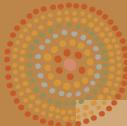




UNIT 1

THE NATURE OF NURSING



Throughout its distinguished history, nursing has had a significant effect on people's lives. As rapid change continues to transform the profession of nursing and the health care system with which it is intricately linked, nurses embrace broader opportunities to influence human wellbeing. Today, nurses bring knowledge, leadership, spirit and vital expertise to expanding roles that afford increased participation, responsibility and rewards. However, nursing continues to evolve; underlying all is a time-honoured, fervent and profound commitment to caring.

CHAPTER 1
Historical and Contemporary Nursing Practice

CHAPTER 2
Nurse Education, Research and Evidence-based Practice

CHAPTER 3
Nursing Theories and Conceptual Frameworks

CHAPTER 4
Legal Aspects of Nursing

CHAPTER 5
Values, Ethics and Advocacy

CHAPTER 1

HISTORICAL AND CONTEMPORARY NURSING PRACTICE

CHRISTOPHER PATTERSON

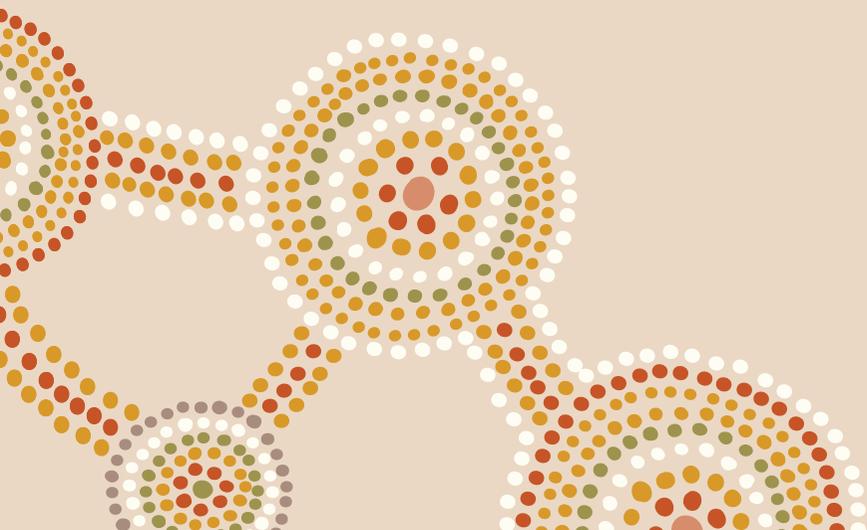
LEARNING OUTCOMES

After completing this chapter, you will be able to:

- Discuss historical and contemporary factors influencing the development of nursing.
- Identify the essential aspects of nursing.
- Identify four major areas within the scope of nursing practice.
- Identify the purposes of nurse practice Acts and standards for nursing practice.
- Describe the roles of nurses.
- Describe the expanded career roles and their functions.
- Discuss the criteria of a profession and the professionalisation of nursing.
- Discuss Benner's levels of nursing proficiency.
- Relate essential nursing values to attitudes, personal qualities and professional behaviours.
- Explain the functions of national and international nurses' associations.

KEY TERMS

caregiver 13
case manager 14
change agent 14
collaborator 13
communicator 13
counselling 14
demography 18
Elizabeth Kenny 7
Fabiola 3
Florence
Nightingale 5
governance 16
Gwen Burbidge 7
Jane Bell 6
Knights of Saint
Lazarus 3
leader 14
Lucy Osburn 6
manager 14
Mary Evans 8
Muriel Doherty 7
nurse advocate 13
person-centred
care 10
patient 10
profession 14
professionalisation
14
professionalism 14
Sally Goold 9
socialisation 16
teacher 13
telehealth 18
Vivian Bullwinkel 8



Contemporary nursing is very different from nursing as it was practised years ago, and we can expect it to continue to change during the twenty-first century. To comprehend present-day nursing and at the same time prepare for the future, one must understand not only past events but also contemporary nursing practice and the sociological and historical factors that affect it.

HISTORICAL PERSPECTIVES

Nursing has undergone dramatic changes in response to societal needs and influences. A look at nursing's beginnings reveals its continuing struggle for autonomy and professionalisation. In recent decades, a renewed interest in nursing history has produced a growing amount of related literature. This section highlights only selected aspects of events that have influenced nursing practice. Recurring themes of women's roles and status, religious (Christian) values, war, societal attitudes and visionary nursing leadership have influenced nursing practice in the past. Many of these factors still exert their influence today.

Women's roles

Nursing has its gendered origins within the home environment, with mothers, daughters, sisters and neighbours undertaking domestic healing practices to care for ill children and other family members in their own home (D'Antonio 2010; Abel 2007). However, what is often not noted is that men also took on the role of nurse in times and circumstances of need (Sabin 2007). In addition, as the Industrial Revolution progressed, some men and women hired out their services as 'nurses'. As such, nurses historically fell into five groups: members of the domestic household; handywomen (nurses who were hired by the working classes); private duty nurses (nurses who were hired by the middle and upper classes); treatment assistants (within hospitals and other institutions); and inmates of poor-houses, asylums and prisons (Norton 1990, p. 7; Dingwall, Rafferty & Webster 1988, p. 7). However, nursing within the domestic environment, either by family or by hired nurses, was the most prevalent.

As gendered roles within the family and society became more defined during the eighteenth and nineteenth centuries, nursing came to be seen as a 'female' role. This was particularly emphasised as part of the reforms that affected nursing from the mid-nineteenth century. Thus, nursing came to be strongly associated with other female social characteristics such as subservience and self-sacrifice, and women's supposed innate ability to 'care' (Reverby 1987).

Religion

Religion has played a significant role in the development of nursing. Although many of the world's religions encourage benevolence, it was the Christian value of 'love thy neighbour as thyself' and Christ's parable of the Good Samaritan that had a significant impact on the development of Western nursing. During the third and fourth centuries, several wealthy matrons of the Roman Empire, such as **Fabiola**, converted to Christianity and used their



Figure 1.1 The Knights of Saint Lazarus (established circa 1200) dedicated themselves to the care of people with leprosy, syphilis and chronic skin conditions. From the time of Christ to the mid-thirteenth century, leprosy was viewed as an incurable and terminal disease.

Source: © Stocksnapper/Shutterstock.com.

wealth to provide houses of care and healing for the poor, the sick and the homeless. Women were not, however, the sole providers of nursing services.

The Crusades saw the formation of several orders of knights, including the Knights of Saint John of Jerusalem (also known as the Knights Hospitalers), the Teutonic Knights and the **Knights of Saint Lazarus** (see Figure 1.1). These brothers in arms provided nursing care to their sick and injured comrades. These orders also built hospitals, the organisation and management of which set a standard for the administration of hospitals throughout Europe at that time.

The deaconess groups, which had their origins in the Roman Empire of the third and fourth centuries, were suppressed during the Middle Ages by the Western churches. However, these groups of nursing providers resurfaced occasionally throughout the centuries, most notably in 1836 when Theodore Fliedner reinstated the Order of Deaconesses and opened a small hospital and training school in Kaiserswerth, Germany. This school was made famous by Florence Nightingale as it is where she received her 'training' in nursing.

Mental health nursing also saw its origins in religion. The Celtic Church in early Britain had a number of itinerant monks attached to each monastery known as 'soul friends' whose role was to befriend and cultivate a spiritual relationship with the

‘disenchanted and melancholic’ in order to guide them back to their community and their family. Later, the Church of St John of God and St Vincent de Paul were dedicated to caring for the insane (Nolan 1993).

The influence of religion was also prevalent in Australian nursing history. The first trained nurses to come to Australia were from the Irish Sisters of Charity, in 1838. This group of five nuns visited the sick poor around Sydney. However, as in other Western countries, the Sisters of Charity came to recognise hospitals as a more effective means of using their resources, and in 1856 St Vincent’s Hospital was opened (Nelson 2001). The more efficient nursing at St Vincent’s Hospital was a key factor in prompting the New South Wales colonial government to introduce ‘Nightingale’ nursing in the 1860s (Godden 2006).

Early religious values, such as self-denial, spiritual calling and devotion to duty and hard work, have dominated nursing throughout its history. Nurses’ commitment to these values often resulted in exploitation and few monetary rewards. For some time, nurses themselves believed it was inappropriate to expect economic gain from their ‘calling’.

War

Throughout history, wars have accentuated the need for nurses. During the Crimean War (1854–56), the inadequacy of care given to soldiers led to a public outcry in Great Britain. The role Florence Nightingale played in addressing this problem is well known. She 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. Nightingale and her nurses transformed the military hospitals by setting up sanitation practices, such as hand washing and washing clothing regularly. Nightingale is credited with performing miracles; the mortality rate in the Barrack Hospital in Turkey, for example, was reduced from 42% to 2% (Donahue 1996, p. 197).

