Nursing Theory

Roy Cunningham



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by Roy Cunningham

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Chapter 1

Nursing

Nursing is a profession within the health care sector focused on the care of individuals, families, and communities so they may attain, maintain, or recover optimal health and quality of life. Nurses may be differentiated from other health care providers by their approach to patient care, training, and scope of practice. Nurses practice in many specialties with differing levels of prescription authority. Nurses comprise the largest component of most healthcare environments; but there is evidence of international shortages of qualified nurses. Many nurses provide care within the ordering scope of physicians, and this traditional role has shaped the public image of nurses as care providers. Nurse practitioners are however permitted by most jurisdictions to practice independently in a variety of settings. Since the postwar period, nurse education has undergone a process of diversification towards advanced and specialized credentials, and many of the traditional regulations and provider roles are changing.

Nurses develop a plan of care, working collaboratively with physicians, therapists, the patient, the patient's family, and other team members that focuses on treating illness to improve quality of life. In the United Kingdom and the United States, advanced practice nurses, such as clinical nurse specialists and nurse practitioners, diagnose health problems and prescribe medications and other therapies, depending on individual state regulations. Nurses may help coordinate the patient care performed by other members of a multidisciplinary health care team such as therapists, medical practitioners, and

dietitians. Nurses provide care both interdependently, for example, with physicians, and independently as nursing professionals.

History

The word "nurse" originally came from the Latin word "nutrire", meaning to suckle, referring to a wet-nurse; only in the late 16th century did it attain its modern meaning of a person who cares for the infirm.

From the earliest times most cultures produced a stream of nurses dedicated to service on religious principles. Both Christendom and the Muslim World generated a stream of dedicated nurses from their earliest days. In Europe before the foundation of modern nursing, Catholic nuns and the military often provided nursing-like services. It took until the 19th century for nursing to become a secular profession.

Ancient history

The early history of nurses suffers from a lack of source material, but nursing in general has long been an extension of the wet-nurse function of women.

Buddhist Indian ruler (268 B.C.E. to 232 B.C.E.) Ashoka erected a series of pillars, which included an edict ordering hospitals to be built along the routes of travelers, and that they be "well provided with instruments and medicine, consisting of mineral and vegetable drugs, with roots and fruits"; "Whenever there is no provision of drugs, medical

roots, and herbs, they are to be supplied, and skilful physicians appointed at the expense of the state to administer them." The system of public hospitals continued until the fall of Buddhism in India ca. 750 CE.

About 100 B.C.E. the *Charaka Samhita* was written in India, stating that good medical practice requires a patient, physician, nurse, and medicines, with the nurse required to be knowledgeable, skilled at preparing formulations and dosage, sympathetic towards everyone, and clean.

The first known Christian nurse, Phoebe, is mentioned in Romans 16:1. During the early years of the Christian Church (ca. 50 C.E.), St. Paul sent a deaconess named Phoebe to Rome as the first visiting nurse.

From its earliest days, following the edicts of Jesus, Christianity encouraged its devotees to tend the sick. Priests were often also physicians. According to the historian Geoffrey Blainey, while pagan religions seldom offered help to the infirm, the early Christians were willing to nurse the sick and take food to them, notably during the smallpox epidemic of AD 165-180 and the measles outbreak of around AD 250; "In nursing the sick and dying, regardless of religion, the Christians won friends and sympathisers".

Following the First Council of Nicaea in 325 AD, Christianity became the official religion of the Roman Empire, leading to an expansion of the provision of care. Among the earliest were those built ca. 370 by St. Basil the Great, bishop of Caesarea Mazaca in Cappadocia in Asia Minor (modern-day Turkey), by Saint Fabiola in Rome ca. 390, and by the physician-priest Saint Sampson (d. 530) in Constantinople, Called the Basiliad,

St. Basil's hospital resembled a city, and included housing for doctors and nurses and separate buildings for various classes of patients. There was a separate section for lepers. Eventually construction of a hospital in every cathedral town was begun.

Christian emphasis on practical charity gave rise to the development of systematic nursing and hospitals after the end of the persecution of the early church. Ancient church leaders like St. Benedict of Nursia (480-547) emphasized medicine as an aid to the provision of hospitality. 12th century Roman Catholic orders like the Dominicans and Carmelites have long lived in religious communities that work for the care of the sick.

Some hospitals maintained libraries and training programs, and doctors compiled their medical and pharmacological studies in manuscripts. Thus in-patient medical care in the sense of what we today consider a hospital, was an invention driven by Christian mercy and Byzantine innovation. Byzantine hospital staff included the Chief Physician (archiatroi), professional nurses (hypourgoi) and orderlies (hyperetai). By the twelfth century, Constantinople had two well-organized hospitals, staffed by doctors who were both male and female. Facilities included systematic treatment procedures and specialized wards for various diseases.

In the early 7th century, RufaidahbintSa'ad (also known as Rufaida Al-Aslamia) became what is now described as the first Muslim nurse. A contemporary of Muhammad, she hailed from the Bani Aslam tribe in Medina and learned her medical skills from her father, a traditional healer. After she had led a group of women to treat injured fighters on the battlefield,

Muhammad gave her permission to set up a tent near the Medina mosque to provide treatment and care for the ill and the needy.

Medieval Europe

Medieval hospitals in Europe followed a similar pattern to the Byzantine. They were religious communities, with care provided by monks and nuns. (An old French term for hospital is *hôtel-Dieu*, "hostel of God.") Some were attached to monasteries; others were independent and had their own endowments, usually of property, which provided income for their support. Some hospitals were multi-functional while others were founded for specific purposes such as leper hospitals, or as refuges for the poor, or for pilgrims: not all cared for the sick. The first Spanish hospital, founded by the Catholic Visigoth bishop Masona in 580AD at Mérida, was a *xenodochium* designed as an inn for travellers (mostly pilgrims to the shrine of Eulalia of Mérida) as well as a hospital for citizens and local farmers. The hospital's endowment consisted of farms to feed its patients and guests. From the account given by Paul the Deacon we learn that this hospital was supplied with physicians and nurses, whose mission included the care the sick wherever they were found, "slave or free, Christian or Jew."

During the late 700s and early 800s, Emperor Charlemagne decreed that those hospitals which had been well conducted before his time and had fallen into decay should be restored in accordance with the needs of the time. He further ordered that a hospital should be attached to each cathedral and monastery.

During the tenth century the monasteries became a dominant factor in hospital work. The famous Benedictine Abbey of Cluny, founded in 910, set the example which was widely imitated throughout France and Germany. Besides its infirmary for the religious, each monastery had a hospital in which externs were cared for. These were in charge of the *eleemosynarius*, whose duties, carefully prescribed by the rule, included every sort of service that the visitor or patient could require.

As the *eleemosynarius* was obliged to seek out the sick and needy in the neighborhood, each monastery became a center for the relief of suffering. Among the monasteries notable in this respect were those of the Benedictines at Corbie in Picardy, Hirschau, Braunweiler, Deutz, Ilsenburg, Liesborn, Pram, and Fulda; those of the Cistercians at Arnsberg, Baumgarten, Eberbach, Himmenrode, Herrnalb, Volkenrode, and Walkenried.

No less efficient was the work done by the diocesan clergy in accordance with the disciplinary enactments of the councils of Aachen (817, 836), which prescribed that a hospital should be maintained in connection with each collegiate church. The canons were obliged to contribute towards the support of the hospital, and one of their number had charge of the inmates. As these hospitals were located in cities, more numerous demands were made upon them than upon those attached to the monasteries. In this movement the bishop naturally took the lead, hence the hospitals founded by Heribert (d. 1021) in Cologne, Godard (d. 1038) in Hildesheim, Conrad (d. 975) in Constance, and Ulrich (d. 973) in Augsburg. But similar provision was made by the other churches; thus at Trier the

hospitals of St. Maximin, St. Matthew, St. Simeon, and St. James took their names from the churches to which they were attached. During the period 1207–1577 no less than 155 hospitals were founded in Germany.

The Ospedale Maggiore, traditionally named Ca' Granda (i.e. Big House), in Milan, northern Italy, was constructed to house one of the first community hospitals, the largest such undertaking of the fifteenth century. Commissioned by Francesco Sforza in 1456 and designed by Antonio Filarete it is among the first examples of Renaissance architecture in Lombardy.

The Normans brought their hospital system along when they conquered England in 1066. By merging with traditional land-tenure and customs, the new charitable houses became popular and were distinct from both English monasteries and French hospitals.

They dispensed alms and some medicine, and were generously endowed by the nobility and gentry who counted on them for spiritual rewards after death.

According to Geoffrey Blainey, the Catholic Church in Europe provided many of the services of a welfare state: "It conducted hospitals for the old and orphanages for the young; hospices for the sick of all ages; places for the lepers; and hostels or inns where pilgrims could buy a cheap bed and meal". It supplied food to the population during famine and distributed food to the poor. This welfare system the church funded through collecting taxes on a large scale and possessing large farmlands and estates.

Roles for women

Catholic women played large roles in health and healing in medieval and early modern Europe. A life as a nun was a prestigious role; wealthy families provided dowries for their daughters, and these funded the convents, while the nuns provided free nursing care for the poor.

Meanwhile, in Catholic lands such as France, rich families continued to fund convents and monasteries, and enrolled their daughters as nuns who provided free health services to the poor. Nursing was a religious role for the nurse, and there was little call for science.

Middle East

The Eastern Orthodox Church had established many hospitals in the Middle East, but following the rise of Islam from the 7th century, Arabic medicine developed in this region, where a number of important advances were made and an Islamic tradition of nursing begun. Arab ideas were later influential in Europe. The famous Knights Hospitaller arose as a group of individuals associated with an Amalfitan hospital in Jerusalem, which was built to provide care for poor, sick or injured Christian pilgrims to the Holy Land. Following the capture of the city by Crusaders, the order became a military as well as infirmarian order.

Roman Catholic orders such as the Franciscans stressed tending the sick, especially during the devastating plagues.

Early modern Europe

Catholic Europe

The Catholic elites provided hospital services because of their theology of salvation that holds that faith accompanied by good works were the route to heaven. The same theology holds strong into the 21st century. In Catholic areas, the tradition of nursing sisters continued uninterrupted. Several orders of nuns provided nursing services in hospitals.

A leadership role was taken by the Daughters of Charity of Saint Vincent de Paul, founded in France in 1633. New orders of Catholic nuns expanded the range of activities and reached new areas. For example, in rural Brittany in France, the Daughters of the Holy Spirit, created in 1706, played a central role. New opportunity for nuns as charitable practitioners were created by devout nobles on their own estates. The nuns provided comprehensive care for the sick poor on their patrons' estates, acting not only as nurses, but took on expanded roles as physicians, surgeons, and apothecaries.

The French Catholics in New France (Canada) and New Orleans continued these traditions. During the French Revolution, most of the orders of nurses were shut down and there was no organized nursing care to replace them. However the demand for their nursing services remained strong, and after 1800 the sisters reappeared and resumed their work in hospitals and on rural estates. They were tolerated by officials because they had widespread support and were the link between elite physicians and distrustful peasants who needed help.

Protestantism closes the hospitals

The Protestant reformers, led by Martin Luther, rejected the notion that rich men could gain God's grace through good works—and thereby escape purgatory—by providing cash endowments to charitable institutions. They also rejected the Catholic idea that the poor patients earned grace and salvation through their suffering. Protestants generally closed all the convents and most of the hospitals, sending women home to become housewives, often against their will. On the other hand, local officials recognized the public value of hospitals, and some were continued in Protestant lands, but without monks or nuns and in the control of local governments.

In London, the crown allowed two hospitals to continue their charitable work, under nonreligious control of city officials. The convents were all shut down but Harkness finds that women—some of them former nuns—were part of a new system that delivered essential medical services to people outside their family. They were employed by parishes and hospitals, as well as by private families, and provided nursing care as well as some medical, pharmaceutical, and surgical services.

In the 16th century, Protestant reformers shut down the monasteries and convents, though they allowed a few to continue in operation. Those nuns who had been serving as nurses were given pensions or told to get married and stay home. Between 1600 and 1800, Protestant Europe had a few notable hospitals, but no regular system of nursing. The weakened public role of women left female practitioners restricted to assisting neighbors and family in an unpaid and unrecognized capacity.

Modern

- Modern nursing began in the 19th century in Germany and Britain, and spread worldwide by 1900.

Deaconess

Phoebe, the nurse mentioned in the New Testament, was a deaconess. The role had virtually died out centuries before, but was revived in Germany in 1836 when Theodor Fliedner and his wife FriederikeMünster opened the first deaconess motherhouse in Kaiserswerth on the Rhine. The diaconate was soon brought to England and Scandinavia, Kaiserswerth model. The women obligated themselves for 5 years of service, receiving room, board, uniforms, pocket money, and lifelong care. The uniform was the usual dress of the married woman. There were variations, such as an emphasis on preparing women for marriage through training in nursing, child care, social work and housework. In the Anglican Church, the diaconate was an auxiliary to the pastorate, and there were no mother houses. By 1890 there were over 5,000 deaconesses in Protestant Europe, chiefly Germany, Scandinavia, and England. In World War II, diaconates in war zones sustained heavy damage. As eastern Europe fell to communism, most diaconates were shut down, and 7,000 deaconesses became refugees in West Germany. By 1957, in Germany there were 46,000 deaconesses and 10,000 associates. Other countries reported a total of 14,000 deaconesses, most of them Lutherans. In the United States and Canada 1,550 women were counted, half of them in the Methodist Church.

William Passavant in 1849 brought the first four deaconesses to Pittsburgh, after visiting Kaiserswerth. They worked at the Pittsburgh Infirmary (now Passavant Hospital). Between 1880 and 1915, 62 training schools were opened in the United States. The lack of training had weakened Passavant's programs. However recruiting became increasingly difficult after 1910 as women preferred graduate nursing schools or the social work curriculum offered by state universities.

