

1. Explore complementary and alternative healing practices within the context of rigorous science,
2. Train complementary and alternative medicine researchers and
3. Disseminate authoritative information to the public and professionals (National Center for Complementary and Alternative Medicine, 2008).

The nomenclature has evolved over time, and the changes are shown in Figure 20-2.



**InfoQuest:** Visit the NCCAM website. Look at the A–Z topics for research-based information and select a topic of interest for you. What did you learn?

## Complementary Therapies

NCCAM has organized different CAM therapies into four categories: mind-body therapies, biologically based therapies, manipulative body-based therapies, and energy

TABLE 20–1 Examples of CAM Interventions

|                                       |                                                                                                                                                                                 |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mind and Body Interventions           | Acupuncture, meditation, guided imagery, progressive relaxation, yoga, hypnosis, reflexology, art therapy, eye movement desensitization and reprocessing, prayer, music therapy |
| Manipulative and Body-Based Practices | Acupressure, aromatherapy, dance therapy, movement therapy, physical therapy, shiatsu, trigger point therapy, massage, qi gong, chiropractic therapy                            |
| Biologically Based Practices          | Biofeedback, herbal therapy, hydrotherapy, diet and nutritional supplements                                                                                                     |
| Energy Medicine                       | Magnetic therapy, Reiki, therapeutic touch, energy work, chi kung                                                                                                               |

therapies. An overriding category defined by NCCAM as Whole Medical Systems encompasses one or more CAM therapies from one or more categories and includes traditional Chinese medicine (TCM), osteopathic medicine, ayurvedic medicine, and homeopathy. For example, TCM approaches to treatment include the use of herbal therapies and acupuncture. The four therapy categories, with examples of each, are shown in Table 20–1.



**InfoQuest:** Go to NCCAM’s website. Peruse the A–Z index of health topics and choose a topic that is of interest to you. Look at the recommendation for CAM. What is the evidence base?

Nurses need to be cognizant of the various modalities that encompass body-based manipulations, since many of their clients are currently using these modalities as an adjunct to traditional care. In the acute-care setting, nurses are most familiar with the services of physical therapists in the treatment of musculoskeletal problems. However, as many integrative therapies become part of mainstream medicine, it is important to remain knowledgeable about the variety of modalities and their effect on health and disease. In fact, many insurance providers now provide reimbursement for these integrative therapies. Consumers often call upon nurses to provide advice and counsel on a wide variety of health-related topics, and these types of therapies may very well be something that clients ask the nurse for advice about. If nurses are not familiar with the therapy in question, they should investigate the integrative modality through evidence-based resources such as NCCAM. Their knowledge will then assist the consumer in making the best decision for selecting an appropriate therapy to enhance healing and wellness.

Biologically Based Therapies

Biologically based therapies in CAM include the use of substances found in nature, such as herbs, vitamins/supplements, and organic whole foods. Herbal products

and supplements are currently used for a wide variety of diseases, including the common cold, arthritis, diabetes, hypertension, and cardiac disease. Several different herbal remedies and supplements are currently being investigated for their potential effect on cholesterol and heart disease.

A **botanical** is a plant or plant part used for its medicinal or therapeutic properties, flavor, and/or scent. Herbs are a subset of botanicals. Products made from botanicals that are used to maintain or improve health may be called *herbal products*, *botanical products*, or *phytomedicines*. They may or may not be considered dietary supplements. Dietary supplements must fit the following criteria: They must be intended to supplement the diet; must contain one or more dietary ingredient such as vitamins, minerals, or amino acids; must be intended to be taken by mouth; and must be labeled as being a dietary supplement.

Botanicals are sold in many forms and may be fresh or dried, liquid or solid extracts, tablets, or powders. Common preparations of botanicals include tea or infusion, decoction, tincture, or extract. It is important and appropriate to ask if these products are safe. Products labeled as natural are not necessarily safe or good for a person; the safety depends upon the product’s chemical makeup and interactions with other substances, how it works in the body, how it is prepared, and the dose. The action may range from mild to potent. Chamomile and peppermint are mild and usually taken as teas for digestive purposes. Kava is a more powerful botanical and may have an immediate action affecting anxiety and muscle relaxation. Some things to consider in deciding to take a botanical are listed in the accompanying box.



**InfoQuest:** A listing of botanicals and their uses can be found on the website of the National Institutes of Health, Office of Dietary Supplements. View the fact sheets for the botanical background health professional. What is the difference between a decoction and a tea? What are the uses of ginger? Senna? Valerian?



## Deciding to Take Herbal Products and Supplements: Points to Consider

- Herbal products and supplements should not be considered safe just because they come from a natural source.
- Some herbal products and supplements might contain other ingredients that can cause illness or reactions with other supplements or medications.
- Consult your healthcare provider or pharmacist about using these products.
- Read directions carefully, and take only recommended amounts at recommended time intervals.
- Herbal products may be contraindicated in the presence of certain health problems such as blood clotting problems, cancer, diabetes, heart disease, and hypertension.

- Herbal products that affect clotting should not be taken when surgical procedures are done.
- Herbal products and supplements may interact with or potentiate certain prescribed medications:
  - Glucosamine products contain sodium.
  - Kava can increase the effect of alcohol.
  - Phytoestrogen black cohosh contains salicylates.

Source: Based on "Herbal Products and Supplements," by the editorial staff of Familydoctor.org, 2013. Retrieved from [familydoctor.org/familydoctor/en/drugs-procedures-devices/over-the-counter/herbal-products-and-supplements.html](http://familydoctor.org/familydoctor/en/drugs-procedures-devices/over-the-counter/herbal-products-and-supplements.html)

One of the major concerns regarding biologically based therapies that nurses need to know about are the potential hazards that can be associated with herbal therapies. Although all herbal remedies are derived from nature and considered by some to be natural and not harmful, this is not always the case. Some herbal therapies are contraindicated in the presence of certain illnesses, diseases, and medications, and many consumers are not aware of these contraindications. Therefore, it is important for healthcare providers to become aware of the herbs that patients are taking. Patients may not always think to tell about herbs since they are often not thought of as medications. Nurses must directly ask clients about their current use of biologically based products. The fact that herbal remedies labeling does not contain any contraindications also contributes to this misnomer. Because the Food and Drug Administration (FDA) does not monitor herbal products, the labeling

of herbal remedies is minimal. Labels on these products may not list any contraindications. Providing examples of biologically based products may prompt clients to discuss their use of these products, thus providing an opportunity to educate them regarding the use, safety, and efficacy of biologically based products. There are several professional resources both online and in print to assist the nurse in enhancing her or his knowledge about the products.

### Reflect On . . .

- ways that you care for yourself that are complementary or alternative to Western medicine. How did you learn about them? Until now, did you consider them complementary or alternative?

## RESEARCH CURRENT

### CAM Use In Dermatology: Is There a Potential Role for Honey, Green Tea, and Vitamin C?

Barbosa and Kalaaji created a systematic review of the dermatological effects of honey, green tea, and vitamin C using PubMed, MEDLINE, and the Cochran Database of Systematic Reviews. Many studies have shown honey to be effective in wound healing due to its antibacterial, anti-inflammatory, and antioxidant properties. It is considered safe, widely accessible, and inexpensive. Data indicate that honey components can lead to tissue growth and epithelialization. However, the activity against pathogens cannot be generalized.

Green tea has been shown to have dermatological benefits in the protection of photoaging, photoimmunosuppression, skin cancer growth and invasion, and keloid proliferation. Topical green tea has shown protective effects on UV-induced events.

Vitamin C is known for its antioxidant properties and in collagen synthesis, which have beneficial effects on skin hyperpigmentation and aging.

Although the majority of the studies in this review were short-term trials and involved small numbers of subjects, they were able to show efficacy for skin conditions, including wound healing, skin cancer, hyperpigmentation, and aging. Further studies using large clinical trials would help to determine optimal formulations, dosages, and topical delivery of these products to the skin.

Source: "CAM Use in Dermatology: Is There a Potential Role for Honey, Green Tea, and Vitamin C?" by N. S. Barbosa and A. N. Kalaaji, 2014, *Complementary Therapies in Clinical Practice*, 20(2014), 11–15.

**CRITICAL THINKING EXERCISE**

Mr. R. Scarsella is a 48-year-old male being seen in urgent care for the complaint of “back pain.” He states that the problem started 3 months ago, when he twisted and fell out of his helicopter as he disembarked. At the time he felt a “twinge” in his back. Over the next 4 hours he experienced increasing pain and noted some numbness radiating down his left leg. He was taking ibuprofen and applying heat, which initially seemed to help. He states that over the past 3 months he has continued to experience pain and occasional spasms in his lower back and that he needs some help and is considering seeing a chiropractor for treatment. He also expresses a preference

for “natural” treatment and would like to be referred for massage therapy. Both massage and chiropractic care are covered by his insurance, if he is referred by his primary care provider. While you are checking Mr. Scarsella into the clinic, he asks you what you think about chiropractic care and whether or not it is safe.

**Questions**

1. What other information do you want to obtain from Mr. Scarsella?
2. How will you respond to him regarding his question about chiropractic care for back problems?

**Manipulative Body-Based Therapies**

This area of integrative health is defined by NCCAM (2008) as the manipulation of one or more parts of the body to restore health. It includes chiropractic medicine, massage, osteopathic manipulation, and naturopathy. Most commonly, clients will choose this modality of CAM to treat musculoskeletal problems. Two common manipulative body-based therapies from this category are massage and chiropractic care.

The most common musculoskeletal problem that patients seek integrative health care for is back pain. Back pain is a complicated illness that can resolve in less than 2 weeks with minimal intervention for an acute episode or have lifelong consequences that can affect a client’s personal health and his or her family relationships and

severely curtail the client’s income and lifestyle. In 2002, Main and Williams proposed that a more comprehensive theoretical model was necessary for the assessment of back pain and described a model with biopsychosocial dimensions for back pain that assesses pain within the context of attitudes and beliefs, that is, within the context of one’s psychological distress and within the framework of illness behavior.

Chiropractic care has become a frequent treatment option for musculoskeletal problems today. NCCAM defines chiropractic care as focusing on the relationship between the body’s structure—mainly the spine—and its functioning. Central to the philosophy of chiropractic care is the belief that the body has the natural ability to heal itself but must be in proper alignment to do so.

**RESEARCH CURRENT****The Effects of Foot Reflexology Massage on Anxiety in Patients Following Coronary Artery Bypass Graft Surgery**

Bagheri-Nesami, Shorofi, Zargar, Sohrabi, Gholipour-Baradari and Khalilian used a randomized, controlled trial to test the effects of foot reflexology on anxiety in patients following coronary artery bypass graft (CABG). Foot reflexology is based on the idea that energy flow is stimulated from feet to head within the body and that it decreases sympathetic nervous system arousal, relieves anxiety, and promotes relaxation. Eighty patients who met the inclusion criteria were randomly allocated to an experimental or a control group after being matched for gender and age. Anxiety was measured by the short form of the Spielberger State-Trait Anxiety Inventory (STAI) and by a visual analog scale for anxiety. For the reflexology intervention, a lubricating cream was applied to the left foot for 1 minute, followed by 20 minutes of

foot reflexology massage on the sole. The control group had the left leg softly rubbed with lubricating cream for 1 minute. The intervention was done at least 4 hours after the last dose of analgesic. The anxiety levels differed significantly between the two groups. Patients reported mild to moderate anxiety on the STAI. Both instruments showed a significant decrease in anxiety following the foot reflexology massage. The authors concluded that this CAM therapy can be used to provide relief from anxiety post-CABG surgery.

*Source:* “The Effects of Foot Reflexology Massage on Anxiety in Patients Following Coronary Artery Bypass Graft Surgery: A Randomized Controlled Trial,” by M. Bagheri-Nesami, S. A. Shorofi, N. Zargar, M. Sohrabi, A. Gholipour-Baradari, and A. Khalilian, 2014, *Complementary Therapies in Clinical Practice*, 20(2014), 42–47.

Chiropractors perform “spinal manipulation” to straighten the spine and put it in alignment for healing. At one time, chiropractic therapy was considered unconventional medicine and was viewed with suspicion by mainstream medicine. Today, chiropractic care is considered more mainstream, and physicians often initiate referrals for this care.

## Energy Therapies

Energy therapies use energy fields to create a change in the body. In 1972, Delores Kreiger, a nurse, introduced a new modality for healing: therapeutic touch. It was believed that this energy healing modality could enhance healing. In 1975, Kreiger’s article on the use of therapeutic touch to increase hemoglobin levels in ill patients was published by the *American Journal of Nursing* and had a profound effect. The belief that “invisible energy” could be channeled to enhance healing was a totally new concept for most nurses. The philosophy underlying energy healing was through the “laying on of hands,” where a healer would help to harness or redirect the client’s own energy or *prana* (life force) to create healing from within. Krieger continued her work and published a book for nurses in 1979 titled *The Therapeutic Touch: How to Use Your Hands to Help or to Heal*. In this book, Kreiger described her evolution in teaching this modality at New York University and cataloged her experiences using therapeutic touch with a wide variety of illnesses/diseases. She described the four phases used in performing a therapeutic touch session, describing it as a “healing meditation.” The four phases are:

- (1) centering one’s self physically and psychologically to prepare for the healing session, (2) preparing the field of energy for therapeutic touch through sensitizing the hands to detect subtle changes in energy flow, (3) mobilizing the energy in the client’s field that may be stuck or congested by laying on hands and (4) helping the client to “re-pattern” their energy through the use of the healer’s excess energy. (Kreiger, 1979, p. 36)

These sessions vary in the amount of time and depend on the needs of the client. The overall experience of having a therapeutic touch session elicits a relaxation response and can often eradicate or lessen pain in clients. Many nurses have been trained to use therapeutic touch and are using it in both acute-care and ambulatory care settings for a wide variety of problems, including pain preoperatively and postoperatively.

Dr. Barbara Brennan, a psychotherapist and physicist, began studying human energy fields and published her first

book, *Hands of Light: A Guide to Healing Through the Human Energy Field*, in 1988. Brennan’s basic tenet was based on her research that humans are able to channel their “bio-energy” for healing. In her second book, *Lights Emerging: The Journey of Personal Healing* (1993), Brennan continued to write about the bio-energy field and its potential for healing and believed that learning more about bio-energy in our laboratories and clinics would support the idea of a human energy field directly connected to our health. In the late 1970s and 1980s, the idea that energy fields around us influence health or disease was new and not easy for most to conceptualize. Kreiger’s and Brennan’s seminal works began to influence a paradigm shift in mainstream Western medicine’s beliefs about health and healing, but the concept that something that cannot be seen by most people can influence health/healing was difficult for many to conceive. However, with continued sustained experimentation and research, these modalities have increased in popularity and have become a legitimate category within the domain of energy therapies as defined by NCCAM.

NCCAM (2014) describes this category of integrative modalities as manipulating two types of energy: veritable and putative energy. The major distinction between the two is that *veritable energy* can be measured, and there is at present no objective measure for *putative energy*. Examples of veritable energy include laser beams, visible light, magnetism, and electromagnetic forces. Putative energies are known as biofields and are related to the subtle energy that is emitted from a person’s body. This domain focuses on harnessing or restoring the energy or vital force of the body to help in healing itself. This type of energy, often referred to as the *chi*, or life force, has been described by Eastern philosophy for thousands of years and is the focus of intervention for modalities such as acupuncture, Reiki, tai chi, and qi gong. The Eastern philosophy regarding chi is that the balancing of this energy from within will place the body in an optimal environment for healing. If this life or vital force is out of balance, illness or disease will occur. Energy therapies are focused on helping to rebalance this vital or life force. Energy therapies have gained momentum and hold promise for enhancing the health and well-being of all clients. This domain, under the auspices of NCCAM is making progress as a legitimate form of integrative health.

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## Reflect On . . .

- your thoughts about therapeutic touch.
  - your own experiences with energy fields. Have you seen evidence of energy fields in your work or your personal experience?
-

**RESEARCH CURRENT****Therapeutic Touch: Effects of Therapeutic Touch on Anxiety, Vital Signs, and Cardiac Dysrhythmia in a Sample of Iranian Women Undergoing Cardiac Catheterization**

A quasi-experimental design was used by Zolfaghari, Eybpoosh, and Hazrati to test the effect of therapeutic touch (TT) on anxiety, vital signs, and cardiac dysrhythmia in women undergoing cardiac catheterization. Power analysis showed that an adequate sample size for power of .80, significance of .05, and effect size of .554 is 16 per group. Sixty-nine women were randomly assigned to three groups of 23 each. One group received 10–15 minutes of TT, while another group received 10–15 minutes of simulated touch, and a third group received no touch therapy. Both state and trait anxiety were measured using Spielberger's State-Trait Anxiety Inventory, vital signs were recorded, and a cardiac dysrhythmia checklist was completed. The TT intervention used the process described by Nurse Healers Professional Associates International. The simulated touch used similar movements but did not use

the concentration on energy. At pretest, there was no significant difference between the groups on any of the measures. At posttest there was a significant difference in state anxiety between the TT group and the other two groups. The TT group had significantly lower state anxiety, and vital signs had decreased. The incidence of cardiac dysrhythmias, except for premature ventricular contraction, was also found to be lower. The authors concluded that TT is effective for managing state anxiety, regulating vital signs, and decreasing the incidence of cardiac dysrhythmia during stressful situations such as cardiac catheterization.

*Source:* "Effects of Therapeutic Touch on Anxiety, Vital Signs, and Cardiac Dysrhythmia in a Sample of Iranian Women Undergoing Cardiac Catheterization: A Quasi-Experimental Study," by M. Zolfaghari, S. Eybpoosh, and M. Hazrati, 2012, *Journal of Holistic Nursing*, 30(4), 225–234.

**Mind-Body–Based Therapies**

Mind-body approaches use techniques that promote the mind's ability to affect body functions and include such practices as meditation, prayer, and creative outlets that include art, music, and dance. According to NCCAM (2008), mind-body therapies encompass an array of modalities that focus on the interaction of mental, social, emotional, and behavioral factors and the state of health.

Modalities under this domain are categorized by the philosophical belief that there is a mind-body connection, and that the psychological, emotional, and social status of a client along with these dimensions has an impact on the presence of health and/or disease. Both progressive relaxation and visualization therapies can be taught to patients so that they can use them at home. One of the major aspects of mind-body modalities is that they are focused

**RESEARCH CURRENT****Nurse-Led Hypnotherapy**

A nurse-led hypnotherapy service for irritable bowel syndrome (IBS) provided the site for Bremner's survey of effectiveness in symptom control, quality of life, dependence on medication, and general health. The service provided one-to-one structured hypnotherapy in the community near the patients' homes. Hypnotic induction was achieved through breath control and progressive relaxation, and the methods used included guided imagery, metaphors, ego strengthening, forgiveness of self and others, releasing and letting go of problems, direct and indirect suggestions for bowel control, and emotional empowerment. Exclusion criteria eliminated those with unmanaged mental health problems. Patients completed several questionnaires at baseline, midpoint, and dis-

charge. The questionnaires were validated and measured symptom severity, quality of life, and general health. Symptom severity improved for 85% of patients, quality of life improved for 96%, and general health improved for 88%. In addition 26 of 28 patients completing full discharge paperwork reported reduced healthcare-seeking posthypnotherapy. Bremner concluded that hypnotherapy for IBS is effective in primary care and saves resources due to reduced medication use and preventing unnecessary referrals, while improving and integrating care for patients with IBS.

*Source:* "Nurse-Led Hypnotherapy: An Innovative Approach to Irritable Bowel Syndrome," by H. Bremner, 2013, *Complementary Therapies in Clinical Practice*, 19(2013), 147–152.



## RESEARCH CURRENT

## Intraoperative Stress and Anxiety Reduction with Music Therapy

The effect of music therapy on intraoperative anxiety levels was tested by Jimenez-Jimenez, Garcia-Escalona, Martin-Lopez, De Vera-Vera and De Haro in 40 patients undergoing craniotomy with stripping of the great saphenous vein. Power analysis indicated that the sample size was sufficient for 80% power at a .05 significance level. Efficacy, safety, and feasibility were also assessed. A prospective randomized clinical trial was the method used, with the subjects being randomly assigned to the experimental or control group; the data collector was blind to group assignment. Experimental intervention consisted of music therapy, whereby the subject listened to fragments of musical selections during the surgery. The control group experienced routine operative attention. Assessment of state and trait anxiety was done 20 minutes preop in the surgery

waiting room, along with a visual-analog scale of anxiety. Biophysiological measures were recorded during the surgery. Postoperatively state and trait anxiety were again assessed. There were no significant differences in biophysiological changes between groups. Anxiety was significantly lower in the music therapy group. Further, the patients using music therapy had a lower increase of adrenergic amine levels that would indicate stress-induced changes. The authors conclude that music therapy used as a nursing intervention during varicose vein surgery reduces anxiety and is a feasible, cost-effective, and safe procedure.

*Source:* "Intraoperative Stress and Anxiety Reduction with Music Therapy: A Controlled Randomized Clinical Trial of Efficacy and Safety," by M. Jimenez-Jimenez, A. Garcia-Escalona, A. Martin-Lopez, R. De Vera-Vera, and J. De Haro, 2013, *Journal of Vascular Nursing*, 31(3), 101–106.

on empowering clients through self-knowledge and encourage self-care. Mind-body therapies encompass several integrative modalities and can include hypnosis, meditation, mental healing, prayer, visual imagery, tai chi, spirituality, and creative therapies: art, dance, and music therapy.

This area of integrative therapy has seen significant growth in the past 20 years. In 1975, Dr. Herbert Benson published his book, *The Relaxation Response*. In this book, Benson described the connection between using the mind (to induce relaxation) to effect changes in the body (physiological changes that lowered heart rate and blood pressure). Benson, a Harvard-educated cardiologist, began his research in this area after working with patients diagnosed with hypertension who complained about the side effects experienced from taking blood-pressure-lowering medications. Benson began to speculate about the possibility of inducing the lowering of blood pressure through relaxation. In his introduction to the second edition of *The Relaxation Response* (2000), Benson noted that just three decades prior he had been unique among medical professionals, who would never have considered risking their reputation in research relating stress to disease or showing the benefit of mental techniques. Today the connection between mind and body is widely accepted, and scientists actively pursue research in the field.

Dr. Bernie Siegel, a surgeon and author, has also contributed to mind-body medicine through his research with cancer patients. In working with cancer patients with a

terminal diagnosis, Siegel began to note some distinct differences between them. What he discovered was that certain patients were beating the odds and living well beyond their life expectancy with a cancer diagnosis, while other cancer patients were actually dying at the rate expected for a patient with cancer. He began to study the group of patients who were continuing to live despite their cancer diagnosis. He called these patients his "exceptional" cancer patients. He found that these patients had a different belief about their cancer diagnosis as compared to patients with a similar diagnosis. These cancer patients did not accept the short life expectancy timeline that they were given. In addition, they continued to live their life fully, and some actually were found over time to be cancer-free (without treatment). They differed significantly from other cancer patients who were given a short life expectancy and, in fact, died within the time frame given. Siegel realized that there was something to learn from these "exceptional" cancer patients.

Siegel published several books on this phenomenon, including *Love, Medicine and Miracles: Peace, Love and Inner Healing* (1988). These books offered cancer patients hope. Prior to work such as this, patients often believed that a cancer diagnosis was a terminal sentence. Siegel continued his efforts by helping other oncology patients learn techniques of creative visualization and art therapy to enhance their health and well-being.

The examples discussed highlight just a few of the remarkable successes that have been achieved with mind-body therapies. It is important for nurses to be

## Glossary of Selected Terms

**Acupressure:** Use of finger and/or hand pressure over specific points on the body to influence the function of internal organs and body systems.

**Acupuncture:** The use of fine-gauged needs that are inserted into specific points on the body to affect the flow of energy.

**Aromatherapy:** The use of essential oils to treat physical imbalances and achieve psychological and spiritual well-being.

**Biofeedback:** A relaxation technique using monitoring of vital functions that provides signals based upon changes in the vital functions.

**Dance therapy:** Use of the combination of music and dance to refresh and uplift the body, mind, and spirit and experience the freedom of natural movement.

**Energy work:** Body work directed to influencing the energy centers (chakras) and the flow of energy around and through them.

**Guided imagery:** Assisting the person in connecting with his or her inner knowledge at the thinking, feeling, and sensing levels to promote his or her own healing.

**Healing touch:** An energy-based use of touch to influence the energy system.

**Homeopathy:** The stimulation of healing through substances prescribed according to three basic principles: (1) Like cures like, (2) the more the substance is diluted the greater the potency, and (3) treatment is based on the whole person rather than symptoms.

**Osteopathic medicine:** A form of medicine focusing on the relationship of the structure and the function of the body. Treatment uses various forms of physical manipulation to help the body's self-healing mechanism.

**Shiatsu:** Energy-based use of firm sequence of rhythmic pressure to awaken acupressure meridians.

**Tai chi:** Movement and Chinese martial art that enhances coordination, balance, and breathing and promotes well-being.

**Therapeutic touch:** A touch technique for balancing energy flow through the body by use of human energy transfer.

**Yoga:** The use of postures, controlled breathing, relaxation, meditation, and nutrition to release tension and increase oxygen levels in the blood.

cognizant of these types of modalities, as some of them may be beneficial integrative therapies to be used in helping clients deal with illness/disease. Utilizing interventions such as relaxation techniques or creative visualization may be the best strategies that nurses can teach their clients to use after they are discharged from the acute-care setting.

Research focused on mind-body modalities continues to be an area with great potential as an integrative therapy that can be safe, effective, and self-empowering for clients facing many life-threatening illnesses and disease.

## Reflect On . . .

- how you have used relaxation.
- what effects of relaxation you have noticed.
- how you have used distraction.
- when distraction was most effective.

See the accompanying box for a glossary of terms useful in this field.

## Chapter Highlights

- The focus of health care has expanded to include consideration of the multiple dimensions of a person and their contribution to health or disease.
- Healthcare providers are more comprehensive in their approach to a client by including assessment of his or her physical, spiritual, emotional, and psychological attributes, providing a more holistic view of the client.
- One change in health care has been the focus on prevention and health promotion rather than biological disease entities.
- Prevention can be primary, secondary, or tertiary.
- Primary prevention focuses on health promotion and education and is considered the optimal level of prevention.
- The secondary level of prevention focuses on screening and early detection of disease.

- The tertiary level of prevention is defined as the care and restoration of a patient after an insult or injury.
- The goal is to focus more on the primary and secondary levels of prevention, as much as is possible.
- In 1997, the National Institutes of Health established an Office of Alternative Medicine in response to the public's use of alternative methods of treatment and the demand for availability of these services
- The integration of alternative methods with traditional care evolved from holistic care (more comprehensive) to alternative medicine to complementary and alternative medicine (CAM) to integrative health care.
- The National Center for Complementary and Alternative Medicine has recognized complementary therapies and categorized them into four different domains: biologically based, manipulative body-based, energy, and mind-body-based.
- Biologically based therapies in CAM are defined as the use of substances found in nature such as herbs.
- Manipulation of one or more parts of the body to restore health includes such measures as chiropractic medicine, massage, osteopathic manipulation, and naturopathy.
- Energy methods use energy fields to enhance the body's ability to heal or maintain homeostasis through such measures as healing touch and Reiki.
- Mind-body methods focus on the interaction of mental, social, emotional, and behavioral factors and the state of health.
- Holistic nursing is recognized by the American Nurses Association as a specialty area with its own scope of practice and standards.
- The American Holistic Nurses Association offers certification as a basic holistic nurse or an advanced holistic nurse.
- Holistic nurses focus on the mind-body-spirit connection and incorporate some of the CAM modalities in their practice.

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# 21

## Nursing in a Culturally Diverse World

### Chapter Outline

#### Challenges and Opportunities

##### Concepts Related to Culture

- Characteristics of Culture
- Components of Culture

##### Culture and Health Care

- Leininger's Sunrise Model
- Purnell's Model for Cultural Competence

##### Integrating Cultural Knowledge in Care

- Barriers to Integrating Culture and Care
- Conveying Caring to Diverse Groups

##### Selected Cultural Parameters Influencing Nursing Care

- Health Beliefs and Practices
- Family Patterns
- Communication Style
- Space Orientation
- Time Orientation
- Nutritional Patterns
- Pain Responses
- Childbirth and Perinatal Care
- Death and Dying

##### Providing Culturally Competent Care

##### Chapter Highlights

### Objectives

1. Analyze concepts related to cultural diversity in nursing.
2. Discuss components of culture pertinent to nursing care.
3. Describe the components of Leininger's Sunrise Model.
4. Describe the components of Purnell's Model of Cultural Competence.
5. Describe barriers to cultural competence.
6. Assess clients from a cultural perspective.
7. Plan and implement culturally competent care.

Nurses need to become informed about and sensitive to culturally diverse subjective meanings of health, illness, caring, and healing. A transcultural caring perspective is considered essential for nurses and other healthcare professionals to deliver culturally competent health care to all clients.

The United States and Canada are home to many cultural groups. Table 21–1 provides statistical data reflecting the present and projected diversity of the United States. In addition to the indigenous peoples (Native Americans and Aboriginals), there is much diversity in immigrant and refugee groups in North American. According to the U.S. Census Bureau (2013), minorities, now approximately one third of the U.S. population, are expected to become one half of the U.S. population by 2043. Contributing to the cultural mosaic of the United States is the increase in foreign-born residents. In 1960, 1 in 20 residents, or 5.4% of the total population, was foreign-born. By 2010, 1 in 8 of U.S. residents (12.9%) was foreign born. Table 21–2 shows the foreign-born population of the United States by region of origin in 2010. The term *cultural mosaic* is used to describe the way in which many people of different cultures maintain the cultural values, beliefs, traditions, practices, and language of their homelands for many generations. These diverse cultural beliefs and practices influence healthcare decision making.

Nurses must understand how their own cultural beliefs and biases relate to people whose beliefs are different from their own. Healthcare professionals are not expected to know and understand all cultures of the world; it is possible, however, for healthcare professionals to develop an awareness of those cultural belief



**TABLE 21–1 Population Diversity of the United States, Projections for 2015 through 2055**

| Race                                   | 2015 (%) | 2025 (%) | 2035(%) | 2045(%) | 2055 (%) |
|----------------------------------------|----------|----------|---------|---------|----------|
| <b>One race*</b>                       |          |          |         |         |          |
| White                                  | 77.3     | 75.4     | 73.4    | 71.4    | 69.4     |
| African American/Black                 | 13.2     | 13.4     | 13.7    | 13.9    | 14.2     |
| American Indian and Alaska Native      | 01.2     | 01.2     | 01.3    | 01.3    | 01.3     |
| Asian                                  | 05.4     | 06.4     | 07.3    | 08.2    | 09.0     |
| Native Hawaiian/Other Pacific Islander | 00.2     | 00.2     | 00.3    | 00.3    | 00.3     |
| Two or more races                      | 02.6     | 03.2     | 03.9    | 04.8    | 05.7     |
| Hispanic or Latino **                  | 17.7     | 20.3     | 22.3    | 25.3    | 27.6     |

\*Beginning with the 2000 census, for the first time participants could select multiple races if they were of mixed racial heritage; therefore, the total can exceed 100%.

\*\*Persons of Hispanic origin may be of any race; thus projections are determined by race and then separated into categories of non-Hispanic.

Source: Projections of the Population by Sex, Hispanic Origin, and Race for the United States: 2015 to 2060," by the U.S. Census Bureau, Population Division, 2014 Retrieved from <http://www.census.gov/population/projections/data/national/2014/summarytables.html>

systems that are prevalent in the community or region where they practice. Awareness by healthcare providers of potential differences is important as they try to deliver culturally competent care to a diverse population. Nurses must be aware that although people from a given ethnic group share certain beliefs, values, and experiences, often there is also widespread intraethnic diversity. Major differences within ethnic groups may be related to such factors as age, sex, level of education, socioeconomic status, religious affiliation, area of origin in the home country

(e.g., rural or urban), and the length of time living in the new country. These factors influence the client's beliefs about health and illness, health and illness practices, health-seeking behaviors, and expectations of health professionals.

In 1991, the American Nurses Association stated, "Culture is one of the organizing concepts upon which nursing is based and defined" (p. 1). This position was reaffirmed in the document *Nursing: Scope and Standards of Practice* (American Nurses Association, 2004, p. 2), which states, "The cultural, racial, and ethnic diversity of the patient must always be taken into account in providing nursing services," and again in 2010, "Nursing practice respects diversity and is individualized to meet the unique needs of the healthcare consumer or situation" (American Nurses Association, 2010, p. 4). The American Association of Colleges of Nursing (2008, pp. 3–7) identified five competencies considered essential for graduates of baccalaureate nursing programs to provide culturally competent nursing care:

- Apply knowledge of social and cultural factors that affect nursing and health care across multiple contexts.
- Use relevant data sources and best evidence in providing culturally competent care.
- Promote achievement of safe and quality outcomes of care for diverse populations.
- Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities.
- Participate in continuous cultural competence development.

**TABLE 21–2 Foreign-Born Population by Region of Birth: 2010**

| Region of Origin                | Population |
|---------------------------------|------------|
| Africa                          | 1,607,000  |
| Asia                            | 11,284,000 |
| Europe                          | 4,817,000  |
| Latin America and the Caribbean | 21,224,000 |
| Mexico                          | 11,711,000 |
| Other Central American          | 3,053,000  |
| South America                   | 2,730,000  |
| Caribbean                       | 3,731,000  |
| Northern America                | 807,000    |
| Oceania                         | 217,000    |

Source: *The Foreign-Born Population in the United States: 2010* by the U.S. Census Bureau, 2012. Retrieved from <http://www.census.gov/content/dam/Census/library/publications/2012/acs/acs-19.pdf>

Nurses need to know how members of specific cultural groups understand life processes, how they define health and illness, what they do to maintain wellness, what they believe to be the causes of illness, how culturally based healers cure and care for members of the group, and how the cultural background of the nurse influences the way in which the nurse provides care. Because a nurse is expected to provide individualized care based on an assessment of the client's physiological, psychological, and developmental status, the nurse must also understand how the client's cultural beliefs and practices can affect the client's health and illness.

## Challenges and Opportunities

The challenges of working in a culturally diverse environment require nurses to be open to differences in beliefs about health and illness, different types of cultural healers and healing traditions, and the use of traditional healing practices that may be considered untested and unscientific by modern health practitioners. Establishing trust with people whose beliefs are different depends on the nurse's willingness to accept difference and to work with the client's different beliefs to achieve a healing relationship.

A significant challenge for nursing and health care are the numerous health disparities or healthcare inequalities associated with race, ethnicity, and socioeconomic status. *Healthy People 2020* (U.S. Department of Health and Human Services, National Partnership for Action to End Health Disparities, 2015a) defines **health disparities** as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” (p. 1). **Health equity** is the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities” (U.S. Department of Health and Human Services, National Partnership for Action to End Health Disparities, 2015b). For example, people of racial/ethnic minorities are less likely to receive preventive health care than are people of the majority population, even when they have health insurance. African American women are more likely to die of breast cancer than White American women. American Indians and Alaskan Natives have higher rates of death related to tuberculosis, alcoholism, diabetes, unintentional injuries, homicide, and suicide. A goal of *Healthy People 2020* is to “achieve health equity, eliminate disparities, and improve the health of all groups” (U.S. Department of Health and Human Services, 2015b). To achieve this goal, nurses, as well as

other healthcare professionals, need to become culturally competent in the care they provide.

Working with clients of different cultural beliefs provides nurses with the opportunity to enrich their own lives through an understanding of the differences of others. Traditional remedies such as acupuncture, massage, meditation, and some herbs increasingly are being shown to have healing properties. Researchers are examining the effects of complementary, also referred to as alternative or integrative, healing methods, often derived from cultural healing practices, on health and healing. New knowledge derived from traditional beliefs and practices can provide new ways of healing and helping.

## Concepts Related to Culture

All groups of people face similar issues in adapting to their environment: providing nutrition and shelter, caring for and educating children, division of labor, social organization, controlling disease, and maintaining health. Humans adapt to varying environments by developing cultural solutions to meet these needs. An understanding of the cultural dimension of people is the focus of the field of cultural anthropology. Cultural anthropologists attempt to understand culture by studying both similarities and differences among human groups. Medical anthropologists focus on the health beliefs and practices of people of different cultures. Nurses use the information gained by cultural and medical anthropologists to understand and help clients (individuals, their families, or groups) to achieve optimum health.

Culture is a universal experience, but no two cultures are exactly alike. Two important terms identify the differences and similarities among peoples of different cultures. **Culture universals** are the commonalities of values, norms or behavior, and life patterns that are similar among different cultures. **Culture specifics** are those values, beliefs, and patterns of behavior that tend to be unique to a designated culture and do not tend to be shared with members of other cultures. For example, most cultures have ceremonies to celebrate the passage from childhood to adulthood; this practice is a culture universal. However, different cultural groups celebrate this important life event in very different ways. For example, in Latin or Hispanic cultures, the “quince” or “quinceanero” party, which celebrates a girl's fifteenth birthday, signifies that the girl has become a woman. In the Jewish tradition, the bar mitzvah (for boys) and the bat mitzvah (for girls) are celebrations of the passage to adulthood.

Anthropologists have also traditionally divided culture into material and nonmaterial culture. **Material culture** refers to objects (such as dress, art, cultural and

religious artifacts, or eating utensils) and ways these are used. **Nonmaterial culture** refers to beliefs, customs, languages, and social institutions.

The terms *culture*, *diversity*, *ethnicity*, and *race* are often used interchangeably, but they are not synonymous. **Culture** is defined as “the learned, shared, and transmitted values, beliefs, norms, and lifeway practices of a particular group that guide thinking, decisions, and actions in patterned ways” (Leininger, 1988, p. 158). The Office of Minority Health of the U.S. Department of Health and Human Services (2013a) further defines culture as the “thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups” and the “integrated patterns of human behavior that include racial, ethnic, religious, or social groups.”

Because cultural patterns are learned, it is important for nurses to note that members of a particular group may not share identical cultural experiences. Thus, each member of a cultural group will be somewhat different from his or her own cultural counterparts. For example, third-generation Japanese Americans, or *Sansei*, will differ in cultural understandings from first-generation Japanese Americans, or *Issei*.

Large cultural groups often have cultural subgroups or subsystems. A **subculture** is usually comprised of people who have a distinct identity and yet are also related to a larger cultural group. A subcultural group generally shares ethnic origin, occupation, or physical characteristics with the larger cultural group. Examples of cultural subgroups include occupational groups (e.g., nurses), societal groups (e.g., homeless people), and ethnic groups (e.g., Cajuns, who are descendants of French Acadians).

**Bicultural** refers to the integration of two cultures within the individual. In the 2000 U.S. census, individuals could identify themselves as multiracial for the first time. For an immigrant, biculturalism is the integration of the culture of the native country, or homeland, with the culture of the new country. Children whose parents are from two different cultures may grow up in an environment that practices and respects both cultures. The values, beliefs, rituals, and traditions of both cultures may be practiced. For example, a young man whose father is Native American and whose mother is European American may maintain his traditional Native American heritage while also being influenced by his mother’s cultural values.

**Diversity** refers to “the state of having people who are different races or have different cultures in a group or organization” (Merriam-Webster, 2014). Diversity occurs not only between cultural groups but also within cultural groups. Diversity extends beyond race and culture and encompasses differences related to age, gender, sexual orientation, education, income, social status, and so on.

Andrews and Boyle (2012, p. 10) state that the term *diversity* “is frequently viewed as the norm against which the differences in everyone else (ethnocentrically referred to as non-Whites) are measured or compared.” Diversity, in fact, is all-inclusive and comprises the differences between oneself and others regardless of affiliation, whether that affiliation is race, ethnicity, gender, sexual orientation, age, or any other difference.

The term **ethnic** has been used to describe a group of people who share a common and distinctive culture and who are members of a specific group. An ethnic group is a “group of people who have had experiences different from those of the dominant culture in status, background, residence, religion, education, or other factors that functionally unify the group and act collectively on one another” (Purnell, 2013, p. 483). For example, there are many people who identify their race as Black, including people from America, Africa, and the Caribbean. Black Americans born in the United States share a common background that is different from a Black person from Haiti, Jamaica, or the nations of Africa. The characteristics of the groups give an individual a sense of identity. Koppelman (2014, p. 12) defines **ethnicity** as “the historic origins of an individual’s family. . . . For those whose ancestors emigrated from different countries of origin, ethnicity can represent a choice about personal identity based on culture.” Giger (2013, p. 60) states that “the most important characteristic of ethnicity is that members of an ethnic group feel a sense of identity.” Other factors that help to define ethnicity are religion and geographic background of the family.

**Race** is the classification of people according to shared biological characteristics, genetic markers, or features. People of the same race have common characteristics such as skin color, bone structure, facial features, hair texture, and blood type. Different ethnic groups can belong to the same race, and different cultures can be found within the same ethnic group. For example, the terms *Caucasian* and *European American* describe the race of people whose origins are in Europe. Whereas British Americans are a subgroup of European Americans, Scottish Americans (an ethnic subgroup of British Americans) may share different cultural practices than other British Americans. It is important to understand that not all people of the same race have the same culture. Culture should not be confused with either race or ethnic group.

**Acculturation** is the process of “becoming a competent participant in the dominant culture” (Spector, 2013, p. 31). Acculturation, also referred to as *assimilation*, is the integration of the cultural patterns of the dominant or host culture into the person’s way of life. Spector suggests that it takes three generations for a family to become fully acculturated into the American culture.

The cultural beliefs and practices regarding health and illness of North America's many different ethnic and cultural groups are important considerations for nurses when planning nursing care. Nursing ethnoscience study the health beliefs of cultures so that nurses can provide culturally competent care to clients of different cultures. Madeleine Leininger (1978, p. 493), a nurse theorist and anthropologist considered the founder of transcultural nursing, described **transcultural nursing** as the study of different cultures and subcultures with respect to nursing and health, illness, caring practices, beliefs, and values. The goal of transcultural nursing is to provide culture-specific and culture-universal nursing care. **Cultural awareness** is the conscious and informed recognition of the differences between and similarities among varied cultural or ethnic groups. Cultural awareness is not knowledge derived solely from myths and stereotypes. **Cultural sensitivity** is the respect and appreciation for cultural behaviors based on an understanding of the person's perspective. **Cultural competence** is "having the knowledge, abilities, and skills to deliver care congruent with the client's cultural beliefs and practices" (Purnell, 2013, p. 482). The Office of Minority Health of the U.S. Department of Health and Human Services (2001) defines **cultural and linguistic competence in health** as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Culturally and linguistically appropriate services are those health care services that are respectful of and responsive to cultural and linguistic needs." The culturally competent nurse, therefore, works within the cultural belief system of the client to resolve health problems. To provide culturally competent care, nurses need data about the client's personal and cultural views regarding health and illness. To make valid assessments, nurses need to try to see and hear the world as their clients do. When developing care plans, nurses need to consider the client's world and daily experiences. Although a client's needs and behaviors can be better understood when particular cultural health norms are identified, nurses must take care to avoid stereotyping clients by unfounded culture norms in order to provide individualized care.

Culture shock can occur when members of one culture are abruptly moved to another setting. **Culture shock** is a "disorder that occurs in response to transition from one cultural setting to another. Former behavior patterns are ineffective in such a setting and basic cues for social behavior are absent" (Spector, 2013, p. 356). For example, when immigrants first enter the United States or Canada, language and behavior differences may initially cause them difficulty in carrying out normal activities. Nursing students can experience culture shock when they enter

nursing school and must learn medical terminology (new language) and provide care for clients in clinical environments with which they are unfamiliar. Expressions of culture shock can range from silence and immobility to agitation and distress.

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### Reflect On . . .