The various major war-time conflicts since the Crimean War have also provided opportunities for nurses to demonstrate the importance of nursing, and increasingly nurses moved closer to the front line during World War I and World War II. These nurses learnt to nurse under often appalling conditions, but also learnt to improvise and participated in implementing new and experimental technologies as their medical colleagues looked for more effective ways of dealing with the significant injuries and illnesses they saw. These nurses not only played a major role in the treatment and rehabilitation of soldiers and others, they also brought back to civilian nursing much of what they had learnt, including an ongoing respect for military discipline (Bassett 1997) (see Figure 1.2).

Societal attitudes

Society’s attitudes towards nurses and nursing have significantly influenced professional nursing.

Before the mid-1800s, nursing was without organisation, education or social status; the prevailing attitude was that a woman’s place was in the home and that no respectable woman should have a career. The role for the Victorian middle-class woman was that of wife and mother, and any education she obtained was for the purpose of making her a pleasing companion to her husband and a responsible mother to her children. Nurses in hospitals during this period were poorly educated; some were even incarcerated criminals. Society’s attitude towards nursing was reflected in the writings of the period. For example, the gossiping private duty nurse is portrayed in Jane Austen’s *Persuasion* (1817), while Charles Dickens provides a vivid caricature of a handywoman in *Martin Chuzzlewit* (1843–44), that of Sairy Gamp (see Figure 1.3). Indeed, later in the nineteenth century, Gamp came to represent the ‘old style’ of nurse—one who ‘cared’ for the sick by neglecting them, stealing from them and physically abusing



Figure 1.2 Service Nurses National Memorial, Canberra.

Source: © Commonwealth of Australia 2014.



Figure 1.3 Sairy Gamp, a character from Dickens' book *Martin Chuzzlewit*, represented the negative image of nurses in the early 1800s.

Source: © Stapleton Collection/Corbis.

them (Donahue 1996, p. 192), although how truly representative this image is of 'old style' nurses is unclear. Nevertheless, this literary portrayal of nurses greatly influenced the negative image of nurses and the attitude towards them up to contemporary times.

In contrast, the image of a nurse as a *guardian angel* or *angel of mercy* arose in the latter part of the nineteenth century, largely because of the work of Florence Nightingale during the Crimean War. After Nightingale, nurses were viewed as noble, compassionate, moral, religious, dedicated and self-sacrificing (Baly 1997).

Another image arising in the early nineteenth century that has affected subsequent generations of nurses and the public and other professionals working with nurses is the image of *doctor's handmaiden*. This image evolved when women had yet to obtain the right to vote, when family structures were largely paternalistic and when the medical profession was increasingly using scientific knowledge that, at that time, was viewed as a male domain. Since that time, several images of nursing have been portrayed, such as the *heroine* portrayal that evolved from nurses' acts of bravery in World War II. Other images in the late 1900s include the nurse as sex object, surrogate mother, tyrannical mother and body expert.

In more recent times, the nursing profession has tried to counter many of these images and to present to the public a more realistic and contemporary image of nursing. In particular, those views that associated nurses with subservient females have been challenged. Instead, nurses are increasingly being

portrayed as technologically savvy decision makers who are integral members of a multidisciplinary team. And while the majority of nurses in Western societies continue to be women, in these images gender is no longer a deciding factor (Gordon & Nelson 2005).

Nursing leaders

Florence Nightingale, Lucy Osburn, Jane Bell, Elizabeth Kenny, Gwen Burbidge, Muriel Doherty, Vivian Bullwinkel, Mary Evans and Sally Goold are among the leaders who have made notable contributions both to nursing's history and to women's history in Australia and elsewhere. These women were all politically astute pioneers. Their skills at influencing others and bringing about change remain sources of inspiration for political nurse activists today. Other contemporary nursing leaders, such as Virginia Henderson, who created a modern worldwide definition of nursing, and Martha Rogers, a catalyst for theory development, are discussed in Chapter 3.

Nightingale (1820–1910)

Florence Nightingale's contributions to nursing are well documented. Her achievements in improving the standards for the care of war casualties in the Crimea earned her the title 'Lady with the Lamp'. Her efforts in reforming hospitals and in producing and implementing public health policies also made her an accomplished political nurse: she was the first nurse to exert political pressure on government. Although she was one of a number who were instrumental in bringing about reforms to nursing and nurse education, due to the publicity she generated as a result of her Crimean experiences, she became the figurehead of nineteenth-century nursing reforms. Nightingale is also recognised as nursing's first scientist-theorist for her work *Notes on Nursing: What It Is, and What It Is Not*.

Nightingale (see Figure 1.4) was born to a wealthy and intellectual family. She believed she was 'called by God to help others . . . [and] to improve the well-being of mankind' (Schuyler 1992, p. 4). She was determined to become a nurse in spite of opposition from her family and the restrictive societal code for affluent young English women. As a well-travelled young woman of the day, she visited Kaiserswerth in 1847, 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.

When she returned to England from Crimea, a grateful English public gave Nightingale an honorarium of almost £45 000 (Baly 1997, p. 16). She later used this money to develop the Nightingale Training School for Nurses, which opened in 1860. The school served as a model for other training schools. Its graduates travelled to other countries, including Australia, to manage hospitals and institute nurse-training programs.

Nightingale's vision of nursing, which included public health and health promotion roles for nurses, was only partially addressed in the early days of nursing. The focus tended to be on developing the profession within hospitals.



Figure 1.4 Considered the founder of modern nursing, Florence Nightingale (1820–1910) was influential in developing nurse education, practice and administration. Her publication, *Notes on Nursing: What It Is, and What It Is Not*, first published in England in 1859, was intended for all women.

Source: © Anthony Baggett/123RF.

Osburn (1836–1891)

Lucy Osburn was one of Nightingale's early prodigies. Osburn (see Figure 1.5) began her nurse training in 1866 at the Nightingale School of Nursing, St Thomas's Hospital, London, although due to recurring illness she completed only 8 of the required 12 months of training. Immediately upon finishing, Osburn was sent to Sydney Hospital, along with five other trained nurses, to implement the Nightingale system of nursing at that hospital, on the request of the New South Wales Colonial Secretary, Henry Parkes. The decision to put Osburn in this position of authority over her more experienced nursing companions rested in the societal expectations of the time that gave priority and authority to those of the upper classes. Osburn was considered a 'lady'. Although Osburn encountered numerous problems over the next 18 years, and endured considerable conflict with some members of the medical profession who had different ideas on how nursing should be reformed, Osburn was instrumental in instigating Nightingale nurse training within Australia, and graduates from the Sydney Hospital were able to assume matron positions at hospitals throughout the country (Godden 2006).

Bell (1873–1959)

Jane Bell OBE is an example of an Australian trained nurse who went on to become influential in the development of the nursing profession in Australia. Bell (see Figure 1.6) was born in Scotland in 1873 and migrated to Sydney in 1886. She completed her nurse training at the Royal Prince Alfred Hospital,



Figure 1.5 Lucy Osburn introduced 'Nightingale' nursing to Australia.

Source: © New South Wales Ministry of Health for and on behalf of the Crown in right of the State of New South Wales.



Figure 1.6 Jane Bell was instrumental in furthering nursing reforms during the early twentieth century.

Source: Courtesy of the Royal Melbourne Hospital Archives.

Sydney, between 1894 and 1898. In 1899 she became a founding member of the Australasian Trained Nurses' Association. Over the next few years, Bell worked in various positions throughout Australia and overseas before taking up the position of Matron at the Royal Melbourne Hospital in 1910. Aside from some time spent overseas in 1915 as Principle Matron of the First Australian General Hospital in the army during World War I, Bell was instrumental in instigating significant reforms to the training of nurses at the Royal Melbourne Hospital. These included the introduction of the first Sister Tutor, the first Preliminary Training School for Nurses in Australia, the first Diet Kitchen, the first appointment of Charge Sisters in the operating theatres and the introduction of the Melbourne Hospital Nursing Badge for graduates. Bell retired from her position at the Melbourne Hospital in 1934 but continued to be active within the nursing profession, writing, speaking and holding positions within professional nursing organisations such as the Royal Victorian College of Nursing (which later became part of the Australian Nurses Federation) and the (Royal) College of Nursing, Australia (Sherson 2005; Williams & Goodman 1988).