Nightingale's Britain

The Crimean War was a significant development in nursing history when English nurse Florence Nightingale laid the foundations of professional nursing with the principles summarised in the book *Notes on Nursing*. Nightingale arrived in Crimea in 1855, where she became known as "The Lady with the Lamp." She would visit and minister to the wounded all-day and night. In Crimea, she managed and trained a group of nurses who tended to injured soldiers.

When she arrived at Scutari, the British hospital base in Constantinople, she found appalling conditions and a lack of hygiene. The hospital was dirty and filled with excrement and rodents. Supplies, food, and even water were in short supply. Nightingale organized the cleaning of the entire hospital, ordered supplies, and implemented hygienic procedures such as hand washing to prevent the spread of infection. Some credit Nightingale with significantly reducing the death rate at the hospital, on account of her advocacy for proper supplies and sanitary procedures. A fund was set up in 1855 by members of the public to raise money for Florence Nightingale and her nurses' work In 1856, £44,039 (equivalent to roughly

over £2 million today) was pooled and with this Nightingale decided to use the money to lay the foundations for a training school at St Thomas' Hospital. In 1860, the training for the first batch of nurses began; upon graduation from the school, these nurses used to be called 'Nightingales'. Nightingale's contemporary, Mary Seacole, was a Jamaican "doctress" who also nursed soldiers who were wounded during the Crimean War, and in the tradition of Jamaican doctresses, Seacolepractised the hygiene that was later adopted by Nightingale in her writings after the Crimean War.

Nightingale's revelation of the abysmal nursing care afforded soldiers in the Crimean War energized reformers. Queen Victoria in 1860 ordered a hospital to be built to train Army nurses and surgeons, the Royal Victoria Hospital. The hospital opened in 1863 in Netley and admitted and cared for military patients.

Beginning in 1866, nurses were formally appointed to Military General Hospitals. The Army Nursing Service (ANS) oversaw the work of the nurses starting in 1881. These military nurses were sent overseas beginning with the First Boer War (often called Zulu War) from 1879 to 1881. They were also dispatched to serve during the Egyptian Campaign in 1882 and the Sudan War of 1883 to 1884. During the Sudan War members of the Army Nursing Service nursed in hospital ships on the Nile as well as the Citadel in Cairo. Almost 2000 nurses served during the second Boer War, the Anglo-Boer War of 1899 to 1902, alongside nurses who were part of the colonial armies of Australia, Canada and New Zealand. They served in tented field hospitals. 23 Army Nursing sisters from Britain lost their lives from disease outbreaks.

New Zealand

New Zealand was the first country to regulate nurses nationally, with adoption of the Nurses Registration Act on the 12 September 1901. It was here in New Zealand that Ellen Dougherty became the first registered nurse.

Canada

Canadian nursing dates all the way back to 1639 in Quebec with the Augustine nuns. These nuns were trying to open up a mission that cared for the spiritual and physical needs of patients. The establishment of this mission created the first nursing apprenticeship training in North America.

In the nineteenth century, there were some Catholic orders of nursing that were trying to spread their message across Canada. These women had only an occasional consultation with a physician. Towards the end of the nineteenth-century hospital care and medical services had been improved and expanded. Much of this was due to the Nightingale model, which prevailed in English Canada. In 1874 the first formal nursing training program was started at the General and Marine Hospital in St. Catharines in Ontario. Many programs popped up in hospitals across Canada after this one was established. Graduates and teachers from these programs began to fight for licensing legislation, nursing journals, university training for nurses, and for professional organizations for nurses.

The first instance of Canadian nurses and the military was in 1885 with the Northwest Rebellion. Some nurses came out to

aid the wounded. In 1901 Canadian nurses were officially part of the Royal Canadian Army Medical Corps. Georgina Fane Pope and Margaret C. MacDonald were the first nurses officially recognized as military nurses.

Canadian missionary nurses were also of great importance in Henan, China as a part of the North China Mission starting in 1888. In the late nineteenth and early twentieth centuries, women made inroads into various professions including teaching, journalism, social work, and public health. These advances included the establishment of a Women's Medical College in Toronto (and in Kingston, Ontario) in 1883, attributed in part to the persistence of Emily Stowe, the first female doctor to practice in Canada. Stowe's daughter, Augusta Stowe-Gullen, became the first woman to graduate from a Canadian medical school.

Apart from a token few, women were outsiders to the male-dominated medical profession. As physicians became better organized, they successfully had laws passed to control the practice of medicine and pharmacy and banning marginal and traditional practitioners. Midwifery—practiced along traditional lines by women—was restricted and practically died out by 1900. Even so, the great majority of childbirths took place at home until the 1920s, when hospitals became preferred, especially by women who were better educated, more modern, and more trusting in modern medicine.

Prairie provinces

In the Prairie provinces, the first homesteaders relied on themselves for medical services. Poverty and geographic

isolation empowered women to learn and practice medical care with the herbs, roots, and berries that worked for their mothers. They prayed for divine intervention but also practiced supernatural magic that provided as much psychological as physical relief. The reliance on homeopathic remedies continued as trained nurses and doctors and how-to manuals slowly reached the homesteaders in the early 20th century.

After 1900 medicine and especially nursing modernized and became well organized.

The Lethbridge Nursing Mission in Alberta was a representative Canadian voluntary mission. It was founded, independent of the Victorian Order of Nurses, in 1909 by Jessie Turnbull Robinson. A former nurse, Robinson was elected as president of the Lethbridge Relief Society and began district nursing services aimed at poor women and children.

The mission was governed by a volunteer board of women directors and began by raising money for its first year of service through charitable donations and payments from the Metropolitan Life Insurance Company. The mission also blended social work with nursing, becoming the dispenser of unemployment relief.

Richardson (1998) examines the social, political, economic, class, and professional factors that contributed to ideological and practical differences between leaders of the Alberta Association of Graduate Nurses (AAGN), established in 1916, and the United Farm Women of Alberta (UFWA), founded in 1915, regarding the promotion and acceptance of midwifery as a recognized subspecialty of registered nurses. Accusing the AAGN of ignoring the medical needs of rural Alberta women,

the leaders of the UFWA worked to improve economic and living conditions of women farmers. Irene Parlby, the UFWA's first president, lobbied for the establishment of a provincial Department of Public Health, government-provided hospitals and doctors, and passage of a law to permit nurses to qualify as registered midwives. The AAGN leadership opposed midwife certification, arguing that nursing curricula left no room for midwife study, and thus nurses were not qualified to participate in home births. In 1919 the AAGN compromised with the UFWA, and they worked together for the passage of the Public Health Nurses Act that allowed nurses to serve as midwives in regions without doctors. Thus, Alberta's District Nursing Service, created in 1919 to coordinate the province's women's health resources, resulted chiefly from the organized, persistent political activism of UFWA members and only minimally from the actions of professional nursing groups clearly uninterested in rural Canadians' medical needs.

The Alberta District Nursing Service administered health care in the predominantly rural and impoverished areas of Alberta in the first half of the 20th century. Founded in 1919 to meet maternal and emergency medical needs by the United Farm Women (UFWA), the Nursing Service treated prairie settlers living in primitive areas lacking doctors and hospitals. Nurses provided prenatal care, worked as midwives, performed minor surgery, conducted medical inspections of schoolchildren, and sponsored immunization programs. The post-Second World War discovery of large oil and gas reserves resulted in economic prosperity and the expansion of local medical services. The passage of provincial health and universal hospital insurance in 1957 precipitated the eventual phasing out of the obsolete District Nursing Service in 1976.

Recent trends

After World War II, the health care system expanded and was nationalized with medicare. Currently there are 260,000 nurses in Canada but they face the same difficulties as most countries, as technology advances and the aging population requires more nursing care.

Mexico

During most of Mexico's wars in the nineteenth and early twentieth centuries, camp followers known as soldaderas nursed soldiers wounded in warfare. During the Mexican Revolution (1910-1920) care of soldiers in northern Mexico was also undertaken by the Neutral White Cross, founded by Elena Arizmendi Mejia after the Mexican Red Cross refused to treat revolutionary soldiers. The Neutral White Cross treated soldiers regardless of their faction.

France

Professionalization of nursing in France came in the late 19th and early 20th century. In 1870 France's 1,500 hospitals were operated by 11,000 Catholic sisters; by 1911 there were 15,000 nuns representing over 200 religious orders. Government policy after 1900 was to secularize public institutions, and diminish the role the Catholic Churches. The lay staff was enlarged from 14,000 in 1890 to 95,000 in 1911. This political goal came in conflict with the need to maintain better quality of medical care in antiquated facilities. Many doctors, while personally anti-clerical, realized their dependence on the Catholic sisters. Most lay nurses came from peasant or

working-class families and were poorly trained. Faced with the long hours and low pay, many soon married and left the field, while the Catholic sisters had renounced marriage and saw nursing as their God-given vocation. New government-operated nursing schools turned out nonreligious nurses who were slated for supervisory roles. During the World War, an outpouring of patriotic volunteers brought large numbers of untrained middle-class women into the military hospitals. They left when the war ended but the long-term effect was to heighten the prestige of nursing. In 1922 the government issued a national diploma for nursing.

United States

Nursing professionalized rapidly in the late 19th century as larger hospitals set up nursing schools that attracted ambitious women from middle- and working-class backgrounds. Agnes Elizabeth Jones and Linda Richards established quality nursing schools in the U.S. and Japan; Linda Richards was officially America's first professionally trained nurse, having been trained at Florence Nightingale's training school, and subsequently graduating in 1873 from the *New England Hospital for Women and Children* in Boston

In the early 1900s, the autonomous, nursing-controlled, Nightingale-era schools came to an end. Despite the establishment of university-affiliated nursing schools, such as Columbia and Yale, hospital training programs were dominant. Formal "book learning" was discouraged in favor of clinical experience through an apprenticeship. In order to meet a growing demand, hospitals used student nurses as cheap labor at the expense of quality formal education.

Jamaica

Mary Seacole came from a long line of Jamaican nurses, or "doctresses", who worked at healing British soldiers and sailors at the Jamaican military base of Port Royal. These doctresses of the eighteenth century used good hygiene and herbal remedies to nurse their clients back to health. In the eighteenth century, these doctresses included Seacole's mother, who was a mixed-race woman who was most likely a child of a slave, and who acquired medical knowledge of herbal remedies from West African ancestors. Other 18th century doctresses included Sarah Adams and Grace Donne, the mistress and healer to Jamaica's wealthiest planter, Simon Taylor. Another eighteenth century doctress was Cubah Cornwallis, who nursed back to health famous sailors such as the young Horatio Nelson, 1st Viscount Nelson and Sailor Bill, who later became William IV of the United Kingdom.

Hospitals

The number of hospitals grew from 149 in 1873 to 4,400 in 1910 (with 420,000 beds) to 6,300 in 1933, primarily because the public trusted hospitals more and could afford more intensive and professional care.

They were operated by city, state and federal agencies, by churches, by stand-alone non-profits, and by for-profit enterprises run by a local doctor. All the major denominations built hospitals; in 1915, the Catholic Church ran 541, staffed primarily by unpaid nuns. The others sometimes had a small cadre of deaconesses as staff. Most larger hospitals operated a school of nursing, which provided training to young women,

who in turn did much of the staffing on an unpaid basis. The number of active graduate nurses rose rapidly from 51,000 in 1910 to 375,000 in 1940 and 700,000 in 1970.

The Protestant churches reentered the health field, especially by setting up orders of women, called deaconesses who dedicated themselves to nursing services.

The modern deaconess movement began in Germany in 1836 when Theodor Fliedner and his wife opened the first deaconess motherhouse in Kaiserswerth on the Rhine. It became a model and within a half century were over 5,000 deaconesses in Europe. The Chursh of England named its first deaconess in 1862. The North London Deaconess Institution trained deaconesses for other dioceses and some served overseas. William Passavant in 1849 brought the first four deaconesses to Pittsburgh, in the United States, after visiting Kaiserswerth. They worked at the Pittsburgh Infirmary (now Passavant Hospital).

The American Methodists – the largest Protestant denomination—engaged in large-scale missionary activity in Asia and elsewhere in the world, making medical services a priority as early as the 1850s. Methodists in America took note, and began opening their own charitable institutions such as orphanages and old people's homes after 1860. In the 1880s, Methodists began opening hospitals in the United States, which served people of all religious backgrounds beliefs. By 1895 13 hospitals were in operation in major cities.

In 1884, U.S. Lutherans, particularly John D. Lankenau, brought seven sisters from Germany to run the German Hospital in Philadelphia.

By 1963, the Lutheran Church in America had centers for deaconess work in Philadelphia, Baltimore, and Omaha.

Public health

In the U.S., the role of public health nurse began in Los Angeles in 1898, by 1924 there were 12,000 public health nurses, half of them in the 100 largest cities. Their average annual salary in larger cities was $1,390. In addition, there were thousands of nurses employed by private agencies handling similar work. Public health nurses supervised health issues in the public and parochial schools, to prenatal and infant care, handled communicable diseases and tuberculosis and dealt with an aerial diseases.

During the Spanish–American War of 1898, medical conditions in the tropical war zone were dangerous, with yellow fever and malaria endemic. The United States government called for women to volunteer as nurses. Thousands did so, but few were professionally trained. Among the latter were 250 Catholic nurses, most of them from the Daughters of Charity of St. Vincent de Paul.

Nursing schools

Sporadic progress was made on several continents, where medical pioneers established formal nursing schools. But even as late as the 1870s, "women working in North American urban hospitals typically were untrained, working class, and accorded lowly status by both the medical profession they supported and society at large". Nursing had the same status in Great Britain and continental Europe before World War I.

Hospital nursing schools in the United States and Canada took the lead in applying Nightingale's model to their training programmers:

standards of classroom and on-the-job training had risen sharply in the 1880s and 1890s, and along with them the expectation of decorous and professional conduct

In late the 1920s, the women's specialties in health care included 294,000 trained nurses, 150,000 untrained nurses, 47,000 midwives, and 550,000 other hospital workers (most of them women).