- your own cultural values, beliefs, and practices. How do you describe yourself culturally? What meaning does your cultural identification have for you? How do you celebrate your cultural identification?
- 

### Characteristics of Culture

Culture exhibits several characteristics:

- **Everyone has his or her own culture.** It is not something that only other people have or people of minority groups have. Culture is a universal attribute.
- **Culture is learned.** It is neither instinctive nor innate. It is learned through life experiences from birth.
- **Culture is taught.** It is transmitted from parents and primary caregivers to children over successive generations. Family and other group members transmit the values, beliefs, traditions, and acceptable and unacceptable behaviors of the group through verbal and nonverbal communication patterns.
- **Culture is social.** It originates and develops through the interactions of people: families, groups, and communities.
- **Culture is adaptive.** Customs, beliefs, and practices change as people adapt to the social environment and as biological and psychological needs of people change. Some traditional norms in a culture may cease to provide satisfaction and are eliminated. For example, in many cultures it is customary for family members of different generations to live together (extended family); however, education and employment considerations may require children to leave their parents and move to other parts of the country. In such cases, the extended-family norm may change.
- **Culture is satisfying.** Cultural habits persist only as long as they satisfy people's needs. Gratification strengthens habits and beliefs. Once they no longer bring gratification, they may disappear.
- **Culture is difficult to articulate.** Members of a specific cultural group often find it difficult to articulate their own culture. Many of the values and behaviors are habitual and are carried out subconsciously.
- **Culture exists at many levels.** Culture is most easily identified at the material level. For example, art, tools,



### CRITICAL THINKING EXERCISE

Interview individuals from the various cultural and ethnic groups in your community. Consider the values, beliefs, and practices of these cultural and ethnic groups. Is cultural difference valued? If cultural and ethnic difference is valued, in what ways is this value manifested in your community? In what ways are negative responses to cultural difference manifested in your community? Is cultural difference valued in your

school, place of work, or other religious and social organizations? Give examples of practices that demonstrate valuing cultural difference in your school, place of work, or other religious or social organizations. Is cultural and ethnic difference valued nationally and globally? Give examples to support your answer. How might you influence greater valuing of cultural difference in your circle of influence?

and clothes often reveal aspects of a culture relatively readily. More abstract concepts, such as values, beliefs, and traditions, are often more difficult to discover. Nurses may need to ask culturally and linguistically appropriate questions of the client or support persons to obtain information.

### Components of Culture

Cultures are very complex. They consist of aspects that relate to all dimensions of life: language, art, music, value systems (beliefs, morals, rules), religion, philosophy, family interaction, patterns of behavior, child-rearing practices, rituals or ceremonies, recreation and leisure activities, festivals and holidays, nutrition, food preferences, and health practices. Many facets of culture have an effect on nursing practice, such as social structures and gender relationships; health and illness practices; attitudes about touch, territory, and privacy; childbirth and child-rearing practices; and death and dying practices.

### Reflect On . . .

- your own cultural or ethnic background. What are your values, beliefs, and practices about health and health care? How might they affect your nurse-client interactions? How do they influence your practice as a nurse?

### Culture and Health Care

Two transcultural healthcare systems generally exist side by side with limited awareness by practitioners of both systems: an indigenous healthcare system and a professional healthcare system (Leininger, 1978, p. 26). The *indigenous healthcare system* refers to traditional folk methods of healing, such as folk medicines and other home remedies. The modern *professional healthcare system* refers to a structured system maintained by individuals who have engaged in a formal program of study. The indigenous system is the older system and has often provided health care long before a professional system

enters the culture. According to Leininger, few professional healthcare workers are knowledgeable about indigenous healthcare systems or practitioners. Some professionals regard the indigenous system as unscientific, primitive, or even “quackery.” Leininger (1993) emphasizes that the goal of health care should be to use the best of both systems and that health professionals need to consider ways to interface with the two systems for the benefit of the people served: “Every culture has health, caring, and curing processes, techniques and practices viewed as important to the people” (p. 38).

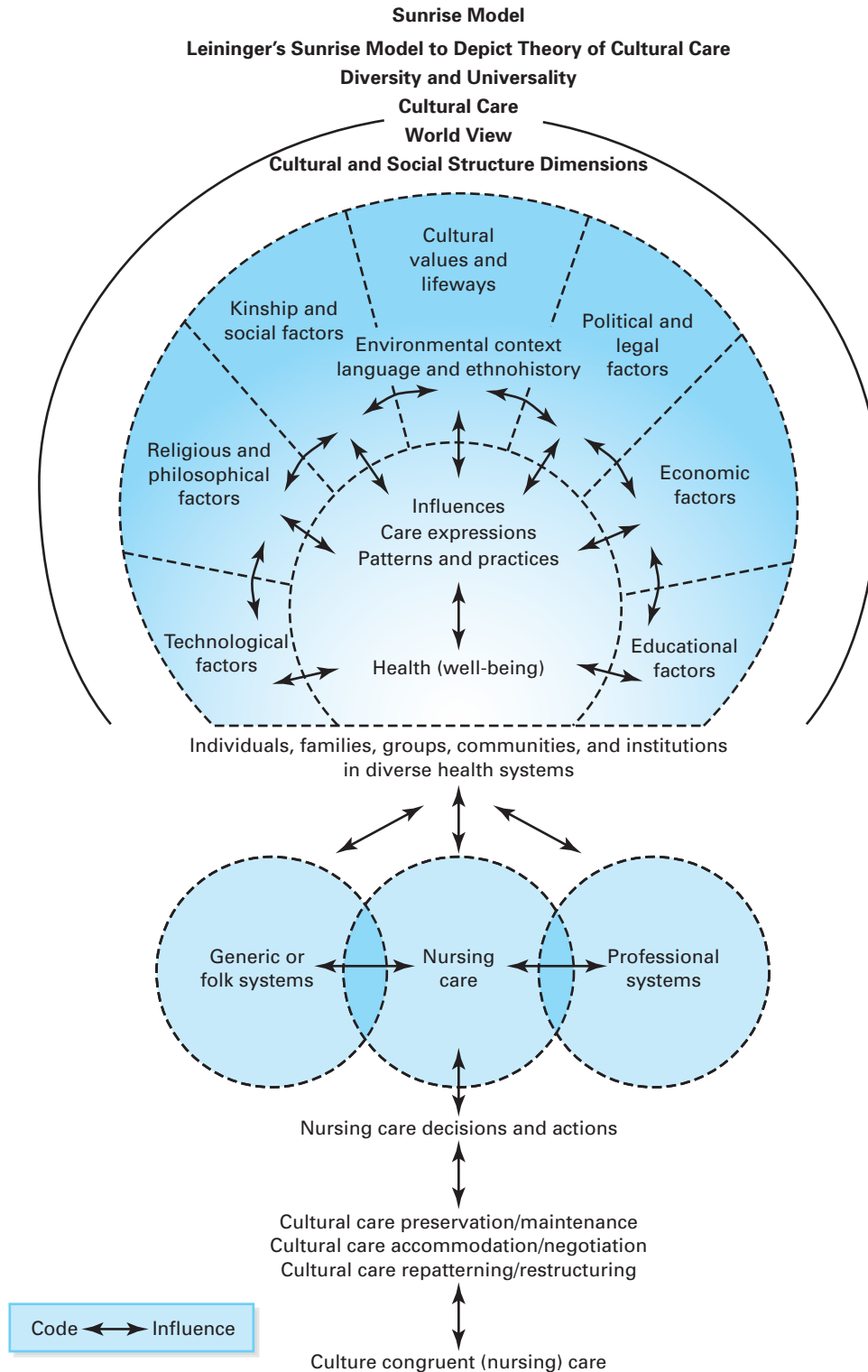
Currently there is much interest in and inquiry into the efficacy of folk healing methods and herbal remedies. In 1998, the National Center for Complementary and Alternative Medicine (NCCAM) was established at the National Institutes of Health to “define, through rigorous scientific investigation, the usefulness and safety of complementary and alternative medicine interventions and their roles in improving health and health care” (National Center for Complementary and Alternative Medicine, 2014a). These healing practices are considered complementary, alternative, or integrative to conventional or scientific medicine. While the terms may seem similar, they have different meanings. **Complementary** or **integrative** “refers to using a non-mainstream approach together with conventional medicine. **Alternative** refers to using a non-mainstream approach in place of conventional medicine” (National Center for Complementary and Alternative Medicine, 2014b).

### Leininger’s Sunrise Model

Leininger created the Sunrise Model to depict her theory of cultural care diversity and universality (see Figure 21–1). This model emphasizes that health and care are influenced by elements of the social structure, such as technological factors, religious and philosophical factors, kinship and social systems, cultural values, political and legal factors, economic factors, and educational factors. These social factors are addressed within environmental contexts, language expressions, and ethnohistory. Each of these systems is part of the social structure of any society; healthcare expressions,

FIGURE 21-1

Leininger's Sunrise Model



Source: From *Culture Care Diversity and Universality: A Theory of Nursing* (Publication No. 15-2402, p. 43), by M. Leininger (Ed.), 1991, New York: National League for Nursing Press. Reprinted with permission.

patterns, and practices are also integral parts of these aspects of social structure (Leininger, 1993).

*Technological factors*, such as the availability of low- and high-technical and electrical equipment, greatly determine what health equipment will be used. For example, many European Americans regard resuscitative and life-extending equipment as essential. The *economic system* determines the quality of health care within a culture; for example, the availability of funds for and access to health-care services materially affects the health of the culture's infants, older adults, and other vulnerable members of the society. The *political system* is a major determinant of what health programs will be available and which health practitioners may provide which types of health services. Legal aspects govern the roles, functions, and standards of health professionals within cultures.

*Kinship patterns* and the *social system* often influence who will or will not receive health care and how promptly it will be provided. For example, in some cultures a person of high status (e.g., tribal leader, CEO, or political leader) may receive prompt care; a person of lower status (e.g., a peasant, housewife, or child) may experience a considerable waiting period for care. Because of male dominance in many cultures, men may receive care before a wife or female child. *Cultural, educational, religious, and philosophical* factors are closely related. They influence the type, quality, and quantity of health care considered desirable, appropriate, or acceptable to the culture. *Environmental and demographic* factors relate to the health needs of the culture and which strategies of care can or will be used in the setting.

Since the development of Leininger's Sunrise Model, several other transcultural nursing models have been developed. These include Murdock's Outline of Cultural Material, appropriate for community cultural assessment (Murdock, 1971); Bloch's Assessment Guide for Ethnic/Cultural Variation (Orque, Bloch, & Monroy, 1983); Giger and Davidhizar's Transcultural Assessment Model (1990, 1995, 2002, 2003, 2008); and the Purnell Model for Cultural Competence (Purnell & Paulanka, 1998, 2003, 2008, 2013).

### Purnell's Model for Cultural Competence

The Purnell Model for Cultural Competence is more complex and provides greater specificity about the factors that influence healthcare practices and decision making. The model consists of concentric circles starting with an outlying rim representing the global society. The next ring represents the community, followed by the family, and next the individual person. This suggests that the person lives within and is influenced by a family; a community, with the broadest possible definition of community that goes beyond physical boundaries; and the larger global society, which includes communication, politics, natural and human-made disasters, international exchanges, advances in health science, space

exploration, and travel between and among global societies. Within the circle representing the person are 12 pie-shaped wedges representing 12 cultural domains:

- **Overview/heritage.** This wedge considers the characteristics related to the individual's or the family's country of origin, where the individual and family currently reside, the economics and politics of the country of origin and the country of current residence, reasons for emigration, and educational status and occupations of family members.
- **Communication.** This wedge considers the individual's dominant language and dialects, as well as the verbal and nonverbal characteristics of communication, such as volume, intonation, tone, and pace of speech, spatial distancing, eye contact, facial expression, touch, and the use of names. Also considered is orientation to time: past-, present-, and/or future-oriented, as well as clock versus social time.
- **Family roles and organization.** This wedge considers family hierarchy (head of household), gender position and roles within the family, decision making, developmental tasks of children and adolescents, child-rearing practices, extended family, roles of family elders, social status, and alternative lifestyles, such as single parenting, divorce, and sexual orientation.
- **Workforce issues.** This wedge considers acculturation and assimilation within the dominant culture, gender roles, level of autonomy, beliefs about individualism, and language barriers.
- **Biocultural ecology.** This wedge considers biological variations related to race, such as skin color, physical stature, heredity, genetics, ecology, endemic disease, and drug metabolism.
- **High-risk behaviors.** This wedge considers health-risk behaviors such as the use of tobacco products, alcohol consumption, and the use of recreational drugs. Also considered are the level of physical activity and the use of safety precautions, such as the use of seat belts when driving/riding in automobiles, or of helmets when riding on bicycles or motorcycles, as well as high-risk sexual behaviors.
- **Nutrition.** This wedge considers the meaning and use of food, the availability of food, culturally preferred foods, food-related rituals and taboos, culturally defined food limitations, nutritional deficiencies, and dietary health promotion practices.
- **Pregnancy.** This wedge considers beliefs and practices about birth control, pregnancy (prepartum, intrapartum, and postpartum), birthing practices, and fertility practices.
- **Death rituals.** This wedge considers culturally related beliefs and practices about dying, death, and bereavement.

- **Spirituality.** This wedge considers religious beliefs and practices, such as the use of prayer, the meaning and purpose of life, spiritual sources of hope and strength, and spiritual practices associated with health and illness.
- **Healthcare practices.** This wedge considers culturally based beliefs and practices (traditional, magicoreligious, and biomedical) related to health and health care, such as the cause and meaning of illness and pain; responsibility for health; medication usage, including use of folk or cultural healing methods; sick role behaviors; and views and practices about mental illness.
- **Healthcare practitioners.** This wedge considers beliefs and practices about the use of cultural (traditional) healers, religious healers, and biomedical healthcare providers. Also considered is the influence of gender (gender of the healthcare provider versus that of the client) on seeking health care.

All domains are interrelated in how the person perceives and receives health care. Each of the 12 domains is further defined and refined. Purnell (2013) states that the model can assist “healthcare providers, managers, and administrators in all health disciplines to provide holistic, culturally competent therapeutic interventions; health promotion and wellness; illness, disease and injury prevention; health maintenance and restoration; and health teaching across educational and practice settings” (p. 15). The Purnell model not only provides a framework for assessing clients from a comprehensive cultural perspective but also enables the healthcare provider to assess her or his own knowledge, skills, beliefs, and values related to cultural competence.



**InfoQuest:** Search the Internet for pictorial representations of the Purnell Model for Cultural Competence. As publishers do not always permit reproductions of copyrighted images, in what ways does seeing the pictorial representation of the Purnell Model for Cultural Competence help you better understand the model? Search the internet for pictorial representations of other theories and models discussed in this text to better understand these ideas.

## Integrating Cultural Knowledge in Care

Strategies that are important in understanding one’s own culture as well as the culture of another include:

1. **Becoming aware of one’s own cultural heritage.** Nurses should identify their own cultural values and beliefs. For example, what behaviors does the nurse

value in relation to healthcare seeking, nutrition, exercise, pain expression? Are the rights of the individual valued over and above the rights of the family? Only by knowing one’s own culture (values, practices, and beliefs) can a person be ready to learn about another’s.

2. **Becoming aware of the client’s culture as described by the client.** It is important to avoid assuming that all people of the same ethnic background have the same culture. When the nurse becomes knowledgeable about the individual client’s culture in the client’s own words, mutual respect between the client and the nurse is more likely to develop.
3. **Becoming aware from the client of adaptations made to live in a North American culture.** During this interview, a nurse should also identify the client’s preferences in health practices, diet, hygiene, and so on.
4. **Developing a plan of care with the client that incorporates his or her culture.** In this way, cultural values, practices, beliefs and individual preferences can be incorporated with care and judgment.

## Barriers to Integrating Culture and Care

Many factors can be barriers to providing culturally sensitive or culturally competent care to clients and their support persons. These factors can also affect communication and working relationships with other healthcare personnel. Ethnocentrism, stereotyping, prejudice, and discrimination are some of these factors.

**Ethnocentrism** refers to an individual’s belief that his or her culture’s beliefs and values are superior to those of other cultures. Spector (2013, p. 357) suggests that there is a tendency “of members of one cultural group to view the members of other cultural groups in terms of the standards of behavior, attitudes, and values of their own group.” In health care, ethnocentrism means that the only valid healthcare beliefs and practices are those held by the healthcare culture. Nurses who take a transcultural view, however, value their own beliefs and practices while respecting the values, beliefs, and practices of others. It is important for nurses to realize that although many people of differing cultural and religious backgrounds have combined their traditional health practices with conventional health practices, other people may be unable to do so.

Most people are gradually exposed to their cultural beliefs, values, and practices over a period of years starting at birth. Ethnocentrism is thought to result from lack of exposure to or knowledge of cultures other than one’s own. **Ethnorelativity** is the ability to appreciate and respect other viewpoints different from one’s own.

**Stereotyping** is assuming that all members of a culture or ethnic group are alike. For example, a nurse may assume that all Italians express pain verbally or that all Chinese people like rice. Stereotyping may be based on



generalizations founded in research or may be unrelated to reality. For example, research indicates that Italians are likely to express pain verbally; however, an Italian client may not verbalize pain. Stereotyping that is unrelated to reality may be either positive or negative and is frequently an outcome of discrimination.

It is important for nurses to realize that not all people of a specific group will have the same health beliefs, practices, and values. It is therefore essential to identify a specific client's beliefs, needs, and values rather than assuming they are the same as those attributed to the larger group.

**Prejudice** is defined by Spector (2013, p. 360) as “negative beliefs or preferences that are generalized about a group and that lead to ‘prejudgment.’” Prejudice may stem from a strong sense of ethnocentrism. For example, nurses educated in the United States may feel that their nursing education is better than that of nurses educated in Europe and therefore view immigrant nurses from Europe as being inferior. Prejudice may also stem from ignorance, misinformation, past experience, or fear. Other types of prejudice are ageism, which suggests negative beliefs about older adults; sexism, such as negative attitudes toward women; and homophobia, which is negativism toward gay, lesbian, and transgender persons.

**Discrimination** is the differential treatment of one person or group over another based on race, ethnicity, gender, age, social class, disability, sexual preference, or other distinguishing characteristics. For example, a nurse takes a patient who is waiting in the emergency department before another patient. The patient taken first appears clean, is neatly dressed, and is smiling; the other patient appears dirty, is wearing worn clothes, and is angry. If there is not a medically urgent reason for taking one patient before the other, the behavior may be a result of discrimination. **Racism** is a form of discrimination related to ethnocentrism. Spector (2013, p. 360) defines racism as “the belief that members of one race are superior to those of other races.”

In 2001, the U.S. Department of Health and Human Services, through the Office of Minority Health, developed national standards for culturally and linguistically appropriate services (CLAS) in health care as a strategy to correct inequities that exist in the provision of health services and to make health care more responsive to the individual needs of all patients/consumers (U.S. Department of Health and Human Services, 2001, p. ix). Since then, the National CLAS Standards have been further developed “to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation’s increasingly diverse communities” (U.S. Department of Health and Human Services, 2015). The 15 CLAS standards are shown in box on page 405. Although the standards

articulate the standards for healthcare organizations, one must remember that nurses are the largest group of health-care providers; therefore, individually and collectively, they must work to ensure that healthcare organizations provide an environment that promotes cultural competence.



**InfoQuest:** Search the Internet for additional governmental and nongovernmental sources of information about strategies for achieving cultural competence in health care. For example, one of the overarching goals of *Healthy People 2020* is “to achieve health equity, eliminate disparities, and improve the health of all groups” (U.S. Department of Health and Human Services, 2015). What strategies are recommended by this document to achieve this goal? What strategies are recommended by the World Health Organization to effect positive health outcomes around the world?

## Conveying Caring to Diverse Groups

It is important for nurses to be culturally aware and to convey their understanding and interest to clients and their families, support persons, and other healthcare personnel. Some of the ways to do so follow:

- Always address clients and their families by their title and last names (e.g., Mrs. Rodriguez, Dr. Simpson) until given permission to use other names. In some cultures, the more formal style of address is a sign of respect, whereas the informal use of first names may be considered disrespectful. It is important to ask clients how they wish to be addressed. In all cases, avoid the use of endearments such as “honey” or “dearie.”
- When meeting a person for the first time, introduce yourself by name, and when appropriate, explain your position, for example, “I’m Mary Johnson and I will be your registered nurse today.” This helps establish a relationship and provides an opportunity for both clients and nurses to clarify pronunciation of one another’s names and to understand the expected roles. It may be helpful to introduce yourself again to your client throughout the shift or on another day if they forget. Wearing a name badge that includes your full name and title (e.g., Mary Johnson, RN, BSN) can also be helpful.
- Be authentic with people, and share your lack of knowledge about their culture. When possible, ask about their cultural beliefs and practices so that you can provide more culturally competent care to clients and improve communication and interaction with

## The National Culturally and Linguistically Appropriate Services (CLAS) Standards

### Principal Standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

### Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

### Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

Source: *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*, by the U.S. Department of Health and Human Services, Office of Minority Health, 2015. Retrieved from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>

colleagues. This approach demonstrates an interest in and respect for their culture.

- Use language that is culturally sensitive. For example, say *gay*, *lesbian*, or *bisexual* rather than *homosexual*; do not use *man* or *mankind* when referring to a woman or women. *African American* is currently preferred over *Black*; however, recent immigrants to the United States, as well as Black people whose family history includes many generations in the United States may view the term *African American* as referring to individuals whose ancestry is bound in the culture of slavery. Therefore, some people may prefer to be referred to by their country of origin, for example, *Haitian American*, *Jamaican American*, or *Nigerian*. The terms *Latino* and *Hispanic* are preferred differently in different regions of the country; for example, *Latino* tends to be preferred in California and Texas, whereas *Hispanic* tends to be preferred in Florida. Some

people may prefer to be referred to by their country of origin, for example, *Cuban American*, *Mexican American*. *Asian* may be more acceptable than *Oriental*. It is important for nurses to keep up with language changes or specific language preferences appropriate to their region of practice.

- Find out what the client knows about his or her health problems or illness, and what treatments have been tried. Assess whether this information is congruent with the dominant healthcare culture. If the beliefs and practices are incongruent, establish whether this will have a negative effect on the client's health.
- Do not make any assumptions about the client or others, and always ask about anything you do not understand.
- Respect the client's values, beliefs, and practices, even if they differ from your own or from those of the dominant culture. If you don't agree with them, it is important to respect the client's right to hold these beliefs.

- Show respect for the client's support people. In some cultures males in the family make decisions affecting the client, whereas in other cultures females make the decisions.
- Make an effort to obtain the client's trust, but do not be surprised if it develops slowly or not at all.

## Selected Cultural Parameters Influencing Nursing Care

This section outlines selected cultural and ethnic phenomena of significance to nursing.

### Health Beliefs and Practices

Andrews and Boyle (2012) describe three health belief views: **magicoreligious**, **scientific**, and **holistic**. In the **magicoreligious health belief view**, health and illness are controlled by supernatural forces. The client may believe that illness is the result of “being bad” or opposing God’s will. Getting well is also viewed as dependent on God’s will. The client may make statements such as, “If it is God’s will, I will recover,” or “What did I do wrong to be punished with cancer?” People of some cultures may believe that magic can cause illness. A sorcerer or witch may put a spell or hex on the client. Some people view illness as possession by an evil spirit. Although these beliefs are not supported by empirical evidence, clients who believe that such things can cause illness may, in fact, become ill as a result. Such illnesses may require magical treatments in addition to scientific treatments. For example, a man who experiences gastric distress, headaches, and hypertension after, he believes, a curse has been placed on him may recover only if he believes the curse has removed by a cultural healer, regardless of medical treatments.

The scientific or **biomedical health belief view** is based on the belief that life and life processes are controlled by physical and biochemical processes that can be manipulated by humans (Andrews & Boyle, 2012). The client with this view will believe that illness is caused by germs, viruses, bacteria, or a breakdown of the human machine, the body. This client will expect a pill or a treatment or a surgery to cure health problems.

The **holistic health belief view** holds that the forces of nature must be maintained in balance or harmony. Human life is one aspect of nature that must be in harmony with the rest of nature. When the natural balance or harmony is disturbed, illness results. The Medicine Wheel is an ancient symbol used by indigenous people of the Americas (who also may be referred to as Native Americans, American Indians, or Aborigines) to express many concepts. Related

to health and wellness, the Medicine Wheel teaches the four aspects of the individual’s nature: the physical, the mental, the emotional, and the spiritual. Each of the dimensions must be in balance to be healthy. The Medicine Wheel also can be used to express the individual’s relationship with the environment as a dimension of wellness. The concept of yin and yang in the Chinese culture and the hot/cold theory of illness in many Hispanic/Latino cultures are examples of holistic health beliefs. When the client has a yin illness, or a “cold” illness, the treatment will need to include a yang, or “hot” treatment. For example, a Chinese client who has been diagnosed with cancer, a yin disease, will want to eat cultural foods that have yang properties. What is considered as hot or cold varies considerably across cultures. In many cultures, pregnancy is considered a “hot” condition; however, the hot properties of pregnancy are lost during the birthing process; therefore the mother who has just delivered a baby should be offered warm or hot foods and kept warm with blankets. The nurse must keep in mind that a treatment strategy that is consistent with the client’s beliefs may have a better chance of being successful. For example, the Mexican American client who avoids “hot” foods when he has a stomach disturbance such as an ulcer may be eating foods consistent with the bland diet that is normally prescribed by physicians for clients with ulcers.

Sociocultural forces, such as politics, economics, geography, religion, and the predominant healthcare system, can influence the client’s health status and health-seeking and healthcare behaviors. For example, people who have limited access to scientific health care may turn to folk medicine or folk healing. **Folk medicine** is defined as those beliefs and practices relating to illness prevention and healing that derive from cultural traditions rather than from Western medicine’s scientific base. The nurse may recall special teas or curatives that were used by older family members to prevent or treat colds, fevers, indigestion, and other common health problems. For example, many people continue to use chicken soup as a treatment for flu or tea with honey for a sore throat.

There are many reasons why individuals use their traditional folk healing methods. Folk medicine, in contrast to biomedical health care, is thought to be more humanistic. The consultation and treatment take place in the community of the recipient, frequently in the home of the healer or the patient. It is less expensive than scientific or biomedical care because the health problem is identified primarily through conversation with the client and the family. The healer often prepares the treatments, for example, tisanes or teas to be ingested, poultices to be applied, or charms or amulets to be worn. A frequent component of treatment is some ritual practice on the part of the healer or

the client to cause healing to occur. Because folk healing is more culturally based, it is often more comfortable and less frightening for the client.

It is important for the nurse to obtain information about folk/cultural or family healing practices that may have been used prior to the client's seeking Western scientific medical treatment. Often clients are reluctant to share home remedies with healthcare professionals for fear of being laughed at or rebuked. Nurses must remember that clients may continue to use these practices in lieu of or in addition to prescribed Western (conventional) or scientific treatments. The nurse should remember that treatments once considered to be folk treatments, including many herbal remedies, acupuncture, therapeutic touch, and massage, are now being investigated for their therapeutic effect.

### Reflect On . . .

- your own beliefs about causes of and treatments for illness. What do you believe about the causes of illness or injury? What do you do when you have a cold? The flu? A muscle ache? Stomach upset? What family or cultural remedies have been passed down through the generations of your family? Do the remedies work? If yes, can you think of a scientific reason for their effectiveness?

### Family Patterns

The family is the basic unit of society. Cultural and religious values can determine communication within the family group, the norm for family size, and the roles of specific family members. In cultures that are patriarchal, the man is usually the provider and decision maker. The woman may need to consult her husband or father before making decisions about her medical treatment or the treatment of her children. Some cultures are matriarchal; that is, the mother or grandmother is viewed as the leader of the family and is the decision maker. Other cultures follow shared decision making, where some decisions are made by the males (e.g., finances) and other decisions are made by the females (e.g., child rearing until the age of adulthood). The nurse

needs to identify who has the explicit authority to make decisions in the client's family. If the decision maker is someone other than the client, the nurse needs to include that person in healthcare discussions.

The value placed on children and the elderly within a society is culturally derived. In some cultures, children are not disciplined by spanking or other forms of physical punishment. Rather, children are allowed to interact with their environment and to learn from their environment while caregivers provide subtle direction to prevent harm or injury. In some cultures, the elderly are considered the holders of the culture's wisdom and are therefore highly respected. Responsibility for caring for older relatives is determined by cultural practices. In many cultures, older relatives who cannot live independently often live with a married daughter and her family.

Culture and religious norms about sex-role behaviors may also affect nurse-client interaction. In some countries, the male dominates and women have little status. The male client from these countries may be less receptive to instruction from a female nurse or physician than to the same instruction given by a male physician or nurse. In some cultures, there is a prevailing concept of machismo, or male superiority. The positive aspects of machismo require that the adult male provide for and protect his family, including extended family members. The woman is expected to maintain the home and raise the children.

Cultural family values may also dictate the extent of the family's involvement in the hospitalized client's care. In some cultures, the nuclear and the extended family will want to visit for long periods of time and participate in care. In other cultures, the entire clan may want to visit and participate in the client's care. This can cause concern on nursing units with strict visiting policies. The nurse should evaluate the positive benefits of family participation in the client's care and modify visiting policies as appropriate.

Cultures that value the needs of the extended family as much as those of the individual may hold the belief that personal and family information must stay within the family. Some cultural groups are very reluctant to disclose family information to outsiders, including healthcare professionals. This attitude can present difficulties for healthcare professionals who require knowledge of family

### CRITICAL THINKING EXERCISE

Consider nursing situations in your experience that reflect each of the health belief views as described by Andrews and Boyle: the magicoreligious health belief view, the biomedical health belief view, and the holistic

health belief view. Describe culturally competent nursing interventions that would be appropriate for each of your nursing situations.



## RESEARCH CURRENT

## Motivators and Barriers to Participating in Health Promotion Behaviors in Black Men

The purpose of this study by Calvert and Isaac-Savage was to examine the relationship between motivators and barriers to participating in health promotion behaviors of low-income Black men. The sample consisted of 107 Black men, ages 21 to 56, who had participated or were participating in a 6-week program offered by the Fathers' Support Center. The majority of participants were single (63.2%) and unemployed (68.9%) and had at least a high school education (61.7%). The 6-week program provides a wide range of services, including GED preparation, employment training, and parenting and health education classes. Current participants of the program were approached during the biweekly Male Health and Wellness class. Graduates of the program were recruited by mail. Investigators collected demographic information including age, ethnicity, race, marital status, highest educational level attained, and current employment status. The Health Promotion Lifestyle Profile II, 52 items that use a Likert-type scale format, was used to collect data about health promotion behaviors. The six subscales are Health Responsibility, Interpersonal Relations, Physical Activity, Spiritual Growth, Stress Management, and Nutrition. The Motivators and Barriers of a Healthy Lifestyle Scale, 14 items split between motivators and barriers, was used to identify motivators for and barriers to routine health promotion activities. The majority of participants agreed or strongly agreed with the following motivators: "I am motivated to practice a healthy lifestyle because I may live longer" (90.7%), "want to be healthy" (96.3%), "believe that God wants

me to take care of my body" (94.4%), "feel more energetic" (93.5%), "want to manage weight" (85.0%), "have someone to encourage or help me" (67.3%), and "have seen others get sick from unhealthy behaviors" (98.8%). The majority of participants disagreed or strongly disagreed with the following barriers to health promotion behaviors: I am NOT able to practice a healthy lifestyle because I "am not motivated" (72.9%), "do not have someone to encourage me" (74.8%), "live in an unsafe neighborhood" (90.3%), "have too many other things to do" (84.8%), "have health problems" (77.6%), "don't know what to do" (85.0%), and "am unable to afford healthy foods" (69.1%). Of concern is that almost one third of participants "were not motivated" (27.1%), "did not have someone to encourage them" (25.2%), and were "unable to afford healthy foods" (30.9%). Correlation analysis indicated that those who had fewer motivators and more barriers took less responsibility for their health, participated in less physical activity, and had less spiritual growth. The investigators point out that the participants were men who had already chosen to participate in a program to improve their life. Thus the findings of this study may not reflect the general population of Black men. The findings do identify various motivators for engaging in healthy behaviors that healthcare providers can incorporate into community education programs.

Source: "Motivators and Barriers to Participating in Health Promotion Behaviors in Black Men," by W. J. Calvert and E. P. Isaac-Savage, 2013, *Western Journal of Nursing Research*, 35(7), pp. 829–848.

interaction patterns to help clients with either physical or emotional problems.

In many cultures, naming systems differ from those in North America. In some cultures (e.g., Japanese and Vietnamese), the family name comes first and the given name, second. One or two names may or may not be added between the family and given names. Other nomenclature may be used to delineate gender, child, or adult status. For example, in traditional Japanese culture, adults address other adults by their surname followed by *san*, meaning *Mr.*, *Mrs.*, or *Miss*. An example is Murakami-san. The children are referred to by their first names followed by *kun* for boys and *chan* for girls. Sikhs and Hindus traditionally have three names. Hindus have a personal name, a complimentary name, and then a family name. Sikhs have a personal name, then the title *Singh* for men and *Kaur* for women, and last the family name. Names by marriage also vary. In Central America, a woman who marries retains her father's name and takes her husband's. For example, if Louisa

Viccaro marries Carlos Gonzales she becomes Louisa Viccaro de Gonzales. The connecting *de* means "belonging to." A male child will be Pedro Gonzales Viccaro. Nurses need to become familiar with appropriate ways to address clients. In many cultures, using a client's first name is considered disrespectful, offensive, or patronizing.

## Reflect On . . .

- your own family behaviors. Interview your grandparents and parents. How were major decisions made in their families? Who made the final decision? How are decisions made in your current family? Who make the final decision? Have decision-making processes changed in your family over the generations? If the processes have changed, what do you think are the reasons for those changes?

## Communication Style

Communication style and culture are closely interconnected. Through communication, the culture is transmitted from one generation to the next, and knowledge about the culture is transmitted both within the group and to those outside the group. Communicating with clients of various ethnic and cultural backgrounds is critical to providing culturally competent nursing care. Cultural variations in communication can exist in both verbal and nonverbal communication patterns.

### Verbal Communication

The most obvious cultural difference is in verbal communication: vocabulary, grammatical structure, voice qualities, intonation, rhythm, speed, pronunciation, and silence (Giger, 2013). In North America, the dominant language is English; however, immigrant groups who speak English still encounter language differences, because English words can have different meanings in different English-speaking cultures. For example, in the United States a *boot* is a type of footwear that comes to the ankle or higher; in England, a *boot* also can be the trunk of a car.

Spanish is spoken by people in several regions of the world: Spain, South America, Central America, Mexico, the Caribbean, and the Philippines. It is the second most commonly spoken language in the United States. Nevertheless, each cultural group that speaks Spanish may use different vocabulary, apply rules of grammar differently, and use different pronunciation, so that often two people of different Hispanic/Latino cultures, speaking Spanish together, may have difficulty understanding each other.

Initiating verbal communication may be influenced by cultural values. The busy nurse may want to complete nursing admission assessments quickly. The client, however, may be offended when the nurse immediately asks personal questions or doesn't include the accompanying family member in the conversation. In some cultures, it is believed that social courtesies should be established before business or personal topics are discussed. Discussing general topics can convey that the nurse is interested in and has time for the client and his or her family. This enables the nurse to develop a rapport with the client before progressing to more personal discussion.

Verbal communication becomes even more difficult when an interaction involves people who speak different languages. Both clients and health professionals experience frustration when they are unable to communicate verbally with each other. For clients who have limited knowledge of English, the nurse should avoid slang

words, medical terminology, and abbreviations. Augmenting spoken conversation with gestures or pictures can increase the client's understanding. The nurse should speak slowly, in a respectful manner, and at a normal volume. Speaking loudly does not help the client understand and may be offensive. The nurse must also frequently validate the client's understanding of what is being communicated. The nurse must be wary of interpreting a client's smiling and head nodding to mean that the client understands; the client may only be trying to please the nurse or acknowledge that he or she heard the nurse but not necessarily understand what is being said.

For the client who speaks a different language, a translator or interpreter may be necessary. A **translator** is one who changes words from one language into another language. An **interpreter** moves beyond simple translation (word to word) and renders the speaker's intention or meaning of the words from one language to another. It is best to use a professional medical interpreter who can facilitate communication between people speaking different languages in a healthcare setting.

Interpreters should be objective individuals who can provide accurate translation of the client's information and of the health professional's questions, information, and instruction. Many institutions that are located in culturally diverse communities have professional medical interpreters available on staff or maintain a list of employees who are fluent in other languages. Embassies, consulates, ethnic churches (e.g., Russian Orthodox, Greek Orthodox), ethnic clubs (e.g., Polish American Club, Italian American Club), or telephone communication companies may also be able to provide translating or medical interpreting services. Nursing and other health personnel can use pictures and gestures to augment verbal communication. Some schools of nursing and healthcare institutions do not permit nursing students to translate for a procedure consent because a lack of knowledge about the procedure may lead the student to give inaccurate information. The student should check the institution's policy before agreeing to translate for institutional staff and physicians. Guidelines for using an interpreter are shown in the accompanying box.

Nurses and other healthcare providers must remember that clients for whom English is a second language may lose command of their English when they are in stressful situations. It is not uncommon for clients who have used English comfortably for years in social and business communication to forget and revert back to their primary language when they are ill or distressed. It is important for the nurse to assure the client that this is normal and to promote behaviors that facilitate communication.

## Using an Interpreter

- Avoid asking a member of the client's family, especially a child or spouse, to act as interpreter. The client may not wish family members to know about his or her problem, therefore, may not provide complete or accurate information if a family member is interpreting.
- Be aware of gender and age differences; it is preferable to use an interpreter of the same sex as the client to avoid embarrassment and faulty translation of sexual matters. Children should not be used as interpreters.
- Avoid an interpreter who is politically or socially incompatible with the client.
- Address questions to the client, not to the interpreter. Face the client, not the interpreter; you want to see the nonverbal message while the client is speaking.
- Ask the interpreter to translate as closely as possible to the words and meaning used by the healthcare provider.
- Speak slowly and distinctly. Do not use metaphors; for example, do not say "Does it swell like a grapefruit?" or "Is the pain stabbing like a knife?" It is better to ask, "Describe the pain."
- Observe the facial expressions and body language that the client assumes when listening and talking to the interpreter.

## Nonverbal Communication

To communicate effectively with culturally diverse clients, the nurse needs to be aware of two aspects of nonverbal communication behaviors: what nonverbal behaviors mean to the client and what specific nonverbal behaviors mean in the client's culture. It is not required that the nurse be knowledgeable about the nonverbal behavior patterns of all cultures; however, before the nurse assigns meaning to nonverbal behavior, the nurse must consider the possibility that the behavior may have a different meaning for the client and the family. Furthermore, to provide safe and effective care, nurses who work with specific cultural groups should learn more about cultural behavior and communication patterns within those cultures.

Nonverbal communication can include the use of silence, touch, eye movement, facial expressions, and body posture. It also includes cultural perceptions of space orientation and distance. Some cultures are quite comfortable with long periods of silence, whereas others consider it appropriate to speak before the other person has finished talking. Many persons value silence and view it as essential to understanding a person's needs or use silence to preserve privacy. Providing periods of silence when talking with clients gives them the opportunity to remember and think about what they are trying to say. Some cultures view silence as a sign of respect, whereas to other persons silence may indicate agreement.

Touch and touching is a learned behavior that can have both positive and negative meanings. In the American culture, a firm handshake is a recognized form of greeting that conveys character and strength. In some European cultures, greetings may include a kiss on one or both cheeks along with the handshake. In some societies, touch is considered magical, and because of the belief that the soul can leave the body on physical contact, casual touching is

forbidden. In the Hmong culture, one should not touch the head of adults or children. Nurses should therefore touch a client's head only with permission (Purnell, 2013). The sex of the person touching and being touched often has cultural significance. Kulwicki and Ballout (2013, p. 161) caution that, "Islamic teachings forbid unnecessary touch (including shaking hands) between unrelated adults of opposite sexes." It is best to assign a nurse of the same sex to care for a client who is Muslim.

Cultures also dictate what forms of touch are appropriate for individuals of the same sex and the opposite sex. In many cultures, for example, a kiss is not appropriate for a public greeting between persons of the opposite sex, even those who are family members; however, a kiss on the cheek is acceptable as a greeting among individuals of the same sex. Touch of any type between members of the opposite sex, including a handshake, may be inappropriate in some cultures. The nurse should watch interaction among clients and families for cues to the appropriate degree of touch in that culture. The nurse should inform the client of the need to touch during assessment, nursing care, or procedures. The nurse can also assess the client's response to touch when providing nursing care, for example, by noting the client's reaction to the physical examination or the bath.

Facial expression can also vary between cultures. Giger (2013) states that Italian, Jewish, African American, and Hispanic persons are more likely to smile readily and use facial expression to communicate feelings, whereas Irish, English, northern European, and Asian persons tend to have less facial expression and are less open in their response, especially to strangers. Facial expression can also convey the opposite meaning of what is felt or understood. For example, clients who have difficulty understanding English may smile and nod their heads as though they understand what is being said, when, in fact, they do

not understand at all but do not want to display ignorance or displease the caregiver.

Eye movement during communication has cultural foundations. In Western cultures, direct eye contact is regarded as important and generally shows that the other is attentive and listening. It conveys self-confidence, openness, interest, and honesty. Lack of eye contact may be interpreted as secretiveness, shyness, guilt, lack of interest, or even a sign of mental illness. Other cultures may view eye contact as impolite or an invasion of privacy. The nurse should not misinterpret the character of the client who avoids eye contact.

Body posture and gestures are also culturally learned. Finger pointing, the “V” sign with the index and middle fingers, and the thumbs up sign may have different meanings. For example, the “V” sign means victory in some cultures, whereas it may be an offensive gesture in other cultures. In some Asian cultures, bowing the head slightly when entering the room where an elder is present and using both hands to give something to someone are considered signs of respect.

Communication is an essential part of establishing a relationship with a client and his or her family. It is also important for developing effective working relationships with healthcare colleagues. To enhance their practice, nurses can observe the communication patterns of clients and colleagues and be aware of their own communication behaviors. The accompanying box provides strategies for communicating with clients from different cultures. The same strategies can be used in communication with professional colleagues.

### Reflect On . . .

- your own values, beliefs, and practices related to verbal and nonverbal communication. How might your values, beliefs, and practices related to communication conflict with those of people from different cultural groups in your community? What strategies will you implement to improve your communication with people of other cultures?

### Space Orientation

Space is a relative concept that includes the individual, the body, the surrounding environment, and objects within that environment. The relationship between the individual's own body and objects and persons within space is learned and is influenced by culture. For example, in nomadic societies space is not owned; it is occupied temporarily until the tribe moves on. In Western societies people tend to be more territorial, as reflected in phrases such as “This is my space” or “Get out of my space.” In Western cultures, spatial distances are defined as the intimate zone, the personal zone, the social zone, and the public zone. The intimate zone is the smallest area of space around the individual, the public zone the largest area. The size of these areas may vary within different cultures. Nurses move through all four zones as they provide care for clients: the intimate zone when they listen to heart and breath sounds, the personal zone when adjusting an intravenous flow rate, and the social zone when greeting the client on entering the

## Strategies for Communicating with Clients from Different Cultures

- Consider the cultural component of communication, and integrate it into the relationship with clients, their families, and other healthcare professionals.
- Encourage the client to communicate cultural interpretations of health, illness, treatments, and planned care. Incorporate these into the plan of care so that it is congruent with the client's lifestyle and needs as the client views them.
- Understand that respect for clients, their culture, and their communicated needs is crucial to an effective helping relationship.
- Use an open and attentive approach so that the client knows you are really listening.
- Relate to the client in an unhurried manner that considers the social and cultural amenities. Give the client time to answer. Engage in appropriate social conversation before discussing more intimate or personal details.
- Use validation techniques while communicating to check that the client understands. Note that big smiles and frequent head nodding may indicate only that the client has heard you or is trying to please you, not necessarily that the client understands you.
- Sexual concerns may be difficult for clients to discuss. Try to have a nurse of the same sex as the client present when discussing sexual matters.
- Use alternative methods of communication for clients who do not speak English: trained medical interpreters, foreign language dictionaries or phrase books, gestures, pictures, facial expressions, tone of voice.
- Learn key phrases in languages that are commonly spoken in the community. For example, medical phrase books are available in various languages. Learning to say “Good day, my name is \_\_\_\_\_” in the client's language can be the first step in an effective helping relationship.



room. Nurses who are teaching community education classes are working in the public zone. The nurse needs to be aware of the client's response when she or he moves toward the client. The client may physically withdraw or back away if the nurse is perceived as being too close. The nurse will need to explain to the client why it is necessary to be close to the client. To assess the lungs with a stethoscope, for example, the nurse needs to move into the client's intimate space. The nurse should first explain the procedure and await permission to continue.