Kenny (1880–1952)

Elizabeth Kenny gained an international reputation for her nursing skill during the 1930s and 1940s, although somewhat controversially. Sister Kenny (see Figure 1.7), as she preferred to be known, gained her title of 'Sister' during her nursing service in World War I, although the details of her training are unknown and it is unlikely she completed a formal three- or four-year general nursing certificate. Kenny



Figure 1.7 Elizabeth Kenny gained world renown for her work in treating and rehabilitating polio victims.

Source: Australian War Memorial, Negative Number P04258.001.

nursed in rural Queensland for a number of years where she gradually developed her techniques of treating polio patients. These techniques differed markedly from the conventional use of splinting. Instead, Kenny used hot packs, massage and movement of the limbs. Her success gained attention from the Queensland government, which backed her treatments for some years, resulting in Kenny clinics opening in Townsville and a small number of other sites. However, her inability to convince the medical profession to alter its approach to the treatment of polio, and indeed the growing antagonism that existed between Kenny and the local medical profession, forced Kenny to take her techniques overseas from 1940, where she gained particular attention and support in the United States. In 1951 she shared the title of Most Influential Woman in America with Eleanor Roosevelt. Although the Australian medical profession gradually adopted many of her techniques after her departure, polio epidemics gradually subsided as vaccination programs became more widespread during the 1950s (Alexander 2002).

Burbidge (1904–2000)

Gwendolen Burbidge OBE was one of a number of influential nurses during the middle of the twentieth century in Australia. In particular, she is renowned as the author of the first Australian nursing textbook, *Lectures for Nurses*, published in 1934 and widely used by trainee nurses and medical orderlies. Burbidge completed her nurse training at the Royal Melbourne Hospital between 1926 and 1929, and by 1933 was teaching student nurses at the Alfred Hospital where she set up and ran its Preliminary Training School (PTS). This was a time of increasing formalisation of nurse training in Australia and Sister Tutors were being employed to oversee the syllabus of trainees. Burbidge undertook a teaching course with the Victorian Teachers College and continued her studies in London where she obtained the First Class Certificate for Sister Tutors, the Sister Tutor's Diploma and Diploma of Nursing from the University of London in 1938. Upon her return to Australia, Burbidge took up the position of Matron of the Queen's Memorial Infectious Diseases Hospital, Fairfield, Victoria—the first Australian hospital to deal exclusively with infectious disease. Here she actively worked on changing the attitude of nurses, and the public, towards infectious diseases from one of fear to one of understanding the necessity of positive treatment. Burbidge was also an active member of professional nursing organisations such as the Grand Council of the Florence Nightingale International Foundation, as well as local organisations, and was Australia's representative to the International Council of Nurses (Bright Sparcs 2006).

Doherty (1896–1988)

Muriel Knox Doherty RRC will be remembered by many nurses who trained in the mid-twentieth century as one of the authors of a popular nursing textbook, *Modern Practical Nursing Procedures*, co-written with M. B. Sirl and O. J. Ring, first published in 1944. However, Doherty (see Figure 1.8),



Figure 1.8 Muriel Doherty was a well-known Australian nurse educator who worked with survivors of World War II.

Source: Australian War Memorial. Image ref. no: VIC1530. This item is in the Public Domain.

while influential within nursing, particularly nurse education, in Australia where she initiated Preliminary Nurse Training at the Royal Prince Alfred Hospital in 1936 after completing her Sister Tutor's course at the University of London, also contributed to the rebuilding of Europe after World War II. In particular, Doherty oversaw the nursing and rehabilitation of displaced persons (former concentration camp prisoners) after their liberation from Bergen-Belsen, one of the more notorious German concentration camps. As matron, Doherty had the inordinate task of coordinating and implementing the physical and emotional recovery of some 10 000 patients of various European nationalities with the aid of a small group of multinational nurses, many of whom were German, with very limited resources. After this experience, she went to Poland to advise the Polish government on the post-war reorganisation of nursing in that country. Upon returning to Australia, Doherty became a founding member of the Council of the New South Wales College of Nursing and an active member of the Australasian Trained Nurses' Association, and helped inaugurate the National Florence Nightingale Memorial Committee in Australia. She also wrote a history of the Royal Prince Alfred Hospital, a place with which she continued a long association after completing her training between 1921 and 1925 (Doherty 2000; Doherty 1996).

Bullwinkel (1915–2000)

Vivian Bullwinkel AO, MBE, ARRC, ED is remembered by the nursing profession and Australians in general for demonstrating inordinate courage and duty during extraordinary



Figure 1.9 Vivian Bullwinkel and a small group of nurses held in prisoner-of-war camps during World War II continued to administer nursing to fellow inmates.

Source: Australian War Memorial, Negative Number P03960.001.

circumstances, and her story is a remarkable one. Bullwinkel (see Figure 1.9) completed her nurse training at the Broken Hill and Districts Hospital between 1934 and 1938. She completed her midwifery training before enlisting in the Australian Army Nursing Service, Australian Imperial Force. In 1941, after being posted to Singapore, she was forced to flee as the front line approached. Sadly, the boat in which she was travelling sank under Japanese attack. A group of survivors surrendered to a Japanese patrol on Bangka Island. However, the patrol herded the group into the sea and shot them. Bullwinkel remarkably was the sole survivor. After living in the jungle for some time, she surrendered and was taken prisoner of war. Over the ensuing 3.5 years, Bullwinkel and a small group of nurses lived with minimal food and resources, yet continued to administer nursing to the other occupants of the camps. A number of her colleagues died as a result of the extreme conditions. After the war, Bullwinkel took up civilian nursing at Heidelberg Repatriation Hospital and was Director of Nursing at Fairfield Infectious Diseases Hospital from 1961 to 1977. She continued to promote nursing in the many public engagements she undertook and was instrumental in having a memorial dedicated to those members of the Australian Army Nursing Service who lost their lives on Bangka Island. This was unveiled in 1993 (Manners 1999).

Evans (1915–2004)

Mary Evans was a dynamic leader in district nursing in Australia during a time of unprecedented growth and change during the 1960s and 1970s. With minimal education, Evans



Figure 1.10 Mary Evans was a strong advocate for district nursing in Australia during the 1960s and 1970s.

Source: Photo courtesy of Royal District Nursing Service (Vic).

(see Figure 1.10) worked as a dressmaker before beginning her nursing career at the Mareeba Babies Hospital. She then completed her general training at the Royal Adelaide Hospital. Her midwifery training was completed at Queen Victoria Memorial Hospital in 1940. She joined the staff at the Melbourne District Nursing Service (later Royal District Nursing Service) in 1943 as part of the Home Midwifery team. In 1959, she was granted a scholarship to travel overseas where she completed a Health Visitors course and then toured several district nursing services in the United Kingdom, Canada and America. This experience stimulated a number of ideas within Evans, which she implemented upon becoming Deputy Matron in 1961 and as Matron in 1963. In particular, she emphasised in-service and postgraduate education for district nurses and instigated a greater focus on rehabilitation within the home and in patient education. Evans was instrumental in organising the first international domiciliary nursing conference in 1970, held in Melbourne. She also oversaw the installation of the first computers for maintaining records within district nursing in Australia from 1970. Evans wrote about the role of the district nurse in the *Australian Family Physician* journal and frequently travelled the country to share her vision of district nursing. She retired from the Royal District Nursing Service in 1978 (Armocida 1992).

Goold

Sally Goold OAM (nee Bablett) was Senior Australian of the Year in 2006 and a pioneer for Indigenous nursing in Australia. Goold (see Figure 1.11), the youngest of seven children, was born in Narrandera in south-western New South Wales but moved to Sydney with her family when she was quite young.



Figure 1.11 Sally Goold was a pioneer for Indigenous nursing in Australia.

Source: © National Australia Day Council.

Similar to many other Indigenous children, she remembers being hospitalised on a number of occasions and, for as long as she could remember, she wanted to become a nurse. When she was 16 she applied to undertake her nursing training at the Royal Prince Alfred Hospital, Sydney, and was accepted. Goold then became the first Indigenous nursing student in New South Wales and later one of the first Indigenous nurses. In 1971, after being approached by Fred Hollows and Dulcie Flower, she helped establish the Aboriginal Medical Service in Redfern. Goold's list of achievements is long and includes academic and government appointments. However, what stands out is her dedication and commitment to nursing, and especially her encouragement of and inspiration for other Indigenous nurses.

CONTEMPORARY NURSING PRACTICE

An understanding of contemporary nursing practice includes comprehending and appreciating definitions of nursing, recipients of nursing, scope of nursing, settings for nursing practice, nurse practice Acts and current standards of clinical nursing practice.