In recent decades, professionalization has moved nursing degrees out of RN-oriented hospital schools and into community colleges and universities. Specialization has brought numerous journals to broaden the knowledge base of the profession.

World War I

Britain

By the beginning of World War I, military nursing still had only a small role for women in Britain; 10,500 nurses enrolled in Queen Alexandra's Imperial Military Nursing Service (QAIMNS) and the Princess Mary's Royal Air Force Nursing Service. These services dated to 1902 and 1918, and enjoyed royal sponsorship. There also were Voluntary Aid Detachment (VAD) nurses who had been enrolled by the Red Cross. The ranks that were created for the new nursing services were Matron-in-Chief, Principal Matron, Sister and Staff Nurses. Women joined steadily throughout the War. At the end of 1914, there were

2,223 regular and reserve members of the QAIMNS and when the war ended there were 10,404 trained nurses in the QAIMNS.

Grace McDougall (1887–1963) was the energetic commandant of the First Aid Nursing Yeomanry (FANY), which had formed in 1907 as an auxiliary to the home guard in Britain. McDougall at one point was captured by the Germans but escaped. The British army wanted nothing to do with them so they drove ambulances and ran hospitals and casualty clearing stations for the Belgian and French armies.

Canada

When Canadian nurses volunteered to serve during World War I, they were made commissioned officers by the Canadian Army before being sent overseas, a move that would grant them some authority in the ranks, so that enlisted patients and orderlies would have to comply with their direction. Canada was the first country in the world to grant women this privilege. At the beginning of the War, nurses were not dispatched to the casualty clearing stations near the front lines, where they would be exposed to shell fire. They were initially assigned to hospitals a safe distance away from the front lines. As the war continued, however, nurses were assigned to casualty clearing stations. They were exposed to shelling, and caring for soldiers with "shell shock" and casualties suffering the effects of new weapons such as poisonous gas, as Katherine Wilson-Sammie recollects in *Lights Out! A Canadian Nursing Sister's Tale*. World War I was also the first war in which a clearly marked hospital ship evacuating the wounded was targeted and sunk by an enemy submarine or torpedo boat, an act that had

previously been considered unthinkable, but which happened repeatedly (see List of hospital ships sunk in World War I). Nurses were among the casualties.

Canadian women volunteering to serve overseas as nurses overwhelmed the army with applications. A total of 3,141 Canadian "nursing sisters" served in the Canadian Army Medical Corps and 2,504 of those served overseas in England, France and the Eastern Mediterranean at Gallipoli, Alexandria and Salonika. By the end of the First World War, 46 Canadian Nursing Sisters had died In addition to these nurses serving overseas with the military, others volunteered and paid their own way over with organizations such as the Canadian Red Cross, the Victorian Order of Nurses, and St. John Ambulance. The sacrifices made by these nurses during the War in fact gave a boost to the women's suffrage movement in many of the countries that fought in the war. The Canadian Army nursing sisters were among the first women in the world to win the right to vote in a federal election; the Military Voters Act of 1917 extended the vote to women in the service such as Nursing Sisters.

Australia

Australian nurses served in the war as part of the Australian General Hospital. Australia established two hospitals at Lemnos and Heliopolis Islands to support the Dardanelles campaign at Gallipoli. Nursing recruitment was sporadic, with some reserve nurses sent with the advance parties to set up the transport ship HMAS *Gascoyne* while others simply fronted to Barracks and were accepted, while still others were expected to pay for their passage in steerage. Australian nurses from

this period became known as "grey ghosts" because of their drab uniforms with starched collar and cuffs. During the course of the war, Australian nurses were granted their own administration rather than working under medical officers. Australian Nurses hold the record for the maximum number of triage cases processed by a casualty station in a twenty-four-hour period during the battle of Passchendale. Their work routinely included administering ether during haemostatic surgery and managing and training medical assistants (orderlies).

Some 560 Australian army nurses served in India during the war, where they had to overcome a debilitating climate, outbreaks of disease, insufficient numbers, overwork and hostile British Army officers.

Interwar

Surveys in the U.S. showed that nurses often got married a few years after graduation and quit work; other waited 5 to 10 years for marriage; careerists some never married. By the 1920s increasing numbers of married nurses continued to work.

The high turnover meant that advancement could be rapid; the average age of a nursing supervisor in a hospital was only 26 years. Wages for private duty nurses were high in the 1920s—$1,300 a year when working full-time in patients' homes or at their private rooms in hospitals. This was more than double what a woman could earn as a teacher or in office work. Rates fell sharply when the Great Depression came in 1929, and continuous work was much harder to find.

World War II

Canada

Over 4000 women served as nurses in uniform in the Canadian Armed Forces during the Second World War. They were called "Nursing Sisters" and had already been professionally trained in civilian life. However, in military service they achieved an elite status well above what they had experienced as civilians. The Nursing Sisters had much more responsibility and autonomy, and had more opportunity to use their expertise, then civilian nurses. They were often close to the front lines, and the military doctors – all men – delegated significant responsibility to the nurses because of the high level of casualties, the shortages of physicians, and extreme working conditions.

Australia

In 1942, sixty five front line nurses from the General Hospital Division in British Singapore were ordered aboard the Vyner Brook and Empire Star for evacuation, rather than caring for wounded. The ships were strafed with machine gun fire by Japanese planes. Sisters Vera Torney and Margaret Anderson were awarded medals when they could find nothing else on the crowded deck and covered their patients with their own bodies. A version of this action was honoured in the film *Paradise Road*. The Vyner Brook was bombed and sank quickly in shallow water of the Sumatra Strait and all but twenty-one were lost at sea, presumed drowned. The remaining nurses swam ashore at Mentok, Sumatra. The twenty-one nurses and

some British and Australian troops were marched into the sea and killed with machine gun fire in the Banka Island massacre. Sister Vivian Bullwinkel was the only survivor. She became Australia's premier nursing war hero when she nursed wounded British soldiers in the jungle for three weeks, despite her own flesh wound. She survived on the charity provided by Indonesian locals, but eventually hunger and the privations of hiding in mangrove swamp forced her to surrender. She remained imprisoned for the remainder of the war.

At around the same time, another group of twelve nurses stationed at the Rabaul mission in New Guinea were captured along with missionaries by invading Japanese troops and interred at their camp for two years. They cared for a number of British, Australian and American wounded. Toward the end of the war, they were transferred to a concentration camp in Kyoto and imprisoned under freezing conditions and forced into hard labour.

United States

As Campbell (1984) shows, the nursing profession was transformed by World War Two. Army and Navy nursing was highly attractive and a larger proportion of nurses volunteered for service higher than any other occupation in American society.

The public image of the nurses was highly favorable during the war, as the simplified by such Hollywood films as "Cry 'Havoc'" which made the selfless nurses heroes under enemy fire. Some nurses were captured by the Japanese, but in practice they were kept out of harm's way, with the great majority stationed

on the home front. However, 77 were stationed in the jungles of the Pacific, where their uniform consisted of "khaki slacks, mud, shirts, mud, field shoes, mud, and fatigues." The medical services were large operations, with over 600,000 soldiers, and ten enlisted men for every nurse. Nearly all the doctors were men, with women doctors allowed only to examine the WAC.

President Franklin D. Roosevelt hailed the service of nurses in the war effort in his final "Fireside Chat" of January 6, 1945. Expecting heavy casualties in the invasion of Japan, he called for a compulsory draft of nurses. The casualties never happened and there was never a draft of American nurses.

Britain

During World War II, nurses belonged to Queen Alexandra's Imperial Military Nursing Service (QAIMNS), as they had during World War I, and as they remain today. (Nurses belonging to the QAIMNS are informally called "QA"s.) Members of the Army Nursing Service served in every overseas British military campaign during World War II, as well as at military hospitals in Britain.

At the beginning of World War II, nurses held officer status with equivalent rank, but were not commissioned officers. In 1941, emergency commissions and a rank structure were created, conforming with the structure used in the rest of the British Army.

Nurses were given rank badges and were now able to be promoted to ranks from Lieutenant through to Brigadier. Nurses were exposed to all dangers during the War, and some were captured and became prisoners of war.

Germany

Germany had a very large and well organized nursing service, with three main organizations, one for Catholics, one for Protestants, and the DRK (Red Cross). In 1934 the Nazis set up their own nursing unit, the Brown Nurses, absorbing one of the smaller groups, bringing it up to 40,000 members. It set up kindergartens, hoping to seize control of the minds of the younger Germans, in competition with the other nursing organizations. Civilian psychiatric nurses who were Nazi party members participated in the killings of invalids, although the process was shrouded in euphemisms and denials.

Military nursing was primarily handled by the DRK, which came under partial Nazi control. Front line medical services were provided by male medics and doctors. Red Cross nurses served widely within the military medical services, staffing the hospitals that perforce were close to the front lines and at risk of bombing attacks. Two dozen were awarded the highly prestigious Iron Cross for heroism under fire. They are among the 470,000 German women who served with the military.

Definition

Although nursing practice varies both through its various specialties and countries, these nursing organizations offer the following definitions: Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a

safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

- — *International Council of Nurses*

The use of clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

- — *Royal College of Nursing (2003)*

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 responses; and advocacy in health care for individuals, families, communities, and populations.

- — *American Nurses Association*

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.

- — *Virginia Avenel Henderson*

As a profession

The authority for the practice of nursing is based upon a social contract that delineates professional rights and responsibilities

as well as mechanisms for public accountability. In almost all countries, nursing practice is defined and governed by law, and entrance to the profession is regulated at the national or state level.

The aim of the nursing community worldwide is for its professionals to ensure quality care for all, while maintaining their credentials, code of ethics, standards, and competencies, and continuing their education. There are a number of educational paths to becoming a professional nurse, which vary greatly worldwide; all involve extensive study of nursing theory and practice as well as training in clinical skills.

Nurses care for individuals of all ages and cultural backgrounds who are healthy and ill in a holistic manner based on the individual's physical, emotional, psychological, intellectual, social, and spiritual needs. The profession combines physical science, social science, nursing theory, and technology in caring for those individuals.

To work in the nursing profession, all nurses hold one or more credentials depending on their scope of practice and education. In the United States, a Licensed Practical Nurse (LPN) works independently or with a Registered Nurse (RN). The most significant difference between an LPN and RN is found in the requirements for entry to practice, which determines entitlement for their scope of practice. RNs provide scientific, psychological, and technological knowledge in the care of patients and families in many health care settings. RNs may earn additional credentials or degrees.

In the United States, multiple educational paths will qualify a candidate to sit for the licensure examination as an RN. The

Associate Degree in Nursing (ADN) is awarded to the nurse who has completed a two-year undergraduate academic degree awarded by community colleges, junior colleges, technical colleges, and bachelor's degree-granting colleges and universities upon completion of a course of study usually lasting two years. It is also referred to as Associate in Nursing (AN), Associate of Applied Science in Nursing (AAS), or Associate of Science in Nursing (ASN). The Bachelor of Science in Nursing (BSN) is awarded to the nurse who has earned an American four-year academic degree in the science and principles of nursing, granted by a tertiary education university or similarly accredited school. After completing either the LPN or either RN education programs in the United States, graduates are eligible to sit for a licensing examination to become a nurse, the passing of which is required for the nursing license. The National Licensure Examination (NCLEX) test is a standardized exam (including multiple choice, select all that apply, fill in the blank and "hot spot" questions) that nurses take to become licensed. It costs two-hundred dollars to take the NCLEX. It examines a nurses ability to properly care for a client. Study books and practice tests are available for purchase. Some nurses follow the traditional role of working in a hospital setting. Other options include: pediatrics, neonatal, maternity, OBGYN, geriatrics, ambulatory, and nurse anesthetists and informatics (eHealth). There are many other options nurses can explore depending on the type of degree and education acquired. RNs may also pursue different roles as advanced practice nurses.

Nurses are not doctors' assistants. This is possible in certain situations, but nurses more often are independently caring for their patients or assisting other nurses. RNs treat patients,

record their medical history, provide emotional support, and provide follow-up care. Nurses also help doctors perform diagnostic tests. Nurses are almost always working on their own or with other nurses. Nurses will assist doctors in the emergency room or in trauma care when help is needed.

Gender issues

Despite equal opportunity legislation, nursing has continued to be a female-dominated profession in many countries; according to the WHO's 2020 *State of the World's Nursing*, approximately 90% of the nursing workforce is female. For instance, the male-to-female ratio of nurses is approximately 1:19 in Canada and the United States. This ratio is represented around the world. Notable exceptions include Francophone Africa, which includes the countries of Benin, Burkina Faso, Cameroon, Chad, Congo, Côte d'Ivoire, the Democratic Republic of Congo, Djibouti, Guinea, Gabon, Mali, Mauritania, Niger, Rwanda, Senegal, and Togo, which all have more male than female nurses. In Europe, in countries such as Spain, Portugal, Czech Republic and Italy, over 20% of nurses are male. In the United Kingdom, 11% of nurses and midwives registered with the Nursing and Midwifery Council (NMC) are male. The number of male nurses in the United States doubled between 1980 and 2000. However female nurses are still more common, but male nurses receive more pay on average.

Theory and process

Nursing practice is the actual provision of nursing care. In providing care, nurses implement the nursing care plan using

the nursing process. This is based around a specific nursing theory which is selected in consideration with the care setting and the population served. In providing nursing care, the nurse uses both nursing theory and best practice derived from nursing research.

In general terms, the nursing process is the method used to assess and diagnose needs, plan outcomes and interventions, implement interventions, and evaluate the outcomes of the care provided. Like other disciplines, the profession has developed different theories derived from sometimes diverse philosophical beliefs and paradigms or worldviews to help nurses direct their activities to accomplish specific goals.