Clients who reside in long-term-care facilities, or who are hospitalized for an extended time, may want to personalize their space. They may want to arrange their space differently and control the placement of objects on their bedside cabinet or over-bed table. The nurse should be responsive to clients' needs to have some control over their space. When there are no medical contraindications, clients should be permitted and encouraged to wear their own clothing and have objects of personal significance. Wearing cultural dress or having personal, cultural, and spiritual items in one's environment can increase self-esteem by promoting not only one's individuality but also one's cultural identity. Of course, the nurse should caution the client about responsibility for loss of personal items.

## Time Orientation

Time orientation refers to an individual's focus on the past, the present, or the future. Most cultures combine all three time orientations, but one orientation is more likely to dominate. The European American focus on time tends to be directed to the future, emphasizing time and schedules (Purnell, 2013). Nursing students know what times they must be in class or clinical. They know what courses they will take in future semesters. European Americans often plan for next week, their vacation, or their retirement.

Other cultures may have a different concept of time. People who are present-oriented may not see the future benefits of changing present-day behaviors (e.g., diet, activity levels); they may not see saving money for retirement as important, as retirement may never come. Present-oriented people live in the here and now.

People who have a past orientation focus on what happened in the past for explanations of the present, believing that what has happened cannot be changed. In relation to health and wellness, a past-oriented person may believe that illness was predetermined and they cannot change anything.

The cultures of nursing and health care value time. Appointments are scheduled and treatments are prescribed with time parameters (e.g., changing a dressing once a day). Medication orders include how often the medicine is to be taken and when (e.g., digoxin 0.25 mg, once a day, in

the morning). Nurses need to be aware of the meaning of time for clients. Giger (2013) states that when caring for clients who are "present-oriented," it is important to avoid fixed schedules. The nurse can offer a time range for activities and treatments. For example, instead of telling the client to take digoxin every day at 10:00 a.m., the nurse might tell the client to take it every day in the morning, or every day after getting out of bed.

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## Reflect On . . .

- your own perception of time. Do you believe yourself to be past-, present-, or future-oriented? What time do you show up if you have a class that meets at 8:00 a.m.? What time do you show up when you receive an invitation to a party that starts at 9:00 p.m.? What time do you show up for a job interview scheduled at 10:00 a.m.? As you look at the answers to these questions, what does the information say about your sense of time?
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## Nutritional Patterns

Most cultures have staple foods, that is, foods that are plentiful or readily accessible in the environment. For example, the staple food of Asians is rice, and of eastern Europeans, wheat. Sources of protein for people who live near the sea may be fish, but for those who live more distant from oceans or inland lakes, poultry and beef may be more plentiful. Even clients who have been in the United States or Canada for several generations often continue to eat the cultural foods of their homeland.

The way food is prepared and served is also related to cultural practices. For example, in the United States, a traditional food served for the Thanksgiving holiday is turkey with stuffing; however, in different regions of the country the contents of the stuffing may vary. In southern states, the stuffing may be made with cornbread, and in New England, of seasoned bread and chestnuts.

The ways in which staple foods are prepared also vary. For example, some Asian cultures prefer steamed rice; others prefer boiled rice. Southern Asians from India prepare unleavened bread from wheat flour rather than the leavened bread of Anglo Americans.

Food-related cultural behaviors can include whether to breast-feed or bottle-feed infants, and if choosing breast-feeding, culture may influence how long the mother breast-feeds. Culture also influences when to introduce solid foods to the infant.

Food can also be considered part of the remedy for illness. Foods classified as hot foods or foods that are hot in temperature may be used to treat illnesses that are classified

as cold illnesses. For example, cornmeal (a hot food) may be used to treat arthritis (a cold illness). Each cultural group defines what it considers to be hot and cold entities.

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### Reflect On . . .

- the nutritional content of the foods of various cultures. Identify the food preferences of cultural groups in your community. How do these diets fulfill nutritional requirements? What nutritional deficiencies exist in these diets? How would you counsel a client to modify his or her diet to achieve health outcomes (e.g., low sodium, low cholesterol, diabetic) within cultural dietary preferences?
  - your own nutritional preferences. What foods have meaning for you from a cultural perspective? What foods did your mother prepare for you when you were ill? Did these foods have healing properties or comfort properties? What foods do you believe to be important for health promotion and disease prevention? Is your diet consistent with a healthy diet?
  - the healthcare organization where you work. Does your organization provide menu options that reflect dietary preferences of the cultural groups that you serve?
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### Pain Responses

Research has demonstrated that beliefs about and responses to pain vary among ethnic/racial groups. Cultural response to pain must be viewed in relation both to the actual perception of pain and to the meaning or significance of pain to the client and family. In some cultures, pain may be considered a punishment for bad deeds; the individual is expected, therefore, to tolerate pain without complaint in order to atone for sins or misdeeds. In other cultures, self-infliction of pain is a sign of mourning or grief. In other groups, pain may be anticipated as a part of the ritualistic practices of passage ceremonies, and therefore, tolerance of pain signifies strength and endurance. In yet other cultures, the expression of pain elicits attention and sympathy, whereas in other cultures, boys especially are taught “to take pain like a man” and “big boys don’t cry.”

Client responses to pain should be assessed within the context of their culture, including ethnicity, age, gender, and previous pain experiences. If the client does not complain of pain, nurses should not assume that the client is not experiencing pain. The nurse must be aware of what conditions are likely to cause pain and offer clients pain relief as appropriate. Treatment for pain may also vary

with culture. In European American cultures, medication is typically used for pain relief. In other cultures, heat, cold, relaxation, meditation, or other techniques and treatments may be used.

### Childbirth and Perinatal Care

#### Prenatal Care

In North America, emphasis is placed on regular prenatal medical visits, prenatal classes for both parents, and avoidance of communicable disease through immunization or hygiene practices. These practices are accepted in varying degrees by people of other cultures. To some, for example, regular medical checkups are often avoided because they are equated with problems or abnormalities. Traditionally, these women will see a physician only if there is a problem. Many immigrants may also prefer not to attend prenatal classes for a variety of reasons. Some of these relate to language problems or discomfort and embarrassment about doing exercises in front of others, discussing sexual matters, or seeing movies about childbirth.

Because in many cultures pregnancy and childbirth are considered the exclusive realm of women, some women prefer to have a female friend or relative attend prenatal classes and the birth rather than the husband. Nurses need to respect this choice. However, some new immigrant husbands, in the absence of a mother, mother-in-law, or other female, may indicate interest in attending prenatal classes and the birth, if only to act as interpreters for their wives.

Prenatal practices vary in regard to safeguarding the health of the fetus and mother. People in several cultures (e.g., Mexican Americans, Asians) emphasize the equilibrium model of health—that is, balancing hot and cold or yin and yang—during pregnancy. Pregnant women therefore try to avoid too much hot or cold food as determined by their culture. Some women believe that hot foods during the first trimester of pregnancy can cause miscarriage or a premature delivery; as a result, they emphasize the ingestion of cool foods, such as some fruit, coconut, buttermilk, and yogurt, and the avoidance of hot foods, such as meat, nuts, and eggs, during this period. It is important to note that hot and cold do not necessarily relate to the temperature of the food, but rather to the balancing or holistic characteristic of the food.

#### Labor and Delivery

In some cultures, pregnant women traditionally return to their parents’ home for the delivery of the first child and, sometimes, subsequent births. Births in the home are usually managed by a midwife with the assistance of the woman’s mother, mother-in-law, or married sister. Traditionally, the husband is not present. In other cultures, childbirth takes place in homes, hospitals, and clinics and is attended

## RESEARCH CURRENT

## Exploring the Impact of Cultural Background on Parental Perceptions of Children's Pain

The purpose of this study by Batista, Fortier, Maurer, Tan, Huszti, and Kain was to examine the relationship between ethnic background and parent perceptions of children's pain expression. The sample consisted of 215 parents (50 Spanish-speaking Hispanic, 72 English-speaking Hispanic, 93 English-speaking White) of healthy children ages 1 month to 17 years who underwent outpatient surgery for ENT, orthopedic, ophthalmological, general, urological, or plastic surgical procedures. The parents were categorized by ethnicity and language spoken: Spanish-speaking Hispanic, English-speaking Hispanic, and English-speaking White. The Parental Pain Expression Perceptions questionnaire, which consists of nine items assessing parental beliefs about children's pain expression, was used to assess the parent attitudes. Questionnaire items related to active pain behaviors (e.g., crying, whining), attention-seeking pain behaviors, and quiet pain behaviors (e.g., if children are quiet they are not in pain). The questionnaire was administered in English to English-speaking parents and Spanish to Spanish-speaking parents. Results indicated that parental misconceptions regarding the pain expressions of children were common: 54% agreed that "children always express pain by crying or whining," and that "children always tell their parents when they are in pain"; 43% reported that "children who are experiencing pain report it immediately"; and 38% that "children complain about pain to get attention." Investigators examined the

influence of ethnic background and language on parents' perceptions of their child's pain expression. After controlling for other factors (e.g., age, education, income, marital status, and gender of parent), significant differences in ethnicity and language were still present. Spanish-speaking Hispanic parents reported greater misconceptions of children's pain expression than the English-speaking Hispanic parents and the English-speaking White parents, specifically in relation to "children always express pain by crying or whining," "children always tell parents when in pain," "children who are quiet are not in pain," "children who are playing are not in pain," and "children experiencing pain report it immediately." No Spanish-speaking Hispanic parents agreed that "children in pain have trouble sleeping." This study suggests that there are differences in parent beliefs about their children's pain expression related to ethnicity. There are several implications for nursing practice related to this study: (1) Nurses need to assess children's pain by assessing the child's verbal and nonverbal behaviors, (2) nurses should consider parents' reports of their child's pain within the context of their child's verbal and nonverbal behaviors, and (3) nurses need to educate parents about children's expressions of pain.

*Source:* "Exploring the Impact of Cultural Background on Parental Perceptions of Children's Pain," by M. L. Batista, M. A. Fortier, E. L. Maurer, E. Tan, H. C. Huszti, and Z. N. Kain, 2012, *Children's Health Care*, 41, pp. 97–110.

by physicians and certified midwives. The father may actively participate in the labor and delivery process, serving as labor coach during labor and cutting the umbilical cord following delivery.

Positions used for delivery vary from the standard lithotomy position of North Americans. In other cultures, other positions—for example, squatting, kneeling, sitting, or standing—may be preferred. In some cases, a special birthing stool is used for delivery of the newborn.

Responses to labor pain vary. Some women may tolerate considerable pain and stoically accept pain for many reasons. They may, for example, want to avoid showing weakness or calling undue attention to themselves for fear of shaming themselves and their families, or they may act accordingly simply because it is expected behavior within their culture. In other cultures, women express pain and anguish more freely; for example, screaming and sobbing are acceptable and expected responses. It is important for the nurse to know that the absence of crying and moaning does not necessarily mean that the laboring mother feels

no pain, nor does the presence of crying and moaning necessarily mean that pain relief is desired at that moment. With clients from some cultures, nurses may use touching and the support of others (husband, female relative, or friend) to decrease pain during labor. Various other cultures may or may not value the same comfort measures. Pain relief medications may also be used, but some clients are hesitant to request them.

### Postpartum Care

Most cultures emphasize certain postpartum routines or rituals for mother and baby. These are frequently designed to enable the mother to rest after labor and focus on the newborn, or to restore harmony or the "hot-cold" balance of the body. In many cultures, the mother's health status is classified as "cold" due to stress and the loss of blood. Thus, people take care to warm the body and to avoid cold after birth. This prohibition includes cold air and wind, as well as designated foods and fluids. Showers, tub baths, and shampoos are restricted, often until the

lochia stops or longer, to avoid chilling. Sponge baths may be taken using warm water and/or special products that have medicinal properties. Some women may wear binders around the abdomen and perineum not only to protect the body from cold but also to aid the uterus in returning to its normal size.

Confinement periods also vary and in many cultures are considerably longer than in the healthcare system of North America. For example, traditional Chinese practice a “sitting in” period for 1 month to avoid cold winds. This confinement also applies to the newborn. New Mexican American mothers may remain in bed for 3 days following delivery, may begin to walk inside the home after 1 week, and may go outside after 2 weeks.

For most cultures, the extended family frequently plays an essential role during the postnatal period. A grandmother, mother, mother-in-law, aunt, or married sister may be the primary helper for the mother and newborn. This arrangement gives the new mother time to rest as well as provides access to someone who can help with problems and concerns as they arise.

**The Newborn** Breast-feeding is the traditional feeding method in most cultures. However, bottle-feeding is not uncommon especially among women who are employed. The current emphasis in North America on breast-feeding is confusing to some new immigrants because effective advertising campaigns have convinced women of the superiority of bottle-feeding; they believe babies grow faster on the formulas. Nurses need to provide additional encouragement and clear explanations for these women. In some cultures, newborn babies may have a coin placed on the umbilicus or their waist tied with a bellyband to prevent a protruding umbilicus or hernia.

It is important to remember that younger members of a specific cultural group may have been acculturated to the dominant culture and no longer follow traditional practices. In other instances, they follow some practices but not others. Sensitive nurses can work toward a blending of old and new behaviors to meet the goals of all concerned.

## Death and Dying

Death is a universal experience, and people want to die with dignity. Various cultural traditions and practices associated with death, dying, and the grieving process help people cope with these experiences. Nurses are often present through the dying process and at the moment of death, especially when it occurs in a healthcare facility. Knowledge of the client’s cultural heritage helps nurses provide individualized care to clients and their families, even

though they may not participate in the rituals associated with death.

Dying alone is unacceptable in most cultures. In many cultures, people prefer a peaceful death at home rather than in the hospital. Some may request that health professionals not reveal the prognosis to dying clients. They believe the person’s last days should be free of worry and pain. Other people prefer that a family member (preferably a male in some cultures) be told the diagnosis so that the client can be tactfully informed by a family member in gradual stages or not be told at all. Nurses also need to determine whom to call, and when, as the impending death draws near.

Beliefs and attitudes about death, its cause, and the soul also vary among cultures. Unnatural deaths, or “bad deaths,” are sometimes distinguished from “good deaths.” The death of a person who has behaved well in life is considered less threatening because that person will be reincarnated into a good life, or go to a better place, in some cultures/religions called “the afterlife” or “heaven.” Religious beliefs and practices are often integral to cultural beliefs and practices. Specific rituals may be required prior to or immediately after death to ensure that the client passes on to whatever follows. The nurse needs to support the dying client and his or her family and friends by providing an environment where required death rituals can be observed.



**InfoQuest:** Search the Internet for professional organizations that might help the nurse improve her or his knowledge of care preferences for people from different cultures. One such organization is the Transcultural Nursing Society. What is the mission of the organization? What resources are provided for nurses to improve their knowledge and cultural competence? What other resources can you find?

## Reflect On . . .

- personal cultural beliefs and practices related to death and dying.
- cultural beliefs and practices related to death and dying among people of the different cultural groups in your community. How can the nurse support the client and family in the performance of death and dying practices?



## RESEARCH CURRENT

## Parent's Report of Child's Response to Sibling's Death in a Neonatal or Pediatric Intensive Care Unit

The purpose of this study by Youngblut and Brooten was to describe parents' reports of children's response to the death of a sibling in a neonatal (10) or pediatric (8) intensive care unit. Qualitative interviews were conducted with 27 parents (19 English-speaking and 8 Spanish-speaking; 5 fathers and 22 mothers) in their homes 7 months after the death of their child. Parents reported their ethnicity/race as Black (48%), Hispanic (37%), or White (15%). There were 44 surviving children: 10 of preschool age (2-5 years), 19 of elementary-school age (6-12 years), and 15 adolescent (13-19 years). Most parents' comments were about their school-age children and adolescents. Six themes emerged based on parents' comments about their children: "changed behaviors" (38%), "not understanding what was going on" (23%), "maintaining a connectedness with sibling" (14%), "not enough time to be with sibling and/or to say goodbye" (9%), "believing that the sibling is in a good place" (9%), and "not believing that the sibling would die" (6%). Examples of changes in sibling behavior

included "not talking, being distant from parents, crying, and avoiding activities/things shared with their sibling." Differences in parents' responses associated with race/ethnicity: White parents made the fewest (8) comments, and half ( $n=4$ , 50%) of those comments were about changes in behavior. Black parents commented most about lack of understanding ( $n=11$ , 31%) followed by changed behaviors ( $n=8$ , 23%) and comments about the sibling being in a good place ( $n=6$ , 17%). Hispanic parents commented about changed behaviors ( $n=12$ , 57%), followed by lack of understanding ( $n=4$ , 19%). Children's responses to the death of a sibling varied by age, race/ethnicity, and the unit where the sibling died. Nurses need to prepare parents for the possible reactions of siblings when a child is critically ill or dies.

*Source:* "Parent's Report of Child's Response to Sibling's Death in a Neonatal or Pediatric Intensive Care Unit," by J. M. Youngblut and D. Brooten, 2013, *American Journal of Critical Care*, 22(6), pp. 474-480.

## Providing Culturally Competent Care

Today providing culturally competent care is an essential component of quality nursing care. The American Academy of Nursing in collaboration with the Transcultural Nursing Society developed Standards of Practice for Culturally Competent Nursing Care. See the box on page 417.

All phases of the nursing process are affected by the client's and the nurse's cultural values, beliefs, and behaviors. As the client and the nurse come together in the nurse-client relationship, a unique cultural environment is created that can influence the client's outcome. Self-awareness of personal biases can enable nurses to modify behaviors or (if they are unable to modify behaviors) to remove themselves from situations where care might be compromised. Nurses can become more aware of their own cultural values through values-clarification activities. Nurses must also consider the cultural values of the healthcare setting because they, too, may influence a client's outcome.

To obtain cultural assessment data, nurses use broad statements and open-ended questions that encourage clients to express themselves fully. The important principle to remember when conducting an assessment is that the nurse is learning about the client, his or her

beliefs, and his or her culture, and that the client is the teacher and expert regarding his or her culture. At this stage nurses make no conclusions but obtain information from clients.

There are several cultural assessment tools available. Spector created the 29-item Heritage Assessment Tool (2013, pp. 376-378) to help determine "how deeply a person identifies with his/her traditional heritage." The tool can be used to assess and understand a person's traditional beliefs and practices about health and illness and to identify appropriate community resources to support the client and his or her family.

Nurses need to use tools that are appropriate to the situation and adapt them as required. For example, a nurse in an emergency department of an urban hospital may need a different format than a nurse working in a home care setting. It is unnecessary to complete a total cultural assessment for every client. Instead, nurses need to collect enough basic data to identify patterns of behavior that may either facilitate or interfere with a nursing strategy or treatment plan.

The process of assessment is critical to understanding the client; cultural assessment is one aspect of a complete client assessment. It is important to remember that a thorough cultural assessment takes time and usually extends over several sessions. A trusting relationship must first be

## Key Concepts from the Standards of Practice for Culturally Competent Nursing Care

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**Standard 1 Social Justice:** Promoting social justice is the domain of all professional nurses.

**Standard 2 Critical Reflection:** Critical reflection on a nurse's personal values, beliefs, and cultural heritage is essential in order to sustain awareness of their impact on culturally congruent nursing care.

**Standard 3 Knowledge of Cultures:** Nurses have a responsibility to understand the cultural diversity of the people and populations for whom they care, revealed through their traditions, values, practices, and family systems.

**Standard 4 Culturally Competent Practice:** Nurses effect culturally congruent nursing through cross-cultural knowledge and cultural sensitivity.

**Standard 5: Cultural Competence in Healthcare Systems and Organizations:** In order to meet the cultural and communication needs of patients, healthcare organizations must create the structure and allocate the resources necessary to evaluate those needs.

**Standard 6: Patient Advocacy and Empowerment:** Recognizing the effect that healthcare policies, delivery systems and the application of resources have on patient populations, nurses' roles include empowering and advocating for their patients in general, and specifically, advocating for their patients' cultural beliefs and practices.

**Standard 7: Multicultural Workforce:** Nurses endeavor to establish and support a multicultural workforce in healthcare settings.

**Standard 8: Education and Training in Culturally Competent Care:** Nurses shall pursue educational goals toward promoting and providing culturally congruent health care.

**Standard 9: Cross-Cultural Communication:** The culturally appropriate application of verbal and nonverbal communication skills to identify patients' values, beliefs, practices, perceptions, and unique healthcare needs are the purview of nurses.

**Standard 10: Cross-Cultural Leadership:** In order to achieve positive outcomes of culturally competent care nurses shall apply their skills and knowledge to influence individuals, groups, and systems where needed.

**Standard 11: Policy Development:** Policy development requires use of skills and knowledge toward influencing public and private organizations, professional associations, and for working within communities in order to establish policies for comprehensive implementation of culturally competent care.

**Standard 12: Evidence-Based Practice and Research:** Nursing practice shall be based on systematically tested interventions that have been shown to be the most effective ones for culturally diverse populations.

established between the client and the nurse before the nurse can expect clients to reveal personal and possibly sensitive information. The nurse must be cognizant of her or his own cultural values and beliefs and how they may affect her or his understanding of the patient. Even when the nurse shares the same ethnic background of the client, the nurse should expect differences in beliefs and values. Assessment includes both observation of the client's behaviors and nonverbal responses and his or her verbal responses to questions. Asking questions about a person's culture requires sensitivity and patience.

Before a cultural assessment begins, the nurse determines what language the client speaks and the client's degree of fluency in the English language. The nurse can also learn about the client's communication patterns and space orientation by observing both verbal and nonverbal communication. For example, does the client speak for himself or herself or defer to another? What nonverbal communication behaviors does the client exhibit, for example, touching or making eye contact? What significance do

these behaviors have for the nurse-client interaction? What is the client's proximity to other people and objects within the environment? How does the client react to the nurse's movement toward the client? What cultural objects within the environment have importance for health promotion/health maintenance?

For the initial cultural assessment, regardless of the approach used, nurses should ask themselves the following questions:

- What does the client think about the nature of the illness or injury? What does the client believe to be its cause? How does the client usually deal with illness or injury? What are the client's expectations about treatment? How can others help?
- What support systems are available to the client? Is support from family, community, or ethnic groups available to the client during and after treatment? Does the client need assistance contacting these individuals?

## Examples of Open-Ended Questions for a Cultural Assessment

### Cultural Affiliation

I am interested in learning about your cultural heritage. Can you tell me about your cultural group, where you were born, and how long you have lived in this country?

### Beliefs About Current Illness

What do you call your problem? What name do you give it? What do you think has caused it? Why did it start when it did? What does your sickness do to your body? How severe is it? What do you fear most about your sickness? What are the chief problems your sickness has caused for you personally, for your family, and at work?

### Healthcare Practices

What kinds of things do you do to maintain health? For example, what types of food do you eat to maintain health? What foods do you eat during illness, and how is food prepared? What other activities do you or your family do to keep people healthy (e.g., wearing amulets, religious or spiritual practices)? How do you know when you are healthy?

### Illness Beliefs and Care Practices

What kinds of things do you do to treat illnesses? Do you use traditional healers (shaman, *curandero*, *sabador*, priest/priestess, *espiritualista*, herbalist, acupuncturist)? Who determines when a person is sick? How would you describe your past experiences with cultural healers and Western health professionals? What special remedies are generally used for the illness you have? What remedies are you currently using (e.g., herbal remedies, potions, massage, wearing of talismans, copper bracelets, or charms)? What remedies have you used in the past, and which did you find helpful? What remedies or treatments are you considering now, and how can we help?

### Family Life and Support System

I would like to learn about your family. Who are the members of your family? What family duties do women and men usually perform in your culture? Whom do you consult when making healthcare decisions (e.g., other family member, cultural or religious leader)? Who will be able to help you during and after treatment? Do you need help to contact these people?

- What strategies does the client use to promote or maintain health, to prevent illness/injury, and to treat existing illness? Are nontraditional healers involved? What remedies or treatments are ongoing or under consideration? What assistance will be needed from the healthcare institution or staff to accommodate a combined approach to a problem?
- What biological and social factors should the nurse consider when planning care? What healthcare risks and individual needs characterize the client's culture? What communication problems might occur?
- What does the client want from traditional medicine? What problems are foreseeable? What decisions can be anticipated? Are there potential conflicts between the client's traditional remedies and the regimen prescribed by the physician? How will these conflicts be resolved? How might any legal or ethical problems be addressed?

As the client answers these questions, the sensitive nurse will identify other concerns and issues that can be queried. Examples of open-ended questions to elicit cultural data are shown in the accompanying box.

To provide culturally congruent care that benefits, satisfies, and is meaningful to the people nurses serve, Leininger (1991, pp. 41–42) conceptualizes three major modes to guide nursing judgments, decisions, and actions:

1. **Cultural care preservation and/or maintenance.**  
The nurse accepts and complies with the client's cultural beliefs. For example, the nurse provides herbal tea to ease a "nervous stomach," a practice the client says has worked well in the past.
2. **Cultural care accommodation and/or negotiation.**  
The nurse plans, negotiates, and accommodates the client's culturally specific food preferences, religious

### CRITICAL THINKING EXERCISE

Interview a client using the open-ended questions in the accompanying box. Observe the client's verbal and non-verbal communication. What nursing interventions will be required to provide culturally competent care to this

client? How will you identify and evaluate the client's response to your interventions? What other family members or significant others will be important in the delivery of culturally competent nursing care to this client?

practices, kinship needs, child care practices, and treatment practices.

3. **Cultural care repatterning or restructuring.** The nurse is knowledgeable about cultural care and develops ways to repattern or restructure nursing care.

Cultural care preservation may involve, for example, encouraging the use of cultural healthcare practices, such as ingesting herbal tea, chicken soup, or hot or cold foods by the ill client. Accommodating the client's viewpoint and negotiating appropriate care require expert communication skills, such as responding empathetically, validating information, and effectively summarizing content. Negotiation is a collaborative process. It acknowledges that the nurse-client relationship is reciprocal and that differences exist between the nurse and client about ideas of health, illness, and treatment. The nurse attempts to bridge the gap between the nurse's (scientific) and the client's (cultural) perspectives. During the negotiation process, the nurse first elicits the client's views and acknowledges these views and then, if appropriate, provides relevant scientific information. If the client's views reveal that certain behaviors would not affect the client's condition adversely, then the nurse incorporates these views in planning care. If the client's views can lead to harmful behaviors, then the nurse attempts to shift the client's perspectives to the scientific view. Negotiation therefore occurs when cultural treatment practices conflict with those of the healthcare system and when the cultural practices are considered harmful to the client's well-being. The nurse must determine precisely how the client is managing the illness, what practices could be harmful, and which practices can be safely combined with Western medicine. For example, reducing dosages of an antihypertensive medication or replacing insulin therapy with herbal measures may be detrimental. In situations where harm may occur, the nurse needs to inform the client about possible outcomes. When a client chooses to follow only cultural practices and refuses all prescribed medical or nursing interventions, the nurse needs to adjust the

client's goals. Monitoring the client's condition to identify changes in his or her health status and recognizing impending crises before they become irreversible may be all that is realistically achievable. At a time of crisis, the nurse may have the opportunity to renegotiate the plan of care with the client. It is important that at no time should the nurse and other healthcare providers impose a plan of care without collaboration and agreement from the client.

Transcultural nursing care is challenging. It requires discovery of the meaning of the client's behavior, flexibility, creativity, and knowledge to adapt nursing interventions to the client's values and beliefs. For example, a culturally sensitive nurse knows that a Chinese woman who has just given birth and refuses to eat fruit and vegetables, refuses to drink the cold water at her bedside, stays in bed, and refuses to take sitz baths, baths, or showers needs to increase the return of yang forces. The nurse will make plans to adapt nursing interventions accordingly.

Nurses also need to identify community resources that are available to assist clients of different cultures. Nurses should try to learn from each transcultural nursing situation they encounter to increase their knowledge and to improve the delivery of culture-specific care to future clients. The accompanying box offers suggestions for providing culturally competent nursing care.

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### Reflect On . . .

- resources (e.g., churches, synagogues, temples, or mosques; civic groups; embassies or consulates) available in your community that will assist healthcare providers in delivering culturally competent care.
  - the value of learning the language of culturally different clients in your community. What resources are available in your community for nurses to learn different languages or phrases related to health care?
- 

## Providing Culturally Competent Care

- 
- Learn the rituals, customs, and practices of the major cultural groups with whom you come into contact. Learn to appreciate the richness of diversity as an asset rather than a hindrance in your practice.
  - Identify your personal biases, attitudes, prejudices, and stereotypes.
  - Incorporate cultural practices into care. Recognize that cultural symbols and practices can often bring a client comfort.
  - Include cultural assessment of the client and family as part of overall assessment.
  - Recognize that it is the client's (or family's) right to make his or her own healthcare choices.
  - Provide the services of a qualified interpreter if one is needed.
  - Convey respect, and cooperate with traditional healers and caregivers.
-



## CRITICAL THINKING EXERCISE

Interview a colleague of a different culture than your own about her or his beliefs and practices related to communication, health and illness care, family and kinship patterns, space orientation, time orientation, nutritional patterns and preferences, pain responses, childbirth

practices, child-rearing practices, and death and dying. How do your colleague's beliefs and practices differ from your own? What did you learn from this interview that would help you provide more culturally competent care to clients of different cultures?

## Chapter Highlights

- North Americans come from a variety of ethnic and cultural backgrounds, and many retain at least some of their traditional values, beliefs, and practices.
- Many people in North America are bicultural; that is, they embrace two cultures—their original ethnic culture and a North American culture.
- Health disparities are particular health differences that are closely linked with social, economic, and/or environmental disadvantage. Health equity is the attainment of the highest level of health for all people.
- Leininger's Sunrise Model emphasizes that health and care are influenced by elements of the social structure, such as technological factors, religious and philosophical factors, kinship and social systems, cultural values, political and legal factors, economic factors, and educational factors.
- Purnell's Model for Cultural Competence builds upon Leininger's model, placing the person within and being influenced by the family, the family within and influenced by the community, and the community within and influenced by the global society. Within the circle of the person are 12 interrelated cultural domains that affect how the person perceives and receives health care.
- Through acculturation people modify some of their traditional cultural beliefs and practices.
- Barriers to cultural competence include ethnocentrism, stereotyping, prejudice, and discrimination.
- Nurses must be aware of their own cultural beliefs as these may influence the care they give.
- Health beliefs and practices, family patterns, communication style, space and time orientations, nutritional patterns, pain responses, perinatal care and childbirth practices, death and dying practices, and ethnicity influence the relationship between a nurse and a client, especially when the client and the nurse are from different cultural backgrounds.
- When assessing a client, the nurse considers the client's cultural values, beliefs, and practices related to health and health care.
- It is the nurse's responsibility to not only be aware of cultural difference but also to integrate and respect the client's culture when providing care.
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care can be used by individuals and organizations as a guide for providing culturally competent care.

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# 22

## Nursing in a Spiritually Diverse World

### Chapter Outline

#### Challenges and Opportunities

#### Concepts Related to Spirituality

Spirituality, Religion, and Faith  
Spiritual Development  
Prayer and Meditation

#### Selected Spiritual and Religious Beliefs Influencing Nursing Care

Holy Days  
Sacred Writings and Symbols  
Dress  
Health Beliefs and Practices  
Childbirth and Perinatal Care

#### Pain, Suffering, and Their Spiritual Meaning

Death and Dying

#### Spiritual Distress

#### Providing Spiritually Competent Care

Spiritual Assessment  
Diagnosing, Planning, and Implementing  
Spiritually Competent Care

#### Chapter Highlights

### Objectives

1. Analyze concepts related to spirituality and religion in nursing and health care.
2. Differentiate between spirituality, religion, and faith.
3. Differentiate between atheism and agnosticism.
4. Describe the spiritual development of the individual across the life span.
5. Describe the relationship between spirituality, prayer, and meditation.
6. Discuss the influence of spiritual beliefs about diet, dress, birth, pain, and death on health and healing practices.
7. Assess clients from a spiritual perspective.
8. Plan and implement spiritually competent care.

A holistic view of persons includes body (physical), mind (mental, emotional), and spirit (soul). This chapter focuses on nurses' roles in providing care for the spirit and distress of the spirit. Nursing has a long history of attending the spirit as part of nursing care. From ancient times through today, nursing has been viewed as a vocation or calling, at times even a spiritual calling. Nurses often were a part of religious orders caring for the physical, mental, and spiritual concerns of their patients. In order to provide that care, nurses needed to care for their own spirit through prayer and religious observance. Today, nurses include assessment of the spirit as part of a comprehensive assessment and implement nursing interventions to help strengthen the client's spirit.

There is great diversity of spiritual and religious beliefs throughout North America and the world; therefore, nurses must be informed about and sensitive to the spiritual and religious influences on the beliefs and practices related to health and illness, particularly of people living in their practice area. Data about religious affiliation in the United States are difficult to obtain as the U.S. Census no longer asks questions regarding religious affiliation. However, a study conducted by the Pew Research Center (2008) provides a listing of the most commonly practiced religions in the United States (Table 22–1). One must understand that there are subgroups within most of the major religious belief systems. For example, within the Protestant grouping, there are evangelical,



**TABLE 22–1 Religious Diversity in the United States, 2008**

| Religion                            | (%)  |
|-------------------------------------|------|
| Protestant                          | 51.3 |
| Evangelical Protestant Churches     | 26.3 |
| Mainline Protestant Churches        | 18.1 |
| Historically Black Churches         | 6.9  |
| Catholic                            | 23.9 |
| Orthodox                            | 0.6  |
| Greek Orthodox                      | 0.3  |
| Russian Orthodox                    | 0.3  |
| Other Christian                     | 0.3  |
| Jehovah's Witnesses                 | 0.7  |
| Jewish                              | 1.7  |
| Reform                              | 0.7  |
| Conservative                        | 0.5  |
| Orthodox                            | <0.3 |
| Mormon                              | 1.7  |
| Buddhist                            | 0.7  |
| Muslim                              | 0.6  |
| Sunni                               | 0.3  |
| Shia                                | 0.3  |
| Hindu                               | 0.4  |
| Other Faiths                        | 1.2  |
| Unitarians and other liberal faiths | 0.7  |
| New Age                             | 0.4  |
| Native American                     | <0.3 |
| Unaffiliated                        | 16.1 |
| Atheist                             | 1.6  |
| Agnostic                            | 2.4  |
| Nothing in particular               | 12.1 |

Source: From U.S. Religious Landscape Survey: Religious Affiliation by the Pew Forum on Religion & Public Life, 2008. Retrieved from [religions.pewforum.org/reports](http://religions.pewforum.org/reports)

mainline, and historically Black churches and religious traditions, and within each of these three groupings, there are more than 20 unique religious traditions. Judaism has Orthodox, Conservative, and Reformed religious traditions, and Islam has Sunni and Shia religious traditions. As the diversity of the United States changes, new Americans bring religious beliefs from their homeland. For example, with increasing numbers of people from India, we see the practice of Jainism and Zoroastrianism in addition

to Hinduism as major religious traditions of India. Nurses should understand how individuals' spiritual beliefs influence their health decision making, providing strength during illness and times of adversity, and how spiritual and faith communities can provide support for health, healing, and dying.

Nurses must also understand how their own spiritual beliefs affect their ability to relate to people whose beliefs are different from their own. Healthcare professionals are not expected to know and understand all spiritual and religious belief systems of the world. It is possible, however, for healthcare professionals to develop an awareness of those spiritual and religious belief systems that are prevalent in the community where they practice.



**InfoQuest:** Access the Pew Forum on Religion and Public Life on the Internet at [religions.pewforum.org/reports](http://religions.pewforum.org/reports). In reviewing this document, what trends do you see regarding religious practice in the United States? How do spiritual and religious beliefs influence people's thinking about healthcare issues such as euthanasia and abortion? What implications do you see for nursing and health care on the basis of the religious makeup of the United States?

## Challenges and Opportunities

The challenges of working in a spiritually diverse environment require nurses to be open to differences in beliefs about health and illness, and to the importance of faith and spiritual beliefs and practices in healing. Establishing trust with people whose spiritual beliefs are different depends on the nurse's willingness to accept difference and to work with the client's different beliefs in achieving a healing relationship. Spiritual beliefs influence clients' beliefs about cause of illness, choice of healers and healing practices, acceptance of treatment recommendations, and response to treatments. Questions about illness and health that are founded in spiritual and religious beliefs include the following: Is illness the result of God's will? Is illness punishment for doing evil? Can prayer heal? Can faith prevent illness/death? What is the relationship between illness and health in religious tradition? How do I resolve differences or conflicts between my spiritual or religious beliefs and practices and medically prescribed therapy? It is important for nurses to respect clients' spiritual beliefs and integrate their beliefs and practices into care as appropriate.

Working with clients of different spiritual beliefs provides nurses with the opportunity to enrich their own lives through an understanding of and appreciation for



the differences of others. Faith-based remedies such as prayer and meditation are increasingly being shown to have an effect on healing. Researchers are examining the effects of prayer and faith on health and healing. New knowledge derived from traditional spiritual and religious beliefs and practices can provide new ways of healing and helping.

## Concepts Related to Spirituality

Spiritual beliefs and religious traditions are an integral part of a person's belief and value system and can influence a client's beliefs about the cause of illness, healing practices, and the choice of healer or healthcare provider. Spiritual and religious beliefs can be a source of strength and comfort for clients experiencing illness, a crisis, or approaching death.

### Spirituality, Religion, and Faith

*Spirituality, religion, and faith*, although often used interchangeably, are different. At the same time, there is a great deal of overlap between the concepts. The nurse must be aware of the differences and similarities in order to understand the depth of feeling that clients have about their beliefs.

#### Spirituality

The word *spiritual* derives from the Latin word *spiritus*, which means “to blow” or “to breathe” (the same word origin for *inspire* and *respiration*), and has come to mean that which gives life or essence to the soul. The Ontario Consultants on Religious Tolerance (2014) provides multiple definitions of spirituality including “activities which renew, lift up, comfort, heal and inspire both ourselves, and those with whom we interact”; “practices to develop an inner life, including meditation, private prayer, yoga meditation, quiet reflection, contemplation”; “belief in a power operating in the universe that is greater than oneself”; and “a sense of interconnectedness with all living creatures, and an awareness of the purpose and meaning of life.” There also are many definitions of spirituality in the nursing literature. Berman and Snyder (2012) define spirituality as the “belief in or relationship with some higher power, creative force, driving being, or infinite source of energy” (p. 1571). Mauk and Schmidt (2004) define spirituality as “the core of a person's being, involving one's relationship with God or a higher power” (p. 15). Spector (2012) describes spirituality as “the experience of meaning and unity” (p. 361), and Andrews and Boyle (2012) add that spirituality includes “a broad sense of the inner experience of the self and a search for meaning” (p. 270). According to O'Brien (2014), spirituality includes “love, compassion, caring, transcendence, relationship with God, and connection of body, mind, and spirit” (p. 6). Buck (2006),

through a concept analysis of the research on spirituality, provides a more inclusive definition of spirituality in nursing: “that most human of experiences that seeks to transcend self and find meaning and purpose through connectedness with others, nature, and/or a Supreme Being, which may or may not involve religious structures or traditions” (p. 288). Spirituality is the belief in and relationship and interconnectedness with a higher power, creative force, divine being, or infinite source of energy.

There are different ways in which people express or experience their spirituality. Some express their spirituality through the practice of a particular religion, whereas others express their spirituality outside specific organized religious systems. An example of spirituality outside an organized religious system is the Native American traditional belief system. According to Lowe and Struthers (2001, p. 282), the Native American concept of spirituality includes the five characteristics of relationship, unity, honor, balance, and healing. The spiritual components of relationship are touching, learning, and using cultural traditions in all relationships. A second Native American cultural concept related to spirituality is connectedness and includes the connectedness with all others, with the environment, and with the Creator (Lowe & Struthers, 2001, p. 281). Still others express their spirituality through the blending of different religious and philosophical traditions. Burkhardt (1993) tells us that spirituality helps one:

- Deal with the unknown or uncertainties in life.
- Find meaning and purpose in life.
- Be aware of and able to use inner resources and strength.
- Have a feeling of inner connectedness with oneself, others, the environment, and with a Supreme Being.

“The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and especially comes into focus or sustaining power when the person faces emotional stress, physical illness, or death. It goes outside a person's own power” (Murray & Zentner, 2009, p. 182). “Stressful events can shatter individuals' spiritual center or conversely can move individuals to seek comfort in spiritual or religious practice, beliefs, or community” (Horowitz, 2014, p. 301). Characteristics of spirituality are listed in the accompanying box.



**InfoQuest:** Explore the Internet to find information about spirituality and health. One site you may want to access is the National Center for Complementary and Alternative Medicine; search the site for research and publications related to spirituality, faith, and health.

## Characteristics of Spirituality

### Personal Connectedness

- Awareness and acceptance of self (self-esteem, self-knowledge)
- Ability for self-reflection
- Inner strength
- Attitude of trust, optimism

### Connectedness to Others

- Sharing self with others in a caring relationship
  - Caring for family (children, parents, siblings, extended family)
  - Caring for friends
  - Caring for others
- Sharing knowledge and resources

### Connectedness to the Environment

- Feeling of harmony with the environment
- Respect for nature
- Protection of the environment

### Connectedness to a Supreme Being

- Feelings of belief and faith
- Religious or nonreligious belief
- Prayer and/or meditation
- Use of religious articles (symbols, sacred writings)
- Participation in religious/spiritual rituals

## Religion

There are many definitions of religion and not all are in agreement. A **religion** might be defined as an organized collection or set of beliefs (and this may include cultural systems and worldviews) concerning the cause, nature, and purpose of the universe. It may consider the belief in and worship of a Supreme Being (e.g., God, Yahweh, Allah, the Creator) or multiple gods. It may focus on the belief in that Supreme Being(s) and at the same time may refer to the system of ceremonies and rules used to worship. In nursing,

religion has been defined by Burkhardt and Nagai-Jacobson (2013) as “an organized system of beliefs regarding the cause, purpose, and nature of the universe that is shared by a group, and the practices, behaviors, worship, and ritual associated with that system” (p. 721). Spector’s (2013, p. 361) definition of religion—“belief in a divine or superhuman power or powers to be obeyed and worshipped as the creator(s) and ruler(s) of the universe”—avoids the characterization of religion as being organized and focuses on the relationship between the person and a greater being.

## RESEARCH CURRENT

### A Qualitative Metasynthesis of Spirituality from a Caring Science Perspective

The purpose of this study by Rykkje, Eriksson, and Raholm was to get a deeper understanding of the concept of spirituality from a caring science perspective. The theoretical framework for the study was Katie Eriksson’s Theory of Caritative Caring, which includes concepts of health and suffering, and caring as a “communion where human being’s dignity comprises the fundamental worth.” Using a hermeneutic approach, the investigators analyzed and synthesized 17 research articles identified through a search of literature databases using the terms *spiritual* or *spirituality* combined with *care* or *caring*. Searches also looked for quantitative and qualitative research studies along with other key terms related to methods such as hermeneutic, grounded theory, and ethnonursing. To explore the most current thinking, investigators limited their search to publications between 2000 and 2010. Categories that emerged from the analysis included (1) connectedness with inner space, which is the center of spirituality and overlaps (2) connectedness

with a higher power, (3) connectedness with community, (4) connectedness with others, and (5) connectedness with nature. The investigators frame “love in connectedness” as an ontological core category “concerning the presence of a transcendent or universal love,” which is seen as “a power and potential health resource.” Love is “the glue that works between the categories enabling the individual to form durable connections.” Spirituality is seen as love in action, and such love is present in caring relationships of compassion and concern. The investigators state, “To care for the patient’s spirit is important to maintain human dignity and, as such, it is an ethical obligation.” Spiritual care may include fostering the connectedness with others or to ask about and provide for spiritual needs, to show compassion, and by being present with the patient.