Definitions of nursing

Florence Nightingale defined nursing nearly 150 years ago as 'the act of utilizing the environment of the patient to assist him in his recovery' (Nightingale 1859/1969). Nightingale considered a clean, well-ventilated and quiet environment essential for recovery. Often considered the first nurse theorist, Nightingale

raised the status of nursing through education; nurses were no longer untrained housekeepers but people educated in the care of the sick.

Virginia Henderson was one of the first modern nurses to define nursing. 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)

Henderson saw the nurse as concerned with both healthy and ill individuals, acknowledged that nurses interact with people even when recovery may not be feasible and mentioned the teaching and advocacy roles of the nurse.

In the latter half of the twentieth century, a number of nurse theorists developed their own theoretical definitions of nursing. Theoretical definitions describe what nursing is and the inter-relationship between nurses, nursing, the person, the environment and the intended outcome: health (see Chapter 3).

Certain themes are common to many of these definitions:

- Nursing is caring.
- Nursing is an art.
- Nursing is a science.
- Nursing is person centred.
- Nursing is holistic.
- Nursing is adaptive.
- Nursing is concerned with health promotion, health maintenance and health restoration.
- Nursing is a helping profession.

Professional nursing associations have also examined nursing and developed their own definitions of it. The Australian Peak Nursing Forum—a consortium of professional nursing organisations such as the Australian Nursing Council, Council of Deans of Nursing and Midwifery, Royal College of Nursing, Australia (now the Australian College of Nursing), the Australian Nursing Federation and the Congress of Aboriginal and Torres Strait Islander Nurses—developed a document in 2004 outlining nursing in Australia. This document highlights nursing as a ‘combination of skills and knowledge to provide physical, mental and emotional care to people who are trying to: improve their health; prevent illness and disability; respond to events such as childbirth; or recover their health following an illness or disability. Nurses also support people who are dying, and their families’ (Nursing and Midwifery Board of Australia (NMBA) 2016a).

Throughout its history, the profession and practice of nursing has often been discussed in relation to the construct of ‘caring’. Indeed, study of the meaning of caring in nursing continues today. For example, in an exploratory discussion of how caring relates to nursing, Adams (2016) concludes that caring remains integral to the nursing profession, perhaps even more so now than in the past. Details about caring are discussed in Chapter 26. See also ‘Watson’s assumptions of caring’ (Box 3.1) in Chapter 3.

Recipients of nursing

When describing the people nurses care for, this book will seek to use the term ‘person’ rather than the traditional ‘patient’. This is in recognition of a shift towards ‘**person-centred care**’ and recognises the holistic nature of nursing practice.

Scope of nursing

Nurses provide care for three types of people: individuals, families and communities. Theoretical frameworks applicable to these types, as well as assessments of individual, family and community health, are discussed in Chapters 7 and 25.

Nursing practice involves four areas: promoting health and wellness, preventing illness, restoring health and caring for the dying.

Promoting health and wellness

Health and wellness promotion is a fundamental role within nursing (Strout 2012). Wellness is a process that people engage in to maximise their quality of life and achieve full potential (Strout 2012). Nurses promote wellness both in people who are healthy and people who are ill. This may involve individual and community activities to enhance healthy lifestyles, such as improving nutrition and physical fitness, preventing drug and alcohol misuse, restricting smoking and preventing accidents and injury in the home and workplace. See Chapter 17 for details.

Preventing illness

The goal of illness-prevention programs is, as the term suggests, preventing illness. It generally refers to actions that are done to or for people (Jones & Creedy 2012). Nursing activities that prevent illness include immunisations, prenatal and infant care, and health education.

Restoring health

Restoring health focuses on the ill person and extends from early detection of disease through to helping the person during the recovery period. Nursing activities include the following:

- providing direct care to the ill person
- performing diagnostic and assessment procedures
- consulting with other health care professionals about the person’s problems
- teaching people about rehabilitation activities
- rehabilitating people to their optimal functional level following physical or mental illness, injury or chemical addiction.

Caring for the dying

This area of nursing practice involves comforting and caring for people of all ages who are dying and caring for their families. It includes helping people to live as comfortably as possible until death and helping support persons to cope with death. Nurses carrying out these activities work in homes, hospitals and extended care facilities. Some agencies, called *hospices*, are specifically designed for this purpose.



Figure 1.12 Nurses practise in a variety of settings. Clockwise from top left: operating room nursing, specialist nursing, emergency nursing, paediatric nursing and rehabilitation nursing.

Sources: © Lisa Eastman/Shutterstock.com; © Levent Konuk/Shutterstock.com; Lisa Young/123RF; Lucian Coman/123RF; © Marcin Sadlowski/Fotolia.com.

Settings for nursing

During the twentieth century, the acute care hospital became the main practice setting open to most nurses. Today, many nurses continue to work in hospitals but increasingly they are returning to community settings and primary health settings, peoples' homes, community agencies, ambulatory clinics, long-term care facilities, health clinics and medical centres (see Figure 1.12).

Nurses have different degrees of nursing autonomy and nursing responsibility in the various settings. They may provide assessment, direct care, health management, health education and promotion. They may serve as advocates and agents of change, and help determine health policies affecting people, the community, public health and health service settings. For information about the models for delivery of nursing, see Chapter 6.

Nurse practice Acts

Nurse practice Acts, or legal Acts for professional nursing practice, regulate the practice of nursing in Australia. In 2009, the Nursing and Midwifery Board of Australia (NMBA) was established under the *Health Practitioner (Administration Arrangements) National Law Act 2008*. Prior to this, each state and territory had its own Act. The NMBA has a number of functions: registration of nurses, midwives and students; developing standards, codes and guidelines for nursing and

midwifery; handling notifications, complaints, investigations and disciplinary hearings; assessing overseas-trained practitioners who wish to practise in Australia; and approving accreditation standards and accrediting courses of study. For additional information, see Chapter 4.

Standards of nursing practice

Establishing and implementing standards of practice are major functions of a professional organisation. One such function of the NMBA is to provide codes and guidelines to provide guidance to the nursing professions. The NMBA provides codes of ethics and professional conduct, competency standards, decision-making frameworks and a number of other guidelines for practice. In 2013, codes and guidelines began to be rebranded to no longer include the name Australian Nursing and Midwifery Council (ANMC) and to include the NMBA. This was done to reflect the NMBA taking responsibility for the regulation of nurses and midwives in Australia in 2010.

The NMBA *Registered Nurse Standards for Practice* (NMBA 2016a) describe the responsibilities for which nurses are accountable and provide for the practice of nursing regardless of the area of specialisation (see Box 1.1). Various specialty nursing organisations have further developed specific standards of nursing practice for their area.

BOX 1.1 *NMBA Registered Nurse Standards for Practice***Standard 1: Thinks critically and analyses nursing practice**

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.

The Registered Nurse:

- 1.1 accesses, analyses and uses the best available evidence, which includes research findings, for safe, quality practice
- 1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice
- 1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures
- 1.4 complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions
- 1.5 uses ethical frameworks when making decisions
- 1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision making, actions and evaluations
- 1.7 contributes to quality improvement and relevant research.

Standard 2: Engages in therapeutic and professional relationships

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.

The Registered Nurse:

- 2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships
- 2.2 communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights
- 2.3 recognises that people are the experts in the experience of their life
- 2.4 provides support and directs people to resources to optimise health-related decisions
- 2.5 advocates on behalf of people in a manner that respects the person's autonomy and legal capacity
- 2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes
- 2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others to share knowledge and practice that supports person-centred care
- 2.8 participates in and/or leads collaborative practice
- 2.9 reports notifiable conduct of health professionals, health workers and others.

Standard 3: Maintains the capability for practice

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals' capability for practice. RNs are responsible for their pro-

fessional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.

The Registered Nurse:

- 3.1 considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice
- 3.2 provides the information and education required to enhance people's control over health
- 3.3 uses a lifelong learning approach for continuing professional development of self and others
- 3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role and for the actions of others to whom they have delegated responsibilities
- 3.5 seeks and responds to practice review and feedback
- 3.6 actively engages with the profession
- 3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

Standard 4: Comprehensively conducts assessments

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data, and communicate outcomes as the basis for practice.

The Registered Nurse:

- 4.1 conducts assessments that are holistic as well as culturally appropriate
- 4.2 uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice
- 4.3 works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/ or for referral
- 4.4 assesses the resources available to inform planning.

Standard 5: Develops a plan for nursing practice

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RN's appraisal of comprehensive, relevant information and evidence that is documented and communicated.

The Registered Nurse:

- 5.1 uses assessment data and best available evidence to develop a plan
- 5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and time frames are agreed with the relevant persons
- 5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes
- 5.4 plans and negotiates how practice will be evaluated and the time frame of engagement
- 5.5 coordinates resources effectively and efficiently for planned actions.