Scope of activities

Activities of daily living assistance

Nurses manage and coordinate care to support activities of daily living (ADL). Often the provision of such care is delegated to nursing assistants. This includes assisting in patient mobility, such as moving an activity intolerant patient within bed.

Medication

Medication management and administration are a part of most hospital nursing roles, however, prescribing authority varies between jurisdictions. In many areas, registered nurses administer and manage medications prescribed by a professional with full prescribing authority such as a nurse practitioner or a physician. As nurses are responsible for

evaluating patients throughout their care - including before and after medication administration - adjustments to medications are often made through a collaborative effort between the prescriber and the nurse. Regardless of the prescriber, nurses are legally responsible for the drugs they administer. There may be legal implications when there is an error in a prescription, and the nurse could be expected to have noted and reported the error. In the United States, nurses have the right to refuse any medication administration that they deem to be potentially harmful to the patient. In the United Kingdom there are some nurses who have taken additional specialist training that allows them to prescribe any medications from their scope of practice.

Patient education

The patient's family is often involved in the education. Effective patient education leads to fewer complications and hospital visits.

Specialties and practice settings

Nursing is the most diverse of all health care professions. Nurses practice in a wide range of settings but generally nursing is divided depending on the needs of the person being nursed.

The major populations are:

- communities/public
- family/individual across the lifespan
- adult-gerontology

- pediatrics
- neonatal
- women's health/gender-related
- mental health
- informatics (eHealth)
- acute care hospitals
- ambulatory settings (physician offices, urgent care settings, camps, etc.)
- school/college infirmaries

There are also specialist areas such as cardiac nursing, orthopedic nursing, palliative care, perioperative nursing, obstetrical nursing, oncology nursing, nursing informatics, telenursing, radiology, and emergency nursing.

Nurses practice in a wide range of settings, including hospitals, private homes, schools, and pharmaceutical companies. Nurses work in occupational health settings (also called industrial health settings), free-standing clinics and physician offices, nurse-led clinics, long-term care facilities and camps.

They also work on cruise ships and in the military service. Nurses act as advisers and consultants to the health care and insurance industries. Many nurses also work in the health advocacy and patient advocacy fields at companies such as Health Advocate, Inc. helping in a variety of clinical and administrative issues. Some are attorneys and others work with attorneys as legal nurse consultants, reviewing patient records to assure that adequate care was provided and testifying in court. Nurses can work on a temporary basis, which involves doing shifts without a contract in a variety of

settings, sometimes known as *per diem nursing*, *agency nursing* or *travel nursing*. Nurses work as researchers in laboratories, universities, and research institutions. Nurses have also been delving into the world of informatics, acting as consultants to the creation of computerized charting programs and other software. Nurse authors publish articles and books to provide essential reference materials.

Occupational hazards

Internationally, there is a serious shortage of nurses. One reason for this shortage is due to the work environment in which nurses practice. In a recent review of the empirical human factors and ergonomic literature specific to nursing performance, nurses were found to work in generally poor environmental conditions. Some countries and states have passed legislation regarding acceptable nurse-to-patient ratios.

The fast-paced and unpredictable nature of health care places nurses at risk for injuries and illnesses, including high occupational stress.

Nursing is a particularly stressful profession, and nurses consistently identify stress as a major work-related concern and have among the highest levels of occupational stress when compared to other professions. This stress is caused by the environment, psychosocial stressors, and the demands of nursing, including new technology that must be mastered, the emotional labor involved in nursing, physical labor, shift work, and high workload. This stress puts nurses at risk for short-term and long-term health problems, including sleep disorders, depression, mortality, psychiatric disorders, stress-related

illnesses, and illness in general. Nurses are at risk of developing compassion fatigue and moral distress, which can worsen mental health.

They also have very high rates of occupational burnout (40%) and emotional exhaustion (43.2%). Burnout and exhaustion increase the risk for illness, medical error, and suboptimal care provision.

Nurses are also at risk for violence and abuse in the workplace. Violence is typically perpetrated by non-staff (e.g. patients or family), whereas abuse is typically perpetrated by other hospital personnel. Of American nurses, 57% reported in 2011 that they had been threatened at work; 17% were physically assaulted.

Prevention

There are a number of interventions that can mitigate the occupational hazards of nursing. They can be individual-focused or organization-focused. Individual-focused interventions include stress management programs, which can be customized to individuals. Stress management programs can reduce anxiety, sleep disorders, and other symptoms of stress.

Organizational interventions focus on reducing stressful aspects of the work environment by defining stressful characteristics and developing solutions to them. Using organizational and individual interventions together is most effective at reducing stress on nurses. In some Japanese hospitals, powered exoskeletons are used. Lumbar supports (ieback belts) have also been trialled.

Worldwide

America

United States

In the US, scope of practice is determined by the state or territory in which a nurse is licensed. Each state has its own laws, rules, and regulations governing nursing care. Usually the making of such rules and regulations is delegated to a state board of nursing, which performs day-to-day administration of these rules, licenses for nurses and nursing assistants, and makes decisions on nursing issues. In some states, the terms "nurse" or "nursing" may only be used in conjunction with the practice of a registered nurse (RN) or licensed practical or vocational nurse (LPN/LVN).

In the hospital setting, registered nurses often delegate tasks to LPNs and unlicensed assistive personnel.

RNs are not limited to employment as bedside nurses. They are employed by physicians, attorneys, insurance companies, governmental agencies, community/public health agencies, private industry, school districts, ambulatory surgery centers, among others.

Some registered nurses are independent consultants who work for themselves, while others work for large manufacturers or chemical companies. Research nurses conduct or assist in the conduct of research or evaluation (outcome and process) in many areas such as biology, psychology, human development, and health care systems.

Many employers offer flexible work schedules, child care, educational benefits, and bonuses. About 21 percent of registered nurses are union members or covered by union contract.

Nursing is the nation's largest health care profession. In 2017, there were more than 4,015,250 registered nurses and 922,196 licensed practical nurses nationwide. Of all licensed RNs, 2.6 million or 84.8% are employed in nursing. Nurses comprise the largest single component of hospital staff, are the primary providers of hospital patient care, and deliver most of the nation's long-term care. The primary pathway to professional nursing, as compared to technical-level practice, is the four-year Bachelor of Science in Nursing (BSN) degree. Registered nurses are prepared either through a BSN program; a three-year associate degree in nursing; or a three-year hospital training program, receiving a hospital diploma. All take the same state licensing exam. (The number of diploma programs has declined steadily—to less than 10 percent of all basic RN education programs—as nursing education has shifted from hospital-operated instruction into the college and university system.)

Educational and licensure requirements

Diploma in Nursing

The oldest method of nursing education is the hospital-based diploma program, which lasts approximately three years. Students take between 30 and 60 credit hours in anatomy, physiology, microbiology, nutrition, chemistry, and other subjects at a college or university, then move on to intensive nursing classes. Until 1996, most RNs in the US were initially

educated in nursing by diploma programs. According to the Health Services Resources Administration's 2000 Survey of Nurses only six percent of nurses who graduated from nursing programs in the United States received their education at a Diploma School of Nursing.

Associate Degree in Nursing

The most common initial nursing education is a two-year Associate Degree in Nursing (Associate of Applied Science in Nursing, Associate of Science in Nursing, Associate Degree in Nursing), a two-year college degree referred to as an ADN. Some four-year colleges and universities also offer the ADN. Associate degree nursing programs have prerequisite and corequisite courses (which may include English, Math and Human Anatomy and Physiology) and ultimately stretch out the degree-acquiring process to about three years or greater.

Bachelor of Science in Nursing

The third method is to obtain a Bachelor of Science in Nursing (BSN), a four-year degree that also prepares nurses for graduate-level education. For the first two years in a BSN program, students usually obtain general education requirements and spend the remaining time in nursing courses. In some new programs the first two years can be substituted for an active LPN license along with the required general studies. Advocates for the ADN and diploma programs state that such programs have an on the job training approach to educating students, while the BSN is an academic degree that emphasizes research and nursing theory. Some states require a specific amount of clinical experience that is the

same for both BSN and ADN students. A BSN degree qualifies its holder for administrative, research, consulting and teaching positions that would not usually be available to those with an ADN, but is not necessary for most patient care functions. Nursing schools may be accredited by either the Accreditation Commission for Education in Nursing (ACEN) or the Commission on Collegiate Nursing Education (CCNE).

Graduate education

Advanced education in nursing is done at the master's and doctoral levels. It prepares the graduate for specialization as an advanced practice registered nurse (APRN) or for advanced roles in leadership, management, or education. The clinical nurse leader (CNL) is an advanced generalist who focuses on the improvement of quality and safety outcomes for patients or patient populations from an administrative and staff management focus. Doctoral programs in nursing prepare the student for work in nursing education, health care administration, clinical research, public policy, or advanced clinical practice. Most programs confer the PhD in nursing or Doctor of Nursing Practice (DNP).

Advanced practice registered nurse (APRN)

Areas of advanced nursing practice include that of a nurse practitioner (NP), a certified nurse midwife (CNM), a certified registered nurse anesthetist (CRNA), or a clinical nurse specialist (CNS). Nurse practitioners and CNSs work assessing, diagnosing and treating patients in fields as diverse as family practice, women's health care, emergency nursing, acute/critical care, psychiatry, geriatrics, or pediatrics,

additionally, a CNS usually works for a facility to improve patient care, do research, or as a staff educator.

Licensure examination

Completion of any one of these three educational routes allows a graduate nurse to take the NCLEX-RN, the test for licensure as a registered nurse, and is accepted by every state as an adequate indicator of minimum competency for a new graduate. However, controversy exists over the appropriate entry-level preparation of RNs. Some professional organizations believe the BSN should be the sole method of RN preparation and ADN graduates should be licensed as "technical nurses" to work under the supervision of BSN graduates. Others feel the on-the-job experiences of diploma and ADN graduates makes up for any deficiency in theoretical preparation.

Shortage in the United States

RNs are the largest group of health care workers in the United States, with about 2.7 million employed in 2011. It has been reported that the number of new graduates and foreign-trained nurses is insufficient to meet the demand for registered nurses; this is often referred to as the nursing shortage and is expected to increase for the foreseeable future. There are data to support the idea that the nursing shortage is a voluntary shortage. In other words, nurses are leaving nursing of their own volition. In 2006 it was estimated that approximately 1.8 million nurses chose not to work as a nurse. The Bureau of Labor Statistics (BLS) reported that 296,900 healthcare jobs were created in 2011. RNs make up the majority of the healthcare work force, therefore these positions will be filled

primarily by nurses. The BLS also states that by 2020, there will be 1.2 million nursing job openings due to an increase in the workforce, and replacements.

Causes

The International Council of Nursing (ICN), the largest international health professional organization in the world, recognizes the shortage of nurses as a growing crisis in the world. This shortage impacts the healthcare of everyone worldwide. One of the many reasons is that nurses who pursue to become nurses do so very late in their lives. This leads to a non-lengthy employment time. A national survey prepared by the Federation of Nurses and Health Professionals in 2001 found that one in five nurses plans to leave the profession within five years because of unsatisfactory working conditions, including low pay, severe under staffing, high stress, physical demands, mandatory overtime, and irregular hours. Approximately 29.8 percent of all nursing jobs are found in hospitals. However, due to administrative cost cutting, increased nurse's workload, and rapid growth of outpatient services, hospital nursing jobs will experience slower than average growth. Employment in home care and nursing homes is expected to grow rapidly. Though more people are living well into their 80s and 90s, many need the kind of long-term care available at a nursing home. Many nurses will also be needed to help staff the growing number of out-patient facilities, such as HMOs (Health Maintenance Organizations), group medical practices, and ambulatory surgery centers. Nursing specialties will be in great demand. There are, in addition, many part-time employment possibilities.

Levsey, Campbell, and Green voiced their concern about the shortage of nurses, citing Fang, Wilsey-Wisniewski, &Bednash, 2006, who state that over 40,000 qualified nursing applicants were turned away in the 2005–2006 academic year from baccalaureate nursing programs due to a lack of masters and doctoral qualified faculty, and that this number was increased over 9,000 from 32,000 qualified but rejected students from just two years earlier. Several strategies have been offered to mitigate this shortage including; Federal and private support for experienced nurses to enhance their education, incorporating more hybrid/blended nursing courses, and using simulation in lieu of clinical (hospital) training experiences.

Furthermore, there is a shortage of academically qualified instructors to teach at schools of nursing worldwide. The serious need for educational capacity is not being met, which is the underlying most important preparation resource for the nurses of tomorrow. The decrease in faculty everywhere is due to many factors including decrease in satisfaction with the workforce, poor salaries, and reduction in full-time equivalent. Throughout the span of 6 years the nursing faculty shortage has been written about an increasing amount. There is no clear consensus or an organized plan on how to fix the ongoing issue.

Continuing education

With health care knowledge growing steadily, nurses can stay ahead of the curve through continuing education. Continuing education classes and programs enable nurses to provide the best possible care to patients, advance nursing careers, and keep up with Board of Nursing requirements. The American

Nurses Association and the American Nursing Credentialing Center are devoted to ensuring nurses have access to quality continuing education offerings. Continuing education classes are calibrated to provide enhanced learning for all levels of nurses.

Many States also regulate Continuing Nursing Education. Nursing licensing boards requiring Continuing Nursing Education (CNE) as a condition for licensure, either initial or renewal, accept courses provided by organizations that are accredited by other state licensing boards, by the American Nursing Credentialing Center (ANCC), or by organizations that have been designated as an approver of continuing nursing education by ANCC. There are some exceptions to this rule including the state of California, Florida and Kentucky. National Healthcare Institute has created a list to assist nurses in determining their CNE credit hours requirements. While this list is not all inclusive, it offers details on how to contact nursing licensing boards directly.