Source: “A Qualitative Metasynthesis of Spirituality From a Caring Science Perspective,” by L. Rykkje, K. Eriksson, and M. Raholm, 2011, *International Journal for Human Caring*, 15(4), pp. 40–53.

## RESEARCH CURRENT

## Spirituality, Self-Efficacy, and Quality of Life Among Adults with Sickle Cell Disease

The purpose of this study by Maxine Adegbola was to explore the relationships among spirituality, self-efficacy, and quality of life (QOL) in adults with sickle cell disease. Adegbola defines spirituality as the “synthesis of personal beliefs about the essence of being that balances and connects other dimensions and domains of human traits and health” and defines self-efficacy as the “belief in one’s ability to execute a course of action for a required task pertaining to day to day symptom and disease management.” The sample consisted of 90 individuals with sickle cell disease, 67 female and 23 male. Instruments used to measure the constructs were the Functional Assessment of Chronic Illness Therapy—Spiritual, a 12-item measure of spirituality; the Sickle Cell Self-Efficacy Scale, a 9-item disease-specific instrument that measures the individual’s self-efficacy and ability to function and manage sickle cell

disease symptoms on a day-to-day basis; and the Functional Assessment of Cancer Therapy, a measure of quality of life. The results indicate that adults with sickle cell disease report strong, positive relationships between spirituality and quality of life, self-efficacy and quality of life, and self-efficacy and spirituality. This study supports the inclusion of spiritual assessment as a component of the assessment of clients with sickle cell disease. It may also suggest the benefit of including spiritual assessment in the health assessment of clients with other chronic diseases. Including spiritual assessment and intervention for clients with sickle cell disease may improve self-efficacy and quality of life.

Source: “Spirituality, Self-Efficacy, and Quality of Life Among Adults with Sickle Cell Disease,” by M. Adegbola, 2011, *Southern Online Journal of Nursing Research*, 11(1).

However it is defined, religion provides a way of spiritual expression that guides people in responding to life’s questions, concerns, and crises. Organized religious systems provide:

- A sense of community for members that is bound by common beliefs, rituals and traditions.
- The study of scripture (the Bible, Torah, Koran, or others) as direction for faith and living.
- The performance of rituals that reinforce faith and provide support in crises.
- The use of disciplines and practice, commandments, and sacraments to guide living.
- Direction for taking care of one’s soul (such as fasting, prayer, confession, and meditation).

Many traditional religious practices and rituals are related to life events such as birth, transition from childhood to adulthood, marriage, illness, and death. Religious rules of conduct, like cultural beliefs, may also apply to matters of daily life such as dress, food, social interaction, and sexual relationships. Religious development of an individual refers to the acceptance of specific beliefs, values, rules of conduct, and rituals. Religious development may or may not parallel spiritual development. For example, a person may follow certain religious practices yet not internalize the symbolic meaning behind the practices. Conversely, a person can have an internalized religious belief system but not participate in the outward manifestations of religious practice (e.g., attend religious services, participate in organized rituals of the religion such as fasting or confession).

### Faith

Faith is “deeper and more personal than organized religion. . . . [It relates] to one’s transcendent values and relationship with a higher power, or God” (O’Brien, 2014, p. 58). Faith is belief in something that cannot be directly observed (Mauk & Schmidt, 2004). Faith is about expectation or hope, conviction and devotion. A person who has faith in a Supreme Being (God, Allah, Jehovah, etc.) has certain expectations of that Supreme Being; for example, a person may have faith that the Supreme Being will heal him or her or provide the strength to cope with pain or illness.

### Atheism and Agnosticism

Nurses must also provide care for those who don’t believe in or doubt the existence of a Supreme Being. An *atheist* is one who believes that there is no Supreme Being. An *atheist* believes that the concept of a god or many gods or supernatural beings was created by humans. An *agnostic* is one who believes that there is no evidence or proof of the existence of a Supreme Being and therefore doubts and is unsure that such a Supreme Being exists. Atheists and agnostics may believe in a connectedness with one’s inner self (e.g., consciousness, conscience, self-awareness), with others (e.g., love, respect), and/or with nature (e.g., respect, wonder), and therefore care must be provided within the context of the person’s inner spirit.

### Spiritual Development

Spiritual development is also referred to as *faith development* and *spiritual formation*. As with other types of growth and

**TABLE 22–2 Westerhoff’s Four Stages of Faith**

| Stage             | Age                               | Behavior                                                                                                                               |
|-------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| Experienced faith | Infancy through early adolescence | Experiences faith through interaction with others (family, friends, faith leaders) who are living a particular faith tradition.        |
| Affiliative faith | Late adolescence                  | Participates in activities that characterize a particular faith tradition; experiences awe and wonderment; feels a sense of belonging. |
| Searching faith   | Young adulthood                   | Through a process of questioning and doubting own faith, acquires a cognitive as well as an affective faith.                           |
| Owned faith       | Middle adulthood through old age  | Puts faith into personal and social action and is willing to stand up for beliefs even against the nurturing community.                |

Source: Adapted from *Will Our Children Have Faith?* by J. Westerhoff, 1976, New York, NY: Seabury Press (pp. 79–103).

development, spiritual or faith development occurs in a linear fashion, and a person can be in more than one stage at a time. The works of Westerhoff (1976) and Fowler (1981) serve as the foundation of our understanding of spiritual development. Westerhoff describes four stages of faith: experienced faith, affiliative faith, searching faith, and

owned faith. Fowler describes seven stages of faith development that parallel the developmental stages described by Jean Piaget (cognitive development), Lawrence Kohlberg (moral development), and Erik Erikson (socioemotional development). Tables 22–2 and 22–3 present Westerhoff’s and Fowler’s stages of faith development.

**TABLE 22–3 Fowler’s Stages of Faith Development**

| Stage                      | Description                                                                                 | Developmental Tasks                                                                                                                                                                                                                                                                              |
|----------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Infancy                    | Primal Faith—original or primitive faith                                                    | <ul style="list-style-type: none"> <li>• Separation without anxiety, developing trusting relationships</li> <li>• Consistent, loving, respectful responses from parents/caregivers/nurturers</li> </ul>                                                                                          |
| Early Childhood            | Intuitive Faith—without conscious reasoning<br>Projective Faith—impulsive                   | <ul style="list-style-type: none"> <li>• Listening and reacting to spiritual stories, songs, religious rituals and celebrations</li> </ul>                                                                                                                                                       |
| Childhood and Beyond       | Mythic Faith—imaged<br>Literal Faith—realistic, factual                                     | <ul style="list-style-type: none"> <li>• Development of concrete images of a Supreme Being, heaven, and hell</li> <li>• Adherence to scripture-based codes of behavior</li> <li>• Acceptance that scriptures are truth</li> </ul>                                                                |
| Adolescence and Beyond     | Synthetic Faith—composed<br>Conventional Faith—ordinary and commonplace, generally accepted | <ul style="list-style-type: none"> <li>• Talking with others about the meaning of faith or spirituality</li> <li>• Believing that the Supreme Being is the only one who really knows them</li> </ul>                                                                                             |
| Young Adulthood and Beyond | Individuative Faith—unique, independent, distinct                                           | <ul style="list-style-type: none"> <li>• Questioning the existence of a Supreme Being</li> <li>• Struggling with faith</li> <li>• Developing an intimacy with or a withdrawal from faith</li> </ul>                                                                                              |
| Early Midlife and Beyond   | Conjunctive Faith—connected                                                                 | <ul style="list-style-type: none"> <li>• Discussions of early midlife in relation to faith</li> <li>• Discussions of ecumenicism and religious diversity/pluralism</li> </ul>                                                                                                                    |
| Midlife and Beyond         | Universalizing Faith—holistic                                                               | <ul style="list-style-type: none"> <li>• Prayers of contemplation and meditation</li> <li>• Serving in social ministries, such as soup kitchens, food pantries, hospices, or prison ministries</li> <li>• Living a lifestyle that places faith as the basis and framework for living.</li> </ul> |

Source: Adapted from *Spiritual Care in Nursing Practice*, by K. L. Mauk and N. K. Schmidt, 2004, Philadelphia, PA: Lippincott Williams & Wilkins; *Stages of Faith Development: The Psychology of Human Development and the Quest for Meaning*, by J. W. Fowler, 1981, New York, NY: Harper & Row.



Prayer and Meditation

Prayer is a communication with or petition to a Supreme Being in word or thought. Meditation is an internal reflection or contemplation. Prayer and meditation are part of most religions. Depending on the specific religion, prayer is a communication with God, Jehovah, Allah, or some other Supreme Being. In some religions, prayers may be channeled through another; for example, Catholics may pray to God through a saint or the Virgin Mary. Prayers may be a petition or request (e.g., cure from illness or relief from pain), a thanksgiving (e.g., for healing), or a spiritual communion (e.g., to find peace or acceptance). A prayer can include thanksgiving for blessings received and a petition for a need (e.g., relief from physical or emotional suffering). Dossey (1993) identifies seven forms of prayer that may be used when someone is ill (Table 22–4). Some religions have formal prayers that are printed in a prayer book, such as the Anglican or Episcopal Book of Common Prayer or the Catholic Missal. Some religious prayers are attributed to the source of faith; for example, the Lord’s Prayer is attributed to Jesus, and the first *sura* for Muslims is attributed to Muhammad.

Daily prayers are prescribed by some religions. For example, Muslims perform the five daily prayers, or *Salat*, while facing toward Mecca, at dawn, noon, mid-afternoon, sunset, and evening. Jews may say the *Kaddish* daily for the first year after the death of a loved one. People who are ill may want to continue their prayer practices. Clients may

even increase their prayer and meditation practices in response to illness. People may memorize prayers during childhood, and their repetition becomes a source of comfort during illness or adversity.

Clients may need uninterrupted quiet time or want to have their sacred writings, books of daily meditations, prayer books, rosaries, prayer beads, or other sacred symbols readily available to them at the side of their bed or chair. Some clients may want their minister, priest, rabbi, imam, or other spiritual adviser with them when they pray. There may be times when the patient asks the nurse or physician to pray with him or her.

“Meditation is a mind and body practice. There are many types of meditation, most of which originated in ancient religious and spiritual traditions. Some forms of meditation instruct the practitioner to become mindful of thoughts, feelings, and sensations and to observe them in a nonjudgmental way” (National Center for Complementary and Alternative Medicine, 2014). Berman and Snyder (2012) describe **meditation** as the “act of focusing one’s thoughts or engaging in self-reflection or contemplation” (p. 1063). Some religions encourage meditation for individuals to reflect on their relationship or connectedness to their inner self, to others, to nature, to the universe, or to a Supreme Being. Meditation can also provide relaxation from stress and renewed energy. Some believe that through meditation, one can control physiological and psychological functioning. For example, some will use meditation to manage pain either alone or as an adjunct to pain medication.

TABLE 22–4 Types of Prayer

|                                          |                                                 |
|------------------------------------------|-------------------------------------------------|
| <b>Prayers of Supplication or Asking</b> |                                                 |
| Petition                                 | Asking something for oneself                    |
| Intercession                             | Asking something for another                    |
| Confession                               | Repentance of wrongdoing and asking forgiveness |
| Lamentation                              | Crying in distress and asking for vindication   |
| <b>Prayers of Giving</b>                 |                                                 |
| Thanksgiving                             | Offering gratitude                              |
| Adoration                                | Giving honor and praise                         |
| <b>Prayer of Calling</b>                 |                                                 |
| Invocation                               | Summoning the presence of the Supreme Being     |

Source: Adapted from *Healing Words: The Power of Prayer and the Practice of Medicine*, by L. Dossey, 1993, San Francisco, CA: Harper (p. 5).

Reflect On . . .

- your own spiritual and religious beliefs and traditions. How do they affect your beliefs about health and illness? How important would it be for you to be able to practice your spiritual and religious traditions if you were ill?
- your comfort with patients/clients who ask you to pray with them or for them. How would you respond to patients or clients who ask you to pray with them? Do you think that nurses should pray with patients and/or their families when requested to do so?
- the various spiritual and religious groups in your community. Is religious difference valued? Where could you go to learn more about the religious groups in your community? In what ways could you as a professional nurse support the spiritual and religious practices of your clients?

## RESEARCH CURRENT

## Responses to Mantram Repetition Program from Veterans with Posttraumatic Stress Disorder: A Qualitative Analysis

The purpose of the study by Bormann, Hurst, and Kelly was to identify types of situations where and ways that mantram repetition could be used to manage symptoms of posttraumatic stress disorder (PTSD) in U.S. military veterans. A mantram is the repeating of a “sacred word” with the focus on slowing down one’s thoughts and practicing one-pointed attention, concentrating on the mantram with awareness. Mantram is “a portable, meditation-like, mind-body-spiritual technique that transcends cultures and religious beliefs.” Veterans in the Mantram Repetition Program (MRP) are taught to repeat a mantram “silently and frequently throughout the day during nonstressful times so that it can be habitually employed to regulate emotions during triggering events.” Of the 146 veterans who participated in the study, 75 received usual care and 71 received usual care plus the MRP. The MRP consisted of six weekly 90-minute sessions that covered how to “(1) choose and use a mantram, (2) practice slowing down one’s thinking process, and (3) develop one-pointed attention to manage stress.” Slowing down both cognitively and behaviorally, making wiser choices, setting new priorities, and noticing hurried behavior were part of slowing down one’s thinking process. The purpose of one-pointed attention was to increase the individual’s ability to repeat the mantram and engage in or focus on one thing at a time. This study analyzed the qualitative data from the study group that received usual care plus the MRP. From the original group of 71 veterans, 65 participated in the follow-up study. Data were obtained from interviews with the participants that were audiotaped, transcribed, and coded to identify and categorize the number of stressful incidents reported and how the participants responded to

those incidents. There were 268 triggering events identified by the 65 participants that were categorized as (1) social interactions, (2) driving, (3) sleep disturbances, (4) interpersonal relationships, (5) reminiscence, (6) environmental sounds, (7) health problems, (8) personal issues, (9) media violence, (10) dealing with death, and (11) VA group discussions. The greatest number of triggering events fell into the social interaction category and included waiting for service, difficulty or discomfort in a crowd, and conflicts with others. The next largest number of triggering events occurred during driving and included traffic congestion, rude drivers and road rage. Participants’ responses to the triggering events included symptoms of reexperiencing, avoidance, hyperarousal, depression, survivor guilt, and physical pain. Sixty (92%) of the participants reported using mantram repetition effectively to achieve one or more of the following outcomes: relaxing and calming down; letting go of negative feelings such as anger, anxiety, panic, and fear; thinking clearly and rationally; diverting attention away from triggering events; focusing attention; refining mantram skills; dealing with sleep disturbances; coming back from flashbacks; slowing down; feeling in touch spiritually; and letting go of physical pain and controlling blood pressure. The researchers suggest that mantram repetition and building spiritual strength may be “valuable alternatives and serve as an adjunctive support for veterans” experiencing PTSD or other mental illness.

*Source:* “Responses to Mantram Repetition Program from Veterans With Posttraumatic Stress Disorder: A Qualitative Analysis, by J. E. Bormann, S. Hurst, and A. Kelly, 2013, *Journal of Rehabilitation Research and Development*, 50(6), pp. 769–784.



**InfoQuest:** Explore the Internet for information about prayer, meditation, and healing. The National Center for Complementary and Alternative Medicine, [www.nccam.nih.gov](http://www.nccam.nih.gov), is one site that provides research results related to meditation and healing.

## Selected Spiritual and Religious Beliefs Influencing Nursing Care

This section discusses some selected spiritual phenomena of significance to nursing. Nurses should be aware of holy days, sacred writings and symbols, religious and cultural beliefs about dress, and spiritual beliefs and practices as

they relate to health and nursing care of people of the predominant religious groups in their community.

### Holy Days

A holy day is a day set aside for special religious observance. In addition to special holy days observed throughout the year, most religions have a weekly day set aside for rest, prayer, reading of sacred writings, and worship. Most Christians observe the Sabbath Day on Sunday as a day of rest and worship in remembrance of Christ’s resurrection. Other Christian religious groups observe Saturday as the Sabbath. Jews observe the time from sundown on Friday until sundown on Saturday as a holy day of rest and worship in commemoration of the final day of Creation and observance of the biblical injunction to “remember the

Sabbath day and keep it holy.” Muslims observe Friday as a day of meditation and worship.

Holy days also can be special days of celebration and feasting that occur once a year, such as the Christian celebrations of Christmas, which celebrates the birth of Christ, and Easter, the observance of the death and resurrection of Christ. The Jewish celebrations of Sukkoth, the Feast of Tabernacles, celebrates the end of the harvest, and Pass-over commemorates God’s protection of the first-born children of the Israelites and their exodus from Egypt. The Eid al Fitr celebrates the end of the month of Ramadan in the Muslim religion. Solemn religious observances throughout the year may be referred to as high holy days and may require fasting, reflection, and prayer. Examples of such holy days are Good Friday, the day of Christ’s crucifixion, in the Christian religion. In the Jewish religion, Rosh Hashanah, also called the Day of Judgment or Day of Remembrance, is the start of the Jewish New Year. Rosh Hashanah begins a 10-day period that culminates in Yom Kippur, or Day of Atonement, a day of fasting and purification. In the Muslim religion, Ramadan is the month-long observance of daylight fasting and meditation that ends with Lailat Al-Qadr, a commemoration of the revelation of the Quran (Koran) to the Prophet Muhammad, and the Eid al Fitr, or the breaking of the month-long fast.

Many religions require fasting, extended prayer, and reflection or ritual observances on sacred days; however, believers who are seriously ill are often exempted from such requirements. Many hospitals and health organizations facilitate ritual observances for patients, clients, and staff on religious holy days. For example, a hospital may provide kosher meals for Jewish patients or provide fish or other nonmeat entrée on Fridays for Catholic patients who still practice the latter requirement. Because many religions, such as the Jewish, Muslim, and Hindu faiths, follow a calendar of religious observances different from the Gregorian calendar, a calendar that lists the holy days of the major religions is useful in anticipating patients’ spiritual needs.

## Sacred Writings and Symbols

Sacred writings or scriptures are believed to be the thought or word of the Supreme Being and are held to have been written by that deity’s appointed disciples or prophets. Each religion has its sacred writings that tell the stories of the religion’s leaders, kings, and heroes, such as the stories of Abraham and Solomon in both Jewish and Christian Scriptures. Sacred writings also contain rules or commandments or other guidelines for living. For example, dietary laws of the Jewish religion are contained in the Torah, and literal interpretations of the Bible provide guidelines for relationships, health and hygiene, and dress. Religious

laws or commandments are often used as the basis for secular law, such as those derived from the Ten Commandments contained in the Old Testament of the Bible, which forbid killing, stealing, adultery, and so on. Religious interpretations of these laws often provide the foundations for ethical debates about abortion and euthanasia.

Religious law may affect a client’s willingness to accept treatment suggestions. For example, blood transfusions are in conflict with the religious teachings of Jehovah’s Witnesses.

People who are ill or in distress often gain comfort and hope from reading religious writings. Examples of sacred stories that may give comfort to patients are Job’s suffering in the Jewish and Christian scriptures and Jesus healing people who were physically or mentally ill in the New Testament of the Bible.

Symbols of religious belief include jewelry, medals, amulets, icons, totems, or body ornamentation (e.g., tattoos) that hold religious or spiritual significance. They may be worn as an assertion of one’s faith, to provide protection, or as a source of comfort or strength. People may wear religious medals at all times, and they may wish to wear them when undergoing diagnostic studies, medical treatment, or surgery. A Catholic may carry a rosary for prayer, a Muslim may carry prayer beads, and a Buddhist may use prayer beads (*mala*) during meditation.

Other religious symbols are pictures or statues of saints or religious prophets. They may be found in the believer’s home, car, or workplace as a reminder of his or her faith. Some people may have personal altars in their homes that include icons, candles, incense, or other articles of faith. Patients in hospitals or residents of long-term care facilities may want to have their spiritual symbols at their bedside as an expression of faith and a source of comfort.

## Dress

Many religions have laws or traditions that dictate dress. For example, Orthodox and Conservative Jewish men believe that it is important to have their head covered at all times and therefore wear a yarmulke. Orthodox Jewish women may wear a wig or scarf to cover their hair as a sign of respect to God. Muslim men wear a head covering during prayer and may wear head coverings at all times. Muslim women may wear a hijab or headscarf that fully covers the hair. In strict Muslim countries, women may wear the *chador*, a body-enveloping robe. While people in Western countries often view the *chador* as a sign of women’s oppression, many Muslim women feel that the *chador* protects them.

Some religions (e.g., Seventh Day Adventist, Mormon) require that women dress in a conservative manner. These religions may have restrictions against wearing sleeveless

or low-cut tops and skirts that are above the knees. Clients who are trying to comply with religious rules about dress may feel uncomfortable about wearing or refuse to wear hospital gowns.

## Health Beliefs and Practices

Andrews and Boyle (2012, pp. 75–77) describe the magicoreligious, the biomedical, and the holistic health belief systems. Both the magicoreligious and holistic health belief systems have spiritual and religious connotations to consider. In the magicoreligious health belief view, health and illness are controlled by supernatural forces. The client may believe that illness is the result of “being bad” or opposing God’s will. For example, the diagnosis of cancer may be considered a punishment from God, as expressed by the patient’s statement, “What did I do wrong that God is punishing me this way?” Getting well also may be viewed as dependent on God’s will. The client may make statements such as “Only through God’s will can I recover” or “If it is God’s will, I will get well.”

Some cultures believe that magic can cause illness. A sorcerer or witch may put a spell or hex on the client. Some people view illness, particularly mental illness, as possession by an evil spirit. Although these beliefs are not supported by empirical evidence, clients who believe that such things can cause illness may, in fact, become ill as a result. Such illnesses may require magical treatments in addition to scientific treatments for healing to occur. For example, a man who experiences gastric distress, headaches, and hypertension after being told that a spell has been placed on him may recover only if he believes that the spell has been removed by an appropriate spiritual healer.

The holistic health belief view is based on the spiritual belief systems of many cultures and holds that the forces of nature must be maintained in balance or harmony. Human life is one aspect of nature that must be in harmony with the rest of nature. When one’s natural balance or harmony is disturbed, illness results. The medicine wheel is an ancient symbol used by Native Americans of North and South America to express many concepts associated with humans’ inner and external relationships with others, the environment, and the Creator. Related to health and wellness, the medicine wheel teaches the four aspects of the individual’s nature: the physical, the mental, the emotional, and the spiritual. Each of the dimensions must be in balance to be healthy. The medicine wheel can also be used to express the individual’s relationship with the environment and the Creator as a dimension of wellness.

Spector (2013, p. 136) describes four types of healing that involve spiritual and/or religious belief: spiritual healing, inner healing, physical healing, and deliverance or exorcism. *Spiritual healing* occurs through repentance

for personal sin that results in suffering. When the person repents, natural healing occurs. *Inner healing* is used when one is suffering from emotional or mental illness. Inner healing attempts to heal the person’s conscious or unconscious mind. *Physical healing* occurs when one has some form of bodily damage. “Laying on of hands” is often incorporated into physical healing. *Deliverance* or exorcism is used to be set free from (deliver) or drive out/rid (exorcise) the evil that affects the person’s body or mind.

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## Reflect On . . .

- your own beliefs about causes of illness and healing. How do your own spiritual or religious beliefs influence your beliefs about cause of illness? How do your own spiritual or religious beliefs influence your beliefs about healing? Is there conflict between your various beliefs? If yes, how do you manage the conflict?
  - patients’ expressions of spiritual or religious causes for their illness and healing. What are your thoughts or feelings regarding these beliefs?
  - how you might support a client’s spiritual or religious beliefs and provide quality nursing care.
- 

## Dietary Beliefs

Religious beliefs may also dictate dietary practices. Examples of religions that have specific beliefs or laws about diet include Judaism, Islam, Hinduism, and Christianity.

Orthodox Jews observe a kosher diet. **Kosher** means that food is considered clean according to Jewish law. Meat and dairy products must not be eaten at the same meal. If meat is eaten, then bread cannot be buttered and milk or cream cannot be served with tea or coffee. Some meats and fish are prohibited in a kosher diet; for example, lamb, beef, and chicken can be eaten but pork and shellfish are forbidden. Strict observers of Jewish dietary laws require that their meat be slaughtered according to religious tradition. Some Orthodox families will maintain two sets of cooking utensils and china in order to strictly observe the prohibition of mixing meat and dairy. Jews of Conservative and Reformed Judaism may vary in their observance of dietary laws. Fasting is required during the High Holy Days of Rosh Hashanah and Yom Kippur. People who are ill are usually excused from fasting requirements. Many hospitals and long-term-care facilities will provide kosher meals for patients who observe Jewish dietary laws.

Islamic (Muslim) dietary practices forbid the eating of pork or any meat of the pig. Animals that are being killed



for food must be slaughtered according to religious law. The ingestion of alcohol is strictly forbidden. Fasting is required during daylight hours for the entire month of Ramadan.

Some religious traditions require a vegetarian diet. For example, people who practice Hinduism, Buddhism, and Jainism are predominantly vegetarian.

Christian belief systems vary widely in their dietary requirements. Many people who are Roman Catholic abstain from meat on certain days, such as Ash Wednesday and Good Friday. Some Christian religions encourage fasting on Ash Wednesday and Good Friday or before attending weekly services. Other Christian religions encourage fasting as a way of cleansing the body. Several Christian religions discourage or even prohibit the ingestion of alcohol, others discourage the ingestion of caffeine, and some discourage the ingestion of meat.

It is important for nurses to determine the dietary requirements of their patients and clients and convey dietary preferences to the dietitian for hospitalized patients or residents of long-term-care facilities. When providing health teaching related to diet, religious requirements must be considered and supported. The nurse will need to ensure that clients' nutritional needs are met within the context of their religious dietary requirements.

## Childbirth and Perinatal Care

Religious and spiritual beliefs may provide guidance for the management of life events such as the birth of a baby. Christian religions that practice baptism during infancy believe that the infant is born with sin and must be baptized in order to go to heaven. Because of this belief, the infant who is in danger of dying at birth must be baptized shortly after birth. Although it is acceptable for the nurse or other healthcare provider to baptize an infant with the parents' permission if the infant is at risk for dying, it is preferable for the family's priest or minister to perform this ritual.

In the Jewish tradition, circumcision is a religious rite performed by a mohel (a Jewish person trained in the practice of Brit Milah, or the covenant of circumcision, on the male child 8 days after birth. When the boy is circumcised, he receives his Hebrew name. This name will be used at his bar mitzvah, at his wedding, and on his gravestone.

Muslims may wish that the first sound the newborn baby hears is the call to prayer, which is whispered in each ear. The call to prayer is "Allah is most great. I testify that there is no God but Allah. I testify that Muhammad is the prophet of Allah. Come to prayer. Come to salvation. Allah is most great. There is no God but Allah." Muslim boys must be circumcised between the ages of 7 days and 12 years.

## Pain, Suffering, and Their Spiritual Meaning

Beliefs about and responses to pain vary among people. Spiritual or religious beliefs about pain and suffering must be considered in relation to both the actual perception of pain and the meaning or significance of pain and suffering to the client and family. Some patients may consider pain and suffering are punishments for bad deeds; therefore, the individual is expected to tolerate pain and suffering without complaint in order to atone for sins. People may also use their faith to help manage their pain and suffering through prayer and meditation. Spiritual or religious practices that relieve pain and suffering, such as meditation, should be supported and encouraged, while at the same time the nurse offers medication and other nonpharmacological remedies to alleviate pain and suffering.

## Death and Dying

Religious and spiritual beliefs may also prescribe the care of patients immediately before death, at the time of death, and during the period after death. Beliefs about preparation of the body, autopsy, organ donation, cremation, and prolonging life are closely associated with a person's religious beliefs. Autopsy, for example, may be prohibited, opposed, or discouraged by Eastern Orthodox religions, Muslims, Jehovah's Witnesses, and Orthodox Jews. Some religions prohibit the removal of body parts and dictate that all body parts be given appropriate burial. Organ donation is prohibited by Jehovah's Witnesses and Muslims, whereas Buddhists in America consider it an act of mercy and encourage it. Cremation is discouraged, opposed, or prohibited by the Mormon, Eastern Orthodox, Islamic, and Jewish faiths. Hindus, in contrast, prefer cremation and cast the ashes in a holy river. Prolongation of life is generally encouraged; however, some religions, such as Christian Science, are unlikely to use medical means to prolong life, and the Jewish faith generally opposes prolonging life after irreversible brain damage. In hopeless illness, Buddhists may permit euthanasia.

Nurses also need to be knowledgeable about the client's death-related rituals, such as administration of the Sacrament of the Sick (formerly referred to as Last Rites) and Holy Communion, prayer and chanting at the bedside, and other rituals, such as special procedures for washing, dressing, positioning, and shrouding the dead person. In some religions, family members of the same sex and religion wash and prepare the body for burial and cremation.

Jews may want to speak the Shema or have it said for them at the time of their death. The Shema is a prayer of praise learned by Jews in childhood: "Hear, O Israel, the

Lord our God is one Lord. . . .” Autopsy is discouraged. When autopsy is warranted, it must be limited to essential organs or systems, and all body parts must be buried together.

Muslims believe that their deaths are predetermined by Allah, and therefore death should not be feared. The body is ritually washed and wrapped in a linen shroud. Autopsy is permitted only for medical or legal purposes.

Nurses need to ask family members about their preferences and verify who will carry out these activities. Burial clothes and other cultural or religious items are often important symbols after death and for funeral observances. For example, faithful Mormons are often dressed in their “temple clothes.” Some Native Americans may be dressed in elaborate apparel and jewelry and wrapped in new blankets with money. The nurse must ensure that any ritual items present in the healthcare agency are given to the family or to the funeral home.

### Reflect On . . .

- spiritual or religious beliefs and practices related to death and dying among people of the different spiritual or religious groups in your community. How can the nurse support the client and family in the performance of death and dying prayers and rituals?



**InfoQuest:** There are many sites on the Internet that explore the religious belief systems of the world. Using the criteria for evaluating websites, search the Internet to find information about religions that are practiced in your community, the nation, and the world (e.g., Christianity, Hinduism, Islam, Judaism, Shintoism). What religious beliefs may influence your practice as a nurse and your relationship with clients of different religions? How will you accommodate these various beliefs in your practice?

## Spiritual Distress

Spiritual distress, or risk for spiritual distress, is defined as “impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than one-self” (Carpenito, 2013, p. 622). Spiritual distress may be the cause of illness, especially emotional distress, or it may occur as a result of illness as one questions why “God is

allowing this (illness) to happen to me.” Sometimes people experience a crisis of faith when they question their relationship with a Supreme Being. Such questioning can be a part of faith development as the individual progresses from one stage of faith to another. One must remember that faith is belief that is based on something that cannot be observed. When spiritual or religious beliefs that persons have held on faith are being challenged by outside forces, they may become unsure about their beliefs. This may result in a search for new meaning in the spiritual self. The nurse must be aware of patients and families who are experiencing spiritual distress because this can affect their response to medical treatment.

Spiritual distress can also be a result of physiological problems, treatment concerns, or situational issues. Physiological problems include having a medical diagnosis of a terminal illness such as cancer, an irreversible illness or injury such as paralysis or amputation, or a debilitating disease such as Parkinson’s, Alzheimer’s, or other neuromuscular disease. Pain is a physiological problem that may lead to spiritual distress, especially if the pain is extreme or cannot be relieved effectively. Situational issues that may result in spiritual distress include the death or illness of a significant other, domestic violence, beliefs about sexuality, or the inability to practice one’s religious rituals.

The inability to practice one’s religious rituals is part of the nursing diagnosis *Impaired Religiosity*, or *Risk for Impaired Religiosity*, which is defined as “impaired ability to exercise reliance on beliefs and/or participate in rituals of a particular faith tradition” (Carpenito, 2013, p. 628). Hospitalized patients, people living in assisted-living or long-term-care facilities, or chronically ill individuals who are confined to their home and cannot attend religious services may not be able to practice religious rituals that have provided comfort and strength throughout their life. In institutional care, clients may have difficulty in receiving a religiously preferred diet (e.g., kosher diet for Jews, fasting during daytime hours for Muslims during Ramadan, abstaining from meat or fasting for various Christian denominations); participating in formal worship or holy day observances; or wearing religiously required dress. Treatment-related factors resulting in impaired religiosity include recommendations for treatments that the patient’s religious beliefs prohibit, such as blood transfusion, amputation, abortion, organ donation or transplantation, dietary restrictions, or surgery. Religious beliefs may also influence patient and family decisions regarding resuscitative procedures at the end of life.

The inability to participate in one’s religious practices may result in spiritual distress. It is the nurse’s responsibility to provide an environment that supports the client’s ability to carry out his or her religious and spiritual practices.

## Providing Spiritually Competent Care

All phases of the nursing process are affected by the client's and the nurse's spiritual beliefs and practices. As the client and the nurse come together in the nurse-client relationship, a unique spiritual environment is created that can improve or impede the client's desired outcomes. Self-awareness of personal biases can enable nurses to modify behaviors or (if they are unable to modify behaviors) to remove themselves from situations where care might be compromised. Nurses can become more aware of their own spiritual values through values-clarification activities. The nurse also needs to be aware that each individual may have variations in belief and practice from the traditions of his or her own professed religion. An assessment must be made of the client's specific beliefs and practices rather than assuming the client's beliefs and practices.

### Spiritual Assessment

To obtain spiritual-assessment data, nurses use broad statements and open-ended questions that encourage clients to express themselves fully. At the assessment stage nurses make no conclusions but obtain information from clients.

### Assessing Spiritual Needs

#### Environment

- Does the client have religious objects, such as a Bible, prayer book, devotional literature, religious medals, rosary, prayer beads, photographs of historic religious persons or contemporary church leaders (e.g., pope, Jesus, religious leader), paintings of religious events or persons, religious sculptures, crucifixes, objects of religious significance at entrances to rooms (e.g., a mezuzah [small parchment scroll inscribed with an excerpt from the Torah or Bible], holy water fonts), candles of religious significance (e.g., Pascal candle, menorah), shrine, or other?
- Does the client wear clothing that has religious significance (e.g., head covering, undergarment, uniform)?
- Are get-well greeting cards religious in nature or from a representative of the client's church, synagogue, temple, or other place of worship?
- Does the client receive flowers or bulletins from his or her church, synagogue, temple, or other place of worship?

#### Behavior

- Does the client appear to pray at certain times of the day or before meals?
- Does the client make special dietary requests (e.g., kosher diet, vegetarian diet, or diet free from caffeine, pork, shellfish, or other specific food items)?
- Does the client read religious magazines or books?

There are spiritual-assessment tools available. Nurses need to use tools that are appropriate to the situation and adapt them as required. For example, a nurse in the hospital may need a different format or different information than a nurse working in a community setting. It is not necessary to complete a total spiritual assessment for every client. Instead, nurses need to collect enough basic data to identify spiritual practices that are important to the client, especially during illness or crisis. Sometimes, simply asking clients what their spiritual or religious needs are may be sufficient to provide effective spiritual support. A spiritual assessment method using the acronym SPIRIT was developed for physicians but can also be used by nurses (Table 22–5). The HOPE tool describes four key areas to discuss with the client when conducting a spiritual assessment (Table 22–6). These models are useful for all healthcare providers who want to provide spiritually competent care. The accompanying box provides guidelines for assessing spiritual needs of clients.

### Diagnosing, Planning, and Implementing Spiritually Competent Care

Conclusions based on the spiritual assessment result in identifying nursing diagnoses related to spiritual needs. Six nursing diagnoses have been developed by the North

#### Verbalization

- Does the client mention God (Allah, Buddha, Yahweh, etc.), prayer, faith, church or other place of worship, or religious topics?
- Does the client ask for a visit by a priest, minister, rabbi, imam, or other religious representative?
- Does the client express anxiety or fear about pain, suffering, or death?
- Does the client talk about spiritual or religious causes of illness/injury and ways of healing?

#### Interpersonal Relationships

- Who visits? How does the client respond to visitors?
- Does a priest, rabbi, imam, minister, elder, or other religious or spiritual representative visit? If yes, how does the client relate to this person?
- How does the client relate to his or her family members? To the nursing staff? To his or her roommate(s)? To family and caregivers of the opposite sex?
- Does the client prefer to interact with others or to remain alone?

Source: Adapted from *Spiritual Care: The Nurse's Role* (3rd ed.), by J. A. Shelly and S. Fish, 1988, Downers Grove IL: InterVarsity Press; and *Spiritual Care: A Guide for Caregivers*, by J. A. Shelly, 2000, Downers Grove, IL: InterVarsity Press.

TABLE 22–5 SPIRIT Model for Assessing Spirituality

|                                                                                                                              | Information Needed                                                                                                                                                                                                                                                                                                                             | Questions to Ask                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>S</b> = Spiritual belief system/religious affiliation/theology                                                            | <p>What is the client's formal religious affiliation or spiritual belief system?</p> <p>How might religious or spiritual beliefs affect the client's response to illness or treatment decisions?</p>                                                                                                                                           | <ul style="list-style-type: none"> <li>What is your source of strength, hope, and comfort? Do you believe in a higher being(s) (e.g., God, Allah, Jehovah, the Creator, etc.)?</li> <li>What gives your life meaning/purpose?</li> <li>Do you have spiritual beliefs and practices that are important to you?</li> <li>Do you have a formal religious affiliation?</li> <li>What should I (the nurse) know about your (the client) spiritual or religious beliefs to plan and provide care consistent with your beliefs?</li> </ul> |
| <b>P</b> = Personal spirituality as shaped by one's life experiences. May or may not be related to a formal religious belief | <p>What are the religious or spiritual beliefs of the client, and how do they influence daily life? Health and healing practices? What life experiences has the client had (e.g., near-death experience, death or loss of a loved one, etc.) that influenced their beliefs and practices related to health and healthcare decision-making?</p> | <ul style="list-style-type: none"> <li>What does your spirituality/religion mean to you?</li> <li>Describe the beliefs and practices of your religion/personal spiritual belief system.</li> <li>Describe the beliefs or practices that you do not accept.</li> <li>When you are afraid or in pain, how do you find comfort?</li> <li>What are your sources of hope and strength?</li> <li>In what ways is your spirituality/religion meaningful to you in your daily life?</li> </ul>                                              |
| <b>I</b> = Integration and involvement with a faith or spiritual community                                                   | <p>Does the client belong to a spiritual or religious group or community? What is the importance of this affiliation for the client?</p> <p>Does the community provide support for the client?</p>                                                                                                                                             | <ul style="list-style-type: none"> <li>Do you belong to any religious or spiritual community (e.g., church, temple, synagogue)?</li> <li>What importance does this group/community have for you?</li> <li>In what ways is this group a source of support for you? In what ways might this community support you in dealing with health concerns?</li> </ul>                                                                                                                                                                         |
| <b>R</b> = Ritualized practices and restrictions, behaviors and lifestyle practices that influence health                    | <p>Are there specific rituals or practices related to daily life (e.g., diet, childbearing/childrearing) or worship (worship practices, prayer rituals, holy day observances) that are important to the client? Are there components of medical care or treatment that are forbidden based on spiritual or religious obligation?</p>           | <ul style="list-style-type: none"> <li>What lifestyle activities or practices (e.g., diet, worship practices, prayer rituals, holy day observances, medical treatment, childbearing/child-rearing practices,) does your religion encourage, discourage, or forbid?</li> <li>What meaning do these practices hold for you?</li> <li>To what extent do you follow these practices?</li> <li>Are there any specific elements of nursing/medical care that you forbid on the basis of your religious/spiritual beliefs?</li> </ul>      |
| <b>I</b> = Implications for health and nursing/medical care                                                                  | <p>How do the client's spiritual or religious beliefs and practices influence his or her healthcare decisions? How can the nurse or physician provide care that is congruent with the client's spiritual or religious beliefs?</p>                                                                                                             | <ul style="list-style-type: none"> <li>Would you like to discuss religious/spiritual implications of your nursing and health care?</li> <li>Are there any barriers to our relationship (nurse/client) based on your religious or spiritual beliefs?</li> <li>Are there specific elements of nursing and medical care that your beliefs/religion discourage/forbid?</li> <li>Are there any persons you would like us to include in your spiritual care planning (e.g., family, spiritual counselor)?</li> </ul>                      |
| <b>T</b> = Terminal events planning or end-of-life care                                                                      | <p>Are there specific spiritual or religious beliefs or practices that the client holds in regard to end-of-life care?</p> <p>What does the client believe follows death (e.g., heaven/hell, purgatory, nothing, reincarnation, etc.)?</p>                                                                                                     | <ul style="list-style-type: none"> <li>Are there any unresolved areas of your life at this point that you would like us to assist you with addressing?</li> <li>Are there spiritual or religious practices or rituals you would like available in the hospital or at your place of residence?</li> <li>In what ways can the nursing staff assist you and your family during this time?</li> </ul>                                                                                                                                   |

Sources: Adapted from "The SPIRITual History," by T. A. Maugans, 1996, *Archives of Family Medicine*, 5(1), pp. 11–16; "Spiritual Care: Nursing Theory, Research, and Practice" by E.J. Taylor, 2002, Prentice-Hall, Upper Saddle River, NJ; "Assessment and Diagnosis in Spiritual Care" by K. Massey, G. Fitchett, & P.A. Roberts, in *Spiritual Care in Nursing Practice* by K.L. Mauk & N.K. Schmidt, 2004, Lippincott Williams & Wilkins, Philadelphia, PA; "Pain Care Fast Facts: 5-Minute Clinical Inservice: Pain, Suffering, and Spiritual Assessment by University of Wisconsin Hospitals and Clinics," University of Wisconsin Hospital & Clinics, 2006, [prc.coh.org/pdf/Suffering-FF%2011-06.pdf](http://prc.coh.org/pdf/Suffering-FF%2011-06.pdf); "Taking a Spiritual History", 2nd ed. by Bruce Ambuel, Medical College of Wisconsin, 2013, <http://www.mcw.edu/FileLibrary/User/jrehm/fastfactpdfs/Concept019.pdf>



TABLE 22–6 HOPE Tool for Spiritual Assessment

|          |                                                                                                                                                                                                                                   |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>H</b> | What are the sources of <b>H</b> ope, strength, comfort, meaning, purpose, peace, love and connectedness for the client?                                                                                                          |
| <b>O</b> | What is the role of <b>O</b> rganized religion for the client? Is the client a practicing member of an organized religion? Does the client identify with a specific religion but is not an active member of a faith congregation? |
| <b>P</b> | What are the <b>P</b> ersonal practices of spirituality and/or religion for the client? How do those Personal spiritual/religious practices influence health and healing?                                                         |
| <b>E</b> | What are the <b>E</b> ffects of spiritual/religious beliefs on health and nursing care?                                                                                                                                           |

Source: Adapted from “Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment,” by G. Anadarajah and E. Hight, 2001, *American Family Physician*, 63(1), pp. 81–89.

American Nursing Diagnosis Association (NANDA) related to spirituality and religiosity: Spiritual Distress, Risk for Spiritual Distress, Readiness for Enhanced Spiritual Well-Being, Impaired Religiosity, Risk for Impaired Religiosity, and Readiness for Enhanced Religiosity.