Standard 6: Provides safe, appropriate and responsive quality nursing practice

RNs provide and may delegate quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment and the best available evidence to achieve planned and agreed outcomes.

The Registered Nurse:

- 6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people
- 6.2 practises within their scope of practice
- 6.3 appropriately delegates aspects of practice to Enrolled Nurses and others, according to Enrolled Nurse's scope of practice or others' clinical or non-clinical roles
- 6.4 provides effective, timely direction and supervision to ensure that delegated practice is safe and correct

- 6.5 practises in accordance with relevant policies, guidelines, standards, regulations and legislation
- 6.6 uses the appropriate processes to identify and report potential and actual risk-related system issues and where practice may be below the expected standards.

Standard 7: Evaluates outcomes to inform nursing practice

RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes, and revises practice accordingly.

The Registered Nurse:

- 7.1 evaluates and monitors progress towards the expected goals and outcomes
- 7.2 revises the plan based on the evaluation
- 7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.

Source: Nursing and Midwifery Board of Australia (NMBA) (2016a). *Registered Nurse Standards for Practice*. Retrieved from <www.nursingmidwifery-board.gov.au/Codes-Guidelines-Statements>. Printed with permission of the Nursing and Midwifery Board of Australia.

ROLES AND FUNCTIONS OF THE NURSE

Nurses assume a number of roles when they provide person-centred care. Nurses often carry out these roles concurrently, not exclusively of one another. For example, the nurse may act as a counsellor while providing physical care and teaching aspects of that care. The roles required at a specific time depend on the needs of the person and aspects of the particular environment. The following are examples of the roles and functions of a nurse.

Caregiver

The **caregiver** role has traditionally included those activities that assist a person physically and psychologically while preserving the person's dignity. The required nursing actions may involve full care for the completely dependent person, partial care for the partially dependent person and supportive–educative care to assist people in attaining their highest possible level of health, wellness and recovery. Caregiving encompasses the physical, psychosocial, developmental, cultural and spiritual levels. The nursing process provides nurses with a framework for providing care (see Chapters 11–16). Registered Nurses may provide care directly or delegate it to other caregivers.

Collaborator

Collaboration is essential in nursing. The **collaborator** role involves the nurse recognising the roles and experience of others, and working with other individuals and groups for the assessment, planning, coordination, implementation and evaluation of care (NMBA 2016a). The nurse works with others to achieve goals and health outcomes. The nurse establishes, sustains and concludes therapeutic relationships with people,

families, carers and communities. The role also involves the nurse establishing and sustaining professional collaborative relationships with other health professionals in the interdisciplinary health care team.

Communicator

Communication is an integral part of all nursing roles. Nurses communicate with the individual requiring care, support persons, other health professionals and people in the community.

In the role of **communicator**, nurses establish a trusting and therapeutic relationship with the person, identify their problems and then communicate these verbally or in writing to other members of the health team. The quality of a nurse's communication is an important factor in nursing care. The nurse must be able to communicate empathically, clearly and accurately in order for a person's health care needs to be met (see Chapters 16 and 27).

Teacher

As a **teacher**, the nurse helps people learn about their health and health care procedures. The nurse assesses the person's learning needs and readiness to learn, sets specific learning goals in conjunction with the person, enacts teaching strategies and measures learning. Nurses also teach unlicensed Assistants in Nursing (AINs) to whom they delegate care and share their expertise with other nurses and health professionals. See Chapter 28 for additional details about the teaching/learning process.

Nurse advocate

A **nurse advocate** acts to protect the person. In this role, the nurse may represent the person's needs and wishes to other

health professionals, such as relaying the person's wishes for information to the doctor and ensuring that the person understands the information they are given. Nurse advocates also assist people in exercising their rights and help people speak up for themselves (see Chapter 5).

Counsellor

Counselling is the process of helping a person to recognise and cope with perceived stressful psychological or social problems, to develop improved interpersonal relationships and to promote personal growth. It involves providing emotional, intellectual and psychological support. The generalist nurse counsels primarily healthy individuals with normal adjustment difficulties. Counselling is likely to focus on helping the person develop new attitudes, feelings and behaviours by encouraging the person to look at alternative ways of viewing the situation and recognise the different choices available. Mental health nurses provide more specific and targeted counselling as a result of additional expertise.

Change agent

The nurse acts as a **change agent** when assisting people to modify their behaviour. Nurses also often act to make changes in a system, such as clinical care, if it is not helping a person return to health. Nurses are continually dealing with change in the health care system. Technological change, change in the age of the population and changes in medications are just a few of the changes nurses deal with daily. See Chapter 29 for additional information about change.

Leader

A **leader** positively influences others to work together to accomplish a specific goal. The leader role can be employed at different levels: the individual, family, groups, colleagues or the community. Effective leadership is a learned process requiring an understanding of the needs and goals that motivate people, the knowledge to apply the leadership skills and the interpersonal skills to influence others. The leadership role of the nurse is discussed in Chapter 29.

Manager

The nurse manages the nursing care of individuals, families and communities. The nurse **manager** also delegates nursing activities to ancillary workers and other nurses, and supervises and evaluates their performance. Managing requires knowledge about organisational structure and dynamics, authority and accountability, leadership, change theory, advocacy, delegation and supervision and evaluation. See Chapter 29 for additional details.

Case manager

Nurse case managers work with the multidisciplinary health care team to measure the effectiveness of the case management plan and to monitor outcomes. Each agency or unit specifies the role of the nurse **case manager**. In some institutions,

the case manager works with primary or staff nurses to oversee the care of a specific caseload. In other agencies, such as mental health settings, the case manager is the primary nurse or provides some level of direct care to the person and family. Regardless of the setting, case managers help ensure that care is centred on the person by respecting their dignity, culture, ethnicity, values and beliefs.

Research consumer

Nurses often use research to improve care. In a clinical area, nurses need to:

- have some awareness of the process and language of research
- be sensitive to issues related to protecting the rights of human subjects
- participate in the identification of significant researchable problems
- be a discriminating consumer of research findings.

Expanded career roles

Nurses are fulfilling expanded career roles, such as those of Nurse Practitioner, clinical nurse specialist, nurse midwife, nurse educator and nurse researcher, all of which allow greater independence and autonomy (see Box 1.2).

CRITERIA OF A PROFESSION

Nursing continues to gain increased recognition as a profession. **Profession** has been defined as an occupation that requires extensive education or a calling that requires special knowledge, skill and preparation. A profession is generally distinguished from other kinds of occupations by:

- its requirement for prolonged, specialised training to acquire a body of knowledge pertinent to the role to be performed
- an orientation of the individual towards service, either to a community or to an organisation
- ongoing research
- a code of ethics
- autonomy
- a professional organisation.

Two terms related to profession need to be differentiated: *professionalism* and *professionalisation*. **Professionalism** refers to professional character, spirit or methods. It is a set of attributes; a way of life that implies responsibility and commitment. Nursing professionalism owes much to the influence of Florence Nightingale. **Professionalisation** is the process of becoming professional; that is, of acquiring characteristics considered to be professional.

Specialised education

Specialised education is an important aspect of professional status. In modern times, the trend in education for professions has shifted towards programs in colleges and universities. Many nursing educators believe that the undergraduate nursing curriculum should include a liberal arts education in

BOX 1.2 Selected expanded career roles for nurses

Nurse Practitioner

A Nurse Practitioner is a nurse who has an advanced education, usually at master's level, and is a graduate of a Nurse Practitioner program. Nurse Practitioners are endorsed by the NMBA and have standards for practice which build upon those of a Registered Nurse (NMBA 2014). According to the NMBA (2014), Nurse Practitioners have the capability to provide high levels of clinically focused care in a variety of contexts in Australia. They can be found in emergency nursing, rural and remote settings, mental health, aged care, wound management, haematology and oncology, and community and primary health care settings.

Clinical nurse specialist

A clinical nurse specialist is a nurse who has an advanced degree or expertise and is considered to be an expert in a specialised area of practice; for example gerontology or oncology. The nurse provides direct care, educates others, consults, conducts research and manages care.

Midwife

In Australia, a midwife has completed a program in midwifery and is registered by the NMBA. A midwife gives prenatal and postnatal care, and care during labour and birth. The NMBA *National Competency Standards for the Midwife* provide the core competency standards for midwifery practice (NMBA 2010).

Nurse researcher

Nurse researchers investigate nursing problems to improve nursing care and to refine and expand nursing knowledge. They are employed in academic institutions, teaching hospitals and research centres. Nurse researchers usually have advanced education at a master's or doctoral level.