Board certification

Professional nursing organizations, through their certification boards, have voluntary certification exams to demonstrate clinical competency in their particular specialty. Completion of the prerequisite work experience allows an RN to register for an examination, and passage gives an RN permission to use a professional designation after their name. For example, passage of the American Association of Critical-care Nurses specialty exam allows a nurse to use the initials 'CCRN' after his or her name. Other organizations and societies have similar procedures.

The American Nurses Credentialing Center, the credentialing arm of the American Nurses Association, is the largest nursing credentialing organization and administers more than 30 specialty examinations.

Correctional nursing

Due to its large prison population, the United States needs many correctional nurses to help inmates receive proper health-care, including mental health treatments for prisoners with psychological issues.

Canada

History

Canadian nursing dates back to 1639 in Quebec with the Augustine nuns. These nuns were trying to open a mission that cared for the spiritual and physical needs of patients. The establishment of this mission created the first nursing apprenticeship training in North America.

In the nineteenth century, some Catholic orders of nursing were trying to spread their message across Canada. Most nurses were female and only had an occasional consultation with a physician.

Towards the end of the nineteenth century, hospital care and medical services had been improved and expanded. Much of this was due to Nightingale's influence. In 1874 the first formal nursing training program was started at the General and Marine Hospital in St. Catharines in Ontario.

Education

All Canadian nurses and prospective nurses are heavily encouraged by the Canadian Nurses Association to continue their education to receive a bachelor's degree. This degree may result in better patient outcomes. All Canadian provinces and territories, with the exception of the Yukon and Quebec, require that all nurses have a bachelor's degree. The length of time generally required to obtain this degree is four years. However, some Canadian universities offer a condensed program that is two years in length.

Nursing specialty certification is available through the Canadian Nurses Association in 22 practice areas, including:

- cardiovascular nursing
- community health nursing
- critical care nursing
- pediatric critical care nursing
- emergency nursing
- gastroenterology nursing
- gerontological nursing
- hospice palliative care nursing
- medical-surgical nursing
- neonatal nursing
- nephrology nursing
- neuroscience nursing
- occupational health nursing
- oncology nursing
- orthopedic nursing
- pediatric nursing
- peri-anesthesia nursing

- obstetrical nursing
- peri-operative nursing
- psychiatric and mental health nursing
- rehabilitation nursing
- Wound, ostomy, and continence nursing

Nursing specialty certification generally requires practice, experience, and passing a test that is based on competencies for that specific medical or surgical domain in which nursing care is provided. The certification in gerontological nursing, which involves providing care to the elderly, is offered to not only RNs and NPs but also LPNs.

Latin America

Latin American nursing is based on three levels of training: (a) professional/registered, (b) technical, and (c) auxiliary. The nursing education in Latin America and the Caribbean includes the principles and values of the Universal Health and primary health care.

These principles underpin transformative education modalities such as critical and complex thinking development, problem-solving, evidence-based clinical decision-making, and lifelong learning.

The Pan American Health Organization/World Health Organization (PAHO/WHO) proposes the Strategy for Universal Access to Health and Universal Health Coverage to improve health outcomes and other basic objectives of health systems based on the right of each person to receive the best standard of health, without exposing people to financial difficulties through nursing intervention.

Europe

United Kingdom

To practice lawfully as a registered nurse in the United Kingdom, the practitioner must hold a current and valid registration with the Nursing and Midwifery Council. The title "Registered Nurse" can only be granted to those holding such registration. This protected title is laid down in the Nurses, Midwives and Health Visitors Act, 1997. From April 2016, nurses in the United Kingdom are expected to revalidate every three years which involves providing evidence of further development and active practice.

First and second level

First-level nurses make up the bulk of the registered nurses in the UK. They were previously known by titles such as Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN), Registered Mental Nurse (RMN), and Registered Nurse (for the) Mentally Handicapped (RNMH). The titles used now are similar, including Registered Nurse Adult (RNA), Registered Nurse Child (RNC), Registered Nurse Mental Health (RNMH), and Registered Nurse (of) Learning Disabilities (RNLD). Second-level nurse training is no longer provided; however, they are still legally able to practice in the United Kingdom as a registered nurse. Many have now either retired or undertaken conversion courses to become first-level nurses. They are entitled to refer to themselves as registered nurses as their registration is on the Nursing & Midwifery Council

register of nurses, although most refer to themselves as Enrolled Nurses (ENs) or State Enrolled Nurses (SENs).

Advanced practice

- **Nurse practitioners** – Most of these nurses obtain a minimum of a master's degree and a desired post grad certificate. They often perform roles similar to those of physicians and physician assistants. They can prescribe medications as independent or supplementary prescribers, although they are still legally regulated, unlike physician's assistants. Most Nurse Practitioners (NPs) have referral and admission rights to hospital specialties. They commonly work in primary care (e.g. General Practitioner (GP) surgeries), Accident and Emergency (A&E) departments, or pediatrics although they are increasingly being seen in other areas of practice. In the UK, the title "nurse practitioner" is legally protected.
- **Specialist community public health nurses** – traditionally district nurses and health visitors, this group oversees research and publication activities.
- **Lecturer-practitioners (also called practice education facilitators)** – these nurses work both in the National Health Service (NHS), and in universities. They typically work 2–3 days per week in each setting. In university, they train pre-registration student nurses (see below), and often teach on specialist courses post-registration nurses.

- **Lecturers** – these nurses are not employed by the NHS. Instead they work full-time in universities, both teaching and performing research.

Managers

Many nurses who have worked in clinical settings for a long time choose to leave clinical nursing and join the ranks of the NHS management. This used to be seen as a natural career progression for those who had reached ward management positions, however with the advent of specialist nursing roles (see above), this has become a less attractive option.

Nonetheless, many nurses fill positions in the senior management structure of NHS organizations, some even as board members. Others choose to stay a little closer to their clinical roots by becoming clinical nurse managers or *modern matrons*.

Nurse education

Pre-registration

To become a registered nurse, one must complete a program recognised by the Nursing and Midwifery Council (NMC). Currently, this involves completing a degree, available from a range of universities offering these courses, in the chosen branch specialty (see below), leading to both an academic award and professional registration as a 1st level registered nurse. Such a course is a 50/50 split of learning in university (i.e. through lectures, assignments and examinations) and in practice (i.e. supervised patient care within a hospital or

community setting). These courses are three (occasionally four) years' long. The first year is known as the common foundation program (CFP), and teaches the basic knowledge and skills required of all nurses. Skills included in the CFP may include communication, taking observations, administering medication and providing personal care to patients. The remainder of the program consists of training specific to the student's chosen branch of nursing. These are:

- Child nursing.
- Mental health nursing.
- Learning disabilities nursing.

As of 2013, the Nursing and Midwifery Council will require all new nurses qualifying in the UK to hold a degree qualification. However, those nurses who hold a diploma, or even a certificate in nursing are still able to legally practice in the UK, although they are able to undertake university modules to obtain enough credits to top up to a degree.

Midwifery training is similar in length and structure, but is sufficiently different that it is not considered a branch of nursing. There are shortened (18-month) programs to allow nurses already qualified in the adult branch to hold dual registration as a nurse and a midwife. Shortened courses lasting 2 years also exist for graduates of other disciplines to train as nurses. This is achieved by more intense study and a shortening of the common foundation program.

As of 2016 student nurses in England and Wales can apply for a bursary from the government to support them during their nurse training, and may also be eligible for a student loan, although there has been speculation that this will not be

available in the future. Student nurses in Scotland still receive a standard bursary which is not means tested, and their tuition fees continue to be paid – however, they are not eligible for student loans.

Before Project 2000, nurse education was the responsibility of hospitals and was not based in universities; hence many nurses who qualified prior to these reforms do not hold an academic award.

Post-registration

After the point of initial registration, there is an expectation that all qualified nurses will continue to update their skills and knowledge. The Nursing and Midwifery Council insists on a minimum of 35 hours of education every three years, as part of its post registration education and practice (PREP) requirements.

There are also opportunities for many nurses to gain additional clinical skills after qualification. Cannulation, venipuncture, intravenous drug therapy and male catheterization are the most common, although there are many others (such as advanced life support), which some nurses undertake.

Many nurses who qualified with a diploma choose to upgrade their qualification to a degree by studying part-time. Many nurses prefer this option to gaining a degree initially, as there is often an opportunity to study in a specialist field as a part of this upgrading. Financially, in England, it was also much more lucrative, as diploma students get the full bursary during their initial training, and employers often pay for the degree course as well as the nurse's salary.

To become specialist nurses (such as nurse consultants, nurse practitioners etc.) or nurse educators, some nurses undertake further training above bachelor's degree level. Master's degrees exist in various healthcare related topics, and some nurses choose to study for PhDs or other higher academic awards. District nurses and health visitors are also considered specialist nurses, and to become such they must undertake specialist training. This is a one-year full-time degree.

All newly qualifying district nurses and health visitorsare trained to prescribe from the Nurse Prescribers' Formulary, a list of medications and dressings typically useful to those carrying out these roles.

Many of these (and other) nurses will also undertake training in independent and supplementary prescribing, which allows them (as of 1 May 2006) to prescribe almost any drug in the British National Formulary.

This has been the cause of a great deal of debate in both medical and nursing circles.

European Union

In the European Union, the profession of nurse is regulated. A profession is said to be regulated when access and exercise is subject to the possession of a specific professional qualification.

The regulated professions database contains a list of regulated professions for nurse in the European Union (EU) member states, European Economic Area (EEA) countries, and Switzerland. This list is covered by the Directive 2005/36/EC.

Asia

India

Nursing education is governed in India by the central body Indian Nursing Council and its norms are implemented through respective State Nursing councils. The list of state nursing councils are available in the official web page of Indian Nursing Council. First formal education in nursing was offered in Madras Medical college, in Madras presidency. Indian Nursing Council Act, 1947. Act Year Number: Act No. 19 of December enactment Date of enactment: [31 December 19act] Act Objective: An Act to constitute the Nursing Council of India. To establish uniform standards of training for nurses, midwives, and health visitors. It is implemented with 17 sections and each section indicates the specific legislative role of the council.

The nursing profession was dominated by females in the British colonial period, but in Madras Presidency, men were actively engaged in the profession.

Japan

History

Nursing was not an established part of Japan's healthcare system until 1899 with the Midwives Ordinance. From there the Registered Nurse Ordinance came into play in 1915. This established a legal substantiation to registered nurses all over Japan. A new law geared towards nurses was created during

World War II: the *Public Health Nurse, Midwife and Nurse Law*, established in 1948. It established educational requirements, standards and licensure.

There has been a continued effort to improve nursing in Japan. In 1992 the Nursing Human Resource Law was passed.

This law created the development of new university programs for nurses. Those programs were designed to raise the education level of the nurses so that they could be better suited for taking care of the public.

Types of nurses

Japan only recognizes four types of nursing and they are Public Health Nursing, Midwifery, Registered Nursing and Assistant Nursing.

Public health

This type of nursing is designed to help the public and is also driven by the public's needs. The goals of public health nurses are to monitor the spread of disease, keep vigilant watch for environmental hazards, educate the community on how to care for and treat themselves, and train for community disasters.

Midwifery

Nurses that are involved with midwifery are independent of any organization. A midwife takes care of a pregnant woman during labour and postpartum. They assist with things like breastfeeding and caring for the child.

Nursing Assistant

Nursing assistants, also known as nurse assistants or CNAs (Certified Nursing Assistants), assist patients with basic daily tasks. Individuals who are assistant nurses follow orders from a registered nurse. They report back to the licensed nurse about a patient's condition. Assistant nurses are always supervised by a licensed registered nurse.

Education

In 1952 Japan established the first nursing university in the country. An associate degree was the only level of certification for years. Soon people began to want nursing degrees at a higher level of education. Soon the Bachelor's Degree in Nursing (BSN) was established. Currently, Japan offers doctorate-level degrees of nursing in a good number of its universities.

There are three ways that an individual could become a registered nurse in Japan. After obtaining a high school degree the person could go to a nursing university for four years and earn a bachelor's degree, go to a junior nursing college for three years or go to a nursing school for three years. Regardless of where the individual attends school they must take the national exam.

Those who attended a nursing university have a bit of an advantage over those who went to a nursing school. They can take the national exam to be a registered nurse, public health nurse or midwife. In the cases of becoming a midwife or a public health nurse, the student must take a one-year course

in their desired field after attending a nursing university and passing the national exam to become a registered nurse. The nursing universities are the best route for someone who wants to become a nurse in Japan. They offer a wider range of general education classes and they also allow for a more rigid teaching style of nursing. These nursing universities train their students to be able to make critical and educated decisions when they are out in the field. Physicians are the ones who are teaching the potential nurses because there are not enough available nurses to teach students. This increases the dominance that physicians have over nurses.

Students that attend a nursing college or just a nursing school receive the same degree as one who graduated from a nursing university would, but they do not have the same educational background. The classes offered at nursing colleges and nursing schools are focused on more practical aspects of nursing. These institutions do not offer many general education classes, so students who attend these schools will solely be focusing on their nursing educations while they are in school. Students who attend a nursing college or school do have the opportunity to become a midwife or a public health nurse. They have to go through a training institute for their desired field after graduating from the nursing school or college. Japanese nurses never have to renew their licenses. Once they have passed their exam, they have their license for life.

Today

Like the United States, Japan is in need of more nurses. The driving force behind this need is the fact that country is aging

and needs more medical care for its people. However, the number of available nurses does not seem to be increasing. Nurses face poor working conditions and low social status, and there is a cultural idea that married women quit their jobs for family responsibilities. On average, Japanese nurses make around 280,000 yen a month, and it is one of the higher paying jobs. However, physicians make twice as much as nurses. Similar to other cultures, the Japanese people view nurses as subservient to physicians. According to the American Nurses Association article on Japan, "nursing work has been described using negative terminology such as 'hard, dirty, dangerous, low salary, few holidays, minimal chance of marriage and family, and poor image.'"