Spiritual Distress (Risk for Spiritual Distress) is defined as “impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (Carpenito, 2013, p. 622).

Goals for clients experiencing or at risk for experiencing spiritual distress include:

- To be able to express feelings related to beliefs and spirituality.
- To be able to describe one’s spiritual belief system as it relates to illness and healing.
- To be able to find meaning and comfort in religious or spiritual expression.

Readiness for Enhanced Spiritual Well-Being is defined as “a pattern of experiencing and integrating meaning and purpose in life through connectedness with self, others, art,

music, literature, nature, and/or a power greater than oneself that is sufficient for well-being and can be strengthened” (Carpenito, 2013, p. 727). Characteristics associated with Enhanced Spiritual Well-Being include having the following:

- An inner strength that nurtures awareness, inner peace, and trusting relationships
- A sense of meaning and purpose in life
- A sense of connectedness with a power greater than oneself
- A sense of connectedness to art, music, literature, and nature
- A commitment toward love, hope, meaning, beauty, and truth
- A sense of a unifying and sacred source
- A sense of relationship with others, including family, friends, community, environment, and a Supreme Being

For clients who have spiritual distress, the nurse’s role is to support existing spiritual resources, assist clients in maintaining their spiritual connections, and promote further spiritual development. Some people will respond to adversity through an increased spiritual strength that

CRITICAL THINKING EXERCISE

Using the previously shown “Assessing Spiritual Needs” box on page 434, assess clients of different spiritual or religious belief systems. Based on your spiritual assessment, what needs have you identified in your clients? What strategies do you have for meeting these needs?

How do the spiritual needs of one client differ from those of another? What specific strengths are provided through the clients’ religious and spiritual beliefs to influence health, illness, and healing?

CRITICAL THINKING EXERCISE

In class, interview classmates or colleagues using the “Assessing Spiritual Needs” box on page 434. Based on your spiritual assessment, what needs have you identified in your classmate or colleague? What strategies do you and your classmate/colleague recommend for meeting these needs? How do the spiritual needs of one classmate/colleague differ from those of another? What specific strengths are provided through the classmates’/colleagues’ religious and spiritual beliefs that influence not only their own health, illness, and healing, but also how they would provide care to their own clients/patients?

provides hope and comfort and reduces pain and suffering. For clients experiencing spiritual distress, the nurse can plan for and provide an environment and interventions that will help the client to do the following:

- Draw on and use inner resources more effectively
- Maintain or enhance a relationship with a power greater than oneself
- Find meaning and purpose in life and in the present situation
- Promote a sense of hope
- Have needed spiritual resources

Impaired Religiosity, or Risk for Impaired Religiosity, is defined as the “impaired ability to exercise reliance on beliefs and/or participate in rituals of a particular faith tradition” (Carpenito, 2013, p. 628). Readiness for Enhanced Religiosity is defined as “a pattern of reliance on religious beliefs and/or participation in rituals of a particular faith tradition that is sufficient for well-being and can be strengthened” (Carpenito, 2013, p. 720).

For clients experiencing impaired religiosity, the nurse should communicate her or his own understanding of the importance of the client’s religious practices and consider the following interventions:

- Provide an environment that assists the client to fulfill religious obligations.
- Provide privacy and quiet for religious practices such as prayer, meditation, reading religious literature, and visiting with religious counselors.
- Contact the client’s preferred religious leader (e.g., priest, minister, rabbi, imam).
- Inform the client of available resources in the institution that support religious practices (e.g., nutritionist for dietary needs, chaplain, religious services, chapel).
- If comfortable, assist the client with religious observance (e.g., pray with patient).
- Be available should the client want to discuss religious needs.

In general, nursing actions that help clients meet their spiritual and religious needs include (1) providing presence or being there for the client, (2) supporting the client’s religious practices, (3) assisting clients with prayer and meditation, and (4) referring clients for spiritual counseling.

### Providing Presence

**Presence** is defined as being fully/wholly there for the client in the moment and free of physical, mental, or environmental distraction. The nurse demonstrates presence by communicating a willingness to care, to listen, and to be available to the client. Mauk and Schmidt (2004,) state that “nurses often provide the greatest amount of spiritual care to patients without employing multiple strategies or interventions but by simply being with the patient. The gift of presence, being

with the patient in the time of need, can provide a tremendous spiritual benefit” (pp. 248–249). O’Brien (2014, p. 14) suggests that nurses can provide comfort by being a “caring presence,” that is, staying with the client for a few minutes after treatments are done, medications given, and formal interventions are completed. Being with the client when he or she is lonely or suffering demonstrates caring and can be therapeutic by letting the client know that he or she is not alone and by mitigating suffering.

### Supporting Religious Practices

The nurse can support the client’s religious practices by providing privacy or quiet for the client to observe spiritual or religious observances, including prayer, devotional reading, rituals, and clergy visitation. The nurse can call the client’s spiritual counselor, priest, rabbi, or imam to provide spiritual support. The nurse can ensure that dietary requirements are met by notifying the dietitian or nutritional counselor. The box on page 438 provides strategies for supporting religious practices.

### Assisting Clients with Prayer and Meditation

**Prayer** is an “expression of the spirit” that involves a sense of love, connection, and a reaching out. It has many health benefits and healing properties (Dossey, 1993; Dossey & Keegan, 2013). Prayer has been described as talking to or communicating with a Supreme Being. It has also been described as a union with a Supreme Being. Prayer offers a means to:

- Have someone to talk to and with, to speak (verbally or silently) one’s fears, concerns, and desires
- Promote a sense of being loved and cared for unconditionally
- Provide a sense of peace, serenity, and connection with something greater
- Develop compassionate and caring behavior

Clients may choose to participate in private prayer or want group prayer with family, friends, or a spiritual counselor. The nurse’s responsibility is to ensure privacy and a quiet environment. The nurse can also ensure that objects needed for prayer, such as rosaries, prayer beads, prayer books, or prayer shawls, are within easy reach. Nursing care may need to be adjusted to accommodate for prayer times. For example, the devout Muslim prays five times a day: before dawn, just after noon, mid-afternoon, just after sunset, and in the evening. Prior to prayer, a patient may want to bathe his or her face and hands.

Illness can interfere with some clients’ ability to pray. Feelings such as anxiety, fear, guilt, grief, despair, and isolation can produce barriers to relationships in general, and in the relationship the person has with his or her Supreme Being. In these instances clients may ask the nurse to pray with them. Prayers with clients should be done only when

## Supporting Religious Practices

- Create a trusting relationship with the client so that any religious concerns or practices can be openly discussed and addressed.
- If unsure of client religious needs, ask the client how nurses can assist in meeting these needs. Avoid assuming what clients' religious preferences are.
- Do not discuss personal spiritual beliefs with a client unless the client requests it. Be sure to assess whether such self-disclosure contributes to a therapeutic nurse-client relationship.
- Inform clients and family caregivers about spiritual support available at your institution (e.g., chapel or meditation room, chaplain services, dietary preferences).
- Allow time and privacy for, and provide comfort measures before, private worship, prayer, meditation, reading, or other spiritual activities.
- Respect and secure client's religious articles (e.g., rosary, prayer beads, medals, amulets, icons, prayer shawls).
- If desired by client, facilitate visitation of minister, priest, rabbi, imam, or other spiritual counselor. Collaborate with chaplain when available.
- Prepare client's environment for spiritual rituals or visitation of spiritual leader or counselor.
- Make arrangements with dietitian so that dietary needs can be met. If institution cannot accommodate client's dietary needs, ask client's family to bring food if appropriate.
- Acquaint yourself with the religious, spiritual practices and cultures of the area in which you are working.
- Remember the difference between facilitating/supporting a client's religious practice and participating in it yourself.
- Ask another nurse to assist you if a particular religious practice makes you uncomfortable.
- All spiritual interventions must be done within agency guidelines.

Source: Adapted from "Spirituality," in *Fundamentals of Nursing: Concepts, Process, and Practice* (9th ed.), by A. Berman and S. Snyder, 2012, Upper Saddle River, NJ: Pearson.

there is mutual agreement between the client and those praying with the client. If a patient asks the nurse for prayer and the nurse does not feel comfortable, one option may be to suggest a silent prayer. The nurse can stand quietly at the bedside and may even hold the patient's hand. This can provide comfort when no one else is available. When clients are experiencing severe spiritual distress, the nurse should refer them to a chaplain or other spiritual counselor. It is important that nurses not impose their own spiritual beliefs or practices on clients, but rather respond to the spiritual needs expressed or manifested by the client.

Meditation is an internal reflection or contemplation. Spiritual and religious belief systems use prayer and meditation as a means of communication with a Supreme Being, either directly or indirectly, and as a means of self-reflection. The nurse can assist the client by providing a quiet environment for meditation similar to the environment one would provide for prayer.

### Referring Clients for Spiritual Counseling

Referral to a spiritual counselor may be done whenever the client expresses the need for spiritual support. Many clients have their own spiritual or religious support person (e.g., minister, priest, rabbi, imam) in addition to members of their faith community who may provide support and prayer. For clients who do not have a personal spiritual counselor, the agency chaplain may provide spiritual support or obtain an appropriate spiritual support person. If the agency does not employ a chaplain, a list of available spiritual leaders should be kept on the nursing unit. Nurses in home health care or practicing in community settings can check telephone direc-

tories, directories of community service agencies, or religious directories to identify an available spiritual support person. Many religious communities will provide support to members of their faith who are not members of their specific faith community. For example, a priest may visit a client in the hospital or at home even though the client is not a member of the priest's parish. Often parish nurses, or faith community nurses, visit members of their faith community who are ill at home or are hospitalized. In the absence of the spiritual leader, faith community nurses may be permitted to administer religious rituals and other services that the spiritual leader usually provides. In the situation in which there is conflict with prescribed treatment and the client's religious beliefs or practices, the nurse can encourage the client, the client's physician, and the client's spiritual counselor to discuss the conflict and explore alternatives to the recommended treatment. The major roles of the nurse are (1) to provide information and resources so that clients can make an informed decision within the context of their spiritual or religious belief system and (2) to support the clients' decision.

### Reflect On . . .

- resources (e.g., churches, synagogues, or mosques) that are available in your community that will assist healthcare providers in your healthcare agency in delivering spiritually competent care. What services are provided? Are services available to clients who are not members of the specific faith community?

## Chapter Highlights

- In viewing people holistically, nurses must consider the spiritual and religious beliefs and practices of clients when providing care.
- There is a diversity of spiritual and religious belief systems that can influence clients' beliefs about causes of illness, healing practices, and the choice of healthcare provider.
- Spiritual and religious beliefs can be a source of strength and comfort for clients and families experiencing illness.
- *Spirituality* refers to one's feelings of connectedness to self, others, the environment, and to a Supreme Being (which also may be called God, Allah, Jehovah, the Creator, etc.).
- *Religion* refers to an organized system of beliefs shared by a group of people and the practices, including worship, related to that belief system.
- Faith is belief in something that cannot be directly observed.
- An atheist is one who believes that there is no Supreme Being. An agnostic is one who believes that there is no evidence or proof in the existence of a Supreme Being. Therefore they doubt and are unsure that such a Being exists. In both cases, atheists and agnostics may believe in a connectedness with their inner self, with others, and/or with nature and must be cared for within the context of their inner spirit.
- The works of Westerhoff and Fowler serve as the foundation of our understanding of spiritual development. Spiritual or faith development occurs in a linear fashion, and a person can be in more than one stage at a time.
- Prayer is a communication with a Supreme Being in word or thought. There are several types of prayer. Meditation is an internal reflection or contemplation. Prayer and meditation may provide strength and comfort for clients and families experiencing illness.
- Nurses must be knowledgeable about the spiritual and religious belief systems prevalent in the communities where they practice.
- Nurses should have an understanding of holy days, sacred writings and symbols, beliefs about dress, and spiritual and religious beliefs and practices related to health and nursing care.
- Spiritual and religious beliefs may influence dietary practices, beliefs and practices about pain and its management, childbirth and perinatal care, and end-of-life care.
- Nurses must be able to recognize spiritual distress and impaired religiosity and plan appropriate nursing care to assist the client.
- Nurses can assist clients by providing presence for the client, supporting the client's religious practices, assisting clients with prayer and meditation, and arranging for clients to meet with their spiritual counselor.
- Nurses must not proselytize or attempt to convert clients to another spiritual or religious belief system.
- Nurses must be aware of their own spiritual and religious beliefs and practices and understand how they may conflict with established healthcare and nursing practices. Nurses should plan what course of action they will take when such conflicts occur.

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# 23

## Nursing in a Culture of Violence

### Chapter Outline

#### Challenges and Opportunities

##### Violence in Society

##### Family Violence and Abuse

- Intimate Partner Abuse
- Family Violence and Children
- Elder Abuse

##### Violence in the Community

- Exposure to Community Violence
- School Violence

##### Violence in the Workplace

- Risks to the Healthcare Workforce
- Horizontal or Lateral Violence

#### Assessing the Effects of Violence and Abuse

##### Planning/Implementing Interventions for the Abused

- Short-Term Interventions
- Long-Term Interventions

##### Prevention of Violence and Abuse

##### Terrorism and Public Health

- Threats of Mass Destruction
- Strengthening the Public Health System

#### Chapter Highlights

### Objectives

1. Recognize the incidence of violence within the family, in the community, and in the workplace.
2. Discuss theoretical perspectives of violence.
3. Define domestic violence and abuse.
4. Identify essential aspects of assessing the effects of violence and abuse.
5. Discuss lateral violence and bullying within the profession of nursing.
6. Explain the nurse's role in assisting victims of abuse and violence.
7. Discuss methods of violence prevention.
8. Identify risks to the public health from violent events such as terrorism.

**V**iolence and abusive behavior have become major health problems. They are the source of injury and both physical and mental morbidity in people of all ages. The context of the violence and abuse may be the family, the community, or the workplace and often involves bullying behavior. Workplace violence includes worker-on-worker violence, referred to as lateral violence and is particularly applicable to nurses. Threats to the public's health may result from terrorist attacks involving weapons of mass destruction.

### Challenges and Opportunities

The high incidence of violence in society affects large segments of the population, with direct impact on health care. Nurses are challenged in their practice to identify and intervene when providing care for a victim of violence. Because the victims often attempt to hide that they have been attacked, detection requires high levels of skill in communication and assessment on the part of the nurse. Terrorist events and weapons of mass destruction have created new challenges to the public health system. New ways of treating and preventing large-scale injury and disease are needed. Nurses themselves may be the victims of violence in the workplace from patients and families and from each other due to incivility and bullying.

In meeting the challenge of providing care for victims of violence, the nurse has an opportunity to have a positive impact on

client outcomes. Nurses are strategically placed to have a role in primary and secondary prevention programs. The focus on the community places nurses in roles and settings that enable them to have influence on reducing the effects of violence within the community and within families. New systems are being created to meet public health challenges for large-scale injury and disease, and nurses will be involved in these new programs. Nurses also have the opportunity to create a new workplace culture and improve communications.

### Violence in Society

Violence is a public health problem with a substantial impact on health. Each year it is experienced by millions of individuals, affecting families, communities, and society. However, violence can be prevented. The Centers for Disease Control and Prevention (CDC) works to prevent injuries and death from violence through its Division of Violence Prevention (DVP) and is the only federal agency with a focus on stopping it before it starts. In that role, the DVP monitors and tracks trends, conducts research, develops and evaluates prevention strategies, and promotes evidence-based prevention. These activities are shown in Table 23–1.



**InfoQuest:** Visit the website of the National Center for Injury Prevention and Control, Division of Violence Prevention, and review the publication *Understanding and Preventing Violence: Summary of Research Activities*. Review the previous boxes detailing recent findings.

### Family Violence and Abuse

Traditionally the term **domestic abuse** has been thought of as violence against a woman by a spouse or boyfriend. More recently, the term has expanded to include other forms of violence, such as child abuse, elder abuse, women abusing male partners, and violence between same-sex partners, and it includes actions ranging from verbal abuse to light slaps to severe beatings to homicide. The term **intimate partner violence (IPV)** is used to refer to intentional emotional and/or physical abuse by a spouse, ex-spouse, boyfriend/girlfriend, ex-boyfriend/ex-girlfriend, or date. It occurs in all strata of society; it crosses all racial, religious, ethnic, socioeconomic, and educational boundaries, and it is not confined to any particular age group or occupation.

Emotional abuse is damaging. Words can have a devastating impact, and the damage to self-esteem can last a lifetime. Emotional abuse involves one person shaming, embarrassing, ridiculing, or insulting another. It may include the destruction of personal property or the killing of pets in an effort to frighten or control the victim. Emotional abuse may also include statements that are devastating to the victim’s self-esteem, such as, “You never do anything right,” “You’re ugly and stupid,” “No one else would want you,” “I wish you had never been born.”

Abusive individuals come from all walks of life and all strata of society. They have many of the following traits or characteristics in common:

- Overpossessiveness: viewing family members in terms of ownership and property
- Excessive jealousy

TABLE 23–1 The Division of Violence Prevention’s Work in Understanding and Preventing Violence

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Understanding What Protects or Increases Risk for Violence | Understanding what protects against suicide or increases vulnerability<br>Identifying the social and community risks for youth violence<br>Protecting against teen dating violence and adult intimate partner and sexual violence<br>Clarifying the connections between different forms of violence<br>Examining the economic impact of violence and the efficiency of prevention strategies                                                                                                  |
| Testing New and Innovative Prevention Strategies           | Preventing abusive head trauma<br>Expanding the reach and accessibility of child maltreatment strategies<br>Preventing suicide with connectedness<br>Evaluating economic and environmental change approaches to prevent violence<br>Comprehensive youth violence prevention in high-risk communities<br>Family approaches to preventing intimate partner violence<br>Preventing sexual violence among youth<br>Screening for intimate partner violence<br>Promoting health teen relationships |

Source: From *Understanding and Preventing Violence: Summary of Research Activities*, by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, Summer 2013. Retrieved from [www.cdc.gov/violenceprevention/pdf/dvp-research-summary-a.pdf](http://www.cdc.gov/violenceprevention/pdf/dvp-research-summary-a.pdf)

- Desire to control and dominate
- Poor control of impulses
- Low tolerance for frustration
- Belief that physical measures are necessary to control children
- Dependence on an elder for financial support and accommodation
- Drug or alcohol abuse
- History of poor mental health or a personality disorder
- History of abuse as a child by his or her own parents

While these are common features of a perpetrator, care must be taken to avoid profiling and assuming guilt based upon these characteristics.

### Intimate Partner Abuse

Intimate partner abuse refers to physical, sexual, or psychological harm caused by a partner or spouse. It occurs between hetero- or homosexual partners and does not require sexual intimacy. Physical aggression such as beating and threatened use of a weapon and/or psychological abuse such as humiliation and intimidation may be involved. Forced sexual acts and any controlling behavior may also be used. This type of violence occurs worldwide in all cultures, religions, and socioeconomic groups. In many cases, the perpetrator was abused in childhood and is continuing the pattern. It is associated with high rates of mental health disorders, in particular depression and post-traumatic stress disorder (PTSD).

While intimate partner abuse is perpetrated by women against men, men against women, and between partners of the same gender, women are more vulnerable, generally speaking, to this violence because of their disadvantage in size and strength and their social and economic dependence on men. However, men who are victimized in this way have fewer resources available, such as 24-hour toll-free assistance numbers or shelters. Abused men may be less likely to seek help because of the stigma.

Societal acceptance regarding violence against women by husbands has existed historically, and it was considered a private domestic matter. Before 1700, laws allowed a husband to chastise his wife with any reasonable instrument, such as a rod not thicker than the husband's thumb (the origin of the phrase "rule of thumb") (Henderson, 1992, p. 27). Today, there are cultures that have a greater acceptance of abuse than other cultures and may view women and children as possessions. This attitude may exist within a larger culture that does not condone such action.

It is especially difficult for many victims to leave an abusive relationship. Women who do leave an abusive relationship often have several attempted separations before finally ending the relationship. Some women are threatened

with loss of children or with death if they do not return home. Social and cultural beliefs also play a role. Women have been socialized to be self-sacrificing for the good of others and feel responsible for keeping the family together at almost any cost. Cultural beliefs about loyalty and duty may reinforce the role of victim. In addition, many women are financially dependent on their abusive partners; if they have outside employment, they are unlikely to earn as much as their male counterparts. If there are children, the woman may desperately need child support, but many fathers do not honor this obligation and default on the payments. Thus, lack of affordable and adequate child care facilities has become a major problem for the single mother seeking employment.

Many people believe that abused spouses can end the violence by leaving their abuser or that the victim can learn to stop doing those things that provoke violence. These beliefs are not supported by facts. In many cases, the separation process brings on an increased level of harassment and violence and may result in homicide. In a battering relationship the abuser needs no provocation to become violent. It is the abuser's pattern of behavior, and the victim cannot learn how to control it. Even so, many victims blame themselves for the abuse, feeling guilty—even responsible—for doing or saying something that triggers the abuser's behavior. They then suffer a loss of self-esteem. Friends, family, and service providers may reinforce this attitude by laying the blame and the need to change on the shoulders of the victim. Many people who do try to disclose their situation are met with disbelief or denial, which discourages them from persevering. Some facts about IPV are shown in the accompanying box, and suggested actions to take when caring for victims are shown in the following box, titled "Some Recommended Actions in Caring for Victims of IPV."

### Family Violence and Children

#### *Effects of Family Violence on Children*

Children experience domestic violence as victims and as witnesses, affecting not only their physical health and safety but also their psychological adjustment, social relations, and academic achievement. The experience affects their perception of the world, self-concept, ideas about the purpose of life, future expectations, and moral development (Margolin & Gordis, 2000). Domestic violence violates a child's safe haven, and the immediate reaction is likely to be helplessness, fear, anger, and high arousal, which can disrupt the child's efforts in age-appropriate academic and social pursuits.

Children and adolescents who are exposed to intimate partner violence in the home may display a broad range of symptoms and may be impaired in multiple ways, including



## Selected Findings from the National Intimate Partner and Sexual Violence Survey: 2010 Summary Report

- Nearly 1 in 5 women and 1 in 71 men in the United States have been raped at some time in their lives.
- More than half of female rape victims report that they were raped by an intimate partner, and 40.8% were raped by an acquaintance. For males, more than half reported being raped by an acquaintance and 15.2% by a stranger.
- Most female victims of completed rape experienced their first rape before the age of 25 (79.6%), and 42.2% experienced their first rape at the age of 10 years or younger.
- More than a quarter of male victims of completed rape experienced their first rape at the age of 10 years or younger.
- More than 1 in 3 women and more than 1 in 4 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner.
- About 1 in 4 women and 1 in 7 men have experienced severe physical violence by an intimate partner.
- Across all types of violence, the majority of female victims reported that their perpetrators were male.
- Male rape victims and male victims of noncontact unwanted sexual experiences reported predominantly male perpetrators.
- Men and women who experienced rape or stalking by a perpetrator or physical violence by an intimate partner were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, and poorer physical health and poorer mental health than those who did not experience these forms of violence.
- Women who experienced rape, stalking, or physical violence were more likely to report having asthma, irritable bowel syndrome, and diabetes than women who did not experience these forms of violence.

Excerpted from National Center for Injury Prevention and Control, Division of Violence Prevention. *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

PTSD, poor academic functioning, and socialization problems. Each additional exposure to a traumatic event increases the odds of distress or PTSD. Maternal functioning and the child's trauma history have been found to be related to the appearance of symptoms, thus suggesting that those children be evaluated with their mothers. Intervention may be needed to decrease maternal aggression or distress.

### Abuse of the Child

Children of any age, race, religion, or socioeconomic status can be victims of abuse and neglect. Perpetrators may be parents, siblings, a boyfriend or girlfriend, or a babysit-

ter, and the form of the abuse may be physical battering, physical neglect, sexual abuse, or emotional abuse and neglect. Laws mandate the reporting of suspected child abuse or neglect to child protection authorities, and these laws also protect healthcare professionals from any liability that might result from their reporting, in good faith, suspected cases of child maltreatment.

*Physical abuse* is nonaccidental injury of a child and is relatively easy to recognize and treat. The most common types of physical abuse are burns, bruises, fractures, abdominal injuries, and head or spinal injuries. The location and pattern of injuries help determine the likelihood of

## Some Recommended Actions in Caring for Victims of IPV

### Identification, Assessment, and Documentation

Possible questions to ask:

- Sometimes partners or ex-partners use physical force. Is this happening to you?
- Have you felt humiliated or emotionally harmed by your partner or ex-partner?
- Do you feel safe in your current or previous relationships?
- Have you ever been physically threatened or hurt by your partner or ex-partner?
- Have you been forced to have any kind of sexual activity?

Carefully document responses to the questions in the medical record.

### Management, Treatment, and Prognosis

- Advocate for interventions that empower the victims.
- Link victims to community resources.
- Refer for psychological intervention.
- The prognosis is uncertain, and follow-up is important

Source: Excerpted from "Intimate Partner Violence: Position Paper," by D. E. Stewart, H. MacMillan, and N. Wathen, 2013, *Canadian Journal of Psychiatry*, 58(6), 1–15.

## RESEARCH CURRENT

## The Children of Patriarchal Terrorism

Carolina Overlien's exploratory qualitative study of 25 children who had experienced domestic violence by the father or stepfather was conducted using interviews. The research questions were "What are the violent experiences of the children?" and "What from the children's perspective is the nature of violence?" All of the children either were living or had lived in a shelter for abused women in Norway, and all of them had experienced the fathers'/stepfathers' physical, psychological, and in one case sexual violence toward their mothers during their childhoods. Five of them had been physically abused themselves. Open-ended questions were asked in a quiet, separate room at the shelter. The interviews were recorded and transcribed and then subjected to thematic analysis. Six themes emerged:

1. The physical violence is embedded in a pattern with a high degree of coercive control that includes being subjected to "bizarre acts."
2. The physical violence is severe and/or life-threatening and repeated.

3. Physical intervention during the violent episode is perceived as too dangerous and therefore perceived as impossible.
4. The different forms of violence permeate every hour of every day so that the children describe not having a normal life.
5. The children live in a constant state of readiness with strong fear, even when living in a safe setting.
6. The children express feeling that when their lives with the violent fathers/stepfathers are over, they will finally be able to "start living."

Implications for practice include responding effectively to these children, who are in need of immediate help and must have safety as a top priority. Safety plans must be made with mothers, children, and professionals jointly. The right supports and interventions must be provided.

Source: "The Children of Patriarchal Terrorism," by C. Overlien, 2013, *Journal of Family Violence*, 28, 277–287.

abuse. For example, accidental scalds usually occur on the front of the body; scald burns on the back and feet are suspicious. Bruises over bony surfaces such as the shin, forehead, knees, forearms, and chin are common occurrences among active children; bruises on the cheek, abdomen, back, buttocks, and thighs raise suspicion of abuse.

Whiplash-shaking can lead to severe injury in infants. Cerebral damage, neurological defects, blindness, and mental retardation can result. These findings are often seen without external evidence of head injury. Nurses should suspect **shaken baby syndrome** (SBS) in infants less than 1 year of age who present with apnea, seizures, lethargy or drowsiness, bradycardia, respiratory difficulty, coma, or death. Subdural and retinal hemorrhages, accompanied by the absence of external signs of trauma, are hallmarks of the syndrome.

Another common, but often unrecognized, form of family violence occurs between siblings. Many people

assume that it is natural, and even appropriate, for children to use physical force with one another: "It is a good chance for him to learn how to defend himself," "She had a right to hit him; he was teasing her," or "Kids will be kids." These attitudes teach children that physical force is an appropriate method of resolving conflicts. Sibling violence is highest in the early years and decreases with age. In all age groups, girls are less violent toward their siblings than are boys.

Abused children manifest various characteristics, as shown in the accompanying box. Childhood abuse may have far-reaching consequences for the victim's health. Empirical data link child maltreatment and exposure to domestic violence with numerous outcomes, including aggression and violent behavior problems with peers, delinquency, depression, delayed cognitive functioning, poor academic performance, and symptoms of PTSD.

### Behavioral Characteristics of Abused Children

The child may

- Be unusually aggressive, withdrawn, overly compliant, or attention seeking.
- Appear afraid of a parent or wary of physical contact with an adult.
- Be inappropriately clothed during winter.
- Manifest developmental delay and failure to thrive.
- Express violence toward pets.
- Run away from home.
- Demonstrate changes in school performance.
- Be habitually late for school or avoid spending time at home by arriving early and staying late.
- Verbalize fault for injuries: "I deserved it."
- Attempt suicide or abuse alcohol or drugs.

Child sexual abuse is believed to be much more common than indicated by the cases identified through reports to authorities. The child who experiences sexual abuse is at high risk for other negative childhood experiences and outcomes that can continue into adulthood. A variety of psychiatric disorders have been identified, including PTSD, depression, suicide, substance abuse, obesity, and revictimization as an adult.

Recognition of the abuse is important, and screening should be done at well-child appointments. If possible the child and parents should be separated for the screening questions, especially when there is suspicion of occurrence.

## Elder Abuse

No one knows the true incidence of abuse, neglect, or exploitation for older Americans. There are no official national statistics, and the exact incidence worldwide is not reported. There are several reasons for the lack of statistics: The definitions vary, and there is no uniform reporting system so that comprehensive data are not collected in an organized way.

Older adults who can no longer live independently may be vulnerable to mistreatment in the forms of physical abuse, psychological or emotional abuse, sexual abuse, financial manipulation, or neglect. The most likely perpetrators are persons in continual contact with the dependent elder and could be family or nonfamily caregivers such as spouses, children, or professional caregivers. Risk factors for elder abuse include social isolation, chronic disease and/or functional impairment, cognitive impairment, substance abuse by the abuser, psychiatric disorder of the abuser, history of violence by the abuser, dependence of the abuser on the victim, stress affecting the abuser, and shared living arrangement between the victim and the abuser (see the accompanying box).

According to the National Center on Elder Abuse there are three categories of elder abuse: (1) domestic elder abuse, (2) institutional elder abuse, and (3) self-neglect.

*Domestic abuse* refers to any of several forms of maltreatment of an older person by someone who has a special relationship with the elder. *Institutional abuse* refers to abuse occurring in residential facilities such as nursing homes. *Self-neglect* is characterized as the behavior of the elderly person that threatens health and safety; it is usually a failure to provide sufficiently for himself or herself.

In addition to physical, sexual, and emotional/psychological abuse, elders are also vulnerable to other forms. *Financial/material exploitation* involves the illegal or improper use of the elder's funds, possessions, or assets; it may involve cashing checks, forging a signature, or improper use of a power of attorney. *Neglect* is the refusal or failure to fulfill any part of a person's obligations or duties to an elder, such as providing medication or food. *Abandonment* is the desertion by an individual who has assumed responsibility for providing care for the elder (National Committee for the Prevention of Elder Abuse, 2008).

It is believed that only a small proportion of elder abuse is reported to protective services organizations. There are a number of state and federal laws regulating the quality of care provided in nursing homes and long-term-care facilities to protect residents from mistreatment (Gitler, 2008). These laws have addressed the licensing of nursing homes, certification requirements for Medicare and Medicaid funding, elder abuse laws, healthcare fraud laws, and laws establishing ombudsman programs designed to safeguard nursing home residents.

Problems may be encountered with the enforcement of these laws and with inconsistencies from state to state. Historically, the licensing of nursing homes was a state function. However, the Social Security Act Amendments of 1965 broadened this prerogative to include federal regulation through Title XVIII and the authorization of Medicaid, which required the certification of the agency to receive funding. The Nursing Home Reform Act of 1987 further strengthened the certification requirements. These laws and others require

## Clinical Situations Suggestive of Elder Abuse

- When there is a delay between the injury or illness and the seeking of medical attention
- When the accounts of the patient and caregiver do not agree
- When the severity of the injury does not fit the explanation given by the caregiver
- When the explanation of the patient or caregiver is implausible or vague
- When visits to the emergency department for chronic disease exacerbations are frequent, despite an appropriate care plan and adequate resources
- When a functionally impaired patient presents to the physician without a designated caregiver in attendance
- When laboratory findings are inconsistent with the history
- When the caregiver is reluctant to accept home health care (e.g., a visiting nurse) or to leave the elderly person alone with a healthcare practitioner

Source: From *The Merck Manual of Geriatrics* (3rd ed.), by M. H. Beers and T. V. Jones (Eds.), online edition, Table 15–2, Rahway, NJ: Merck. Used by permission.

outcome-focused quality of care and have staffing requirements related to the provision of nursing services. Monitoring and enforcement of compliance are included.

The Elder Justice Act was passed as part of the Patient Protection and Affordable Care Act of 2010 and authorizes federal response to elder abuse through training, services, and demonstration programs. It will also be responsible for issuing human subjects protection guidelines for researchers and establishing elder abuse forensic centers. The act formed the Elder Justice Coordinating Council and the National Advisory Board, which will issue reports and recommend legislative action to congressional committees.

### Reflect On . . .

- how a nurse's previous abusive relationships might affect her or his practice with victims of domestic violence.
- the available resources for victims of abuse in your area. What additional resources might be needed?

## Violence in the Community

### Exposure to Community Violence

Violence in the community has ripple effects. People who are not directly victimized may observe violent acts or at the least may hear about them repeatedly from the news media. Data suggest that in inner-city neighborhoods, one third or more of children have been directly victimized, and almost all children have been exposed to community violence. Children are particularly vulnerable because violence can result in a disruption of the normal developmental trajectory. In Western culture, the home and the neighborhood are considered safe havens for children, but they lose those protective and comforting qualities in the aftermath of violence in the community. Exposure to community violence has been linked to the development of aggressive and antisocial behavior on the part of the child. Although exposure to violence clearly puts children at risk for developing psychological problems, these negative outcomes are not inevitable. It is important for nurses to identify those factors that mediate or moderate the effects and use them to help children who experience violence in the community.

The elderly are particularly vulnerable to violence in the community. They are often easy victims of crimes such as mugging, theft, and robbery. In addition, the threat of violence in the community may keep them from leaving the perceived safety of their homes to go out alone. This contributes to isolation, loneliness, fear, and depression.

The causes of violence have been investigated extensively by many disciplines in the social sciences. The

experience of shame and humiliation is at the root of violent behavior, along with a lack of guilt or remorse. When individuals experience shame and humiliation without the ability to feel guilt or remorse, they may be prone to violence as a way of striking out without self-control. Worldwide, the most powerful predictor of the murder rate is the size of the gap between the income of the rich and the poor. The primary prevention suggested is to ensure that people have access to the means by which they can achieve feelings of self-worth, such as education and employment and equitable levels of income, wealth, and power. Nurses need to be involved in creating safer communities through social policies. This may be approached with political advocacy.

### School Violence

School violence is youth violence that happens on school property and on the way to or from or during school and school-sponsored events. School violence is a subset of youth violence and typically includes those between the ages of 10 and 24 years, although it can begin much earlier. Examples of these behaviors include bullying, fighting, weapon use, electronic or social media aggression, and gang violence.

There has been a growing concern about youth violence in schools, beginning with the preschool child. Children and youth may use aggression to protect their social position and to meet their social needs. School violence has been studied in terms of direct physical bullying, relational or social bullying, and sexual harassment. *Physical bullying* can take the form of hitting, kicking, and taking the possessions of another. *Relational* or *social bullying* targets social relationships to hurt another person; this can include spreading rumors and threatening social ostracism. *Sexual harassment* is characterized by a dominant aggressor who intends to adversely affect the victim's status through physical and/or nonphysical sexual behaviors.

The Institute of Medicine (Matlak, 2014) has proposed a prevention strategy using three approaches: Universal strategies, targeted strategies, and intensive strategies. The *universal strategies* are directed at all students and include things such as schoolwide discipline policies and social skills training. *Targeted Strategies* target students who demonstrate risk of developing antisocial behavior patterns. *Intensive strategies* are interventions for students with disruptive behavior disorders. The overall goals of targeted strategies are to prevent the demonstrated risk behaviors from progressing and to promote adaptation of the child in areas where he or she is showing risk. Intensive strategies usually require multilevel interventions to address multiple problems, and this usually requires an individualized and multidisciplinary plan (Matlak, 2014). School nurses may be directly involved in prevention measures.



## Workplace Violence Prevention Strategies

### Violence Resulting from Criminal Intent

#### Environmental Interventions

- Cash control
- Lighting control
- Entry and exit control
- Surveillance
- Signage

#### Behavioral Interventions

- Training on responses to situations
- Training on use of safety equipment
- Training on dealing with problem behavior

#### Administrative Interventions

- Hours of operation
- Precautions with opening and closing
- Good relationships with police
- Safety and security policies
- Security guards

### Violence Resulting from Customers/Clients

- Adequate staffing and skill mix to meet the client's needs
- Training on managing violence
- Accreditation policies that reflect safety and security

### Worker-on-Worker Violence

- Preemployment background checks and reference checks
- Training on policy and procedure for reporting problem behavior
- Observing the behaviors of coworkers

### Personal Relationship Violence

- Training on policy and procedure for reporting abusive behaviors
- Creating a culture of support for victims of abuse.

*Source:* Based on *Workplace Violence Prevention Strategies and Research Needs*, report from the Centers for Disease Control and Prevention conference Partnering in Workplace Violence Prevention: Translating Research to Practice, November 17–19, 2004, Baltimore, MD. Atlanta, GA: Author.

## Violence in the Workplace Risks to the Healthcare Workforce

Workplace violence may consist of a violent act or the threat of violence against workers and can consist of physical assault and homicide, as well as threats and verbal abuse. Sources of workplace violence include criminal intent such as robbery, customers or clients acting aggressively toward employees, worker-on-worker violence, and personal relationship violence, such as intimate partner violence that spreads to the workplace. The costs of workplace violence include loss of productivity, work disruptions, employee turnover, litigation and legal costs, and other incident-related costs. The workers at greatest risk are those who exchange money with the public, make deliveries, carry passengers in vehicles, work alone or in small groups during late night or early morning hours, or work in community settings in high crime areas. These can affect the healthcare workforce as well as workers in other work sites. Violence in the healthcare workplace can also include patient abuse and neglect, with nurses being the perpetrators.

Education and training can help prevent workplace violence and support the development of coping strategies. A program developed in the Netherlands for home care workers provided information on aggression and recognition of violent behavior and persons, effects of interaction styles with violent persons, and techniques and skills to

prevent and reduce threatening situations. Evaluation of the program showed that insight into aggression was positively related to ability to cope with adverse working conditions and can prevent work-related violence (Oostrom & van Mierlo, 2008). Some prevention strategies are shown in the accompanying box.

### Horizontal or Lateral Violence

Horizontal or lateral violence is recognized as a problem in nursing. Nurse-to-nurse aggression involves disruptive behaviors, which can be verbal or nonverbal, and may involve bullying in the workplace. Behaviors that are often associated are undermining activities, withholding information, sabotage, scapegoating, and backstabbing. These interfere with effective communication and negatively affect performance and retention of nursing staff.

The concept of horizontal or lateral violence includes incivility and bullying. It exhausts nurses' energy and undermines the profession, resulting in work environments that increase chances of error and promote burnout; thus the quality of care is negatively impacted. The pattern of destructive communication and behavior among nurses and professionals in health care has been investigated for over 30 years. It has been identified as being oppressed group behavior resulting from a hierarchical system that devalues nursing knowledge and expertise and creates a feeling of helplessness to change things on the part of nurses. It can be

overt or covert. Overt aggression can be demonstrated by belittling, criticizing, finding fault, and obstructing patient care. Covert aggression consists of less obvious behaviors, such as excluding the intended victim from communication or activities and withholding information. This is of particular concern when considering the evidence documenting that this is a threat to patient safety. An environment demonstrating mutual respect and civility is essential to safe and effective care (Burgess & Curry, 2014).

In response to this problem, the Center for American Nurses (2008) has issued a position statement expressing that “there is no place in a professional practice environment for lateral violence and bullying among nurses or between healthcare professionals. All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior” (p. 20). Generally, bullying is seen as intimidating or malicious behavior associated with abuse of power and may be perpetrated by someone at a higher level of authority. Lateral violence occurs between individuals or groups of similar levels in the hierarchy.

A number of interventions or methods of managing lateral violence have been suggested. Educating nurses about its existence can lead to recognition that these behaviors need to be eliminated from the work environment. Mentoring programs have had a positive effect on promoting productive relationships within nursing. Guiding principles are needed to make leaders and employees accountable for their behavior in the workplace and to implement reporting processes to document incidents so that they can be addressed (Mitchell, Ahmed, & Szabo, 2014). Workshops using cognitive rehearsal technique have been helpful in equipping nurses to deal with lateral violence in a more constructive way (Stanley, Martin, Michel, Welton, & Nemeth, 2007; Griffin, 2004). In their position statement, the Center for American Nurses (CAN) lists recommendations to eliminate disruptive behaviors for nurses, for employers and healthcare organizations, for educational and academic institutions, for nursing research, and for policy makers. The position statement can be found on the CAN website.



**InfoQuest:** On the Center for American Nurses website, search for the position statement on “Lateral Violence and Bullying in the Workplace.” Read the statement and make note of the recommendations to change the work environment and reduce the disruptive behaviors.

## Assessing the Effects of Violence and Abuse

Often the nurse is the first one outside a person’s family to discover that the person is being abused. Some victims may not disclose the abuse, or they may minimize its impact. However, it is the nurse’s responsibility to assess all clients at each visit for and be alert to signs of abuse and not deny the violence.

During the assessment interview, the nurse must ensure privacy. The victim must feel safe from the perpetrator. It may be difficult for the client to admit to the reality of family violence until a trusting nurse-client relationship evolves. The nurse should assure the client of a genuine desire to help the entire family system. The nurse should also approach this topic as if it were any other health risk. In addition, the nurse can offer the option of answering questions about incidents of abuse with “sometimes” instead of “yes” or “no”; this may encourage the client to make a first step to acknowledge the abuse.

Victims of violence enter the healthcare system for a variety of conditions associated with abuse. For example, common physical complaints include chronic pelvic pain, headache, irritable bowel syndrome, arthritis, pelvic inflammatory disease, and neurological damage. Psychiatric illness (e.g., alcoholism) may also be the result of a history of sexual or physical abuse. Depression is also common.

Victims of physical abuse may suffer a variety of injuries. During a head-to-toe assessment, the nurse may observe for indications of abuse, such as the following:

- **Head:** Bald patches on the scalp where hair has been pulled out; evidence of trauma from blows to the head, such as hematoma, facial bruises, facial fractures, bruised or swollen eyes, hemorrhages into the eyes, and petechiae around the eyes from attempted strangulation.
- **Skin:** Swelling or tenderness, bruises, burns, or scars of past injuries on the skin, genitals, and rectal areas.
- **Musculoskeletal system:** Fractures or evidence of previous fractures, particularly of the face, arms/legs, and ribs, or dislocated joints, especially in the shoulder when the victim is grabbed or pulled by the arm.
- **Abdomen:** Bruises, wounds, or intra-abdominal injuries, especially if the person is pregnant.
- **Neurological system:** Hyperactive reflexes due to neurological damage; paresthesias, numbness, or pain from old injuries.

If the nursing assessment reveals possible domestic violence, a team assessment needs to take place. The victim’s medical condition and emotional state must be assessed. The severity and potential fatality of the situation

must be considered, as well as the needs of dependent children and the legal ramifications.

### Reflect On . . .

- the possibility that abuse is underreported in practice settings whose staff are not attuned to the signs and symptoms of violence. How might the ignorance of healthcare providers exacerbate the problem of abuse?
- the responsibility of the nurse if evidence of abuse is detected during assessment.

## Planning/Implementing Interventions for the Abused

Most people involved in intrafamily violence are disturbed by this behavior and would like it to end. Even though they want help to stop the abuse, they may not know how to seek the assistance they need. It is extremely important for nurses to be nonjudgmental in their interactions with all family members. The abusers may be distrustful of the motives of the nurse. Initially, the victims may be unwilling to trust because of family shame and fear of being blamed for remaining in the violent situation. The nurse should convey a nonjudgmental manner; in other words, the nurse should avoid blaming the victim or the abuser or looking for pathological elements in anyone's behavior. It is vital not to impose personal values on the family by offering quick and easy solutions to intrafamily violence (Fontaine, 1996).