Nurse administrator

The nurse administrator manages care of the person, including the delivery of nursing services. The administrator may have a middle management position, such as supervisor or nurse unit manager, or a more senior management position, such as director of nursing services. The functions of nurse administrators include leading and managing services and health staff, budgeting, planning and delivering health care. The educational preparation for nurse administrator positions is preferably a degree in nursing, and frequently administration qualifications as well.

Nurse educator

Nurse educators are employed in nursing programs at educational institutions and in hospital staff education. The nurse educator usually has a degree in nursing or more advanced preparation, and frequently has expertise in a particular area of practice. The nurse educator is responsible for classroom teaching and, often, clinical teaching. Increasingly, nurse education is provided in an online environment, necessitating technological knowledge and skill in computers as well as education principles.

Nurse entrepreneur

A nurse entrepreneur is a nurse who usually has an advanced degree and manages a health-related business. The nurse may be involved in education, consultation or research.

addition to the biological and social sciences, and the nursing discipline.

In Australia today, there are three means of entry into nursing. Registered Nurses undertake an undergraduate degree at a university. Enrolled Nurses or Nurses (Division 2) complete an associate diploma or diploma, while AINs generally complete a shorter certificate. Each of these levels of nursing has defined roles and expectations or scopes of practice.

Body of knowledge

As a profession, nursing is establishing a well-defined body of knowledge and expertise. A number of nursing conceptual frameworks (discussed in Chapter 3) contribute to the knowledge base of nursing and give direction to nursing practice, education and ongoing research.

Service orientation

Nursing began its professionalisation process on the basis of altruism (selfless concern for others). While a service orientation continues to be influential within nursing, nurses are guided by a range of factors within their practice: codes of ethics, occupational health and safety rules, industry awards, professional codes of practice and institutional policies.

Ongoing research

Increasing research in nursing is contributing to nursing practice. In the 1940s, nursing research was at a very early stage of development. Most early research was directed to the study of nurse education. In the 1960s, studies were often related to the nature of the knowledge base underlying nursing practice. Since the 1970s, nursing research has focused on practice-related issues. Until the 1980s, much of the research related to nursing originated in the United States. However, since the move from hospital-based nurse training to universities in 1984, more Australian nurses have been participating in research and completing higher research degrees. Australian nursing research now has a significant role in the study, discovery and shaping of nursing. Nursing research as a dimension of the nurse's role is discussed further in Chapter 2.

Code 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 member is expected to do what is considered right regardless of the personal cost.

Ethical codes change as the needs and values of society change. Nursing has developed its own codes of ethics and in most instances has set up means to monitor the professional behaviour of its members. In Australia, the NMBA, the Australian College of Nursing and the Australian Nursing Federation provide the *Code of Ethics for Nurses* (NMBA 2013). For additional information on ethics, see Chapter 5.



RESEARCH NOTE

Do student nurses experience imposter phenomenon?

M. Christensen, A. Aubeeluck, D. Fergusson, J. Craft, J. Knight, L. Wirihana, L. & E. Stupple. E. (2016) Do student nurses experience imposter phenomenon? An international comparison of final year undergraduate nursing students' readiness for registration. *Journal of Advanced Nursing*, 72(11), 2784–2793.

The purpose of this study was to examine the extent to which imposter phenomenon is evident in final year nursing students. A sample of 223 final year nursing students from Australia, New Zealand and the United Kingdom completed the Clance Imposter Phenomenon Scale and the Preparedness for Hospital Placement Questionnaire for Nursing. Results from the study indicated that participants exhibited mild to moderate feelings

of imposter phenomena, with some feeling inadequately prepared for registration.

Implications The authors contend that the study can be used to guide the development of transition programs which aim to reduce students' experience of imposter phenomenon by reducing feelings of self-doubt and developing new-graduate confidence.

Autonomy

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. If nursing is to have professional status, it must function autonomously in the formation of policy and in the control of its activity. 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.

To practitioners of nursing, autonomy means independence at work, responsibility and accountability for one's actions. Autonomy is more easily achieved and maintained from a position of authority. Therefore, some nurses seek administrative positions rather than expanded clinical competence as a means to ensure their autonomy in the workplace.

Professional organisation

Operation under the umbrella of a professional organisation differentiates a profession from an occupation. **Governance** is the establishment and maintenance of social, political and economic arrangements by which practitioners control their practice, self-discipline, working conditions and professional

affairs. Nurses, therefore, need to work within their professional organisations.

There are a number of professional associations nurses may join. The Australian College of Nursing (ACN) is the main national, generic professional nursing organisation in Australia. There are professional organisations for specialties of nursing; for example, the Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation for mental health nurses.

SOCIALISATION TO NURSING

The standards of education and practice for the nursing profession are determined by the members of the profession rather than by outsiders. The education of the professional involves a complete socialisation process, more far reaching in its social and attitudinal aspects and its technical features than is usually required in other kinds of occupations.

Socialisation can be defined simply as the process by which people (a) learn to become members of groups and society, and (b) learn the social rules defining relationships (Jones & Creedy 2012). The goal of professional socialisation is to instil in individuals the norms, values, attitudes and behaviours deemed essential for survival of the profession.



REAL-WORLD PRACTICE

One of the biggest changes you'll see as you progress from being a novice nurse to becoming an expert nurse is your willingness to 'trust your gut'. You know, that little voice in your head saying, 'Something isn't right here'. There may be no change in the person's vital signs, no change in their mental status, nothing concrete you can put your finger on, no *numbers* you can report to the doctor (oh, how we all love *numbers*). But in your heart, in your gut, you *know* there's something wrong.

What do you do? As a novice nurse, you are likely to talk yourself out of this feeling. You will think you are just over-reacting, hearing hoof-beats and thinking zebras instead of horses. You

may mention this feeling in passing to a trusted co-worker, but that's about as far as you'll take it.

As you progress through your career, more and more often you will find yourself acting on the advice of that little voice. You'll find yourself calling doctors at 2 in the morning because your little voice is telling you that something is wrong.

You'll know you have arrived, however, when you call a doctor at 2 a.m. who tells you, 'I'll be right there because I trust your little voice'.

—Tina Saiani, RN

Children's Hospital at the Medical Centre of Central Georgia

BOX 1.3 Benner's stages of nursing expertise

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 acceptable performance. Recognises the meaningful 'aspects' of a real situation. Has experienced enough real situations to make judgments about them.

Stage III: competent

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

Stage IV: proficient

Has 3 to 5 years' 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 person, which improves decision making. Focuses on long-term goals.

Stage V: expert

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 analytical ability in new situations. Is inclined to take a certain action because 'it felt right'.

Source: Patricia Benner (2001). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Commemorative edition (1st ed.), pp. 20–34.

Various models of the socialisation process have been developed. Benner's model (2001) describes five levels of proficiency in nursing. The five stages, which have implications for teaching and learning, are novice, advanced beginner, competent, proficient and expert. Benner writes that experience is essential for the development of professional expertise (see Box 1.3).

One of the most powerful mechanisms of professional socialisation is interaction with fellow nurses. Within the student culture, students collectively set the level and direction of their scholastic efforts. They develop perspectives about the situation in which they are involved, the goals they are trying to achieve and the kinds of activities that are expedient and proper, and they establish a set of practices congruent with all of these. Students become bound together by feelings of mutual cooperation, support and solidarity.

FACTORS INFLUENCING CONTEMPORARY NURSING PRACTICE

To understand nursing as it is practised today and as it will be practised tomorrow requires an understanding of some of the social forces currently influencing this profession. These forces

usually affect the entire health care system, and nursing, as a major component of that system, cannot avoid the effects.

Economics

Greater financial support provided through public funding and private health insurance programs has increased the demand for nursing care. As a result, people who could not afford certain health care services in the past are increasingly using such health services as private hospitals, mental health counselling, preventive physical examinations, ancillary health services and alternative medicine.

Costs of health care have increased considerably during the past two decades. In 1982, the American system of payment to hospitals and doctors was revised to establish reimbursement fees according to the person's medical diagnosis. This classification system is known as diagnostic-related groups (DRGs). The system has gradually gained popularity in Australia and uses established pre-treatment diagnosis billing categories. With the implementation of this system, people in hospitals are more acutely ill than previously and people once considered sufficiently ill to be hospitalised are now treated at home; however, health care costs continue to rise.

These changes present challenges to nurses. Currently, the health care industry is shifting its emphasis from inpatient to outpatient care with pre-admission testing, increased outpatient same-day surgery, post-hospitalisation rehabilitation, home health care, health maintenance, physical fitness programs and community health education programs. As a result, more nurses are being employed in community-based health settings, such as home health agencies, hospices and community clinics. These changes in employment for nurses have implications for nurse education, nursing research and nursing practice.