There are organizations that unite Japanese nurses like the Japanese Nursing Association (JNA); the JNA is a professional organization and not a union. Members of the JNA lobby politicians and produces publications about nursing. According to the American Nurses Association's article on Japan, the JNA "works toward the improvement in nursing practice through many activities including the development of a policy research group to influence policy development, a code of ethics for nurses, and standards of nursing practice." The JNA also provides certification for specialists in mental health, oncology and community health. There are other organizations, including some that categorize nurses by specialty, like emergency nursing or disaster nursing. One of the older unions that relates to nursing is the Japanese Federation of Medical Workers Union, which was created in 1957. It is a union that includes physicians as well as nurses. This organization was involved with the **Nursing Human Resource Law**.

Australia

Catholic religious institutes were influential in the development of Australian nursing, founding many of Australia's hospitals – the Irish Sisters of Charity were first to arrive in 1838 and established St Vincent's Hospital, Sydney in 1857 as a free hospital for the poor. They and other orders like the Sisters of Mercy, and in aged care the Sisters of the Little Company of Mary and Little Sisters of the Poor founded hospitals, hospices, research institutes and aged care facilities around Australia.

A census in the 1800s found several hundred nurses working in Western Australia during the colonial period of history, this included Aboriginal female servants who cared for the infirm.

The state nursing licensing bodies amalgamated in Australia in 2011 under the federal body AHPRA (Australian Health Practitioner Registration Authority). Several divisions of nursing license is available and recognized around the country.

- Enrolled nurses may initiate some oral medication orders with a specific competency now included in national curricula but variable in application by agency.
- Registered nurses hold a university degree (enrolled nurses can progress to registered nurse status and do get credit for previous study).
- Nurse practitioners have started emerging from postgraduate programs and work in both private practice and public hospitals and clinics.

- Mental health nurses must complete further training as advanced mental health practitioners in order to administer client referrals under the *Mental Health Act*.

Australia enjoys the luxury of a national curriculum for vocational nurses, trained at Technical and Further Education (TAFE) colleges or private Registered Training Organization (RTO). Enrolled and registered nurses are identified by the department of immigration as an occupational area of need, although registered nurses are always in shorter supply, and this increases in proportion with specialization.

In 1986 there were a number of rolling industrial actions around the country, culminating when five thousand Victorian nurses went on strike for eighteen days. The hospitals were able to function by hiring casual staff from each other's striking members, but the increased cost forced a decision in the nurses' favor.

Chapter 2

Women in Nursing

- Historically, **women** have made up a large majority of the profession and academic discipline of nursing. Women's nursing roles include both caring for patients and making sure that the wards and equipment are clean. Currently, females make up the majority of the field of nursing. Statistics show that in 2005, "women comprised 92.3% of Registered Nurses (RNs). Additionally, registered nurses are projected to create the second largest number of new jobs among all occupations between 2004 and 2014, increasing by 29.4%."

Daily tasks throughout history

- Nurses in the past were required to work long days and care for many patients, for very little pay. In addition, the typical university setting where nurses learned the work of the trade was not in existence back then. Instead, nurses learned the trade while working in the field. Another difference was that nursing students were called probationers. As probationers, they were required to follow the strict rules and regulations that were set forth by the institution. Additionally, probationers were required to follow all physicians' orders without question and perform various household duties. After learning how to take orders, probationers were then sent to the

operating room for a 6-week rotation. During that 6-week period, probationers learned how to inventory sterile bandages, keep operating room meticulously clean and provide sterile water for surgeons during surgery. Upon completion of their training, probationers turned into nurses.

As nurses, some of their roles included providing patient education concerning nutrition and child related illnesses when needed. In general, nurses were the ones responsible for bathing patients, inserting catheters, dispensing medications, administering enemas, keeping the ward clean, and making sure that everything was documented correctly. During that time, there were no nurses' aides available to help with the daily care of patients. Thusly, all tasks fell upon the nurse. To add to that long list of tasks, a nurse was also responsible for preparing any holistic medications that were needed at the time to treat the various alignments that patients presented with. In the present time, holistic medications are hardly used, and any medications that are required are generally handled and prepared by a pharmacy. This is with the expectation of some intravenous (IV), antibiotics, and insulin preparations that the nurse will prepare on the floor (after receiving an order from a doctor). Listed below are more duties of nurses in these time periods.

1880s

- Nurses had 50 patients apiece to care for and were in charge of both their nursing notes and keeping the ward clean. Some of their daily tasks are listed below:

- Daily sweep and mop the floors of your ward; dust the patients' furniture and window sills.
- Maintain an even temperature in your ward by bringing in a scuttle of coal for the day's business.
- Light is important to observe the patient's condition; therefore, each day fill kerosene lamps, clean chimneys, and trim wicks. Wash windows once a week.
- The nurse's notes are important in aiding the physician's work. Make your pens carefully. You may whittle nibs to your individual taste.
- Each nurse on day duty will report every day at 7 a.m. and leave at 8 p.m., except on the Sabbath on which day you will be off from noon to 2 p.m.
- Graduate nurses in good standing with the director of nurses will be given an evening off each week if you go regularly to church.
- Each nurse should lay aside from each payday a goodly sum of her earnings for her benefits during her declining years, so that she will not become a burden. For example, if you earn $30 a month, you should set aside $15.
- Any nurse who smokes, uses liquor in any form, gets her hair done at a beauty shop, or frequents dance halls will give the director of nurse's good reason to suspect her worth, intentions, and integrity.
- The nurse who performs her labors, serves her patients and doctors faithfully and without fault for a period of five years will be given an increase by the hospital administration of 5 cents a day, providing there are no hospital debts that are outstanding.

During the war

- War time saw a demand for nurses. For that demand to be filled, nurses made the transition into the battlefield, leaving their home life behind. On the battlefield, the main duty was to care for the sick and wounded.

After the war

- Completion of the war helped nurses gained a new level of respect from having learned about both anesthesia and psychiatric nursing. Additionally, around this time penicillin was created. This in turn helped to cure many infections and ultimately save many lives.

1950s

- During this generation injections were "still prepared with a pestle and mortar. Oxygen tanks were strapped to beds and there was very little equipment that was disposable. Nurses were in charge of sharpening needles and sterilizing catheter units."

1960s

- The 1960s brought about the development of the Intensive Care Units (ICU) where nurses were required to read telemetry monitors and take patient's blood pressure. In addition to the ICU, the ability to be able to specialize in one field of nursing

and obtain an advanced nursing degree (i.e. nurse practitioner degree) become available. Another thing that nurses were required to do (no matter what field they are in) was to stand when doctors entered the room. Lastly, female nurses were still wearing the traditional white uniform and hat.

1970s

- This period saw several changes, with one being that new nurses had to generally work the graveyard shift as they worked their way up in the ranks. Generally, nothing came prepared, which left nurses responsible for mixing, calculating and drawing up both antibiotics and IV medications. To add to this nurses were still using paper charts and medication was kept under lock and key in a cabinet. The last main thing about this period was that nurses were still required to stand when doctors entered the room and the traditional white uniform and hat were still in practice in some facilities but with some modifications.

1980-1990s

- Within this time frame, nurses saw an improvement of technology and its introduction into the field of nursing. The improved technology improved efficiency but it also required that nurses had to go to back to training so that they knew how to use it in practice.

2000s

- Nurses in this period today are still responsible for the direct care of patients (i.e. bathing, feeding, toileting, ambulating, positioning), following doctor's orders, taking vital signs, obtaining daily weights, recording both input and output, obtaining various lab samples, administering medications and charting. Additionally, a nurse may delegate some of those tasks to the nursing aide, but only if the delegation is within the person's skill level and if the facility allows the nurse to delegate that specific task.

Nurse's uniforms throughout history

19th century

During this time nursing uniforms were very similar to "servants' uniforms, which consisted of a full black or printed gown with a white gathered or banded cap and a white apron." Around 1840, the field of nursing gained more respect and nurses were trained more. With this said the uniforms worn at this time started to change from the servant uniforms to the more classic "ladylike gowns with white aprons and caps to indicate that they were nurses." During this time a very influential nurse started their career in the field of nursing; that nurse was Florence Nightingale. She brought many different things to the field. For instance she helped to make the field a more respectable one with the introduction of both better schooling and uniforms. The improvements in uniforms

helped us to determine the rank of all the different nurses practicing. This was accomplished by having nurses wear a hat with a different color band depending on their rank. "Fresh nurse students would wear ribbon bands of pink, blue, or other pastel colors. Senior nurses and nursing teachers would wear black ribbon bands to indicate seniority."

20th century

This period brought about the start of change in the uniforms by adding white bibs and pockets to the dresses. In addition, large hats were worn that resembled a nun's hat and veil. These types of uniforms stayed in practice up until the First World War, when it was decided that the uniforms needed to be revamped to make them more practical and improve nurses' efficiency. For instance, the sleeves on the uniforms were changed so that they rolled up, the bulky aprons were removed, and the shirts shortened. All these things helped with convenience and allowed nurses to function better, and were often coupled with shoulder-covering capes, which were usually navy or dark blue in colour on the outside with red lining on the inside.

By the 1950s, paper hats and simple folded hats replaced the large, elaborate crown-like caps that were worn by nurses during the First World War. The simple paper hats were more comfortable. The policy to use hats to denote seniority level was abolished, since the morality of nurses was affected by the discrimination. Dresses also evolved, since no one has the time to launder elaborately tailored clothing anymore. Dresses became less form fitting and were easy to wash, iron and wear."

By the 1970s with the appearance of males in the field wearing scrubs, the female uniforms once again changed, they "became less gendered".

The hat was lost and uniforms become less formal. In addition, they started to resemble normal clothing. By the 1980s, the cap and the cloth apron was gone. To replace the cloth apron, nurses started to wear disposable ones.

Today

Nurses today continue to wear scrubs with many different colors and patterns available. The scrubs usually consist of drawn string pants and a V-neck top.

The formal uniform (i.e. color and patterns allowed) though varies by policy. In some facilities it is required that the different types of employees all wear different color scrubs so that their specific job title can be determined by their scrub color. For example, "nurses in one color, techs in another, etc." Additionally "some hospitals are even going back to requiring that nurses wear white, though they haven't yet returned to skirts, hats, and stockings."

Female nurses in popular culture

- Christine Chapel
- Carla Espinosa
- Audrey March Hardy
- "Hot Lips" Houlihan
- Samantha Taggart
- Julia (American TV series)

Notable women in nursing

- Florence Nightingale
- Kelli Dee Hidalgo
- Mary Todd Lincoln
- Clara Barton
- Mary Eliza Mahoney
- Mary Seacole
- Mary Breckinridge
- florence Guinness Blake
- Edith Cavell
- Helen Fairchild
- Elizabeth Grace Neill
- Margaret Sanger
- Sophie Mannerheim
- Hazel W. Johnson-Brown
- Joyce Slinsky
- Jeanne Prentice
- Virginia Avenel Henderson
- Christiane Reimann
- Martha Ballard
- Dorothea Dix

Chapter 3

Nursing Assessment

Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status by a licensed Registered Nurse. Nursing assessment is the first step in the nursing process. A section of the nursing assessment may be delegated to certified nurses aides. Vitals and EKG's may be delegated to certified nurses aides or nursing techs. (Nurse Journal, 2017) It differs from a medical diagnosis. In some instances, the nursing assessment is very broad in scope and in other cases it may focus on one body system or mental health. Nursing assessment is used to identify current and future patient care needs. It incorporates the recognition of normal versus abnormal body physiology. Prompt recognition of pertinent changes along with the skill of critical thinking allows the nurse to identify and prioritize appropriate interventions. An assessment format may already be in place to be used at specific facilities and in specific circumstances.

The client interview

Before assessment can begin the nurse must establish a professional and therapeutic mode of communication. This develops rapport and lays the foundation of a trusting, non-judgmental relationship. This will also assure that the person will be as comfortable as possible when revealing personal information. A common method of initiating therapeutic communication by the nurse is to have the nurse introduce

herself or himself. The interview proceeds to asking the client how they wish to be addressed and the general nature of the topics that will be included in the interview.

The therapeutic communication methods of nursing assessment takes into account developmental stage (toddler vs. the elderly), privacy, distractions, age-related impediments to communication such as sensory deficits and language, place, time, non-verbal cues. Therapeutic communication is also facilitated by avoiding the use of medical jargon and instead using common terms used by the patient.

During the first part of the personal interview, the nurse carries out an analysis of the patient needs. In many cases, the client requires a focused assessment rather than a comprehensive nursing assessment of the entire bodily systems. In the focused assessment, the major complaint is assessed. The nurse may employ the use of acronyms performing the assessment:

- **OLDCART**
- **O**nset of health concern or complaint
- **L**ocation of pain or other symptoms related to the area of the body involved
- **D**uration of health concern or complaint
- **C**haracteristics
- **A**ggravating factors or what makes the concern or complaint worse
- **R**elieving factors or what makes the concern or complaint better
- **T**reatments or what treatments were tried in the past or ongoing

Patient history and interview

The patient history and interview is considered to be subjective but still of high importance when combined with objective measurements. High quality interviewing strategies include the use of open-ended questions. Open-ended questions are those that cannot be answered with a simple "yes" or "no" response. If the person is unable to respond, then family or caregivers will be given the opportunity to answer the questions.

The typical nursing assessment in the clinical setting will be the collection of data about the following:

- present complaint and nature of symptoms
- onset of symptoms
- severity of symptoms
- classifying symptoms as acute or chronic
- health history
- family history
- social history
- current medical and/or nursing management
- understanding of medical and nursing plans
- perception of illness

In addition, the nursing assessment may include reviewing the results of laboratory values such as blood work and urine analysis. Medical records of the client assist to determine the baseline measures related to their health.

In some instances, the nursing assessment will not incorporate the typical patient history and interview if prioritization indicates that immediate action is urgent to preserve the

airway, breathing and circulation. This is also known as triage and is used in emergency rooms and medical team disaster response situations. The patient history is documented through a personal interview with the client and/or the client's family. If there is an urgent need for a focused assessment, the most obvious or troubling complaint will be addressed first. This is especially important in the case of extreme pain.