### Short-Term Interventions

Because the nurse may have the only contact with the client, it is essential that the nurse (1) determine the immediacy of danger, (2) convey that the person is not to blame and has the right to be safe, (3) explore options for help, and (4) provide information regarding available services. It is important that the nurse avoid judging and instead support the person's choice about whether to leave the unsafe situation or return to the abusive relationship. Because severely battered women are at risk for homicide, the nurse needs to inform the client about associated risk factors and determine the immediacy of danger.

A collaborative team of nurse administrators and clinical nurses at Harris County Health Department in Houston, Texas, developed a screening and intervention triage tool for abuse. The triage structure facilitates appropriate intervention according to screening data. Each of the triage levels includes related interventions and essential documentation.

Nurses must detect signs of abuse when patients come to a healthcare facility and know what to do when family violence is detected. The abuse should be carefully documented, and the patient should receive appropriate treatment for injuries both physical and psychological. Information should be given about protective services. There is evidence from numerous studies that women who use a shelter for protection experience a reduced rate of re-abuse and an increased quality of life when they also receive advocacy and counseling services. Without those services, there are few data to support the effectiveness of shelter stays to reduce violence (Wathen & MacMillan, 2003).

Abused children need to be encouraged to talk, but they must also be protected from having to provide multiple reports. Nurses need to tell an abused child that they believe the story, and they must reassure the child that he or she has done nothing wrong. The nurse should also avoid making negative comments about the abuser and should follow established protocols for mandatory reporting, documentation, and use of available support services (e.g., the police department, social service agencies, and child welfare agency).

Interventions for abused older adults include developing a positive relationship with both the victim and the abuser. The nurse can help to explore ways for the older person to maximize independence and identify additional support resources for physical, emotional, and financial support. It may be necessary to explore the need for additional home care services or alternative living arrangements.

Nurses must familiarize themselves with agency protocols and resources available for victims of domestic violence. Most municipalities have crisis help lines and hotlines to provide assistance. The nurse should also keep a record of telephone numbers for transition houses and rape crisis centers, alcohol and drug abuse information, support groups, religious organizations, and legal services. There are also several national organizations that offer toll-free contacts, such as the National Organization for Victim Assistance, the National Coalition Against Domestic Violence (in the United States), and the National Clearinghouse on Family Violence (in Canada).

### Long-Term Interventions

Usually, the best way to treat violent families is a multidisciplinary approach involving nurses, physicians, social workers, police, protective services personnel, and, often, lawyers. Most families are more open to accepting help during a time of crisis than at other times. They will more likely be willing to develop new behavior patterns for a short time following a crisis. If they are not helped during that time, they will most likely return to previous behavior patterns, including violence.

### CRITICAL THINKING EXERCISE

Lucy Barnes, a 30-year-old woman who is 25 weeks pregnant, comes to the emergency department of Parkfield Community Hospital. She says she fell and hit her head at home and is having headaches. During the assessment the nurse notices multiple bruises in various stages of healing over her body and asks Lucy how she got them. Lucy says that she is just clumsy and falls a lot. While the nurse is assessing Lucy, another nurse enters the room to tell Lucy that her boyfriend is there to take her back home. At that point, Lucy becomes frightened and tells the nurse that her boyfriend has hit her many times before and had knocked her down today.

She says he has threatened to kill her if she tells anyone and she does not want to leave with him.

1. Make a list of questions that the nurse could use in continuing her assessment and in documenting the discussion with Lucy.
2. What other people should be involved in Lucy's care in the emergency department?
3. Who should make the decision about where Lucy should go?
4. What should be done with the boyfriend?

Nurses should know the laws associated with reporting abuse. In the United States and Canada, nurses are required to report any suspected child abuse. The courts and child protective agencies make decisions in the child's interest. They may allow a child to remain in the home but under court supervision; they may remove the child from the home; and in some instances, they may terminate parental rights if the abuse was severe. State and provincial laws about reporting adult and elder abuse vary. Domestic violence is considered a violent crime; the victim has a right to be protected, and the perpetrator of the violence can be prosecuted.

## Prevention of Violence and Abuse

Given that violence can begin early in a child's life, prevention efforts need to begin early and they include promoting healthy, respectful relationships in families. It is important to address beliefs, attitudes, and messages that are embedded in the social structure and that create a climate allowing sexual violence, stalking, and intimate partner violence. Coordination of efforts to provide services to victims is needed to ensure healing and prevent recurrence. Healthcare professionals must be well trained and available. Implementing strong data systems for monitoring and evaluating violence is critical to understanding trends that allow the development of prevention and intervention programs and the measurement of their effectiveness. Holding perpetrators accountable is important; victims are often afraid to disclose the violence to law enforcement for fear of more violence. Better supports are needed for those who report these crimes.

Nurses in all areas of practice (e.g., maternal/child health; school; community and occupational health; mental health; primary and acute care; and academic settings)

need to take a proactive role in preventing family violence. Early screening of vulnerable people and efforts to promote a change in attitudes and beliefs about family violence are essential. If they are to assist victims effectively, nurses must be aware of their own feelings about family violence. Nurses who are unclear about their own feelings about family violence may deny its existence, blame the victim in crisis, or minimize the effects of the violence.

Nurses also can be instrumental as advocates in developing policies and programs, and in providing inservice training and education to healthcare professionals and the public. Comprehensive violence prevention programs require a variety of disciplines and organizations working together, such as state or provincial and local healthcare agencies, criminal justice agencies, and social service agencies. Promoting healthy dating relationships is an important proactive step to the prevention of intimate partner violence. Strategies that provide support to parents and teach good parenting skills will help prevent child abuse; these strategies include good communication skills, positive discipline, and appropriate response to children's physical and emotional needs. These programs can take place in homes, in schools, in clinics, or in other community settings and may be individual or group sessions.

Leadership skills will be integral to the prevention of lateral violence and incivility in the workplace. A collaborative, interdisciplinary approach will be needed to empower nurses in the effort to alter disruptive behavior. A series of evidence-based workshops has been implemented to disseminate the most up-to-date evidence on the effect of leadership and communication on patient safety. The North Carolina Action Coalition Leadership Task Force (NCACTL) organized and implemented the workshops using adult learning strategies, including online personality inventories, interactive activities such as audience polling, and video discussion. Transformational leadership



## RESEARCH CURRENT

## Resonant Leadership and Workplace Empowerment

The purpose of this study by Laschinger, Cummings, Wong, and Grau was to test a model linking resonant leadership and workplace empowerment to incivility in the workplace, burnout, and job satisfaction. *Resonant leadership* is defined as including visionary, coaching, affiliative, and democratic approaches. Kanter's theory of structural empowerment, used to test correlates of empowering nursing work environments and relationally focused leadership styles, has been found to result in greater work satisfaction. A survey was used to collect data from 3,600 nurses in Canada, and data from 1,241 were considered usable and were included in the study. Instruments sent to the sample were the Resonant Leadership Scale, Global Empowerment Scale, Maslach Burnout Inventory—General Survey, and a global measure of work satisfaction. Structural equation modeling was conducted to test the hypothesized model. The most frequently cited forms of incivility

were not having attention given to one's input, having one's judgment doubted, and condescending remarks. Nurses' emotional exhaustion levels were just below the cutoff for severe burnout, and they reported moderate levels of job satisfaction. Resonant leadership was most strongly correlated to empowerment and job satisfaction and negatively correlated to incivility. Exposure to coworker incivility had a significant relationship to levels of emotional exhaustion. Resonant leadership had a strong direct relationship to workplace empowerment. The results of the study support the role of positive leadership approaches that empower nurses and discourage workplace incivility and burnout in nursing work environment.

*Source:* "Resonant Leadership and Workplace Empowerment: The Value of Positive Organizational Cultures in Reducing Workplace Incivility," by H.K.S. Laschinger, G. G. Cummings, C. A. Wong, and A. L. Grau, 2014, *Nursing Economics*, 32(1), 5–16.

formed the framework and was intended to build strong alliances among champions with similar values. At the final workshop, nurses committed to changing their own communication techniques and to participate in future collaborative initiatives (Burgess & Curry, 2014).

## Terrorism and Public Health

### Threats of Mass Destruction

Terrorism has become a major challenge to public health worldwide. It affects health in many ways, causing injury, illness, and death, and it also creates fear and anxiety. *Terrorism* is an offense calculated to influence or affect the conduct of government by intimidation or coercion. It is intended to have effects beyond the immediate victims and intimidate a wider population. Terrorism can be international or domestic. International terrorism transcends national boundaries. Domestic terrorism occurs primarily within the territorial jurisdiction of the country in question, in this case, the United States. Both types are intended to intimidate or coerce a civilian population through the use of mass destruction, assassination, or kidnapping to influence the conduct of government (Federal Bureau of Investigation, 2013).

There have been efforts to outlaw weapons of mass destruction and terrorism beginning with the Hague Peace Conference in 1899. Today there are a variety of international arms control, nonproliferation, and counterterrorism treaties and agreements. Beyond these security objectives,

outcomes have provided data needed for predicting and managing the results of natural or human-caused disasters worldwide (Dreicer & Pregoner, 2014).

The U.S. Department of Justice (DOJ) Office for Domestic Preparedness (ODP) was established in 1998 to help provide training to first responders on a national level as part of an integrated effort. Emergency Responders Guidelines were developed to guide training at three levels: awareness, performance, and planning and management. This training has intensified in the aftermath of September 11, 2001, and plans have been developed to implement the training in communities nationwide in coordination with state and regional plans.

The role of first responders is of utmost importance following a terrorist event: Mental health and social needs are created, and preparation is necessary for meeting those needs. A wide range of public health professionals have become involved in plans for responding to terrorist events and the threats of future terrorist events. The interdisciplinary approach includes epidemiologists, health educators, nurses, mental health specialists, social workers, and vaccine developers, for example. These groups must plan responses and work to prevent future terrorism, as well as to reduce or prevent inappropriate responses.

Acts of terrorism using weapons of mass destruction are usually motivated by political differences. Weapons of mass destruction are grouped into three categories: nuclear, biological, and chemical. Nuclear weapons involve the spread of radioactive material. Biological agents can cause

## Disaster Mental Health General Principles

1. Conveying a sense of safety
2. Calming
3. Emphasizing a sense of self and community efficacy
4. Fostering connectedness
5. Instilling hope
6. Ensuring the participation in interventions is voluntary
7. Restricting debriefings to operational debriefings
3. Mobilize support for those who are most distressed
4. Keep families together and facilitate reunions with loved ones
5. Provide information and foster communication and education
6. Use effective risk communication techniques

Psychiatric first aid (PFA) includes these elements, which are consistent with the general principles:

1. Protect survivors from further harm
2. Reduce physiological arousal

Source: Excerpted from "A Review and Retrospective Analysis of Mental Health Services Provided After the September 11 Attacks," by A. Pandya, 2013, *Canadian Journal of Psychiatry*, 58(3), 128–134.

diseases such as anthrax and smallpox through the dissemination of materials such as bacteria, viruses, fungi, and toxins. Chemical agents can cause injury by skin contact and inhalation, for example, and may require decontamination of the victim. Chemical agents may also cause explosions that result in injury. The recognition of signs and symptoms as well as the appropriate management for each are important training and education needs for those healthcare workers who will be providing that care should an act of terrorism happen.

Hospitals and healthcare groups have had mass casualty plans and drills for decades, but the breadth of those plans and drills has expanded greatly. Early mass casualty plans were developed for incidents of natural disasters such as hurricanes and mass injuries such as airline crashes. The planning for terrorist events includes broader collaboration among communities and adds procedures such as decontamination.

Recommendations for mental health interventions following a disaster or terrorist event are shown in the accompanying box.

### Strengthening the Public Health System

Current improvements in public health are concerned with disease surveillance and epidemiology. Improvements in laboratory capabilities and in reporting among local, state, and federal agencies are under way. Research on improving vaccines, antitoxins, and antimicrobials is being funded at higher levels than previously. The potential threats to food, water, and air have created new challenges for the public health system and have stepped up surveillance. Arising from the concerns about protecting the public from attack have come concerns about protecting civil liberties and the balance between freedom and regulation.

## RESEARCH CURRENT

### A Review and Retrospective Analysis of Mental Health Services Provided After the September 11 Attacks

A literature search by Anand Pandya was conducted to describe services and research in disaster psychiatry in order to identify evidence-based practices for future disasters. The PubMed search engine found 198 articles since the 9/11 attacks; these articles were reviewed to identify articles that described clinical services. Some additional reports on 9/11 were found through book chapters. Acute services included debriefings and other one-time outreach services. The postacute phase interventions were community outreach with the goal of addressing psychological sequelae; multisession interventions and hospital-based psychiatric services were provided in the context of general

health screenings for response workers. Many programs were developed that integrated medical and nonmedical services post-9/11, but in the time since that event recommended practices have shifted away from psychological debriefings in the acute phase to the implementation of PFA community outreach, integration of mental health services in locations where other services are provided, and implementation of successful strategies for postdisaster psychiatric services.

Source: "A Review and Retrospective Analysis of Mental Health Services Provided After the September 11 Attacks," by A. Pandya, 2013, *Canadian Journal of Psychiatry*, 58(3), 128–134.

The Office of Homeland Security was established in 2002 in response to the threat of terrorism. The responsibilities of the office have expanded to include the oversight and preparedness for natural disasters as well. National response and recovery efforts, including the Federal Emergency Management Agency (FEMA), are coordinated and planned to maximize efficiency and responsiveness.



**InfoQuest:** To see how you can assist your community to be better prepared for a bioterrorist event, go to the readiness website maintained by CDC. Click on the links “Be Informed,” “Make a Plan,” “Build a Kit,” and “Get Involved” for information.

## Chapter Highlights

- The prevalence of violence and abusive behavior in the United States is alarming.
- National healthcare organizations view violence as a major health problem and are directing attention to its recognition, prevention, and treatment.
- Nurses need to know how to identify victims of violence, to appreciate potential risk factors for future injury, to understand some of the unique considerations regarding care of victims of abuse, and to intervene effectively.
- Acts of violence often escalate in frequency and severity and may ultimately result in homicide.
- Family violence includes intimate partner abuse, child abuse and neglect, and elder abuse, neglect, or mistreatment and occurs in all strata of society.
- Abusive individuals have certain traits in common, such as overpossessiveness, desire to dominate, poor control of impulses, and a history of drug or alcohol use.
- Victims of domestic violence most often are women, many of whom have difficulty leaving the abusive relationship largely because of fear, shame, guilt, and economic dependence.
- Laws mandate the reporting of suspected child abuse.
- Elder abuse can involve not only physical, sexual, or emotional abuse but also active or passive neglect, violation of human or civil rights, and financial abuse.
- Those most vulnerable to elder abuse are females over 75 years of age, physically or mentally impaired individuals, and those dependent for care on the abuser.
- Often the nurse is the first one outside the family to discover that a person is being abused, and so appropriate assessment, intervention, and documentation are essential to prevent the abuse from continuing.
- The nurse needs to empower the client to take control and needs to provide support and maximize the client’s safety.
- Treatment of violent families requires a multidisciplinary approach among nurses, social workers, physicians, family therapists, vocational trainers, police, protective services personnel, and lawyers.
- If they are to assist victims effectively, nurses need to be aware of their own feelings about family violence.
- Nurses can advocate in developing programs and policies and provide inservice training and education to other healthcare professionals and the public.
- Workplace violence is becoming an ever-increasing concern; the sources of violence in the workplace are criminal intent, disgruntled customers/clients, and other workers.
- Lateral violence is emerging as a threat to the nursing workforce, along with bullying. A number of position statements have been issued against lateral violence and bullying within nursing.
- Terrorism is a form of violence that affects the community.
- Terrorism often involves weapons of mass destruction that affect large numbers of the population.
- Nurses are involved in interdisciplinary efforts toward preparedness and prevention so these events may be avoided or the effects minimized.

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# 24

## UNIT V

### Into the Future

# Advanced Nursing Education and Practice

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## Chapter Outline

### Challenges and Opportunities

#### Advanced Nursing Education

Preparation for Advanced Nursing Practice  
Master's Degree in Nursing

#### Advanced Nursing Practice

Types of Advanced Practice  
Regulation of Advanced Practice  
The International Perspective  
The Future of Advanced Practice Nursing

#### Selecting a Graduate Program

Professional Career Goals  
Personal and Family Factors  
Program Characteristics

### Chapter Highlights

## Objectives

1. Discuss education for advanced nursing roles.
2. Identify graduate-level nursing roles
3. Describe the historical development of advanced practice nursing.
4. Discuss certification and regulation of advanced practice roles.
5. Compare graduate education programs in nursing.
6. Identify international perspectives on advanced nursing practice roles.

Graduate education provides specialized knowledge and skill to enable nurses to assume advanced roles in education, administration, research, and practice. Nurses prepared to assume advanced nursing roles bring new ideas, insights, and enlightenment to the total healthcare system. Their creativity, competence, commitment, and courage will influence the quality of care in a changing health system. Advanced nursing practice may be in a variety of specialized roles in primary, secondary, and tertiary settings. Advanced practice of nursing is one type of advanced nursing practice and refers to nurse practitioners, nurse midwives, clinical nurse specialists, and nurse anesthetists.

Nurses with graduate education can influence the healthcare system from within by assuming positions of leadership in administration, education, and practice. They can also influence the political system to effect needed change. Choosing a graduate nursing program involves identifying one's personal career goals and then selecting the best program to enable one to meet those goals.

## Challenges and Opportunities

Advanced practice nursing has proliferated in response to healthcare changes. With rapid changes in healthcare financing and societal perspectives, along with an increasing international perspective, we see new development and evolution of advanced practice roles and settings. These changes have challenged the traditional ways of educating nurses and of practicing nursing. As the changes in healthcare delivery continue, the potential for the

advanced practice role increases, and nursing is evolving to meet the new demands.

The opportunities for nursing to redefine its role and practice in response to demands for change are tremendous. The evolution of advanced practice nursing to more autonomous roles needs to be driven by the nursing profession's vision and leadership as opposed to being reactive to outside pressures. Nursing education, leadership, and advanced practice will need to develop in tandem if nursing is to be effective in preserving the best of what nursing has been and to take the profession into the future of health care.

## Advanced Nursing Education

Historically, basic education in nursing prepared the graduate to be a nurse generalist. Nurses obtained education for specialization after completing the basic program, usually through hospital-based postgraduate courses designed to provide knowledge and skill in a specialized area. In the early part of the 20th century this type of specialized preparation generally focused on obstetric nursing and private-duty nursing. As nurses acquired a greater body of knowledge in the sciences of anatomy, physiology, microbiology, chemistry, pathophysiology, and pharmacology, they became better able to make assessments about the nature of clients' problems.

Nurses' increasing skills enabled them to assume a more active role in the care of their clients. Knowledge and skill that had previously been the physician's domain gradually crossed over into nursing practice. For example, nurses acquired the skills to conduct in-depth physical assessments, venipuncture, suturing, ordering basic diagnostic studies, and administering lifesaving medications.

As the nurse's role expanded, nurses became more specialized, and standards of practice required greater consistency in what nurses were permitted to do and could be expected to do. As the settings for practice became more specialized, postbasic specialty nursing courses proliferated to include oncology, critical care, recovery room, operating room, rehabilitation, and so on. These developments created a need for more formalized programs of study to ensure consistency of education and skill training.

## Preparation for Advanced Nursing Practice

Specialty education provided in universities and colleges at the master's degree level evolved during the 1940s and 1950s. The idea was facilitated by the return of nurses from military service during and after World War II. These nurses often had GI benefits to return to school for advanced education. Passage of the National Mental

Health Act in 1946 provided additional funds for education of nurses in the area of psychiatric/mental health nursing.

During a 1952 conference sponsored by the National League for Nursing (NLN), it was agreed that the purpose of baccalaureate education was to prepare nurse generalists, whereas master's education was devoted to the preparation of nurse specialists. Master's level education was envisioned as the appropriate foundation for the preparation of nurses for specialty practice. Early graduate degrees in nursing focused on the functional roles of educator and administrator; for example, the degree offered at Columbia University's Teachers College focused on the preparation of nurse educators. The first clinical master's program was developed in 1954 by Hildegard Peplau at Rutgers University to prepare advanced practice nurses in psychiatric/mental health nursing.

At this time, nurses prepared with graduate degrees in clinical specialties were referred to as nurse clinicians or clinical nurse specialists. The primary purpose of the clinical nurse specialist (CNS) was to improve client care and nursing practice by functioning as an expert nurse in the practice setting. The CNS was considered to be an expert in a specialized area of nursing practice, usually in the acute-care setting, and served as an expert care provider, a resource to novice nurses or general staff nurses for education and development, a consultant to the physician and other health professionals, and an active participant in research related to the specialized area of practice. Some believed that the CNS should not be used as a direct care provider, but as a clinical educator, consultant, or researcher. There was also concern that the role of the CNS was not clearly defined because nurses performed different roles and functions (educator, researcher, consultant, direct care provider, administrator) in different settings (Hamric, Spross, & Hanson, 2014).

During the 1960s, the United States experienced a healthcare personnel shortage as a result of the Vietnam conflict. Also during this time, a maldistribution of primary care physicians exacerbated the problem. In response to this problem, in 1965 Dr. Loretta Ford and Dr. Henry Silver (a physician) developed the first nurse practitioner program at the University of Colorado, focusing on the care of children. Within 9 years, there were 65 nurse practitioner programs in pediatrics; additional programs were developed that focused on women's health or family health.

Because of society's need to meet its healthcare demands and the lack of graduate-level clinical nursing programs, short-term certificate programs were created to prepare nurse practitioners. There was no consistency in the educational prerequisites, the length of the program, or the goals and content of the program in these early

## RESEARCH CURRENT

## Where Is the Evidence That Master's Level Nursing Education Makes a Difference to Patient Care?

This systematic literature review by Cotterill-Walker focused on master's level nursing education in its perceived impact on patient care and outcomes. The author selected 15 studies, 9 quantitative and 6 qualitative, in a systematic approach and then reviewed them for recurrent themes. Recurrent positive themes found with master's level nursing education were increased nursing confidence and self-esteem in assessment of complex situations and care management; enhanced communication, with improved expression of opinion and ability to

question practice; personal and professional growth, including leadership and management skills; improved knowledge and application of theory and research to practice; and enhancement of analytical thinking and decision making, allowing autonomous care. A negative theme was practice constraints limiting newly acquired knowledge utilization.

*Source:* "Where Is the Evidence That Master's Level Nursing Education Makes a Difference to Patient Care? A Literature Review," by S. Cotterill-Walker, 2012, *Nurse Education Today*, 32, 57–64.

nurse practitioner programs. Some programs required the nurse to have a baccalaureate degree for admission, others simply required registered nurse licensure and varying numbers of years of nursing experience. Program lengths ranged from a few months to 2 years. Some programs were taught only by physicians; others were taught by both physicians and nurses. Today, advanced practice education takes place at the graduate level and is making a transition from master's level education to doctoral level education.

## Reflect On . . .

- the changes proposed and under development for advanced practice nursing. Do they elevate the practice of nursing?
- the societal benefits of having advanced practice nurses provide primary care.

## Graduate Programs

Advanced nursing practice requires a graduate degree. The degree depends on the advanced nursing practice role desired and may be within or outside of traditional nursing education. Roles can include educator, researcher, clinician, informatics specialist, consultant, author, advanced practice registered nurse (APRN), administrator, attorney, and multiple others. The trend is to limit doctoral preparation in nursing to either a research-focused doctorate (PhD) or a practice doctorate (DNP). Schools that have offered the doctor of nursing science (DNS and DNSc) degree are being eliminated or changed to the PhD or DNP.

Master's degrees are evolving alongside nursing doctorates. Master's degree programs focus on education and leadership. More specialized master's programs can be found in areas such as informatics, holistic nursing, and

forensic nursing. Dual master's degree programs combine a master's in nursing with degrees in business, public health, administration, and other areas.

## Research Doctorate

PhD programs in nursing emphasize research that builds the science for nursing practice and prepares the researcher to communicate that knowledge (American Association of Colleges of Nursing, 2010). Graduates of doctoral programs in nursing are prepared for research, education, and practice and may assume careers as advanced clinicians, administrators, researchers, educators, or public policy makers.

Nurses interested in enrolling in a doctoral program in nursing should review the curriculum plan, philosophy and faculty of the selected program to select a match for their professional goals. As in other research fields, PhD programs are accredited, along with other university programs, by the various higher education commissions in the region, not by the nursing accreditation organizations.

## Practice Doctorate

Practice doctorates—doctor of nursing practice (DNP)—focus on the application of research to practice and prepare the graduate to provide direct and indirect care services. Graduates have the knowledge and skills to achieve national certification and are eligible for state licensure at the advanced practice level for practice entry. (Regulation of advanced practice is discussed later in the chapter.)

The first practice-focused doctoral degree in nursing was established at Case Western Reserve University in 1979 as the doctor of nursing (ND). Since that time, a number of other practice doctorate programs have emerged with varying titles. In March 2002, the American Association of Colleges of Nursing (AACN) created a task force to examine the status of practice doctorates, compare the various models, and develop recommendations for the future. Its recommendations include preparation of graduates for the highest

level of nursing practice through the DNP degree, and that each program would develop expertise in one area of specialized advanced nursing practice, as well as to prepare leaders for nursing practice. This practice-focused degree would include, but not be limited to, advanced nursing practice in leadership and the advanced practice roles of clinical nurse specialist, nurse anesthetist, nurse midwife, and nurse practitioner. These practice-focused doctorate programs need to be accredited by a recognized accrediting body.

In 2004 the AACN took the position that educational preparation for advanced nursing practice roles should be moved to the doctoral level (DNP) by the year 2015. This decision affects only the accreditation of programs and not the licensure of advanced practice nurses, which is under the regulation of state boards of nursing. States can continue to license nurses with a master's degree as APRNs until the state's nurse practice act is modified. The decision also does not affect certification organizations. In most states, the nurse would need to be certified as an APRN in her or his specialty area in order to be licensed with either a master's or DNP degree.

At the root of the DNP movement is the rationale that nursing is a discipline seeking a higher body of knowledge and that nursing is also a practice requiring skill refinement and use of evidence. Therefore both a research degree (PhD) and a practice degree (DNP) are needed. This is consistent with other healthcare disciplines requiring a practice doctorate, such as physical therapy, pharmacy, and medicine. In tandem is concern about the growing curriculum content for master's programs in nursing, resulting in required credit hours exceeding that of other academic disciplines and bringing the master's degree program closer to the length of a doctoral program but awarding only a master's degree. This increase in necessary curricular content is not only due to the growing knowledge base for the practice of nursing but also the need for developing skills in information systems and technology, healthcare policy development, and advanced epidemiology and prevention (Apold, 2008).

The effect of this change in educational requirement on advanced nursing practice or on the healthcare system is not yet established. Research and evaluation of outcomes will be essential as the role evolves. The education level of nurses in past and even current programs are likely not adequate to prepare the nurse of the future as health care continues to change and become more complex.

### Master's Degree in Nursing Education

Master's degrees in nursing with a focus on education prepare nurses for faculty roles in community colleges and non-tenure-track positions in 4-year programs. With the

faculty shortage, these programs have increased in number. The master's degree programs in nursing education being accredited by AACN are asked to provide an area of clinical competence for the graduates who will be teaching student nurses. They should be eligible for certification in an area of nursing specialization but not as APRNs. Certification as a nurse educator (CNE) is available through the NLN and requires 2 years of full-time teaching within the last 5 years or a master's or doctoral degree in nursing. Nurse educators who hold the rank of assistant professors constitute the largest group of CNEs, followed by associate professors and full professors, in that order. CNEs are employed most often at a baccalaureate or a higher level (National League for Nursing, 2014).

### Clinical Nurse Leader

An initiative from AACN has addressed the need for master's preparation in point of care leadership; this is the clinical nurse leader (CNL) role. The AACN released a "White Paper on the Role of the Clinical Nurse Leader" (2007) calling for the development of a collaborative effort between practice institutions and educational institutions to create this role. The role was not conceived of as one of administration or management but one that would assume accountability for client care outcomes using evidence-based practice to design, implement, and evaluate client plans of care. This role was conceived of as an *advanced generalist* rather than a specialty practice like that of the CNS. The common goal was quality patient care outcomes (Stanley, Holting, Burton, Harris, & Norman, 2007).

AACN updated the competencies and the curricular expectations for the CNL and the curriculum framework in 2013. These provide the basis for a master's degree program or postmaster's certificate preparing the graduate to take the AACN CNL Certification Examination. This represents the first new role introduced into nursing since the 1960s.

## Advanced Nursing Practice

The number of APRNs delivering health care in the United States and around the world is increasing. They are delivering cost-effective and high-quality health care to underserved populations in particular. The advanced practice nurse (APN) is an umbrella term for the registered nurse who has met advanced education and clinical practice requirements. Recently many states and organizations have alternatively adopted the preferred term advanced practice registered nurse. In the United States this term covers four principal types of APRNs: certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners



## RESEARCH CURRENT

## Implementing the New Clinical Nurse Leader Role While Gleaning Insights From the Past

Clinical nurse leaders' experiences in implementing this new role were explored in this qualitative study by Moore and Leahy. Of 49 CNLs, 24 responded (49% response rate) to an online survey with open-ended questions. The data were analyzed for demographics, themes, and challenges in implementing the new role.

Role introduction to the healthcare organization being systematic and planned was noted to be more satisfying to the respondents. The most common challenge in role implementation was the organization's inadequate understanding of the role and role expectations. Of the study participants, 43% were also concerned about workload and the risk of being overburdened. The most positive aspects of the role were thought to be the opportunity to improve the quality of care at the bedside. Physicians and staff nurses were thought to be supportive of the role,

though not all understood it. Nursing administration were frequently viewed as an impediment and thought to not perceive the CNL role as valuable.

The CNL role implementation responses were also compared to the implementation and challenges of implementation of clinical nurse specialist (CNS) roles in the historical literature. Similar parallels were drawn to the documented resistance to CNS roles by nurses and administrators, confusion about CNS role clarity, and the concern about work overload. CNSs have been successful in establishing their role, and the authors suggest that CNLs can utilize the CNS journey knowledge to facilitate CNL role implementation.

*Source:* "Implementing the New Clinical Nurse Leader Role While Gleaning Insights From the Past," by L. W. Moore and C. Leahy, 2012, *Journal of Professional Nursing*, 28(3), 139–146.

(NPs). Table 24–1 gives examples of the scope of practice and populations of each of these four APRN roles.

The requirements for advanced practice and the specialties vary by country. In Canada, the advanced practice roles are nurse practitioner and clinical nurse specialist, and both require a graduate degree as educational preparation (Canadian Nurses Association, 2007). The International Council of Nurses (ICN), through its position statement on career development, supports career mobility to more advanced levels (International Council of Nurses, 2007). It maintains an advanced practice network.



**InfoQuest:** Visit the Nurse Practitioner/Advanced Practice Network page on the website of the International Council of Nurses. Browse for information on the international status of advanced practice nursing.

Frameworks exist to address APRN practices. The Strong Model of Advanced Practice identifies five domains of practice, with activities in each practice domain described in accordance with standards of advanced practice. The five domains are direct comprehensive care, support of systems, education, research, and publication and professional leadership. Within the model, there are unifying strands of collaboration, scholarship, and empowerment describing the attributes of advanced practice, the approach to care, and the professional attitude (Ackerman et al., 1996). Hamric's Integrative Model of Advanced

Practice Nursing considers all APRN roles and their competencies (Hamric et al., 2014).

Much of the primary and preventive care provided traditionally by physicians can be provided by APRNs at a lower cost and with equivalent outcomes. These nurses work collaboratively with physicians and other health professionals to coordinate health services for the benefit of the client. Each of the 50 states in the United States, as well as other countries, provides regulatory oversight for their APRNs. States do this through their respective boards of nursing, sometimes in collaboration with state boards of medicine, which set competency standards and continuing education requirements. Restrictions on the scope of practice from restrictions on independent prescriptive authority and lack of reimbursement from third-party payers have impaired the ability to practice to the full scope of practice of APRN education.

## Types of Advanced Practice

Advanced practice nursing in the United States has evolved into four main types of advanced practitioners: clinical nurse specialists, nurse practitioners, nurse midwives, and nurse anesthetists. Each advanced role has a distinguishable scope of practice in a specific population, but knowledge and skills still overlap. The roles and populations have been standardized by the 2008 Consensus Report (National Council of State Boards of Nursing, 2014).

### Clinical Nurse Specialist

The CNS role evolved as an avenue toward professional advancement for nurses who wanted to remain in clinical

**TABLE 24–1 Examples of the Role and Populations of Advanced Practice Registered Nurses**

| Advanced Practice Nurses          | Application of Advanced Knowledge and Skills                                                                                                                                                   | Patient Population Served                                                                                                                                                                                                                                                                                                                                                                             | Practice Settings                                                                        |
|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| Certified nurse midwives (CNMs)   | Well-women health care, management of pregnancy, childbirth, antepartum and postpartum care; health promotion                                                                                  | Women                                                                                                                                                                                                                                                                                                                                                                                                 | Homes<br>Hospitals<br>Birthing centers<br>Ambulatory care                                |
| Clinical nurse specialists (CNSs) | Management of complex patient healthcare problems in various clinical specialty areas through direct care, consultation, research, education, and administrative roles                         | Individuals with physical disabilities, psychiatric mental health problems, maternal and child health problems, gerontological problems                                                                                                                                                                                                                                                               | Tertiary care<br>Ambulatory care<br>Community care<br>Home health care<br>Rehabilitation |
| Nurse anesthetists (CRNAs)        | Preoperative assessment, administration of anesthesia, and management of postanesthesia recovery                                                                                               | Individuals in all age groups undergoing surgical procedures                                                                                                                                                                                                                                                                                                                                          | Hospital operating rooms<br>Ambulatory care<br>Surgical settings                         |
| Nurse practitioners (NPs)         | Management of a wide range of health problems through physical examination, diagnosis, treatment, and patient/family education and counseling; primary care and health promotion or acute care | Individuals and families (Family Nurse Practitioner [FNP])<br>Adults/geriatrics (Adult/Geriatric Nurse Practitioner [A/GNP])<br>Neonatal (Neonatal Nurse Practitioner [NNP])<br>Pediatrics (Pediatric Nurse Practitioner [PNP])<br>Women's health/gender related (Women's Health Care Nurse Practitioner [WHCNP])<br>Psychiatric/mental health (Psychiatric-Mental Health Nurse Practitioner [PMHNP]) | Primary care<br>Long-term care<br>Ambulatory and community care<br>Tertiary care         |

Source: Adapted from *The Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education*, by the APRN Consensus Work Group and the National Council of State Boards of Nursing, 2008.

practice at the bedside rather than advance to administration or education. CNSs integrate the subroles of expert nurse clinician, consultant, educator, and researcher, requiring skill in collaboration, role modeling, patient advocacy, clinical leadership, and being a change agent. This role tends to be associated with acute-care institutions and specialty practices. The education and expertise should be such that the CNS is eligible for certification as an APRN in a specialty area. The ANCC provides national certification valid for a period of 5 years, and renewal requires either a minimum number of continuing education hours or retaking a certification exam. It should be noted that not all certification is done through ANCC; there are a number of specialty organizations, such as the Holistic Nurses Association, that offer certification. Prescriptive authority can be obtained in some states if the CNS's education and certification meet the state requirements.

### **Nurse Practitioner (NP)**

The NP has an independent scope of practice using comprehensive assessment, clinical reasoning, differential diagnosis, diagnostic testing and interpretation and prescribes therapies including medications over time and across the life span. Health promotion and illness and injury prevention are important focuses. The NP works in a variety of settings, both autonomously and in interdisciplinary groups, providing care for individuals, families, and populations. Of all the advanced practice nursing roles, the largest evidence-base-of-care outcomes are seen in NPs demonstrating equivalent physician outcome benchmarks (O'Grady, 2008). NPs have been described as a disruptive innovation, in particular as an alternative to the traditional medical primary-care-delivery model (Christensen, Bohmer, & Kenagy, 2000). NPs treat many common and complex health problems that historically

**TABLE 24–2 Certifications Available Through the American Nurses Credentialing Center**

| Nurse Practitioners            | Clinical Nurse Specialists | Other Advanced-Level      | Specialties                      |
|--------------------------------|----------------------------|---------------------------|----------------------------------|
| Acute Care                     | Adult Gerontology          | Forensic Nursing—Advanced | Ambulatory Care                  |
| Adult-Gerontology—Acute        | Pediatric                  | Nurse Executive—Advanced  | Cardiac-Vascular                 |
| Adult-Gerontology—Primary Care |                            |                           | Faith Community                  |
| Family                         |                            |                           | Gerontological                   |
| Pediatric Primary Care         |                            |                           | Informatics                      |
| Psychiatric and Mental Health  |                            |                           | Medical-Surgical                 |
| Specialty                      |                            |                           | Nursing Case Management          |
| Emergency                      |                            |                           | Nursing Professional Development |
|                                |                            |                           | Pain Management                  |
|                                |                            |                           | Pediatric                        |
|                                |                            |                           | Psychiatric and Mental Health    |

Source: From *ANCC Certification Exams*, by the American Nurses Credentialing Center, 2014. Retrieved from [www.nursecredentialing.org/certification.aspx](http://www.nursecredentialing.org/certification.aspx)

### Interview ► Sharon S. Cohen, RN, MSN, CEN, CCRN—*Clinical Nurse Specialist*

**What was your area of practice before you became a CNS?** I was a staff nurse in ICU and in the emergency department.

**Why did you decide to become a CNS?** I'm a creative and self-directed person. I wanted to have greater influence on patient care and staff expertise. So when I got my MSN I felt a CNS role offered me more autonomy than a nurse practitioner role. The inquisitive side of me wanted to incorporate research, and that is a part of the CNS role. I basically wanted to elevate the level of expertise at the bedside, and in this role I can see people blossom.

**Describe your practice setting and what you do as a CNS.** My practice setting is a Level 1 trauma center. I see the patients in the Trauma Resuscitation Unit, Surgical-Trauma ICU, or other floors as needed. I respond to trauma alert calls, both pediatric and adult. I am available to staff for questions, particularly clinical questions when the acuity level is high. I am also responsible for program development and continuing education unit offerings and other educational programs. I participate in research and try to get the staff involved in research and in implementing evidence-based practice through policy and protocols.

**Describe your best experience as a CNS.** The one that really taught me the most involved a 12-year-old girl who was hit by a car while she was crossing the street to get to her school bus. She arrived brain dead, and we could do none of our lifesaving measures to help her. Her mother was a single mother who was working as a temp;

we had no contact information and had to send the police to the agency and then out to find her in the workplace. Before the mother could arrive at the hospital, the PICU nurses had cleaned her up, covered the battered part of her head, and had her looking beautiful when the mother arrived. The little girl had the most angelic expression I have ever seen. After the mother arrived and grieved awhile, she kissed her daughter good-bye. It was at this time I had to approach her about organ donation. I said to her that although I knew this was her worst nightmare, she might be able to help someone else by donating organs. The mother said that there had been an organ recipient who visited the daughter's school just a few weeks before and told the kids what a wonderful thing it was to receive an organ. The daughter had gone home and told the mother that she wanted to be an organ donor. The mother felt by agreeing to the organ donation she was fulfilling her daughter's wishes. The human contact with that mother taught me so much, and you don't learn those things in textbooks. Those of us who work in trauma become so centered on lifesaving that we need to remember how to care for the families when we can't save a life.

**What encouragement and advice would you give to a nurse considering becoming a CNS?** Do your homework on all the advanced practice roles and pick the one that best suits you. I think the CNS role is the hardest because it is more autonomous. You have to want that autonomy to be happy in the role.

## Interview ► Susan Meier, DNP, APRN, NNP—*Nurse Practitioner*

**What was your area of practice before you became a nurse practitioner?** I began nursing practice in the neonatal intensive care unit (NICU) and worked in a Level III NICU for 12 years prior to returning to school to become a neonatal nurse practitioner (NNP).

**Why did you decide to become a nurse practitioner?** As an experienced nurse I began to feel that even when I took care of the sickest patients I was repeating the same tasks. I began looking for ways to practice more autonomously and “do more” within my profession. When considering going to graduate school, I looked at the CNS and NP role. I really enjoy education and wasn’t sure which to do. A practitioner in another field advised me to pursue the NP role due to the expanded opportunities.

**Why did you choose your graduate program?** There was (and still is) only one NNP program in the state.

**Describe your practice setting and what you do as a nurse practitioner.** I work in a Level III NICU. I see all NICU patients, develop plans of care, and write daily notes. I attend high-risk deliveries and resuscitate newborns as needed. Admission to the NICU often involves

procedures such as central line placement, intubation, chest tube, or needle thoracentesis, which I perform. My practice is very collaborative with the neonatologist. Because the neonatologist comes round briefly and then is on call, the NNP essentially runs the NICU.

**Describe your best experience as a nurse practitioner.** I used to fly for the NICU transport team as an NNP. We arrived in a rural hospital to pick up a baby with a large tension pneumothorax. I placed a chest tube, providing analgesia and sedation, and transported the baby. The parents subsequently told everyone that I saved their baby’s life. Just being recognized for the special care I provide and feeling like I really made a difference for that patient was a wonderful experience.

**How do you see your role as a NP changing over the next 5–10 years?** I believe the autonomy of the role will continue to expand with the changes the 2010 Patient Protection and Affordable Care Act is bringing.

**What encouragement and advice would you give to a nurse considering becoming a nurse practitioner?** It will be hard, but it will be the best thing you ever do. Go for it!

required a physician’s care. Health care becomes more efficient, more economical, and more accessible through NP care without loss of quality.

Table 24–2 shows certification areas available to NPs through the ANCC. Other certification exams are being retired by December 2015, consistent with the Consensus Model for APRN Regulation. Certifications in other specialties may be available through other organizations. For instance, neonatal nurse practitioners are certified by the National Certification Corporation (2014).



**InfoQuest:** Visit the website for the American Nurses Credentialing Center and browse the certification requirements. Which might be appropriate for your clinical interests?

### Certified Nurse Midwife

The practice of nurse midwifery in the United States began in the 1920s and was established by such early leaders as Mary Breckinridge and Hattie Hemschmeyer. Its history is linked to the Frontier Nursing Service. A certified nurse midwife (CNM) is a registered nurse who

has advanced educational preparation in midwifery, which includes theory and extensive supervised clinical experiences in prenatal care, management of labor and delivery, postpartum care of the mother and infant, family planning, and gynecological care for well women (American College of Nurse-Midwives, 2011). The focus of education is on normal obstetrics and newborn care. Most nurses who choose to become nurse midwives have extensive prior nursing experience in maternity nursing. Nurse midwifery programs in the United States are offered at the DNP, master’s degree, postmaster’s degree, and certificate levels, and all are accredited by the American College of Nurse-Midwives (ACNM). The ACNM is also the credentialing organization that sets the standards by which nurse midwifery is practiced in the United States. Certified nurse midwives practice in all states and territories in the United States delivering babies in hospitals, in birthing centers, and in the home. Although most nurse midwives practice independently, providing care for women and children, all maintain access to a healthcare system for consultation and referral of clients with complications (American College of Nurse-Midwives & American College of Obstetricians and Gynecologists, 2011).



## Interview ► Kathleen Dunemn, PhD, APRN, CNM—*Certified Nurse-Midwife*

**What was your area of practice before you became a nurse midwife?** My area of practice before becoming a CNM was as a labor and delivery, postpartum and newborn nursery (normal newborn and NICU) RN. I practiced as an RN for 17 years before returning to graduate school to become a CNM.