Consumer empowerment

Consumers of nursing services (the public) have become an increasingly effective force in changing nursing practice. On the whole, people are better educated and have more knowledge about health and illness than in the past. Consumers also have become more aware of others' need for care. The ethical and moral issues raised by poverty and neglect have made the public more vocal about the needs of minority groups, the poor and, in particular, Indigenous Australians whose health status remains much lower than it is for other Australians.

The public's concepts of health and nursing have also changed. Most now believe that good health is a right of all people not just a privilege of the rich. The media emphasise the message that individuals must assume responsibility for their own health by obtaining a physical examination regularly, checking for the danger signals of cancer and maintaining their mental wellbeing by balancing work and recreation. Interest in health and nursing services is greater than ever. Furthermore, many people now want more than freedom from disease—they want energy, vitality and a feeling of wellness.

Increasingly, the consumer has become an active participant in making decisions about health and nursing care. Planning

committees concerned with providing nursing services to a community usually have active consumer membership. Recognising the legitimacy of public input, many state and territory nursing associations and regulatory agencies have consumer representatives on their governing boards.

Family structure

Changing family structures influence the need for and provision of nursing services. More people are living away from the extended family and the nuclear family, and the family breadwinner is no longer necessarily the man. Today, many single men and women rear children, and in many two-parent families both parents work. It is also common for young parents to live at great distances from their own parents. These young families need support services, such as daycare centres. For additional information about the family, see Chapter 25.

Adolescent mothers also need specialised nursing services, both while they are pregnant and after their babies are born. These young mothers usually have the normal needs of teenagers as well as those of new mothers. Many teenage mothers are raising their children alone with little, if any, assistance from the child's father. This type of single-parent family is especially vulnerable because motherhood compounds the difficulties of adolescence. In addition, many of these families live in poverty, the children often do not receive preventive immunisations and they are at increased risk of nutritional and other health problems.

Science and technology

Scientific and technological advancement has great implications for health care and nursing practice. Advances in health science and technology mean that there are likely to be great changes in genetics/genomics, nanotechnology, biotechnology, artificial intelligence, robotics and pervasive computing (Calzone et al. 2013; Suby 2013). For example, the recent advances in knowledge in neuropsychiatry brought about by genomic research require nurses to consider genomic information in risk assessment and pharmacological care (Schutte, Davies & Goris 2013).

Recent advances in health-care-related robotics will also have implications for nursing practice, and an increase in such technological interventions has seen the workforce ratio of practitioners to technical staff change. It is postulated that robots that lift and reposition people could also perform duties such as transferring, bathing and dressing. Consideration about how nurses interface with such technology is required.

Information and telecommunication technology

The internet (or World Wide Web) has already affected health care, with more and more people becoming better informed about their health concerns and empowered to be active consumers and participants in health care. It is important for nurses

to deal with the new 'informed' person properly and to be aware that people may already have formed an opinion before seeking health care. Nurses may need to be the interpreters of internet health care. Nurses may need to be the interpreters of internet sources for such people and may also become information brokers so they can help people to access high-quality, valid websites; interpret the information; and evaluate the information and determine its usefulness.

The term **telehealth** refers to the information, technology, education and clinical services that provide long-term wellness, self-management and health services for people distant from the health provider. Telenursing is a component of telehealth and is the practice of nursing from a distance, using information and telecommunication technologies, such as the telephone, computer, video transmission and direct connection to instrumentation (Australian Nursing Federation (ANF) 2013). Examples of telenursing include the nurse who telephones people at home to assess their progress or to answer questions, the nurse who participates in a video teleconference where consultants or experts at various sites discuss a person's health care plan and the nurse who uses webcam technology to assess a person living in a rural area.

Legislation

Legislation about nursing practice and health matters affects both the public and nursing. Legislation related to nursing is discussed in Chapter 4. Changes in legislation relating to health also affect nursing. For example, every competent adult is required to be informed in writing on admission to a health care institution about their rights to accept or refuse medical care and to use advance directives. See also Chapter 4 for more information about the consent and advance directives. These laws, which in many institutions are implemented by nurses, affect the nurse's role in supporting individuals and their families.

Demography

Demography is the study of population, including statistics about distribution by age and place of residence, mortality (death) and morbidity (incidence of disease). The needs of the population for nursing services can be assessed from demographic data. For example:

- The total population in Australia is increasing. The proportion of older persons has also increased, creating an increased need for nursing services for this group.
- The population is shifting from rural to urban settings. This shift signals an increased need for nursing related to problems caused by pollution and by the effects on the environment of concentrations of people. Thus, most nursing services are now provided in urban settings.
- Mortality and morbidity studies reveal the presence of risk factors. Many of these risk factors (e.g. smoking) are major causes of death and disease that can be prevented through changes in lifestyle. The nurse's role in assessing risk factors and helping people make healthy lifestyle changes is discussed in Chapter 17.

Environmental change

Environmental change and environmental hazards are a threat to public health and influence contemporary nursing practice. The World Health Organization (WHO 2013) identifies that environmental hazards such as climate change, stratospheric ozone depletion, changes to ecosystems due to loss of biodiversity, changes in the supplies of freshwater, land degradation and stresses on food-producing systems require the linkage of environmental and health agendas. Nurses need to partake in measures to mitigate climate change as well as the impact that climate change will have on public health, and can be instrumental in influencing the adoption of strategies to better prepare our health facilities and our communities for the health impacts of climate change (Sayre et al. 2010). In Australia, environmental issues such as climate change and the threat to food and water security are recognised as significant dangers for public health (Australian Nursing and Midwifery Federation (ANMF) 2013). Nurses are well placed to develop policy, influence practice and improve energy and water efficiency and waste management practices (ANMF 2013).

The current nursing shortage

Over the past 100 years, the nursing profession has experienced a number of cycles of nursing shortages. Multiple factors influence nursing shortages within Western societies, but those that are pertinent to the current shortage are listed in Box 1.4. Registered Nurses make up the largest group of health care providers. However, fewer nurses are entering the workforce and certain geographical areas are experiencing acute nursing shortages. According to a Health Workforce Australia (HWA) report, ‘projections for the nursing workforce show that in the medium to long term Australia’s demand for nurses will significantly exceed supply, with a projected shortfall of approximately 85 000 nurses by 2025, and 123 000 nurses by 2030 under current settings’ (HWA 2014, p. vii).

Addressing the nursing shortage requires collaborative activities between health care systems, policy makers, nursing educators and professional organisations. Recommendations include, but are not limited to, the following:

- Develop mechanisms for nursing students to progress to and through educational programs more efficiently and be more ‘work ready’ upon graduation.
- Recruit younger people to nursing early, particularly school leavers.
- Improve the nurse’s work environment. Provide greater flexibility in work hours, reward experienced nurses who serve as mentors, ensure adequate staffing and increase salaries.
- Increase nurse education funding.

Nursing associations

To overcome the current nursing shortage, nursing organisations in Australia, such as the Australian College of Nursing and the Australian Nursing and Midwifery Federation, are working cooperatively with various state and federal sectors to try to address some of these shortage issues.

BOX 1.4 Factors affecting the nursing shortage

Ageing nurse workforce

- High student attrition in pre-registration nursing courses.
- New graduates entering the workforce at an older age and with fewer years to work.
- New graduates often take up other career options.
- Difficulty retaining early career nurses.

Ageing of nursing academics

- As nursing academics retire, nursing programs may have fewer staff to educate future nurses.

Reduced entry of younger people into nursing

Ageing population

- Rapidly rising demand for health care driven by ageing population.
- Increasing health care needs of an ageing population.

Increased demand for nurses

- Rapidly rising demand for nurses in health care.
- Increased complexity and acuity of hospitalised people, requiring skilled and specialised nurses.
- Shorter hospital stays resulting in transfer of people to long-term care and community settings, creating increased demand for nurses in the community.

Workplace issues

- Inadequate staffing.
- Heavy workloads.
- Increased use of overtime.
- Lack of sufficient support staff.
- Inadequate wages.
- Increased acuity of people in hospital.

NURSING ORGANISATIONS

As nursing has developed, an increasing number of nursing organisations have formed. These organisations are at the local, state, national and international levels.