Physical examination

A nursing assessment includes a physical examination: the observation or measurement of signs, which can be observed or measured, or symptoms such as nausea or vertigo, which can be felt by the patient.

The techniques used may include inspection, palpation, auscultation and percussion in addition to the "vital signs" of temperature, blood pressure, pulse and respiratory rate, and further examination of the body systems such as the cardiovascular or musculoskeletal systems.

Focused assessment

Neurovascular assessment

The nurse conducts a neurovascular assessment to determine sensory and muscular function of the arms and legs in addition to peripheral circulation. The focused neurovascular assessment includes the objective observation of pulses, capillary refill, skin color and temperature, and sensation. During the neurovascular assessment the measures between

extremities are compared. A neurovascular assessment is an evaluation of the extremities along with sensory, circulation and motor function.

Mental status

During the assessment, interactions and functioning are evaluated and documented. Those specific items assessed include:

- orientation, memory,
- mood, depression, anxiety, coherence, hallucinations, illusions, insight
- speech patterns (rate, clarity clanging)
- grooming, personal hygiene, appropriateness of clothing
- response to verbal and tactile stimuli, level of consciousness, and alertness
- posture, gait, appropriateness of movements

Pain

Pain is no longer being identified as the fifth vital sign due to the prevalence of opioid abuse and over-prescribing of narcotic pain relievers. However, assessment for pain is still very important. Assessment of a patient's experience of pain is a crucial component in providing effective pain management. Pain is not a simple sensation that can be easily assessed and measured. Nurses should be aware of the many factors that can influence the patient's overall experience and expression of pain, and these should be considered during the assessment process. Systematic process of pain assessment, measurement,

and re-assessment (re-evaluation), enhances the healthcare teams' ability to achieve. Pain is assessed for its provocative and palliative associations; quality, region/radiation, severity (numerical scale or pictorial, Wong-Baker Faces scale); and time—of onset, duration, frequency, and length of provocative and relief measures.

Integument

- hair: quantity, location, distribution, texture
- nails: shape and color, presence of clubbing
- lesions: type, location, arrangement, color of lesions, drainage, depth, width, length
- texture, moisture, color, elasticity, turgor

Head

- scalp, facial symmetry, sensation
- eyes
- acuity
- eyelids
- lacrimal glands
- conjunctiva
- visual fields
- peripheral vision
- sclera
- size, shape, symmetry, pupil reactions
- movement (cranial nerves)
- ears
- external structure
- inner ear
- eardrum

- hearing (frequencies of sound detected)
- dentation

Psychosocial assessment

The main areas considered in a psychological examination are intellectual health and emotional health. Assessment of cognitive function, checking for hallucinations and delusions, measuring concentration levels, and inquiring into the client's hobbies and interests constitute an intellectual health assessment. Emotional health is assessed by observing and inquiring about how the client feels and what he does in response to these feelings. The psychological examination may also include the client's perceptions (why they think they are being assessed or have been referred, what they hope to gain from the meeting). Religion and beliefs are also important areas to consider. The need for a physical health assessment is always included in any psychological examination to rule out structural damage or anomalies.

Safety

- environment
- ambulatory aids

Cultural assessment

The nursing cultural assessment will identify factors that may impede or facilitate the implementation of a nursing diagnosis. Cultural factors have a major impact on the nursing assessment. Some of the information obtained during the interview include:

- ethnic origin
- primary language
- second language
- the need for an interpreter
- the client's main support system(s)
- family living arrangements
- Who is the major decision maker in the family? What are the family members' roles within the family
- Describe religious beliefs and practices
- Are there any religious requirements/restrictions that place limitations on the client's care?
- Who in the family takes responsibility for health concerns?
- Describe any special health beliefs and practices:
- From whom does family usually seek medical assistance in time of need?
- Describe client's usual emotional/behavioral response to: Anxiety: Anger: Loss/change/failure: Pain: Fear:
- Describe any topics that are particularly sensitive or that the client is unwilling to discuss (because of cultural taboos):
- Describe any activities in which the client is unwilling to participate (because of cultural customs or taboos):
- What are the client's personal feelings regarding touch?
- What are the client's personal feelings regarding eye contact?
- What is the client's personal orientation to time? (past, present, future)

- Describe any particular illnesses to which the client may be bioculturally susceptible (e.g., hypertension and sickle cell anemia in *African Americans):
- Describe any nutritional deficiencies to which the client may be bioculturally susceptible (e.g., lactose intolerance in Native and Asian Americans)
- Are there any foods the client requests or refuses because of cultural beliefs related to this illness (e.g., "hot" and "cold" foods for Latino Americans and Asian Americans)?

Assessment tools

A range of instruments and tools have been developed to assist nurses in their assessment role. These include: the index of independence in activities of daily living, the Barthel index, the Crighton Royal behaviour rating scale, the Clifton assessment procedures for the elderly, the general health questionnaire, and the geriatric mental health state schedule. Other assessment tools may focus on a specific aspect of the patient's care. For example, the Waterlow score and the Braden scale deals with a patient's risk of developing a Pressure ulcer (decubitus ulcer), the Glasgow Coma Scale measures the conscious state of a person, and various pain scales exist to assess the "fifth vital sign". The use of medical equipment is routinely employed to conduct a nursing assessment. These include, the otoscope, thermometer, stethoscope, penlight, sphygmomanometer, bladder scanner, speculum, and eye charts. Besides the interviewing process, the nursing assessment utilizes certain techniques to collect information such as observation, auscultation, palpation and percussion.

Chapter 4

Nursing Process

The **nursing process** is a modified scientific method. Nursing practise was first described as a four-stage nursing process by Ida Jean Orlando in 1958. It should not be confused with nursing theories or health informatics. The diagnosis phase was added later.

The nursing process uses clinical judgement to strike a balance of epistemology between personal interpretation and research evidence in which critical thinking may play a part to categorize the clients issue and course of action. Nursing offers diverse patterns of knowing. Nursing knowledge has embraced pluralism since the 1970s.

Some authors refer to a mind map or abductive reasoning as a potential alternative strategy for organizing care. Intuition plays a part for experienced nurses.

Phases

The nursing process is goal-oriented method of caring that provides a framework to nursing care. It involves seven major steps:

- A
- Assess (what data is collected?)
- D
- Diagnose (what is the problem?)
- O

- Outcome Identification - (Was originally a part of the Planning phase, but has recently been added as a new step in the complete process).
- P
- Plan (how to manage the problem)
- I
- Implement (putting plan into action)
- R
- Rationale (Scientific reason of the implementations)
- E
- Evaluate (did the plan work?)

According to some theorists, this seven-steps description of the nursing process is outdated and misrepresents nursing as linear and atomic.

Assessing phase

The nurse completes anholisticnursing assessment of the needs of the individual/family/community, regardless of the reason for the encounter. The nurse collects subjectivedata and objectivedata using a nursing framework, such as Marjory Gordon's functional health patterns.

Models for data collection

Nursing assessments provide the starting point for determining nursing diagnoses. It is vital that a recognized nursing assessment framework is used in practice to identify the patient's* problems, risks and outcomes for enhancing health. The use of an evidence-based nursing framework such as Gordon's Functional Health Pattern Assessment should guide

assessments that support nurses in determination of NANDA-I nursing diagnoses. For accurate determination of nursing diagnoses, a useful, evidence-based assessment framework is best practice.

Methods

- Client Interview
- Physical Examination
- Obtaining a health history (including dietary data)
- Family history/report

Diagnosing phase

Nursing diagnoses represent the nurse's clinical judgment about actual or potential health problems/life process occurring with the individual, family, group or community. The accuracy of the nursing diagnosis is validated when a nurse is able to clearly identify and link to the defining characteristics, related factors and/or risk factors found within the patients assessment. Multiple nursing diagnoses may be made for one client.

Planning phase

In agreement with the client, the nurse addresses each of the problems identified in the diagnosing phase. When there are multiple nursing diagnoses to be addressed, the nurse prioritizes which diagnoses will receive the most attention first according to their severity and potential for causing more serious harm. The most common terminology for standardized nursing diagnosis is that of the evidence-based terminology

developed and refined by NANDA International, the oldest and one of the most researched of all standardized nursing languages. For each problem a measurable goal/outcome is set. For each goal/outcome, the nurse selects nursing interventions that will help achieve the goal/outcome, which are aimed at the related factors (etiologies) not merely at symptoms (defining characteristics). A common method of formulating the expected outcomes is to use the evidence-basedNursing Outcomes Classification to allow for the use of standardized language which improves consistency of terminology, definition and outcome measures. The interventions used in the Nursing Interventions Classification again allow for the use of standardized language which improves consistency of terminology, definition and ability to identify nursing activities, which can also be linked to nursing workload and staffing indices. The result of this phase is a nursing care plan.

Implementing phase

The nurse implements the nursing care plan, performing the determined interventions that were selected to help meet the goals/outcomes that were established. Delegated tasks and the monitoring of them is included here as well.

Activities

- pre-assessment of the client-done before just carrying out implementation to determine if it is relevant
- determine need for assistance
- implementation of nursing orders

- delegating and supervising-determines who to carry out what action

Evaluating phase

The nurse evaluates the progress toward the goals/outcomes identified in the previous phases. If progress towards the goal is slow, or if regression has occurred, the nurse must change the plan of care accordingly. Conversely, if the goal has been achieved then the care can cease. New problems may be identified at this stage, and thus the process will start all over again.

Characteristics

The nursing process is a **cyclical** and **ongoing** process that can end at any stage if the problem is solved. The nursing process exists for every problem that the individual/family/community has.

The nursing process not only focuses on ways to improve physical needs, but also on social and emotional needs as well.

- Cyclic and dynamic
- Goal directed and client centered
- Interpersonal and collaborative
- Universally applicable
- Systematic.

The entire process is recorded or documented in order to inform all members of the health care team.

Variations and documentation

The **PIE method** is a system for documenting actions, especially in the field of nursing. The name comes from the acronym *PIE*, meaning Problem, Intervention, Evaluation.

Chapter 5

Nursing Research

Nursing research is research that provides evidence used to support nursing practices. Nursing, as an evidence-based area of practice, has been developing since the time of Florence Nightingale to the present day, where many nurses now work as researchers based in universities as well as in the health care setting.

Nurse education places focus upon the use of evidence from research in order to rationalise nursing interventions. In England and Wales, courts may determine if a nurse acted reasonably based upon whether their intervention was supported by research.

Nursing research falls largely into two areas:

- Quantitative researchis based in the paradigm of logical positivism and is focused upon outcomes for clients that are measurable, generally using statistics. The dominant research method is the randomised controlled trial.
- Qualitative researchis based in the paradigm of phenomenology, grounded theory, ethnography and others, and examines the experience of those receiving or delivering the nursing care, focusing, in particular, on the meaning that it holds for the individual. The research methods most commonly used are interviews, case studies, focus groups and ethnography

Recently in the UK, action research has become increasingly popular in nursing.

Evidence-based quality improvement practices

In 2008, the Agency for Healthcare Research and Quality AHRQ created the AHRQ Health Care Innovations Exchange to document and share health care quality improvement programs, including hundreds of profiles featuring nursing innovations. Each of the nursing profiles contained in this collection contains an evidence rating that assesses how strong the relationship is between the innovative practice and the results described in the profile.

Agency for Healthcare Research and Quality

The **Agency for Healthcare Research and Quality** (**AHRQ**; pronounced "ark" by initiates and often "A-H-R-Q" by the public) is one of twelve agencies within the United States Department of Health and Human Services (HHS). The agency is headquartered in North Bethesda, Maryland, a suburb of Washington, D.C. (with a Rockville mailing address). It was established as the **Agency for Health Care Policy and Research** (AHCPR) in 1989 as a constituent unit of the Public Health Service (PHS) to enhance the quality, appropriateness, and effectiveness of health care services and access to care by conducting and supporting research, demonstration projects,

and evaluations; developing guidelines; and disseminating information on health care services and delivery systems.

History

AHRQ's earliest predecessor was the National Center for Health Services Research and Development, established in 1968 within the PHS Health Resources and Services Administration. When that administration was split up in 1973, it became the Bureau of Health Services Research within the PHS Health Resources Administration, and was renamed the National Center for Health Services Research in 1975. In 1978 it was transferred to the Office of the Assistant Secretary for Health. In 1985 it was renamed the National Center for Health Services Research and Health Care Technology Assessment.

In 1989, the agency became its own operating agency within PHS, and was renamed Agency for Health Care Policy and Research under the Omnibus Budget Reconciliation Act of 1989 (103 Stat. 2159). During its early years, the Agency for Healthcare Policy and Research implemented large multidisciplinary, multi-institutional projects that focused on patient results in certain medical conditions in an effort to improve clinical practice. This has included basic health IT research, patient safety research on wrong site surgery, medical teamwork, and hospital acquired conditions such as MRSA and VRE.

However, AHCPR became controversial when it produced several guidelines that some thought would reduce medical drugs and procedures. This included concern from ophthalmologists on a cataract guideline and concern by the

pharmaceutical industry over a reduction in the use of new drugs. When the agency produced a guideline that concluded that back pain surgery was unnecessary and potentially harmful, a lobbying campaign aided by Congressmen whose backs had been operated on changed the name of the agency and scaled back the guidelines program, which now exists as the National Guideline Clearinghouse. AHCPR was reauthorized December 6, 1999, for Healthcare Research and Quality (AHRQ) under the Healthcare Research and Quality Act of 1999, which amended Title IX of the Public Health Service Act (42 U.S.C. 299 et seq).

Funding

The Trump administration proposed to merge the Agency for Healthcare Research and Quality with the National Institutes of Health. The President's FY 2018 Request to Congress for the Agency was for $378.5 million.