**Why did you decide to become a nurse midwife?** The prompts for me to return to graduate school were the desire to increase my scope of clinical practice by becoming a CNM and to prepare myself academically and clinically to eventually pursue a PhD in nursing. The major prompt to become a CNM was the desire to be an independent, direct healthcare provider for women (puberty through geriatric ages). My desire was to gain the education, clinical expertise, and credentials to safely provide women midwifery care through a holistic approach, during the many transitions they faced not only in their reproductive years but in their postmenopausal years.

**Describe your practice setting and what you do as a nurse midwife.** I have been a CNM for 24-plus years. The concentrated time of my practice as a CNM was as an active duty army nurse working primarily with young families of reproductive age with either one or both parents being on active duty. During this time I practiced as a full-scope CNM. That is, I independently provided well-woman, antepartum, intrapartum, and postpartum care as a member of a physician/CNM practice that supported a population with a birthrate of approximately 350 births per month and an outpatient visit rate of over 3,500 patients a month. The practice setting was a military medical center. Evidence-based practice and standard operating procedure guidelines were used to guide practice. Also as an active duty CNM I was also qualified and functioned as an OB/GYN surgical first assist. During my tenure as an active duty CNM I was also a commander (chief executive officer) of a large outpatient care department. This added responsibility allowed me the opportunity to improve women's health care in the military healthcare environment outside of the United States.

**Describe your best experience as a nurse midwife.** The best experiences as a CNM were those where I could experience outcomes of care provided over time. These best experiences are always those when I care for a couple entirely through the childbearing process (ante-, intra-, and postpartum). The personal relationship that develops between the couple and the CNM is one of mutual respect and trust. Participating in and facilitating the “complete” childbearing experience/process with a couple is truly the use of the full academic and clinical competencies and capabilities of the CNM.

**Where do you see your role as a CNM changing over the next 5–10 years?** I foresee the demand for CNMs in the United States increasing over the next 5–10 years. With the many changes predicted for health care during the decade from 2015 to 2025 the demand for obstetrical/gynecological care that is holistic, patient centered, safe, and affordable (CNM care) will certainly increase.

**What encouragement and advice would you give to a nurse considering becoming a nurse midwife?** As with any advanced practice nurse role one needs to follow her or his passion. To determine one's passion, one must become immersed and work as an RN in the proposed area of focus. My advice would be to have experience in all areas of women's health care (well-woman, ante-, intra-, and postpartum) before making the final decision regarding pursuing graduate education as a CNM. Nurse midwifery practice is generally full scope, meaning the care of women across the life span (puberty through geriatric) and during the reproductive and postmenopausal time frames. To determine if this truly is your passion, not only working as an RN in these areas but also meeting and interacting with local CNMs will give you more knowledge about the special advanced practice role as a CNM. Additionally, I recommend identifying a nursing career mentor (preferably an RN with an MSN or higher graduate degree) to discuss your thoughts and to provide you with needed information about this important career step. Finally, I'd suggest organizing your personal and work life as much as possible prior to beginning the graduate program.

Nurse midwives also practice in Great Britain, Canada, Australia, Europe, and Africa, as well as many of the island nations in the Caribbean. The education, regulation, and extent of practice of nurse midwives vary around the world. The World Health Organization (WHO) has placed increasing emphasis on the role of the midwife providing services worldwide in partnership with the International Confederation of Midwives and the International Council

of Nurses. The growth, development, and support of these roles are viewed as key in achieving health for all (World Health Organization, 2011).

### **Certified Registered Nurse Anesthetist (CRNA)**

The nurse-anesthetist was one of the earliest advanced practice roles in the United States. Nurses started administering anesthesia as early as 1889. A certified registered

## RESEARCH CURRENT

## A Day in the Lives of APNS in the U.S.

Swartz, Grey, Allan, Ridenour, Kovner, Walker, and Marion conducted a national survey of NPs and CNMs, collecting data on their practice for a typical day. They were asked about hours worked, number of patients seen, practice setting, clinical problems encountered, and other information. A total of 676 advanced practice nurses participated in the study. On a typical day NPs and CNMs spent 7.35 hours seeing an average of 15.35 patients. The average time per visit was 27 minutes. Of these nurses, 78% practiced in an office or clinic, 12% practiced in a hospital setting, 2% practiced in a nursing home, and 8% identified another type of practice setting. Overall, laboratory studies were requested for 35% of the patients and radiographic studies for 10%. A physician consult was obtained for 15% of the patients, and 8% were referred to a specialist.

Of the patients, 42% received counseling or patient education and a prescription for one medication. About 16% received prescriptions for two or more drugs. The patients seen by the nurses on that day were racially and culturally diverse, and about two thirds were female. Poor patient adherence to care regimens and patient difficulties with keeping appointments and follow-up visits were among the most challenging clinical problems identified, and these problems were confounded by associated difficulties with patients' financial resources. The results of this survey indicate that NPs and CNMs routinely manage complex caseloads.

*Source:* "A Day in the Lives of APNs in the U.S.," by M. K. Swartz, M. Grey, J. D. Allan, N. Ridenour, C. Kovner, P. Walker, and L. Marion, 2003, *The Nurse Practitioner*, 28(10), 32–39.

nurse anesthetist (CRNA) is a registered nurse who has advanced educational preparation, including classroom and laboratory instruction and supervised clinical practice, in the delivery of anesthesia to clients in a variety of practice settings, including hospitals, ambulatory surgical centers, birthing centers, and clinics. The American Association of Nurse Anesthetists (2011), founded in 1931, established a certification program for nurse anesthetists in 1945 and an accreditation program for educational programs for nurse anesthesia in 1952. It has announced its support for requiring doctoral preparation to be a CRNA by 2025 (American Association of Nurse Anesthetists, 2007). Programs preparing nurse anesthetists are all at the master's level or higher and are accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs, which also administers the certification examination. CRNA programs may be located in schools of medicine in addition to schools of nursing.

CRNAs take care of a patient's anesthesia needs before, during, and after surgery. The tasks they assume in performing the role include the following:

- Performing physical assessment
- Participating in preoperative teaching
- Preparing for anesthetic management
- Administering anesthesia to keep the patient free of pain
- Maintaining anesthesia intraoperatively
- Overseeing recovery from anesthesia
- Following the patient's postoperative course from recovery room to patient care unit

In many settings, such as rural and U.S. military healthcare facilities, nurse anesthetists deliver anesthesia independently to clients for every type of surgery or procedure (American Association of Nurse Anesthetists, 2014). Although CRNAs are legally allowed to provide anesthesia in all 50 states, some states require physician supervision in some settings. When anesthesia is provided by a CRNA, it is recognized as the practice of nursing.

### Reflect On . . .

- client satisfaction with the APRN. What client needs does the APRN meet that the physician may not meet?
- what client needs the physician meets that the APRN may not meet.

### Regulation of Advanced Practice

The regulation of advanced practice nursing in the United States varies from state to state. Each state has the jurisdiction to determine the requirements for licensure of the APRN, including the use of a particular title and the definition of the scope of practice. The variation in state licensure requirements and a desire to minimize confusion about APRNs resulted in the 2008 Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education. This model provides guidance not only for state licensure but also for organizations that accredit educational programs and certify APRNs.

## Interview ► R. Stan Leeper, MSN, ARNP, CRNA—*Certified Nurse Anesthetist*

**What was your area of practice before you became a nurse anesthetist?** I practiced 1 year in critical care before acceptance to anesthesia school.

**Why did you decide to become a nurse anesthetist?** I saw patients preoperatively in nursing school and how anxious they were about their surgery, their diagnosis, and especially having to be put to sleep, or seeing their child having to have surgery. It is a very vulnerable time for patients, when they need caring, and I felt I could help them. I met and established rapport with a person who became a mentor and encouraged me to apply to anesthesia school.

**Describe your practice setting and what you do as a nurse anesthetist.** I practice in a rural part of Texas in a town of 20,000 population (drawing area of 140,000) and do anesthesia for OR, labor and delivery, and ER trauma. The nearest referral hospital is an hour away, by car. Texas CRNAs have a great amount of autonomy, and being an independent practitioner adds more responsibility.

**Describe your best experience as a nurse anesthetist.** Being able to practice in a community where you know most of your patients on a first-name basis, it is rewarding to see them later and know you

helped them through a very stressful time, from a 1-hour-old neonate with a diaphragmatic hernia to a 98-year-old for colonoscopy. It is a great profession!

**What gives you the most satisfaction as a nurse anesthetist?** Early in my career it was the satisfaction of knowing you helped the patients to get better, and now it is rewarding to help nursing students to understand how to care for their patients. Its good to emphasize to students rotating in operating room and postanesthesia care unit (OR/PACU) that they are the eyes and ears of the patient under anesthesia and that patients are totally dependent upon the nurses' knowledge and experience to see them through. When a student has an "aha" moment about what she or he is learning is most satisfying!

**What encouragement and advice would you give to a nurse considering becoming a nurse anesthetist?** Graduate school is not hard; it is an extension of things you already have been introduced to and a guide to what new things you need to be better at to be successful in your new profession. You will need to have a strong will, expend a lot of effort, and have a "never give up" attitude. It is totally worth it!

Various legal titles are conferred by the states to designate the APRN, including nurse practitioner, advanced practice registered nurse, advanced practice nurse, and advanced registered nurse practitioner. In addition, certification titles such as certified nurse midwife, clinical nurse specialist, and certified registered nurse anesthetist cause confusion in the public's mind about who APRNs are and what they do. The state boards of nursing as well as the professional nursing organizations continue to attempt to resolve this issue of variable APRN titling.

Certification is a voluntary process by which an agency or an association grants recognition to a person who has met specified qualifications. Certification is intended to protect the public by enabling the identification of competent people. It signifies the attainment of specific criteria and knowledge, skills, and abilities in a specific specialty field. Certified nurses are in the greatest demand and earn an average of \$9,000 more than their counterparts who are not certified (Smolensky, 2007). Many APRNs are certified by national professional organizations that have

developed educational and experiential criteria for specialty certification. For example, the Pediatric Nursing Certification Board (PNCB) provides pediatric nurses certification opportunities as certified pediatric nurse practitioners (CPNP) and certified pediatric nurses (CPN). Most states require certification by a recognized national certification body and the completion of a graduation degree in nursing with an advanced practice specialty before a nurse can be licensed and function at the advanced practice level. Whereas most states recognize the nurse anesthetist, the nurse midwife, and the nurse practitioner roles, some states do not recognize and license the clinical nurse specialist as an APRN.

APRNs, with the assistance of national professional organizations, have fought to obtain legal authority to practice, to be directly reimbursed for their service, to prescribe medications, and to work to their full scope of practice. Direct reimbursement for APRN services from private insurers, Medicaid, Medicare, and other governmental funders of healthcare services continues to be sought and

improved. Private insurers frequently still limit their provider empanelment to physicians and thus require an APRN to bill through a physician-nurse collaboration. Some insurers authorize a percentage of reimbursement (usually around 85%) when the nurse bills directly but will reimburse at 100% if the nurse bills indirectly through a physician-nurse collaboration. In contrast, governmental funders of federal and state healthcare services provide for some level of direct reimbursement for APRNs.

The right to prescribe medications and other therapies requires legal authority. The majority of states allow APRNs to prescribe, but many require that such prescriptions follow physician protocols and be cosigned by a physician or include the physician's name and drug number on the prescription form. Some states require pharmacist approval. Many states limit the APRN's prescriptive authority to certain classifications of drugs, often prohibiting the nurse from prescribing controlled drugs. Some states have developed a formulary of drugs from which nurses can prescribe. Some states grant prescriptive privileges only to nurses who are working in public health clinics, rural health facilities, or other medically underserved settings. In those states where APRNs have some level of prescriptive authority, they may be required to have a course in advanced pharmacology, some specified period of supervised clinical practice, and/or a graduate degree in nursing. Some states mandate continuing education in pharmacology to maintain prescriptive privileges. Given the variations in APRN state regulations and the ever-changing state nurse practice acts, APRNs must be informed about their state requirements to practice and monitor for state requirement changes.

### The International Perspective

The ICN established an International Nurse Practitioner/Advanced Practice Nursing Network in 2000, responding to new nursing roles emerging worldwide. The goal of the network is to be an international resource for nurses and nurse practitioners, as well as other interested stakeholders such as policymakers, educators, regulators, and healthcare planners. To facilitate common understanding and to guide further development, an official ICN position paper was released in 2002 with the following definition:

A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to

practice. A masters degree is recommended for entry level. (International Council of Nurses, 2008a)

In addition to the advanced level of education, the Nurse Practitioner/Advanced Practice Network (NP/APN) recommends formal recognition of the educational programs through accreditation or other approval process and a formal system of licensure, registration, certification, and credentialing. The ICN estimates that approximately 70 countries have advanced practice nursing roles or are considering implementing those roles (International Council of Nurses, 2008b).



**InfoQuest:** Visit the website of the International Council of Nurses Nurse Practitioner/Advanced Practice Nursing Network for country perspectives on the advanced practice role.

In Canada, advanced nursing practice (ANP) is an umbrella term describing an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill. ANP extends the boundaries of the scope of practice. The domain of practice is usually direct care but may include education, research, or administration (Canadian Nurses Association, 2007). The minimum level of preparation for advanced nursing practice in Canada is a baccalaureate degree in nursing, although 75% of ANP program graduates have a graduate degree (Canadian Association of Schools of Nursing, 2011).

ANPs in Canada are either an NP or a CNS. The CNS is a registered nurse with a master's or doctoral degree in nursing with expertise in a specialty area. The role was introduced in the 1960s and comprises five domains: practice, consultation, education, research, and leadership (Canadian Nurses Association, 2009a). The CNS provides expert client care by applying in-depth knowledge of nursing and other appropriate sciences. Nurse practitioners in Canada specialize in adult, pediatrics, or family care (Canadian Nurses Association, 2009b) and are the only role with additional regulation and titling protection.

The Canadian Nurses Association (CNA) offers a certification program that provides a clinical credential in 20 clinical specialties. Eligibility for certification is based on experience in the specialty or a combination of experience and postbasic education. Nursing legislation across Canada is built on professional responsibility and accountability, and nurses must not act beyond their individual level of competence and preparation. The accompanying box shows the certification areas provided by the CNA.



## Canadian Nurses Association Specialty Certifications

- Cardiovascular
- Community Health
- Critical Care
- Critical Care—Pediatrics
- Emergency
- Enterostomal Therapy
- Gastroenterology
- Gerontology
- Hospice Palliative Care
- Medical-Surgical
- Nephrology

- Neuroscience
- Occupational Health
- Oncology
- Orthopedic
- PeriAnesthesia
- Perinatal
- Perioperative
- Psychiatric/Mental Health
- Rehabilitation

Source: From *Certification*, by the Canadian Nurses Association, 2014  
Retrieved from [www.nurseone.ca/en/certification](http://www.nurseone.ca/en/certification)

The Nursing and Midwifery Board of Australia (NMBA) establishes national competency standards for nurse practitioners and midwives. *Nurse practitioner* is defined as “a registered nurse educated and authorized to function autonomously and collaboratively in an advanced and extended clinical role” (Nursing and Midwifery Board of Australia, 2014). To practice midwifery in Australia, the nurse must have graduated from a midwifery program recognized in the country where it was completed and acquired the qualifications necessary to be licensed or registered to practice midwifery (Nursing and Midwifery Board of Australia, 2006). Accreditation standards for nurse practitioner and midwifery educational programs were drafted in 2009. Review of the nurse practitioner standards occurred in 2014 under the delegation of NMBA to the Australian Nursing and Midwifery Accreditation

Council (ANMAC). Further change in program accreditation standards are anticipated, including those addressing prescriptive authority (Australian Nursing and Midwifery Accreditation Council, 2014).

## The Future of Advanced Practice Nursing

APRNs fill a need for quality primary care services at an affordable cost to clients in both rural and urban settings. Access to affordable care has been one of the driving forces in the increased number of APRNs in recent years. That societal need is likely to continue to influence the delivery of health care. Nursing is strategically positioned to be a major player in policy development for the future.

RNs, APRNs, and professional nursing organizations will need to educate not only the public but also politicians and legislators about the proper role of the advanced

## RESEARCH CURRENT

### 2012 National Sample Survey of Nurse Practitioners

In a U.S. Department of Health and Human Services national random sample survey, almost 13,000 of an estimated 154,000 licensed NPs were surveyed in 2012 with a 60.1% return rate. Information was collected on the NPs' licensure, certification, education, demographics, and clinical practice attributes, including services provided, practice specialty, practice setting, and perceptions of work.

Of the total NP population, about 94% held a graduate degree in nursing. Of those who did not hold a graduate degree, most were educated prior to 1992 and were grandfathered into the profession as states moved to requiring a graduate degree for practice. Certification was held by 96% of the NP population, and 76% held certification in a primary care specialty of adult/gerontology, family, or pediatrics. Over 50% of the workforce

were family NPs. Demographic results showed that the workforce continued to be homogeneous in gender and race/ethnicity, primarily white, non-Hispanic, and female. The average NP age was 48 years.

NPs were overwhelmingly found in direct patient care clinical practices, with only a small number in faculty or administrative roles. About 75% of the NPs provided these services: histories and physical exams, prescribing medications, and obtaining and interpreting diagnostic tests. These NPs reported that they practiced to the fullest extent of their state scope of practice and were satisfied or very satisfied with their NP positions.

Source: *2012 National Sample Survey of Nurse Practitioners*, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2014, Rockville, MD: U.S. Department of Health and Human Services.

**CRITICAL THINKING EXERCISE**

Interview an advanced practice nurse and a nurse working in a traditional role using the criteria on Pavalko's (1971) occupation-to-profession continuum found in

Chapter 1. What differences did you find in the two roles related to the criteria for a profession? Was there a difference in autonomy of practice?

**CRITICAL THINKING EXERCISE**

What knowledge and skills are shared by nurses and physicians? Which specific skills fall in the domain of basic nursing practice, which fall into advanced

nursing practice, and which are specific to the practice of medicine?

practice nurse. The APRN has a major role in preventing illness and promoting health for individuals, families, and communities. As APRNs expand their roles and become more autonomous, role conflict with primary care physicians develops. For the advanced practice roles to fulfill their potential, there must be a cooperative and collaborative relationship established with other healthcare providers, particularly with physicians. The need for further expansion of the scope of practice to include prescriptive privileges and other procedures traditionally performed by physicians will continue into the future.

It is likely that there will be more standardization of the role, scope of practice, and standards of advanced practice internationally as the ICN continues its work in this realm. Standardization of the educational requirement for preparation may be challenged as the United States works toward the DNP as the minimum level of preparation for advanced practice.

**Reflect On . . .**

- the future of advanced practice in your community, state (province, territory), and nation. How do you see APRNs solving some of the problems in today's healthcare system?
- whether advanced practice is a professional career choice for you. Do you have the assertiveness required to perform in an independent role?

**Selecting a Graduate Program**

Choosing a graduate program is an important decision for a nurse who is committed to lifelong work in nursing. Several factors must be considered, including professional

career goals, personal and family factors, and characteristics of the proposed program. See the accompanying box.

**Professional Career Goals**

The nurse must first identify personal career goals. Graduate education is preparation for specialized practice. Not all graduate programs will provide the course work to meet the requirements for all advanced nursing roles and clinical practice settings. Some graduate schools of nursing focus on nurse practitioner roles; others focus on the roles of nurse educator and administrator. Some schools are highly specialized and may provide only a single program, for example, in nurse anesthesia. Some schools of nursing offer highly specialized graduate programs of study, such as nursing informatics, aerospace nursing, or forensic nursing. Some graduate schools of nursing integrate advanced clinical practice roles with functional roles of education or administration but still require that the nurse choose an area of clinical specialization, such as adult/geriatrics health, pediatric health, women's health, or psychiatric/mental health. Graduate study may include shared core or common courses that all students take (e.g., nursing theory, nursing research); however, the student must be assured that the program provides the course work and clinical experiences that the student will need to achieve her or his personal goals. For example, the nurse who wants to become a faculty member in a school of nursing should take courses in teaching methods, curriculum development, and clinical evaluation of students, and the nurse who wants to become a pediatric nurse practitioner must have clinical experience in pediatrics with appropriate faculty and preceptors.

## Criteria for Considering a Graduate Program

- Professional career goals
- Personal and family factors
- Program characteristics
  1. Type of graduate programs offered
  2. School's philosophy of nursing and education
  3. Accreditation status
  4. National standing
  5. Admission requirements
  6. Faculty qualifications
  7. Institutional climate
  8. Resources
  9. Clinical facilities
  10. Assistantships and other financial support
  11. Program graduation requirements

Source: Adapted from "Graduate Education: Making the Right Choice," by G. W. Poteet, L. C. Hodges, and S. Tate, 1994, in *Current Issues in Nursing* (4th ed., pp. 182–187), by J. McCloskey and H. K. Grace (Eds.), 1994, St. Louis, MO: Mosby.

The nurse must also decide whether to pursue a graduate degree in nursing or a graduate degree in another field. For example, some nurses who want to become administrators in healthcare organizations may choose a graduate degree in business or healthcare administration. Nurses in psychiatric/mental health nursing may choose a graduate degree in mental health counseling. Before selecting a nonnursing graduate degree, the nurse should investigate the requirements for nursing licensure and certification in the desired field and consider possible future requirements. Currently, some national certification programs require a graduate degree in nursing (e.g., ANCC clinical nurse specialist in adult/gerontology nursing or adult psychiatric/mental health nursing), whereas others do not (e.g., Association of Operating Room Nurses [AORN] perioperative nurse).

Many professional nursing organizations are anticipating changes in certification requirements that will mandate a doctoral degree in nursing. Most state boards of nursing have mandated the graduate degree in nursing to practice in an advanced nursing role. Further, the nurse who wants to teach nursing will need to consider employment requirements. Accreditation criteria for schools and colleges of nursing specify that graduate preparation be in the content area to be taught. In other words, someone teaching nursing must have an advanced degree in nursing or a closely related field rather than education, psychology, or another discipline. Additionally, if the goal is to teach in a specialty area such as child health, the hiring school or college may require graduate preparation and clinical experience in that specialty area.

Clearly defining professional goals enables the nurse to identify those graduate programs that provide the education and experiences to meet those goals. The nurse then considers personal and family factors and program characteristics to determine which program is most appropriate.

## Personal and Family Factors

Several personal and family factors may affect a nurse's choice of a graduate nursing program. Is the nurse able to travel or relocate to another city or state to pursue graduate education? If there is a long commute to school, should the nurse relocate to be closer to school and its resources, such as the writing center or statistical consult laboratories? Must the nurse support self or family while going to school? If so, the availability of employment opportunities is important. If working while going to graduate school, the nurse may desire flexible school or work schedules to facilitate balancing study and work time. It may be best for the nurse to select a program that allows part-time study if work and family demands are heavy. When travel opportunity is limited, the nurse may want to investigate available online courses and programs.

The nurse who is married needs the support of spouse and other family members while going to school. Working and going to school may limit the nurse's ability to fulfill spousal and parenting responsibilities. At the same time, children who see their parent continuing professional education have a role model for lifelong learning. The nurse who is returning to school needs to strategize with family members about how to meet family responsibilities.

## Program Characteristics

Poteet et al. (1994, p. 184) identify the following essential elements for assessing a graduate program: specific programs of study, program requirements, the school's philosophy of nursing and education, accreditation status, national standing, admission requirements, faculty qualifications, institutional climate, resources, clinical facilities, and assistantships and other financial support. In the context of personal needs and consideration of the return on investment, assessing the convenience of program offerings and program outcomes is also critical. This information may be obtained from the institution's catalog or website, from personal

contact with the faculty or program coordinator, or through discussion with a current student or graduate.

1. **Programs of study offered.** Does the school offer the specific program of study to enable the nurse to achieve her or his professional goals?
2. **Program requirements.** What are the requirements for degree completion? Specifically, how many credit hours, what type of course work, and how many classroom and clinical hours are required? A requirement of nurse practitioner certification, in most clinical areas, is a specified minimal number of hours in clinical practice. Will graduates of the program be eligible to take the national certification exam?
3. **School's philosophy of nursing and education.** Does the school subscribe to the philosophy of one nursing theorist, or does it have an eclectic model, that is, an integration of several theorists? Knowing the school's philosophy helps the prospective student understand the foundational beliefs of the school, its faculty, and the curriculum. Is the school's philosophy of nursing and education consistent with the nurse's philosophy? Inconsistency between the nurse's philosophy and the program's philosophy may interfere with success or satisfaction in the program.
4. **Accreditation status.** Accreditation may be conferred by a state government; by a regional accreditation association, such as the Southern Association of Colleges and Schools (SACS); or by a professional organization, such as the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE). Specialty nursing organizations may also accredit specific programs; for example, the Accreditation Commission for Midwifery Education originating from the American College of Nurse-Midwives accredits graduate programs in midwifery. Graduation from an accredited program is important for the graduate to meet national certification requirements and to obtain licensure for advanced practice. Research doctoral programs are accredited through regional higher education bodies that are not specific to nursing, although quality indicators have been outlined by the American Association of Colleges of Nursing (2001).
5. **National and local standing.** Programs may have a national reputation for excellence in certain fields of study. This reputation is usually based on the achievements of the faculty, the facilities for learning, and the achievements of the graduates. Attending a program with a reputation for excellence may enhance the graduate's opportunities for employment.
6. **Admission requirements.** Admission requirements may include a minimum grade-point average (GPA)

for undergraduate work, a minimum score on a national entrance examination such as the Graduate Record Examination (GRE), and successful completion of specific prerequisite courses such as physical assessment, statistics, or pharmacology. Most graduate nursing programs require completion of a baccalaureate degree in nursing. Some graduate programs allow nurses with a baccalaureate degree in another field to enter the graduate nursing program but require that the student complete any undergraduate nursing courses that were not previously taken (McGriff, 1996, p. 9). Because admission to graduate nursing programs is competitive, students need to be aware of specific admission requirements so that they can take action to meet or exceed the requirements; if they fail to meet the requirements, they may be denied admission. The student who is denied admission should question whether there are any admission waivers under which she or he might still qualify, such as a minority waiver or conditional admission.

7. **Faculty qualifications.** All faculty who teach at the graduate level should have a doctoral degree and a history of scholarly productivity, such as research and publications. Faculty teaching in practice degree programs should be active in practice. Students should expect to be taught by faculty who are experts in their fields and should seek a program where there are faculty who have expertise in the area of their interest.
8. **Institutional climate.** Prospective students may want to question students currently in the program about the climate of the school of nursing and the university/college. Do the university and school of nursing provide an environment of diversity where students can experience the value and strength of human difference? Is there an open climate in the school of nursing and the university community that allows scholarly inquiry without fear of retribution? Are relationships among faculty, students, administration, and other staff open and conducive to learning? Do faculty members have a reputation of being "student friendly"; that is, are they readily available for student consultation, or are they difficult to contact outside scheduled class times? Do faculty members challenge students to achieve their fullest potential in an atmosphere of academic rigor? Do faculty members teach most of the courses, or do teaching assistants or adjunct faculty teach a high percentage of classes? What is the ratio of continuing faculty to temporary or part-time faculty? What is the student cohort size? Cohort size may impact the student's connection with the faculty or learning opportunities. Quality education is significantly associated with a supportive student learning



environment and faculty mentorship (Kim, Park, Park, Khan, & Ketefian, 2014).

9. **Resources.** What resources are available to support and enhance student learning? Are library materials adequate, including books, journals, and online resources, to support the student's field of study? Are computer services and statistical consultation sufficient to facilitate student research? Are study areas, lounges, and dining facilities adequate? Students should also inquire about hours of operation, especially evening, weekend, and holiday hours, to determine whether resources are available when students need them. Is there on-campus housing available for the student who must relocate for graduate study?
10. **Clinical facilities.** Are adequate clinical sites and preceptors available to support students, especially those who are in programs preparing the advanced nurse practitioner? Clinical sites should include settings that provide diverse practice opportunities and address program outcomes. Preceptors who are experts in the desired specialty and who like working with students should be available. If this is a nurse practitioner program, is most of the teaching and clinical precepting done by qualified nurse practitioner faculty, or is there a heavy reliance on physicians? Are students expected to find their own clinical sites, or does the program place the students in clinical sites? Clinical practice settings should provide opportunities for graduate students to demonstrate critical thinking in the delivery of care to diverse clients with complex problems. Some graduate programs provide clinical opportunities that are international in scope, for example, study abroad programs to provide primary care in underdeveloped nations.
11. **Assistantships and other financial support.** What is the availability of financial assistance? Many graduate programs provide teaching or research assistantships, in which the student receives tuition assistance in exchange for providing either teaching or research

support to faculty. For the student whose professional goals involve teaching or research, assistantships provide an opportunity to gain experience in the role while completing formal graduate education. Many professional nursing organizations provide scholarship assistance for graduate nursing students. Other financial assistance may be available, especially for the student pursuing a graduate degree as an advanced nurse practitioner. Students should inquire about opportunities for financial assistance from their professional organizations, the school of nursing, and the university financial aid office.

12. **Convenience of program offerings.** Are programs offered on-campus only, or is distance learning an option through techniques such as video conferencing, community-based learning, or Internet courses, or through a hybrid of on-campus and distance learning techniques? Are on-site programs offered as intensive weekend courses that allow the nurse to work during the week or to commute on weekends to classes? Do online programs require a term of residency, for example, a 2-week on-campus residency during the summer semester? Is the program full-time or part-time study? Part-time options allow continued work but may impact the student's ability to borrow or qualify for some loans, scholarships, and traineeships.
13. **Program outcomes.** What is the certification pass rate for programs that prepare the student as an advanced practice nurse? After graduation, what is the employment rate in the new role?

Some graduate programs may be offered in cooperation with another academic discipline; for example, some programs in nursing administration are offered jointly with schools of business. These may result in dual degrees, one in each discipline; they are typically lengthy because of the need to meet requirements for each discipline. Other programs grant only a nursing degree but cooperate with other schools in offering course content.

## Chapter Highlights

- Advanced practice nursing has evolved from the early 1900s to become a well-defined area of practice that provides services related to disease prevention, health promotion, health restoration, and rehabilitation.
- Advanced nursing practice in the United States includes clinical nurse specialists, nurse practitioners, nurse midwives, and nurse anesthetists. APRNs work in a variety of practice settings across the healthcare

continuum, but most deliver primary care to rural and urban populations, especially underserved populations, such as the poor and the elderly.

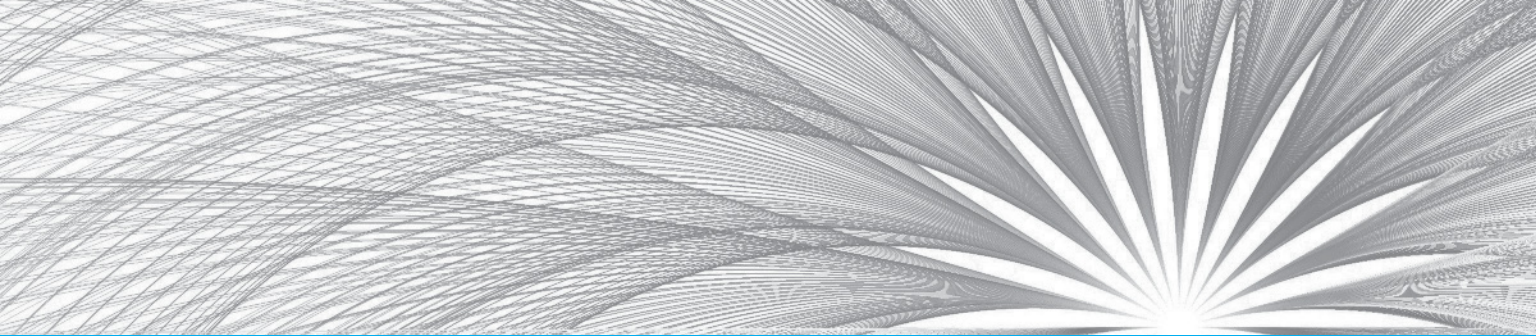
- Internationally, advanced practice nursing is becoming more common, particularly the nurse practitioner and nurse midwife.
- The ICN is developing position statements to guide advanced practice in nursing internationally.
- Certification and regulation of advanced practice has been developed by professional nursing organizations and state boards of nursing to ensure safe practice by qualified practitioners.
- Nurses are required to obtain graduate education for advanced practice to be eligible for certification and state licensure.
- The future of advanced practice in the United States includes a change to include the practice doctorate (DNP) incorporating all advanced practice roles.
- Continued legislative activity by APRNs will be needed to ensure equitable compensation and a broader scope of practice.
- The advanced practice nurse will be a major contributor to the delivery of quality health care at an affordable cost to clients in a changing healthcare environment.
- Nurses planning to pursue graduate study must determine their professional goals before choosing a program.
- After identifying specific programs that will enable the nurse to meet desired goals, she or he needs to evaluate the programs based on personal and family needs and program characteristics.
- Graduate programs in nursing may focus on nursing education, nursing administration, or advanced practice nursing.

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# 25

## The Future of Nursing

### Chapter Outline

#### Challenges and Opportunities

##### Driving Forces for Change

- Healthcare Reform
- Population Changes

##### Past Events That Have Affected Nursing

- Events That Promoted Nursing's Growth and Development
- Events That Have Indirectly Affected Nursing
- Social Movements and Technological Initiatives That Have Affected Nursing

##### Looking Toward the Future of Nursing

- Computer Technology and Its Effect on Health and Nursing Care
- Healthcare System Changes
- Regulatory Changes
- Continued Medical, Surgical, and Pharmacological Advances

##### Applying Past Lessons to the Future

##### Visions of Tomorrow

##### Chapter Highlights

### Objectives

1. Identify past events that have shaped and molded nursing.
2. Discuss projections of future events that will affect nursing.
3. Identify anticipated changes in health care and nursing in the future.

As the millennium began Patricia Benner (2000) predicted that nurses would be doing more in the community and becoming even more integral to the provision of intensive care that would increasingly be the focus of hospital care. She advocated that a major task should be to recover the “Nightingale vision of attending to the world of embodiment, and social, emotional, and physical environments that support well-being and promote health” (p. 35). She further expressed the hope that caring practices would be recognized as good in themselves, regardless of more objective and measurable outcomes. Now that we are well into the second decade of the 21st century, we can see truth to her predictions, but we also see new trends and directions emerging in nursing.

There are numerous trends both within health care itself and within the population that are likely to continue in the years ahead, and they will have a tremendous impact on the discipline and practice of nursing. Foremost among them are healthcare reform and population demographics. Added to this there will be changes that we are yet to anticipate. Nursing as a profession must be ready to adapt to change and engage in lifelong learning.

### Challenges and Opportunities

The nursing profession and nurses as individuals face many challenges. Nursing roles are expanding at a rapidly increasing pace, and that is likely to continue. Old roles and skills are no longer adequate. The challenge is for nurses to take control of these changes and become proactive in meeting society's needs for health care in the future.

Inherent in these challenges are opportunities to create a better system of health care. Nursing is positioned to provide leadership in the development of new and better ways to provide nursing



to the population in the community, nationally, and globally. The vast resources of information technology and distance education can provide an avenue for advancing the delivery of care and for changes within the profession that will be needed to meet the demands both now and in the future.

## Driving Forces for Change

### Healthcare Reform

In 2010 the U.S. Congress passed the Patient Protection and Affordable Care Act, which was signed into law by President Obama. The intent of this law was to transform the U.S. healthcare system with the goal of providing seamless, affordable, and accessible quality care. This care was intended to be family-centered and evidence-based, leading to improved health outcomes. Just prior to the passage of this law, the Robert Wood Johnson Foundation (RWJF) teamed with the Institute of Medicine (IOM) to assess and respond to the need for transforming the nursing profession. They established a 2-year Initiative on the Future of Nursing, resulting in an action-oriented blueprint for the future of nursing. The committee recognized nursing's potential to effect necessary changes because of its regular and close proximity to patients across the continuum of care. Nurses could act as partners with other healthcare providers and professionals to lead in redesign and improvement in the many practice environments.

While the strengths of nursing that would contribute to leading the change were acknowledged, the initiative also noted that the nursing profession was dealing with its own challenges. Nursing does not have the diversity with regard to race, ethnicity, gender, and age that is needed to provide culturally competent care to all populations. Many nurses need a more advanced level of education and preparation to effectively respond to the rapidly changing healthcare setting and evolving healthcare system. Restrictions on scope of practice for advanced registered nurse practitioners vary by state and affect practice opportunities, resulting in professional tensions that can undermine care. Making requisite changes will mean that work environments need transformation, scope of practice must be addressed, and numbers of nurses as well as their education level must increase.

The resulting report from the IOM (2010) included four key messages:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

From these four key messages, came eight recommendations:

1. Remove scope-of-practice barriers. This included recommendations expanding Medicare coverage, authorizing advanced practice nurses to assume more responsibilities, and extending Medicaid reimbursement rates.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Resources should be allocated for developing and implementing best practices and new models of care.
3. Implement nurse residency programs. Support should be provided for transition-to-practice programs after completion of a prelicensure or advanced practice degree or when transitioning to a new area of clinical practice.
4. Increase the proportion of nurses with a baccalaureate degree to 80% by 2020. Schools of nurses are encouraged to offer new academic pathways that allow seamless progression to higher levels of education. Furthermore, healthcare organizations were encouraged to promote entrance into a baccalaureate degree program within 5 years of graduation by offering methods of financial support.
5. Double the number of nurses with a doctorate by 2020. This recommendation was intended to increase the number of nursing faculty who can serve as researchers and provided attention to the need for more diversity within nursing. Specifically, the authors wanted to ensure that at least 10% of baccalaureate graduates enter a graduate program of study within 5 years of graduation.
6. Ensure that nurses engage in lifelong learning. Healthcare organizations should foster a culture of lifelong learning and provide resources for interprofessional competency programs. Faculty from schools of nursing should partner with healthcare organizations to develop and prioritize competencies so that curricula can be built around them.
7. Prepare and enable nurses to lead change to advance health. Nursing education programs and nursing organizations should prepare the nursing workforce to assume leadership positions across all levels and ensure that leadership positions are provided for nurses.

8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data. The National Health Care Workforce Commission should lead a collaborative effort to improve research and the collection and analysis of data on healthcare workforce requirements, and that effort should include state licensing boards, executive management teams, and other key leadership positions.

The power to meet these recommendations does not rest on the shoulders of nurses alone. It lies with a broad spectrum of leaders, including government, professional organizations, policy makers, researchers, and other professionals. Together these groups can transform health care so that it does provide seamless, affordable, quality care that is accessible to the population and results in patient-centered, evidence-based care and improved health outcomes for all.

## Population Changes

Changes in population demographics will impact nursing roles in the future. The U.S. population is expected to expand over the next 40 years, and it is expected to grow older as the baby boomers age. In addition, the population is becoming more racially and ethnically diverse, reflecting the influence of immigration. Nurses will need to provide care to an older population, perhaps with increase in focus on chronic illness. There will be a need for a larger nursing workforce as the population grows, and there will be a greater need for culturally competent care.

These population changes will affect policy decisions. The aging population will create financial pressures in public pension plans such as Social Security. Retirement will decrease the labor force. These changes are interrelated with health, health care, and health spending. Recent changes in fertility have produced more births to women over the age of 40 and to teens; both are groups with added risks in childbirth and outcomes that may require added healthcare resources. There are observed differences in the types of care sought and used according to race and ethnicity as well as differences in health conditions experienced and mortality rates. These differences are in part related to socioeconomic differences but still point to challenges for healthcare planning. Trends in cognitive impairment and dementia will create demand for long-term care as people live longer.

Diversity presents challenges in a number of areas. Lack of assimilation can lead to language barriers and misunderstandings. Income disparities and poverty are persistent problems for newly immigrated people (Shresa & Heisler, 2011). In the past, patients had to adapt to the U.S. culture of health care and, particularly, of hospitals. Now

nursing has the opportunity to adapt health care to the culture of the people who are receiving care.

## Past Events That Have Affected Nursing

### Events That Promoted Nursing's Growth and Development

Many events of the past spurred the growth and development of nursing as a profession; many events and public policy changes had an unintended impact on nursing. Social movements and technological advancements also have propelled nursing into favorable as well as hazardous positions.

#### Women in the Workforce

A discussion about nursing's growth must include the impact of World War II on the quantity and quality of nurses in many countries. World War II and the period following were times of major change for health care, for nursing, and for women. Major medical and surgical advances were discovered (some by intent, others by accident), and new techniques for care were developed. Women played a major role in the military in frontline medical units; some served as volunteers in the American and International Red Cross, whereas others entered the workforce in areas they had never before considered. With so many men at war, women were drawn into a work life that was new to them.

Nursing both advanced during this period and suffered. In answering the call to patriotic duty, many women chose nontraditional roles, particularly because the salaries available to war workers were higher. These changing work opportunities for women had a negative effect on nursing; the challenge and rewards of doing men's work attracted many women who, without the new employment options previously unavailable to them, might have pursued nursing. This shift in work choice, which continued after the war was over, contributed to a shortage of nurses in America. In response to the shortage and in line with the desire of professional nursing organizations in the United States to advance nursing's professional standing, a 2-year associate degree nursing (ADN) program was developed for the junior/community colleges, to quickly train nurses to minimum skill levels.

Although nurses were educated primarily in hospitals prior to World War II, the first university baccalaureate degree program in nursing (BSN) in the United States had been in existence since 1909. However, the number of BSN programs has not increased at the same rate as ADN programs. These changes in the education of nurses have significant implications for the future of professional nursing.

### College Education and Nursing

Another event that has affected nursing's growth and development is a position paper issued by the American Nurses Association (1965), which suggested that all education for nurses take place in institutions of higher learning. Although both ADN and BSN programs existed throughout the United States at that time, most nurses were still prepared in hospital-based diploma programs; as a result the position paper met with resistance and even anger. By 1978, the ANA issued another recommendation, one that was stronger, that there be two levels of nurses prepared in universities or colleges: ADN and BSN nurses. In 1985, the ANA went further still, suggesting different titles for the two levels of nurses. By then, several nursing organizations, including the National League for Nursing (NLN), had joined the movement. However, it was not long before the NLN withdrew its support in an attempt to avoid an intra-professional fight. In 1995, the ANA reaffirmed its position and proposed ways to enact the recommendations while preserving the integrity of the profession. As professional nursing moved toward the goal of requiring the baccalaureate degree as the minimum credential for professional practice, RN/BSN transition programs were developed to enable the ADN nurse to move upward. RN/MSN programs leading to a master's degree have also been developed to enhance career mobility. Although these developments have advanced nursing, the continued inability to reach consensus on the "entry to practice" preparation has resulted in divisiveness among nurses with different educational preparation (Donley & Flaherty, 2008).

In Canada, 2-year and 4-year nursing programs were developed to augment the hospital training schools. In Australia and Great Britain, baccalaureate nursing programs were added as those nations moved toward the goal of educating nurses in institutions of higher learning.

### Advance Nursing Practice

Another historical event that has affected nursing, especially in the United States, is the development of the role of the advanced nurse practitioner. This role evolved from two sources: the nurse practitioner and the clinical nurse specialist (CNS). In 1965, Dean Loretta Ford, in collaboration with Dr. Henry Silver (a physician), initiated a new kind of nurse preparation as a solution for the physician shortage in Colorado. Registered nurses were given 6 weeks of continuing education in which they learned assessment skills and then functioned as physician extenders. Almost immediately that education was increased, and currently most nurse practitioners hold master's degrees and are certified. The CNS role developed within acute-care settings and was found within higher education from the outset.

The development of advanced practice is another example of nursing responding to a societal need that resulted in a change in the practice of some nurses. Today those advanced nursing practice roles are seeing more change as the doctor of nursing practice (DNP) is becoming the standard. Nursing continues to struggle for legislation in some states that will enable advanced nurse practitioners to receive third-party reimbursement and prescriptive authority.