Australian Nursing Federation

The first organisation to represent Australian nurses was established in 1899. The Australasian Trained Nurses’ Association (ATNA) began in New South Wales and developed branches in Queensland (1904), South Australia (1905), Western Australia (1907) and Tasmania (1908). A separate group formed in Victoria in 1901—the (later Royal) Victorian Trained Nurses’ Association (RVTNA), which had similar objectives to the ATNA. These early professional nursing organisations were primarily concerned with promoting the interests of trained nurses, establishing a system of registration for trained nurses and regulating the training offered by hospitals. As the various states passed nurse registration legislation and established registration boards for nurses by the 1920s, the role of the ATNA and RVTNA changed and they gradually came to be associated more with industrial issues. While the development of nursing

unions is different in each state, these original nursing organisations eventually merged to form the Australian Nursing Federation (ANF). Nursing had primarily promoted its professionalism on altruism for much of the nineteenth and twentieth centuries, which did not sit well with unionism and the push for better wages and conditions. This uneasy feeling was eventually overcome during the 1980s when nurses took the unprecedented stand of striking for wages and conditions they believed better represented the status and responsibilities associated with the work they undertook.

As it is currently known, the Australian Nursing and Midwifery Federation (ANMF) is the primary nursing industrial body that represents nurses at all levels of practice, from Registered Nurses to Enrolled Nurses (Division 2) to Assistants in Nursing (also known as personal care assistants among a variety of titles) and midwives. This organisation negotiates, on behalf of its members, with employers, governments and the various industrial authorities to establish the wages and conditions for nursing work, a process known as collective bargaining. The ANMF produces a monthly journal, *Australian Nursing and Midwifery Journal*, which outlines issues relevant to industrial, and to a lesser extent clinical, nursing issues.

Australian College of Nursing

As a result of the changes in roles of the ATNA, by the 1940s it became apparent another professional organisation was required—one that focused on the postgraduate educational needs of nurses. While the various state and territory boards of nursing oversaw the regulation of training for general, midwifery, mental health and other formal certificates such as child welfare, there was no provision for experienced nurses wanting to extend their knowledge in areas such as education, management and administration, or public health. The (later Royal) College of Nursing, Australia (RCNA) was established in 1949 with a representative from each state on the council. Unfortunately, nurses in New South Wales had simultaneously established the New South Wales College of Nursing, so the RCNA tended to have nurses from all states other than New South Wales. The site for the delivery of the educational programs was initially Melbourne, although later some courses were offered in other states, and eventually courses came to be offered via correspondence (Smith 1999).

In 2012, the RCNA and ATNA combined to form the Australian College of Nursing (ACN). As a result, the ACN now has offices in Canberra in the Australian Capital Territory and Burwood in New South Wales. The ACN is Australia's 'key national professional nursing organisation open to nurses in all settings and at every stage of their careers'. It is 'an authorised higher education provider and registered training organisation and the body is now the Australian member of the International Council of Nurses' (ACN 2013).

Australian Nursing and Midwifery Accreditation Council

In 1990, representatives at the Australasian Nurse Registering Authorities Conference decided to create a body to focus

on the ethical standards of nurses within Australia. A group was formed that included the main professional nursing organisations to create the Australian Nursing Council (in 2004 this became the Australian Nursing and Midwifery Council (ANMC)), which produced the *Code of Ethics for Nurses in Australia* in 1993 (NMBA 2013). This code was revised in 2002 and 2008. A *Code of Professional Conduct for Nurses* was also devised along with competency standards (NMBA 2016b). These codes and standards outline the knowledge, skills and behavioural expectations of Registered Nurses, including professional and ethical practice, critical thinking and analysis, management of nursing (using the nursing process in a critical and effective manner) and enabling (enhancement of a safe and therapeutic environment).

On 1 July 2010, the Australian Nursing and Midwifery Council (ANMC) changed its name to the Australian Nursing and Midwifery Accreditation Council (ANMAC). The name change takes into account the Council's role as the independent accrediting authority for nursing and midwifery under the new National Registration and Accreditation Scheme.

International Council of Nurses

The International Council of Nurses (ICN) was established in 1899. Nurses from Great Britain, the United States, Canada and Australia were among the founding members. The Council is a federation of national nurses' associations.

The ICN provides an organisation through which member national associations can work together for the mission of representing nursing worldwide, advancing the profession and influencing health policy. The five core values of the ICN are visionary leadership, inclusiveness, flexibility, partnership and achievement (ICN 2005). The official journal of the ICN is the *International Nursing Review*.

International Honour Society: Sigma Theta Tau

Sigma Theta Tau, the international honour society in nursing, was founded in 1922 and has its headquarters in Indianapolis, Indiana. The Greek letters stand for the Greek words *storga*, *tharos* and *tima*, meaning 'love', 'courage' and 'honour'. The society is a member of the Association of College Honour Societies. The society's purpose is professional rather than social. Membership is attained through academic achievement. Students in undergraduate programs in nursing, and nurses in master's, doctoral and post-doctoral programs are eligible to be selected for membership. Potential members who hold a minimum of a bachelor's degree and have demonstrated achievement in nursing can apply for membership as a nurse leader in the community.

The official journal of Sigma Theta Tau, *Journal of Nursing Scholarship*, is published quarterly. The journal publishes scholarly articles of interest to nurses. The society also publishes *Reflections*, a quarterly newsletter that provides information about the organisation and its various chapters.



Chapter 1 review

CHAPTER HIGHLIGHTS

- Historical perspectives of nursing practice reveal recurring themes or influencing factors. For example, women have traditionally cared for others, but often in subservient roles. Religious orders left an imprint on nursing by instilling values such as compassion, devotion to duty and hard work. Wars created an increased need for nurses and medical specialties. Societal attitudes have influenced nursing's image. Visionary leaders have made notable contributions to improve the status of nursing.
- The scope of nursing practice includes promoting wellness, preventing illness, restoring health and caring for the dying.
- Although a majority of nurses were employed in hospital settings during the twentieth century, today the numbers of nurses working in home health care, ambulatory care and community health settings are increasing.
- In 2009, the Nursing and Midwifery Board of Australia (NMBA) was established, replacing individual state and territory legislation. Nurses are responsible for knowing the Act that governs their practice.
- Standards of nursing practice provide criteria against which the effectiveness of nursing care and professional performance behaviours can be evaluated.
- Every nurse may function in a variety of roles that are not exclusive of one another; in reality, they often occur together and serve to clarify the nurse's activities. These roles include caregiver, communicator, teacher, advocate, counsellor, change agent, leader, manager, case manager and research consumer.
- With advanced education and experience, nurses can fulfil advanced practice roles such as clinical nurse specialist, Nurse Practitioner, midwife, educator, administrator and researcher.
- A desired goal of nursing is professionalism, which necessitates specialised education, a unique body of knowledge, including specific skills and abilities, ongoing research, a code of ethics, autonomy, a service orientation and a professional organisation.
- Socialisation is a lifelong process by which people become functioning participants of a society or a group. It is a reciprocal learning process that is brought about by interaction with other people and established boundaries of behaviour. Socialisation to professional nursing practice is the process whereby the values and norms of the nursing profession are internalised into the nurse's own behaviour and self-concept. The nurse acquires the knowledge, skill and attitudes characteristic of the profession.
- Although several models of the socialisation process have been developed, Benner's five stages of novice, advanced beginner, competent, proficient and expert may serve as guidelines to establish the phase and extent of an individual's socialisation.
- Contemporary nursing practice is influenced by economics, consumer demand, family structure, science and technology, information and telecommunications, legislation, demographic and social changes, the nursing shortage, collective bargaining and the work of nursing associations.
- Participation in the activities of nursing associations enhances the growth of involved individuals and helps nurses collectively influence policies that affect nursing practice.

CONCEPT CHECK

1. Which of the following women made significant contributions to the nursing care of soldiers during the Crimean War? Select all that apply.
 1. Jane Bell.
 2. Florence Nightingale.
 3. Fabiola.
 4. Vivian Bullwinkel.
 5. Lucy Osburn.
2. Health promotion is best represented by which of the following activities?
 1. Administering immunisations.
 2. Giving a bath.
 3. Preventing accidents in the home.
 4. Performing diagnostic procedures.
3. Who introduced 'Nightingale' nursing to Australia?
 1. Florence Nightingale.
 2. Elizabeth Kenny.
 3. Lucy Osburn.
 4. Muriel Doherty.
4. A nurse with 2 to 3 years' experience who has the ability to coordinate multiple complex nursing care demands is at which stage of Benner's stages of nursing expertise?
 1. Advanced beginner.
 2. Competent.
 3. Proficient.
 4. Expert.
5. Which professional organisation developed national competency standards?
 1. ACN.
 2. ANMF.
 3. ANMC.
 4. ICN.
6. Which of the following social forces is most likely to significantly affect the future supply and demand for nurses?
 1. Ageing.
 2. Economics.
 3. Science/technology.
 4. Telecommunications.