### National Healthcare Changes

In the United States in the mid-1990s, President Clinton's attempts at national healthcare reform and increases in the number of for-profit healthcare corporations also affected nursing. In an effort to avoid national regulation and the perceived problems associated with socialized health care in other countries, insurance companies, physicians, and hospitals moved toward a system of managed care. This resulted in redesign of hospital-based client care delivery and consequent downsizing of both professional and support staff. To reduce costs, hospitals have instituted shorter length of stays, integrated systems, case management, and the use of unlicensed assistive personnel (UAPs). Other countries have implemented similar changes to provide their citizens with affordable health care.

### Events That Have Indirectly Affected Nursing

Medical advances (e.g., new surgical procedures, the proliferation of diagnostic and monitoring instrumentation, and new pharmacological preparations) have changed not only the physician's practice but also nursing practice. In the past, the nurse's hands, eyes, and ears were the principal tools for assessing clients; today, the nurse augments these tools with data from monitoring equipment that can provide more subtle and accurate information. Some of these advances have made the nurse's job easier; others, such as the development of new and more powerful drugs, have broadened the nurse's responsibilities. Knowing the drug's expected action, adverse effects, and compatibility with other drugs is a complicated directive. Nurses have significantly more responsibility and accountability today than they had in the past, and this increase is likely to continue.

Cost containment measures instituted by hospitals in many countries have also changed nursing practice. Changes that began as downsizing, or a reduction in staff to save money, quickly became a redesign of the entire hospital delivery system. Cross-training, focusing on the client, streamlining processes using continuous quality improvement (CQI), are only a few of the outcomes of the redesign. In some cases, the result was a redesign of the nurse's role; in other instances, an elimination of RN positions was the

outcome. Some RN activities were delegated to other, cross-trained healthcare workers (paramedics, respiratory therapists, phlebotomists, ECG technicians), and the RN was educated to assume additional responsibilities.

Managed care in the United States has been another cost containment method that has affected the nurse's role. Managed care is a system in which hospitals (with subsidiary clinics, home care, skilled nursing facilities, and so on) and physician groups provide comprehensive care for groups of people who purchase their insurance and agree to use the program for health services. It is expected that free-market competition will provide the system with the lowest cost for care. And because the price for that care is based on the total number of members, the costs of care will be balanced by those members who are well and do not require services. Keeping members well so that they do not need the system is how costs are contained. Thus there is a new focus on wellness and illness/injury prevention.

Case managers are needed as gatekeepers of the system so that only care that is deemed essential is provided. Cost for the care is determined proactively, so the system must be careful not to spend more than it is paid by capitation (numbers of those insured). Thus, in the new managed-care environment nurses must have case management, coordination, assessment, health promotion, illness prevention, and cost containment skills. The goal of keeping people focused on staying well and out of the hospital constitutes an entirely new paradigm of care. The policy and plans to meet and fund these goals impact the role expectations and responsibilities of the nurse.

Public policy has changed everyone's lives. Informed-consent laws have increased the public's knowledge about and participation in decisions about their health care. The Self-Determination Act of 1991 has allowed people to make decisions about their future health care, well in advance, and before they are unable to make such decisions. People have more choice about how and when health care will be delivered. Monitoring the procedures for gaining consent and implementing procedures to ensure that the client's living will or durable power of attorney for health care is understood and documented are now a part of the nurse's responsibility. Issues such as the right to die, assisted suicide, and other ethical dilemmas are of daily concern to the nurse in all practice settings. These and other added duties change the nurse's role, both in scope and accountability.

### Social Movements and Technological Initiatives That Have Affected Nursing

The women's movement that began in the 1960s has had a major influence on nursing. Predominantly a woman's profession (about 10% of nurses are men), nursing has benefited

from the recognition of women as a force for social change. As a result of the gains made by the feminist movement, nurses have gained better salaries, better working conditions, access to higher education, and access to opportunities as middle managers and executives in many occupations as well as nursing. Nurses have recently seized the opportunity to become entrepreneurs and engage in their own practice. Many nurses would have been unlikely to rise to such challenges if the women's movement had not opened the door to opportunity.

No discussion of the changes in nursing would be complete without a discussion of the effect of the information age and the way that information technology has changed daily life. In health care it has improved storage of and access to healthcare information. Clients can carry a card that contains information about their insurance coverage, health status, medical history, medications, and end-of-life decisions, as well as emergency contact information and demographic information. Insertion of this card into a computer sends that information to all who need to know.

The electronic health record is rapidly becoming the norm. Instead of spending hours on manual recording, the nurse can spend that time with the client. Because the computer is often in the hospital room, at the clinic, or even in the home, the client can also share and participate in the development of the record.

The personal digital assistant (PDA) or a hand-held computer can provide an access point to the Internet and personal and office email. Healthcare professionals use it to download books and protocols and to organize patient data, track patient care visits, and transmit prescriptions. Downloaded pharmacy programs enable providers to check drug dosages, side effects, contraindications, and insurance plan coverage. Charting can be done on a PDA and later downloaded to the patient's medical record. Home health nurses have been able to store information in a portable manner. A major concern about the use of PDAs in health care is security of data and the device itself. In the near future, voice recognition may be available so that the voice of the user is registered and will be recognized before records are accessed.

There are also patient uses for the PDA in the self-management of chronic illness. For example, someone with diabetes could log in blood glucose measurements, insulin doses, amount of exercise, and dietary information and then use the PDA to inform them of necessary steps to take in managing the disease.

Information technology has also affected nursing education by facilitating supervision of students at a distance. PDAs provide information to students visiting clients in the home and act as vehicles for distributing client data to the college or clinic. A major advantage of computer technology is that it enables students to interact with information,



classmates, faculty, and other nurses online at home, in the computer laboratory or library, in the classroom, or in the clinical setting. Thus, it expands the instructional environment so that learning is portable, accessible, and always available. There are no constraints of time, person, or place. These advances and their application to nursing and health care have required nurses to broaden their knowledge.

Through technology and travel, the world has become a smaller place. Immigrants and refugees readily cross national borders to seek opportunity in new lands. Nurses are more able to move rapidly to assist with the delivery of care to victims of natural and manmade health disasters. The shrinking of the worldwide community requires that nurses become more knowledgeable about and accepting of cultural difference. Nurses need to be aware of different beliefs about health and illness and different cultural healing practices. The nurses of tomorrow need to be more than culturally aware: They need to strive for cultural competence.

During the past century, there have been tremendous advances in health care, such as immunizations and antibiotics, and these have contributed to a greatly increased life expectancy. The 2000 census, for the first time, had a three-digit space for age. In the 1900s, when pneumonia and tuberculosis were the leading causes of death, no one could have forecast the advances that would be developed to manage these diseases as well as other health problems. The threat of bioterrorism after September 11, 2001, has influenced healthcare planning. The future will no doubt present anticipated challenges based on what society is experiencing at the present, as well as unanticipated ones.

This overview of changes that have affected nursing and nursing practice is not meant to be comprehensive; there are many more good examples of events that have directly or indirectly influenced nursing, linked to both professional and societal change.

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### Reflect On . . .

- how the changes in healthcare financing have affected your own health care. What has been gained from these changes? What might have been lost from health care?
  - how advances in information technology have affected nursing practice. Do some nurses have a more difficult time adapting to these changes? What might be some helpful strategies for nurses to adapt to the changes?
  - the societal changes in population demographics as they relate to health care. How has nursing adapted to these changes? What related needs might have gone unmet or been undermet?
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## Looking Toward the Future of Nursing

An orientation to the future requires that one know societal and global trends; is aware of social, political, economic, and organizational influences on those trends; and can speculate about the interaction of trends and forces of influence. Using strategic thinking and foresight, those that help to shape the future are able to identify strategies to manage trends and forces. There are four broad categories of futures, ideally approached in the following order: possible, plausible, probable, and preferred. *Possible future* is what can happen if some changes are made. *Plausible future* is the likely outcome when specific efforts are made to accomplish a desired outcome. *Probable future* is the most likely outcome if things continue unchanged. *Preferred future* is the outcome that is wanted (Grossman & Valiga, 2005).

The drivers of change in the future of health care are likely to include consumerism, the disarray of managed

### Ten Forecasts From the World Future Society

1. Thanks to big data, the environment around you will anticipate your every move.
2. We will revive recently extinct species.
3. By 2020 populations will shrink, and wealth will shrink with them.
4. Doctors will see brain diseases many years before they arise.
5. Buying and owning things will go out of style.
6. Quantum computing could lead the way to true artificial intelligence.
7. Phytoplankton death will further disrupt aquatic ecosystems.
8. The future of science is in the hands of crowdsourcing amateurs.
9. Fusion-fueled rockets could significantly reduce the potential time and cost of sending humans to Mars.
10. Atomically precise manufacturing will make machinery, infrastructure, and other systems more productive and less expensive.

Source: "The Futurist Magazine's Top Ten Forecasts for 2014 and Beyond," by the World Future Society, 2014. Retrieved from <http://ieet.org/index.php/IEET/more/tucker20140117>

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## CRITICAL THINKING EXERCISE

Look at forecast 7 from the World Future Society in the accompanying box. List the implications for nursing

practice. Suggest at least three approaches for meeting this challenge. Does it present a crisis or an opportunity?

care, biotechnological innovation, information technology, and community focus (Morrison, 2002). Consumerism is likely to become a force as the public becomes more discontent with the current state of health care. Some key factors in consumer discontent are a better educated public, intensive media coverage of healthcare issues, activities of advocacy groups, and the emergence of complementary alternative medicine. Managed care has lost favor with healthcare consumers due in part to the lack of choice in providers and services. The pharmaceutical industry and the medical technology industries have made great investments that will continue to create innovations. The Internet and health-related portals bring information technology to the public as never before, and telehealth and remote telemetry are changing the way health care is delivered. Focus on communities as a point of entry into health care and delivery of services is increasing along with the recognition of the important role the community can play in health. However, in the arena of change, wild cards cannot be discounted, such as natural disasters that no one could anticipate.

## Reflect On . . .

- the future of nursing as you would like to see it.



**InfoQuest:** Information about trends and insights about the future can be helpful in facing the future and identifying critical issues for future planning. Knowing trends can empower effective action. It enables preparation while there is still time and opportunity to act. Visit the website of the World Future Society and read the discussion of the forecasts.

Note the description of the magazine, *The Futurist: A Magazine of Forecasts, Trends, and Ideas about the Future*. Think about whether this is a resource you would like to use.

## Computer Technology and Its Effect on Health and Nursing Care

The information technology systems of tomorrow will require that all healthcare providers be more than computer literate to function in the computer world. Knowledge of several software programs, the ability to use spreadsheets, skill with search engines, and the ability to adapt to ever-changing computer systems will be only basic skills. For a while, healthcare facilities will need to train their personnel, but eventually all workers will be expected to have these skills when hired. This means that schools of nursing and other departments of colleges and universities will need to ensure that all graduates of their programs are able to access and obtain the information needed.

Some of the projections can be provocative, particularly those that relate to innovative technology. The use of virtual reality in the learning environment is one of those. The technology that has been applied to games can be applied to education, expanding the scope of simulation labs.

Imagine wearing a headset with two small screens, located in front of your eyes, used to project computer graphic images, and earphones to receive computer-generated sound. On your hands you wear data gloves, which contain position sensors. These sensors tell the computer exact positions, especially of your body and arms. The computer responds to the movement of your head, eyes, hands, and arms. It might even have voice recognition and respond to your commands. (Justice, 1999, p. 14)

Any number of clinical scenarios could be displayed in this virtual world, going beyond the programmed manikin to simulation that allows students and nurses to learn skills and refresh existing ones. The nurse educator will need to be involved for guidance and control of the progression of the scenario. The educator will be able to assess the ability of the student to respond to changes and crises and to fit the experience to the learner's level of expected performance. This application of simulation may even be used as testing for licensure.

Three-dimensional images can be made even more lifelike by the use of head-mounted displays, allowing total visual immersion, and of auditory feedback in

response to the viewer's movements and contact with virtual objects. Pilot training has used flight simulators for some time, but the use of this technology has been fairly limited in other contexts. The potential for client education is enormous.

More applications for online services will be implemented in the future. Patient information resources will be increasingly used, creating a more educated healthcare consumer. Nurses can be developers of these information services, as well as referral agents. Online continuing education and formal education will probably continue as a trend in the near future. Programs using digital interactive television that offers two-way communication are becoming mainstream.

Telehealth will continue to grow and expand in the future. Synonymous with telemedicine, online health, and e-health, *telehealth* is an umbrella term encompassing health activity that involves distance. It can be applied to home nursing, health monitoring, consultation, and many other aspects of health care. It holds promise of improving access to health care in areas where there are geographic barriers, and it can reduce costs associated with travel.

Physician and nonphysician offices are able to access the hospital system so that they do not need a paper trail or their own electronic system. With managed care, the system should expand to connect the hospital, the insurance company (or payer), and the physician and nonphysician care providers.

Robotics is another area of advanced technology that could affect the practice of nursing. Early robotic technology has been applied to the use of programmable machines for supply deliveries and even trays within hospitals, but thus far uses have been fairly limited. Speculation about future applications can conjure up images of robotic nurses, but other possibilities may be closer to implementation. Some medical and surgical procedures are robotically assisted, and robotic devices are likely to become more integrated into rehabilitation and prosthetics.

Technologies have changed the practice of nursing in the recent past, and that trend is expected to continue. More and more sophisticated devices for monitoring and administering care have made the delivery of care very different in recent decades. With the shortage of the highly skilled nurses that are needed for the high-tech environments, aggressive recruitment and retention strategies are being implemented. The unique body of knowledge needed for these roles is not acquired in most undergraduate nursing programs as they are currently taught. Nursing education will need to adapt to prepare nurses for practice in the future, and new templates will emerge.

Many more factors will affect nursing in the future. What nurses do, how they are educated, and where they

practice will undoubtedly change. Nurses need to embrace the changes and be a part of shaping the future.

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### Reflect On . . .

- the changes in the nurse-client relationship that has been associated with new nursing roles and the use of technological advances. How does the nurse maintain a therapeutic relationship with the client when machines take over some of the nursing functions?
  - the skills you believe will be important in the future. What are they and how should they be taught?
- 

### Healthcare System Changes

As the healthcare system struggles to provide care for all people at a reasonable cost, it will undergo many changes. Although managed health care is only one attempt to reverse the escalating costs of care; time and the outcomes will determine its impact. However, while managed care is available, there will be fewer professional nurses in hospitals and more multiskilled workers supervised by professional nurses. The term *multiskilled worker* refers to a person who is prepared to provide basic care under supervision but who is not licensed. Basic care will also change as technology takes over the measuring of vital signs and other parameters of assessment. The client's history, which is already on the client's personal computer card, will need revising only as new events occur and information is added to the computer record.

Because the length of stay for a hospitalized person will become shorter, the care provided will address the very acute phase of the illness episode and will be directed toward pain management, respiratory facilitation, cardiac support, and neurological monitoring. Preparing the client for recovery at home will be a major aspect of the nurse's role. To plan and implement effective care, nurses will need to maintain and increase their knowledge of physiological and psychological functioning, technological monitoring systems, client care, and computer systems.

Seriously ill clients confined to a hospital bed will require intensive care given by professionals who will administer medications using equipment that is computer driven. There will be less worry about turning clients because the hospital beds of tomorrow will be designed to rotate the occupant periodically to preserve skin integrity. The professional nurse will assign dressing changes and other treatments to the multiskilled workers, so the cost of care will be contained by the number and level of the

workers assigned to the units. Self-directed work teams made up of cross-trained professionals and multiskilled workers will direct, provide, and evaluate the care.

One of the most exciting possibilities for what might occur in the United States was described in 1994 by Jeffrey Bauer: a healthcare system changed by breaking the monopoly held by physicians over the delivery of health care to American citizens. While this vision has softened somewhat since that time, it is still an option for the future. Bauer proposes that healthcare costs will not decrease until citizens are allowed to select the provider they want. He proposes that health care be placed on the free market so that maximum choice and quality competition are available. He believes we must “take the shackles off America’s many competent non-physician providers and allow the American consumer free access to their services” (Bauer, 1994, p. 19).

If Bauer’s plan were to come into being—and there are good reasons to believe that it will—then advanced nurse practitioners, certified nurse midwives, dentists, pharmacists, certified nurse anesthetists, physical therapists, occupational therapists, and respiratory therapists, to name only a few, would be able to respond directly to the public’s needs. The consumer would be free to choose from an expanded menu of qualified providers, a development that would bring the cost of care down while providing quality care for all.

Nurses will be needed in increasing numbers in ambulatory surgical centers, diagnostic centers, home care, nursing homes, and skilled nursing facilities as hospitals become smaller and health care moves to the community. Those nurses with baccalaureate and master’s degrees will have first choice as nonphysician providers because they are the best prepared for the role required of the nurse in the community. The nurse’s role will include direct and indirect care; nurses will care for and manage others who provide care. Collaborative efforts will be necessary as the world of health care becomes more complex and technology continues to improve and change. The anticipated changes in the healthcare delivery system of the future require that everyone, health professional and consumer alike, change his or her expectations and behaviors. The changing healthcare system requires more personal health responsibility on the part of the consumer and greater responsiveness on the part of healthcare providers.

Complementary and alternative medicine are a trend that is likely to continue into the future. As nurses move into greater roles in case management, they will need to understand which therapies are appropriate for each client and when nontraditional therapies are appropriate. Nurses will assist clients in making decisions regarding alternative treatments.

## Regulatory Changes

In the future there probably will be some major changes in the regulation of physicians and nonphysician healthcare providers. The National Council of State Boards of Nursing (which is composed of representatives from each state’s board) has proposed that there be national standards for licensing entry-level nurses and measuring the competency of nurses over time. The PEW Health Professions Commission (1995) went even further, proposing that the regulation of all physician and nonphysician healthcare providers be carried out at the national level and that the approach be an interdisciplinary one.

What would this mean? It could mean that regulations would be competency based, broad enough to allow for change, and yet definitive enough to assure the public that the provider, regardless of title, is qualified to offer the service. It could mean that quality control would be the key ingredient in determining universal standards for all healthcare providers, no matter where they practice or what title they hold. The state could provide the entry examination, and the professions could be held legally and financially responsible for the conduct of their members under state and federal guidelines based on general norms set across all healthcare disciplines.

The value of this approach to regulation is that competency standards, not titles, would drive decisions; as a result, nonphysician providers would be considered equal partners in healthcare delivery. Having the state control entry to practice based on national standards, as well as having the profession control certification based on its own specific practice expectations for general and advanced practice, will result in more meaningful recertification of providers with the least amount of government intrusion. These radical changes are becoming necessary to the removal of traditional practice barriers among physicians, nurses, and other healthcare providers. Advanced nurse practitioners have demonstrated that they are excellent primary caregivers, but most state regulations, which generally are influenced by physician lobbyists, have kept legislators from making the changes needed for the legitimate use of advanced nurse practitioners. The argument of cost could be used to make the case for national, standardized regulation, but the argument that advanced nurse practitioners are adequately prepared and have demonstrated their value as primary care providers is a better one.

## Continued Medical, Surgical, and Pharmacological Advances

The list of advancements in medicine is a long one. For example, it is possible to clone human tissue (although whether to do so is an ethical controversy); treat highly



infectious diseases with potent chemicals; keep people alive with machines that breathe for them and keep the heart pumping; and remove, sterilize, and replace a person's bone marrow to cure disease. It is possible to perform surgery while the client's blood is cycled through an artificial heart and lungs, transplant organs from human and animal donors, and replace old, worn-out joints with new artificial ones. It is possible to save the life of a 26-week premature infant through mechanical breathing, intravenous feedings, and highly potent drugs. It is possible to replace amputated limbs with artificial ones and to provide computer and mechanical support that can enable a paralyzed person to pursue a career and be self-supporting.

The development of medications that produce desired physiological effects and change psychological moods has prolonged life, made it more comfortable, and enhanced people's ability to enjoy it. Drugs can be a vital part of healthy living for those with chronic physiological or psychological illnesses. Some drugs, however, have also caused dependence, making people less able to cope or function without them.

Medical treatment of chronic conditions and acute phases of infection and much posttrauma care often relies on pharmacological therapy. Furthermore, the number of nonprescription medications has increased as the Food and Drug Administration (FDA) releases many prescription drugs for over-the-counter purchase. The consumer has even more choices than before. A trip to the drugstore or local supermarket or discount store allows the consumer access to a vast variety of remedies for a stuffy nose, sore throat, respiratory congestion, bowel problems, joint aches, heartburn, urinary discomfort, worry, or whatever else is causing distress. It is very easy to acquire medications, and the public uses many of them without the guidance of healthcare providers; in fact, polypharmacy has become a major problem in America because many people combine prescription drugs and nonprescription drugs without an understanding of drug interactions and side effects.

Pharmacological advancements have also had a significant impact on nursing. Nurses have had to expand their knowledge base of pharmacology and their skills in caring for clients who have had surgery or who are undergoing medical treatment. Keeping informed about the newest drugs means the nurse must consult the National Drug Formulary or other drug references more often. Moreover, it is becoming even more urgent for nurses to face the inevitable ethical dilemmas. The need for more information and discussion about ethical issues will continue and escalate as health care in hospitals becomes more acute, as arguments rage over the distribution of financial resources for expensive experimental treatment

(e.g., complex organ transplants) versus less expensive preventive care (childhood immunizations), and as more nonphysician providers deliver care in homes, malls, offices or places of work, schools, churches, clinics, ambulatory centers, and nursing homes.

Nurses respond to the events that confront them; however, nurses' responses need to be quicker and more flexible. This means nurses will need more education and a greater understanding of the community and aggregate care. Nurses will also have to see themselves as "knowledge workers" and facilitators of care rather than individual caregivers. This is a major paradigm shift.

Educating, preparing educational materials, and teaching others how to teach will consume more of a nurse's time. Using interactive video, distance learning, and computers and other audiovisual equipment for learning will expand the market for instructional materials and good teachers. Because people will learn in their homes and at work, instructional materials will need to be portable and self-contained. Group learning will become as common as individual learning, and the information highway will be a key mode of delivery.

Surgical procedures, medical treatment, and pharmacological therapies will continue to advance. There is every reason to believe the advancements will develop even more rapidly, so that only those who are continuous learners will be able to keep pace. Nurses will have to be constant and lifelong learners if they expect to have a place in the new healthcare paradigm.

Historically, nurses have cared for the sick. In the new paradigm, nurses will focus on wellness and prevention. The nurse will be the primary person who works to help individuals stay well and do things that promote health. Nurses will have to increase their knowledge base about nutrition, exercise, vitamin replacement, and the effects of cigarette smoking and the use of alcohol. As models of good health, some nurses will have to adopt healthier behaviors and lifestyles. They will also have to keep abreast of the most recent research in prevention and treatment.

For much of the history of Western-trained nursing, nurses have focused on the physical body of patients. Nurses are now encountering patients in virtual environments, where they are not physically present. The challenge for nurses will be to address the difference between live sight and touch of the patient to visibility through a medium. It challenges traditional ideas of presence, physical proximity, and physical ministrations. Nurses should be interested in how the new technologies enhance nursing practice but also how they might undermine the presence of a nurse. Both will need to be considered in determining the best use of teletechnologies.

## CRITICAL THINKING EXERCISE

After reading the quotation below by Margaret Sandelowski, identify your concerns about how this scenario would affect quality of health care delivered by nurses. Using two columns, write in one the ways you feel

health care might be compromised. In the second column, list at least one action a nurse or nurses could take to address that concern in a positive way.

The patient is no longer necessarily the corporeal person in the bed or on the examining table, but rather the hypertexted, hyperreal representation on screen in the form of a rhythm strip; black-and-white or colorized image; or numeric, graphic, digital, schematic, or other visual display. The clinician, in turn, is no longer necessarily the flesh and blood person next to the bed or examining table, but rather a voice on the telephone, an e-mail correspondent, an on-line presence, or the teleimage of a face or hand holding a medical instrument. (Sandelowski, 2002, p. 66)

## Applying Past Lessons to the Future

From what has happened in health care, nurses can learn many lessons that may help them deal with the future:

1. The healthcare delivery system in the United States is remarkably flexible. Since the 1800s, the U.S. healthcare system has responded quickly to changes in technology, scientific discoveries, and new health threats. Medical science has undergone several revolutionary redefinitions; many infectious diseases have been conquered, and new ones have taken their place; more of the population has been able to survive to old age; the hospital has been redefined from a place for the poor to die to a place for anyone to be restored to health. For those who die, the causes of death have changed.
2. Changes in the healthcare system have always occurred rapidly and sometimes without warning. Most of the changes outlined in this chapter took place quickly, and many of the advancements in medicine were unexpected or the result of war. Government and society did not set out to initiate Medicare or to institute diagnosis-related groups (DRGs) or, for that matter, to turn to managed care. These developments occurred as a way to solve an immediate problem. Clearly, the system is not driven by immutable tradition.
3. No one entity is in control of the healthcare system. Only a brief scan of any newspaper will reveal that no

one body—not physicians, federal or state governments, insurers, or payers—controls the system. In part because it is their tax dollars that support it, consumers are becoming more interested in how the system works and how to change it.

4. Healthcare providers, especially nurses, have made major strides each time the system changed. These most recent changes have clearly presented great opportunities for nurses and other nonphysician caregivers. New roles, roles most appropriately played by providers with an interest and preparation in prevention, are waiting to be filled by nurses.

As soon as one understands these lessons, the possibilities for the future become apparent. For example, it is possible for anyone to influence the development of tomorrow's healthcare system. Modifications will undoubtedly occur quickly and repeatedly as nations seek ways to provide quality health care for all. Control of the system will shift from one source to another. Because control has thus far resided with government, professionals, and insurance companies, it seems likely that consumers may be the next group to want and assume control.

## Visions of Tomorrow

Throughout this chapter several themes have emerged that provide the framework for a vision of tomorrow.

*Health care will be provided mostly in the community.* Whereas acute and critical phases of illness will be attended to in hospitals, most health care will be delivered within the community. During the 1960s, the number of hospitals grew rapidly because funding was available and because it was believed that the best care could be provided there. It has since been learned that hospital care is very costly, disrupts the family, and focuses on cure, not prevention.

Care is shifting primarily to outside the hospital. Schools, churches, shopping malls, the workplace, home clinics, skilled nursing facilities, and nursing homes have become sites for care.

The rise of alcohol and drug abuse in the young, the increasing incidence of chronic conditions including obesity

in adolescents and young adults, and the increasing number of teenage pregnancies will require more preventive care in the school setting. The same is true of the workplace: Occupational health care is growing because prevention is less costly than illness care, and it is changing as more people work from home or other distant locations. Reducing absenteeism and tardiness increases productivity. Employees will more likely avail themselves of services that are easy to access; accessing care on the job is often preferable to taking time from work to visit a clinic. Major drugstore chains, grocery stores, and super stores where prescription medications are sold are instituting primary care clinics staffed by advanced nurse practitioners to provide care in locations convenient to consumers.

Churches and other faith communities are natural places for health care, especially if there is a holistic approach. Much of what ails people is tied into their sense of self and how they cope. For many people, religious and spiritual resources can be integral to their ability to cope with illness or the threat of a health condition. Parish nursing is a new but growing field of nursing and has been particularly helpful in rural regions.

As the population grows older, Americans will receive more long-term care at home. Electronic monitoring equipment will be attached to telephones to allow those who are homebound to relay medical information to clinics or home health agencies. An increasing amount of follow-up will be done by telephone as reimbursement systems switch from fee-for-service to managed care and capitation.

*Independent nonphysician providers, particularly nurses, will deliver a significant proportion of the nation's primary care.* Because advanced nurse practitioners have responded so well to the country's need for more primary care providers, they will deliver a significant portion of the nation's primary care. Advanced nurse practitioners educated in family, pediatric, and geriatric care will complement physician family practitioners as the backbone of the nation's healthcare system. This linking will occur both in nurse-only practices and in collaborative practice arrangements with physicians. Nurse midwives will take over many of the primary care functions of obstetricians/gynecologists, including the management of low-risk pregnancies. Physicians will continue to do what they have been doing, but there will be much more collaborative practice with nurses and other nonphysician providers. The clinical nurse specialist role and the nurse practitioner role will continue to blur as advanced practice nurses provide care in communities as specialists in health promotion.

*Nurses will work collaboratively with physicians and other nonphysician providers.* These groups of

providers will offer their services in retail locations as small businesses (a major reason why all nurses will need a business education). Health stores will vary in size from small basic-care operations located in shopping malls to freestanding buildings with huge clinics offering everything from dentistry and family medical care to physical therapy and lifesaving emergency services.

*The new providers (nurses, physicians, and other nonphysicians) will be much more attuned to what the consumer wants.* The hours of service have been changing so consumers can access services in the evenings and on weekends. Nurses will take the lead in the development of health centers because the framework for nursing throughout its history has been holistic and comprehensive. Nurses have always promoted health and focused on the prevention of illness. Moreover, nurses can lead the way to better health and cut costs by helping the public assume responsibility for their lives as healthy individuals.

Physicians will assume roles as coproviders, specialty-care providers, and consultants. Although many physicians may express serious concern about current changes and what will happen in the future, nurses and consumers can expect that many physicians will quietly lead the way into the new system. Many physicians will remain as specialty-care providers because there will still be a need for physicians who are prepared to care for specific healthcare problems, such as oncologists, orthopedists, neurologists, psychiatrists, and cardiologists. Other physicians will join collaborative practices with advanced nurse practitioners to provide comprehensive basic care. Some physicians will seize the opportunity to enter entrepreneurial businesses. There will be plenty to do in the new system, but everyone will need to change his or her expectations and responsibilities.

Physician activity will affect nursing as nurses seize opportunities for collaborative practice. Advanced practice nurses will need physician consultation in their independent practices, especially for their clients with more complex problems. Over time, physicians and nurses will work together in more ways and in better ways as it becomes clearer how the new system will unfold.

*Informed consumers will become more self-directed and assume more responsibility for their health.* One of the most exciting advances in the future will be one-stop diagnostic centers. Like a full-service gas station, these diagnostic centers will provide informed consumers access to urinalysis, blood tests, throat cultures, and even some radiographic tests. These diagnostic centers will be electronically linked to large, fully equipped laboratories for confirmation of diagnoses and to health databases that

store consumer records. Educational services will also be available through interactive computer programs and video libraries.

Computer terminals in pharmacies will help consumers find answers to questions regarding health and illness. Pharmacists will be able to diagnose such common ailments as throat infections and skin rashes with the help of computer protocols and over-the-counter diagnostic tools. Women already can diagnose pregnancy at home using a simple diagnostic package purchased at a supermarket, pharmacy, or discount store.

For easy access, diagnostic centers will be located in healthcare clinics, supermarkets, shopping malls, and department stores. Consumers will also be able to authorize a pharmacist to access their personal medical records to check for allergies to prescriptive drugs or other medications. It is easy to see that consumers will have much more control, involvement, and accountability in their health care. This is perhaps the most exciting aspect of the new system.

*Access to health care/consultation will resemble the market for other services and products.* Because health care/consultation will be easy to access, it will resemble other kinds of services the consumer uses. The clinics, pharmacies, and diagnostic centers will remain open nights and weekends; some may even remain open 24 hours a day. Clearly, tomorrow's healthcare agencies will be much more attuned to the needs of the customer. Larger agencies will offer comprehensive wellness programs that promote healthy lifestyles, including good nutrition and proper exercise.

Education and prevention will be the major product lines of the retail health and medical stores of the future. The focus of the new clinics will be on keeping people healthy and diagnosing and treating people who are ill. The dream of comprehensive care will finally become a reality.

*Education for nurses will reflect the changes in the healthcare delivery system and the application of new educational technologies.* Nurses' education, consistent with these many changes, will also change and will use virtual reality, simulators, and web-based/enhanced classes. The focus of the programs (regardless of the level) will be on the community and on prevention. Nurses will continue to learn how to care for the sick, but the major emphasis will be how to keep people well. Teaching, consulting, and learning referral skills will be essential for nurses of the future. Therefore much more time will be spent on helping students learn these skills.

Group work and a focus on working with population health will supersede the time spent on individual care. Because nurses will be in the community and focusing on prevention, it will be imperative that they can work with groups. Being able to work with parents, abused women,

persons with chronic illness, and any number of other groups will be necessary if the nurse is to use time efficiently and spend it with the individuals who need the care. This means that the educational program must devote more time to developing nurses' group process skills.

Nursing students and nurses need computer skills. They need not only word processing and spreadsheet skills but also the ability to use virtual reality equipment. Computer competence is now a prerequisite for admission to many nursing programs, and the level of sophistication will increase in the future. In many nursing schools PDAs and/or laptop computers are required as students interact with their textbooks, view streaming videos of patient situations or procedures, and take exams online. This facilitates immediate feedback for students and allows alternative ways of providing care to effect various client outcomes.

An important new focus for nursing education at all levels will be on the community. Although students live in a community and read about communities, until they understand that a community is more than a geographic boundary, they will not be prepared for the health care of tomorrow. Much more time will be spent on the study of community and its impact on the health of the citizens. Nurses will also need to become more aware of the global community and become more geographically knowledgeable and culturally competent.

*Nursing practice will have a global focus.* As geographic barriers become more passable, immigrants and refugees will move from areas with limited resources to areas with more opportunity. These immigrants will bring beliefs and practices about health care that are culturally driven; they also will bring illnesses that may be unique to their race or geographic homeland. Nurses will need to become more aware of global health problems and their impact on nursing practice. Through advances in technology, nurses have a greater ability to communicate or travel to other countries and continents and are better able to network with the global nursing community.

Through technology, students will probably learn more at home than at the college or university. Student access to technology at home and the use of virtual reality will also change faculty behavior. Faculty will need to know how to manage distance education and keep abreast of ever-changing computer and video technology and the broadening concepts of community, prevention, health promotion, and the globalization of America.

*An important and imperative looming change is a decision on the basic preparation of nurses.* Nurses, through their professional organizations, will want to take the lead in this decision. This action will not only help correct the confusion for potential students but will also



## CRITICAL THINKING EXERCISE

Compare and contrast your own vision for the future of health care with the author's vision. Include your thoughts about nursing in your community, your nation, and the world. Are the views consistent? Do you

see different or additional changes that have not been discussed here? If yes, what are they? What trends cause you to forecast these changes?

lay the foundation for advanced practice. Legislators, other professional groups, and the public will finally know the scope of basic professional nursing practice. Statutes will be clearer, and regulations governing practice will be more consistent. Nothing else the profession does will be as important or as necessary as this action.

The world of tomorrow is exciting. Health promotion, rather than medical care, will finally be the focus. Nursing will need to grasp the opportunity and become the leader in the movement toward providing care that

creates a better life for each citizen. Clearly there will be a need for more nurses prepared at the baccalaureate and master's levels to meet the demands of a community-based consumer population. For advanced practice, the level of preparation will be a practice doctorate. New technologies will be available for nurses' use. The system is now ready and able to respond to the need, and the public is ready for the new ways. Nursing education and practice must seize the opportunity to make the necessary changes.

## RESEARCH CURRENT

## Health and Health Care in 2032

At a meeting of the Institute for Alternative Futures (IAF) (2012) participants were asked to project what is needed to be done now to achieve the best status for health and health care by 2032. During a span of 2 days the group discussed possibilities, strengths and weaknesses, opportunities, resources, and possible solutions. It was a generation of ideas without limitation.

Alternative scenarios were developed to be used as the basis of the discussions. The scenarios are as follows:

- **Scenario 1: Slow Reform, Better Health** ("zone of conventional expectation")  
Health and effectiveness of health care vary among states. Health, not health care, becomes the main political issue. Communities address social determinants of health, prevention, and population health while enacting "health in all policies." Self-care and health knowledge reduce demand for medical care and are enhanced through risk behavior management, social networks, digital technologies, predisease identification, data, and new cures and therapies.
- **Scenario 2: Health If You Can Get It** ("zone of growing desperation")  
Medicare and Medicaid experience severe budget cuts, most Americans are underinsured, medical tourism increases, epidemics spread, and health and inequality worsen. The primary care physician shortage hurts community health centers, which struggle to treat many new patients who otherwise visit

unreliable fee-for-service minute clinics. The public becomes highly fractured and disillusioned with the ineffectiveness of governance.

- **Scenario 3: Big Data, Big Health Gains** ("zone of high aspiration")  
Health becomes the primary concern. Initiatives regarding health innovation, health equity, the social determinants of health, and health in all policies reduce healthcare expenditures. The public demands anticipatory democracy, cooperation, sustainability, and transparency. Innovative technologies, "big data," and knowledge transform manufacturing, the economy, and health, yielding cures for Alzheimer's disease, effective management of cancers and widespread implementation of personalized medicine and health avatars.
- **Scenario 4: A Culture of Health** ("zone of high aspiration")  
Leaders create environments to support and improve all domains of health as a "health culture" arises. The nation's focus shifts to disenfranchised youth, and to the development and comprehensive health for children. Healthcare spending is capped. Avatars, enhanced self-care, and transparency in health education and medical knowledge all reduce demand for medical interventions. "Health wisdom" expands as social networks "crowdsource" health. Environmental monitoring is widely implemented among communities.

Following discussions and projects for each of these future scenarios, the following recommendations were made:

*Area of Opportunity:* Develop new health roles beyond just traditional medical care professionals and public health providers.

## Recommendation

*Develop new health roles for both workers and volunteers who focus on health as a value in and of itself.*

We can expand the version of the lay community health worker at the local level and create a new community systems worker to ensure that areas such as education, urban planning, transportation, and the private sector all support health. The definitions of both health and community are expanding. We will need to train current workers in the new understanding of health as having many dimensions, such as social and spiritual health along with the common associations with physical health. The understanding of community will need to be broad enough to incorporate online communities of interest along with geographically and culturally based communities.

We also need health strategists and integrators within the healthcare system to address issues in the community.

Finally, we need to develop career paths for underrepresented communities.

The new roles will bring skills and competencies needed to organize a community and to approach health problems by leveraging statistics and rapid learning. The skills include:

- Awareness of local community resources
- Awareness of digital assistance resources
- Communication skills
- Sensitivity to health literacy, including cultural, generational, community, family, and spiritual content
- Needs assessment skills
- Creative financial skills to show how communities can find monies for the new role
- Behavioral and motivational skills for a person-centered approach

*Area of Opportunity:* Focus the health technology sector on community health metrics.

## Recommendation

*Create market incentives for improving community health outcomes through innovation that uses “big data” drawn from living environments that are increasingly sensitive and responsive to the presence and needs of people.*

Today we have a need but not a market for improved community health. We are blind without the health data in a unified source that is communicable to all as metrics for improvement. Therefore we need to remove restrictions on

putting data in the hands of entrepreneurs and organizations ready to improve the health of communities. Right now large data stores from government health agencies (Department of Veterans Affairs, Medicare, Department of Defense, etc.) are unavailable to innovators in Silicon Valley and around the nation. More data stores will be created as living environments become embedded with “ambient intelligence”—that is, computing technologies that are responsive to the presence of people. We need to liberate these data while creating business incentives for improving population health. These data can flow back to living environments in order to promote smarter individual and community health choices.

The following actions must be taken in order to tap the potential of the technology sector to improve community health:

- Define shared (community) health metrics and align payment systems for health outcomes.
- Develop the business models that offer incentives for prevention and predisease diagnosis so that caregivers and scientists can work with communities to convert personal data clouds into actionable information for improving community health.
- Use regional partnerships between major clinical institutions, systems biology institutes, and communities, with consumers and patients learning to improve population and individual health.
- Build community storage systems for multisource integrated health data, including genomics, proteomics, sensors, lab data, pharmaceutical prescriptions, environmental data, social media data, and nonobvious health data that will emerge as we learn to improve community health.
- Shape policies providing individual ownership of personal data while offering individuals and communities the ability to opt in for release of their data to technology vendors and entrepreneurs.
- Establish sites for rapidly testing innovations in community health, and then distribute the evidence so that successes can be replicated in multiple communities.
- Revamp regulation (e.g., FDA when regulating mobile apps, HIPAA[Health Insurance Portability and Accountability Act]) to make it conducive to the health technology sector’s efforts to improve community health.

*Area of Opportunity:* Cultivate new leadership for a healthy society.

## Recommendation

*Encourage community leadership in a movement for health that increases well-being and vitality and enables progress toward a flourishing society at all levels and in all sectors and communities.*

(Continued)

## RESEARCH CURRENT

## Health and Health Care in 2032 (Cont.)

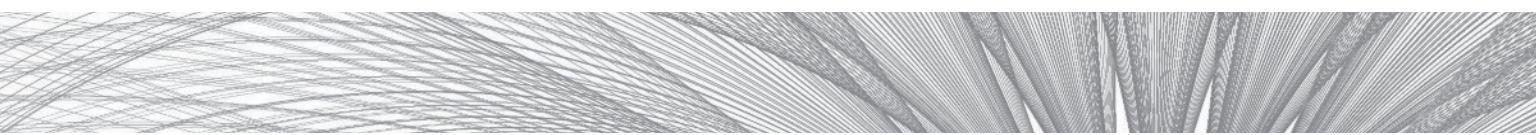
Great leadership has a sense of purpose that generates commitments and motivates followership. Community leadership education and development processes can use an ecological whole person model. This form of leadership is both individual and collaborative and includes working in concert with others who can mobilize people to rally around taking responsibility for health at both the individual and community levels. People need to learn how to self-lead as well as how to lead others in team-based learning that begins with a vision of a healthier society. Learning communities create connections that foster the capacity to listen to the perspectives of both older and younger people and to cross boundaries between fields and organizations so that health permeates all sectors.

The following actions will foster leadership for health so that the nation can flourish through community engagement:

- Convene local leadership sessions supported by people from the military, the Peace Corps, business, and recognized nonprofit organizations.
- Create a cultural change leadership group dedicated to stimulating movement toward a vision of healthy people in healthy places.

- Communicate the key concepts of health, wellness, salutogenesis, and holism using words such as *flourishing* and *well-being* to which people can easily relate.
- Offer leadership teachings to various audiences, including youths and elders, who can diffuse lessons through schools and community projects.
- Create a National Health Corps that includes chapters and programs for people at various stages of their careers and connects virtual as well as geographic communities.
- Use a case-based learning process that incorporates complexity theory and change management knowledge applied through teams that support community health.
- Teach communities to organize around goals and metrics, and then create the conditions for the “first followers” to emerge at the local level while dismantling the old leadership paradigm and structural constraints that inhibit young leaders.

*Source: Health and health care in 2032: Report from the RWJF Futures Symposium, June 20–21, 2012, by the Institute for Alternative Futures, October 2012, Alexandria, VA: Author. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/health-and-health-care-in-2032.html>*



## Chapter Highlights

- Nursing has faced many changes in recent years, and change will continue in the future.
- There are many opportunities for nurses to take charge of the coming changes and help design the future of health care.
- The growth and development of nursing as a profession have been driven by social movements and technological advances. These include the movement of nursing education into higher education, expanded practice within nursing roles, and the development of the advanced practice role.
- Medical advances and cost containment strategies have contributed to changes in nursing practice.
- The women’s movement changed the way nursing is perceived, and information technology and computers have also had an impact on the evolution of healthcare practitioners.
- The future will see an older population needing health care and will encounter a new level of consumerism.
- Complementary and alternative medicine will continue to be aligned with nursing and a more holistic approach to care.
- The healthcare provider may be receiving information via telecommunications and in return delivering care using that medium rather than in a face-to-face setting.

- Physician and nurse working relationships will become more collegial, and care will be multidisciplinary.
- Technology will continue to increase and will demand changes in practice in ways we have yet to see.
- Several themes emerge in a vision of the future. Health care will be more community focused. Non-physician providers will increase in numbers and level of responsibility for primary care. Practice will

be shaped by consumer demands and become more consumer oriented. Informed consumers will become more responsible for the provision of their own health care.

- Education for nurses will change to meet these new demands for practice and performance of roles.
- Health care and the nursing profession will assume a more global orientation.

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