The 2015 budget for AHRQ is US$440 million, $24 million less than FY 2014. Within this total, the budget includes $334 million in Public Health Service (PHS) Evaluation Funds, a decrease of $30 million from FY 2014, and $106 million from the Patient-Centered Outcomes Research Trust Fund, an increase of $13 million above FY 2014.

The FY 2015 budget is intended to ensure the Agency continues its progress on health services research to improve outcomes, affordability, and quality. The budget also supports the collection of information on health care spending and use through the Healthcare Cost and Utilization Project (HCUP) and Medical Expenditure Panel Survey (MEPS).

The FY 2015 budget provides $73 million, an increase of $1 million from FY 2014, for AHRQ's patient safety research and dissemination projects that prevent, mitigate, and decrease the number of medical errors, patient safety risks and hazards, and quality gaps. The budget includes $23 million, a $6 million decrease from FY 2014, for health information technology (health IT) research, and the development and dissemination of evidence and evidence-based tools to inform policy and practice on how health IT can improve the quality of American health care. In FY 2015, AHRQ will provide $20 million to support 40 grants for foundational health IT research to inform and support the meaningful use of health IT.

In July 2018, the National Guideline Clearinghouse (NGC) and the National Quality Measures Clearinghouse (NQMC), two longtime online resources from the AHRQ, were shut down because federal funding ceased to be available to them. Other stakeholders were exploring options for hosting the NGC]; should that happen, it will return to the web.

Leadership

Gopal Khanna, MBA was appointed as Agency director on May 9, 2017, and resigned on January 11, 2021 in response to the January 6 Capitol riot. Prior to that, Dr. Andrew Bindman was the director of AHRQ from April 2016 until January 2017. Prior to joining AHRQ, Dr. Bindman served as faculty of UCSF School of Medicine. Sharon Arnold Ph.D. was acting director from February - April 2016, replacing Richard Kronick in February 2016. Richard Kronick, Ph.D. was director from 2013 to March 2016. Carolyn Clancy M.D. was the director from 2002-2014.

Following Khanna's resignation, deputy director Dr. David Meyers, M.D. has served as acting director.

Divisions

The Agency has multiple offices and centers including the Center for Evidence and Practice Improvement (CEPI), the Center for Financing, Access and Trends, the Center for Delivery, Organization and Markets, the Center for Quality and Patient Safety, the Office of Management Services, the Office of Extramural Research and Priority Populations, and the Office of Communications.

The Office of Communications was previously known as the Office of Communications and Knowledge Transfer.

Within CEPI, the Evidence-Based Practice Centers (EPCs) develop evidence reports and technology assessments on topics relevant to clinical and other health care organization and delivery issues—specifically those that are common, expensive, and/or significant for the Medicare and Medicaid populations.

With this program, AHRQ serves as a "science partner" with private and public organizations in their efforts to improve the quality, effectiveness, and appropriateness of health care by synthesizing the evidence and facilitating the translation of evidence-based research findings.

Topics are nominated by Federal and non-Federal partners such as professional societies, health plans, insurers, employers, and patient groups.

Evidence-based medicine

Background, history and definition

Medicine has a long history of scientific inquiry about the prevention, diagnosis, and treatment of human disease.

The concept of a controlled clinical trial was first described in 1662 by Jan Baptist van Helmont in reference to the practice of bloodletting. Wrote Van Helmont:

Let us take out of the Hospitals, out of the Camps, or from elsewhere, 200, or 500 poor People, that have fevers or Pleuritis. Let us divide them in Halfes, let us cast lots, that one halfe of them may fall to my share, and the others to yours; I will cure them without blood-letting and sensible evacuation; but you do, as ye know ... we shall see how many Funerals both of us shall have...

The first published report describing the conduct and results of a controlled clinical trial was by James Lind, a Scot Naval Surgeon who conducted research on scurvy during his time aboard HMS Salisbury in the Channel Fleet, while patrolling the Bay of Biscay. Lind divided the sailors participating in his experiment into six groups, so that the effects of various treatments could be fairly compared. Lind found improvement in symptoms and signs of scurvy among the group of men treated with lemons or oranges. He published a treatise describing the results of this experiment in 1753.

An early critique of statistical methods in medicine was published in 1835.

The term "Evidence-based medicine" was introduced in 1990 by Gordon Guyatt of McMaster University.

Clinical decision making

Alvan Feinstein's publication of *Clinical Judgment* in 1967 focused attention on the role of clinical reasoning and identified biases that can affect it. In 1972, Archie Cochrane published *Effectiveness and Efficiency*, which described the lack of controlled trials supporting many practices that had previously been assumed to be effective. In 1973, John Wennberg began to document wide variations in how physicians practiced. Through the 1980s, David M. Eddy described errors in clinical reasoning and gaps in evidence. In the mid 1980s, Alvin Feinstein, David Sackett and others published textbooks on clinical epidemiology, which translated epidemiological methods to physician decision making. Toward the end of the 1980s, a group at RAND showed that large proportions of procedures performed by physicians were considered inappropriate even by the standards of their own experts.

Evidence-based guidelines and policies

David M. Eddy first began to use the term "evidence-based" in 1987 in workshops and a manual commissioned by the Council of Medical Specialty Societies to teach formal methods for designing clinical practice guidelines. The manual was eventually published by the American College of Physicians. Eddy first published the term "evidence-based" in March, 1990, in an article in the *Journal of the American Medical Association* that laid out the principles of evidence-based guidelines and

population-level policies, which Eddy described as "explicitly describing the available evidence that pertains to a policy and tying the policy to evidence instead of standard-of-care practices or the beliefs of experts. The pertinent evidence must be identified, described, and analyzed. The policymakers must determine whether the policy is justified by the evidence. A rationale must be written." He discussed "evidence-based" policies in several other papers published in *JAMA* in the spring of 1990. Those papers were part of a series of 28 published in *JAMA* between 1990 and 1997 on formal methods for designing population-level guidelines and policies.

Medical education

The term "evidence-based medicine" was introduced slightly later, in the context of medical education. In the autumn of 1990, Gordon Guyatt used it in an unpublished description of a program at McMaster University for prospective or new medical students. Guyatt and others first published the term two years later (1992) to describe a new approach to teaching the practice of medicine.

In 1996, David Sackett and colleagues clarified the definition of this tributary of evidence-based medicine as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. ... [It] means integrating individual clinical expertise with the best available external clinical evidence from systematic research." This branch of evidence-based medicine aims to make individual decision making more structured and objective by better reflecting the evidence from research. Population-based data are applied to the care of an individual

patient, while respecting the fact that practitioners have clinical expertise reflected in effective and efficient diagnosis and thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences.

Between 1993 and 2000, the Evidence-based Medicine Working Group at McMaster University published the methods to a broad physician audience in a series of 25 "Users' Guides to the Medical Literature" in *JAMA*. In 1995 Rosenberg and Donald defined individual level evidence-based medicine as "the process of finding, appraising, and using contemporaneous research findings as the basis for medical decisions." In 2010, Greenhalgh used a definition that emphasized quantitative methods: "the use of mathematical estimates of the risk of benefit and harm, derived from high-quality research on population samples, to inform clinical decision-making in the diagnosis, investigation or management of individual patients."

The two original definitions highlight important differences in how evidence-based medicine is applied to populations versus individuals. When designing guidelines applied to large groups of people in settings where there is relatively little opportunity for modification by individual physicians, evidence-based policymaking stresses that there should be good evidence to document a test's or treatment's effectiveness. In the setting of individual decision-making, practitioners can be given greater latitude in how they interpret research and combine it with their clinical judgment. In 2005, Eddy offered an umbrella definition for the two branches of EBM: "Evidence-based medicine is a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions,

guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit."

Progress

On the evidence-based guidelines and policies side, explicit insistence on evidence of effectiveness was introduced by the American Cancer Society in 1980. The U.S. Preventive Services Task Force (USPSTF) began issuing guidelines for preventive interventions based on evidence-based principles in 1984. In 1985, the Blue Cross Blue Shield Association applied strict evidence-based criteria for covering new technologies. Beginning in 1987, specialty societies such as the American College of Physicians, and voluntary health organizations such as the American Heart Association, wrote many evidence-based guidelines. In 1991, Kaiser Permanente, a managed care organization in the US, began an evidence-based guidelines program. In 1991, Richard Smith wrote an editorial in the *British Medical Journal* and introduced the ideas of evidence-based policies in the UK. In 1993, the Cochrane Collaboration created a network of 13 countries to produce systematic reviews and guidelines. In 1997, the US Agency for Healthcare Research and Quality (AHRQ, then known as the Agency for Health Care Policy and Research, or AHCPR) established Evidence-based Practice Centers (EPCs) to produce evidence reports and technology assessments to support the development of guidelines. In the same year, a National Guideline Clearinghouse that followed the principles of evidence-based policies was created by AHRQ, the AMA, and the American Association of Health Plans (now America's Health Insurance Plans). In 1999, the National Institute for Clinical Excellence (NICE) was created in the UK.

On the medical education side, programs to teach evidence-based medicine have been created in medical schools in Canada, the US, the UK, Australia, and other countries. A 2009 study of UK programs found the more than half of UK medical schools offered some training in evidence-based medicine, although there was considerable variation in the methods and content, and EBM teaching was restricted by lack of curriculum time, trained tutors and teaching materials. Many programs have been developed to help individual physicians gain better access to evidence. For example, UpToDatewas created in the early 1990s. The Cochrane Collaboration began publishing evidence reviews in 1993. BMJ Publishing Group launched a 6-monthly periodical in 1995 called Clinical Evidence that provided brief summaries of the current state of evidence about important clinical questions for clinicians.

Current practice

By 2000, use of the term "evidence-based" had extended to other levels of the health care system. An example is "evidence-based health services", which seek to increase the competence of health service decision makers and the practice of evidence-based medicine at the organizational or institutional level.

The multiple tributaries of evidence-based medicine share an emphasis on the importance of incorporating evidence from formal research in medical policies and decisions. However, they differ on the extent to which they require good evidence of effectiveness before promoting a guideline or payment policy; hence, the distinction sometimes made between evidence-based medicine and science-based medicine, which also takes into

account factors such as prior plausibility and compatibility with established science as when medical organizations promote controversial treatments such as acupuncture. They also differ on the extent to which it is feasible to incorporate individual-level information in decisions. Thus, evidence-based guidelines and policies may not readily 'hybridise' with experience-based practices orientated towards ethical clinical judgement, and can lead to contradictions, contest, and unintended crises.

The most effective 'knowledge leaders' (managers and clinical leaders) use a broad range of management knowledge in their decision making, rather than just formal evidence. Evidence-based guidelines may provide the basis for governmentality in health care, and consequently play a central role in the governance of contemporary health care systems.

Methods

Steps

The steps for designing explicit, evidence-based guidelines were described in the late 1980s: Formulate the question (population, intervention, comparison intervention, outcomes, time horizon, setting); search the literature to identify studies that inform the question; interpret each study to determine precisely what it says about the question; if several studies address the question, synthesize their results (meta-analysis); summarize the evidence in "evidence tables"; compare the benefits, harms and costs in a "balance sheet"; draw a conclusion about the preferred practice; write the guideline;

write the rationale for the guideline; have others review each of the previous steps; implement the guideline.

For the purposes of medical education and individual-level decision making, five steps of EBM in practice were described in 1992 and the experience of delegates attending the 2003 Conference of Evidence-Based Health Care Teachers and Developers was summarized into five steps and published in 2005. This five step process can broadly be categorized as:

- Translation of uncertainty to an answerable question and includes critical questioning, study design and levels of evidence
- Systematic retrieval of the best evidence available
- Critical appraisal of evidence for internal validity that can be broken down into aspects regarding:
- Systematic errors as a result of selection bias, information bias and confounding
- Quantitative aspects of diagnosis and treatment
- The effect size and aspects regarding its precision
- Clinical importance of results
- External validity or generalizability
- Application of results in practice
- Evaluation of performance

Evidence reviews

Systematic reviews of published research studies are a major part of the evaluation of particular treatments. The Cochrane Collaboration is one of the best-known organisations that conducts systematic reviews. Like other producers of systematic reviews, it requires authors to provide a detailed

and repeatable plan of their literature search and evaluations of the evidence. Once all the best evidence is assessed, treatment is categorized as (1) likely to be beneficial, (2) likely to be harmful, or (3) evidence did not support either benefit or harm.

A 2007 analysis of 1,016 systematic reviews from all 50 Cochrane Collaboration Review Groups found that 44% of the reviews concluded that the intervention was likely to be beneficial, 7% concluded that the intervention was likely to be harmful, and 49% concluded that evidence did not support either benefit or harm. 96% recommended further research. In 2017, a study assessed the role of systematic reviews produced by Cochrane Collaboration to inform US private payers' policies making; it showed that though medical policy documents of major US private payers were informed by Cochrane systematic reviews there was still scope to encourage the further usage.

Assessing the quality of evidence

Evidence-based medicine categorizes different types of clinical evidence and rates or grades them according to the strength of their freedom from the various biases that beset medical research. For example, the strongest evidence for therapeutic interventions is provided by systematic review of randomized, well-blinded, placebo-controlled trials with allocation concealment and complete follow-up involving a homogeneous patient population and medical condition. In contrast, patient testimonials, case reports, and even expert opinion (however, some critics have argued that expert opinion "does not belong in the rankings of the quality of empirical evidence because it does not represent a form of empirical evidence" and continue

that "expert opinion would seem to be a separate, complex type of knowledge that would not fit into hierarchies otherwise limited to empirical evidence alone") have little value as proof because of the placebo effect, the biases inherent in observation and reporting of cases, difficulties in ascertaining who is an expert and more.

Several organizations have developed grading systems for assessing the quality of evidence. For example, in 1989 the U.S. Preventive Services Task Force (USPSTF) put forth the following:

- Level I: Evidence obtained from at least one properly designed randomized controlled trial.
- Level II-1: Evidence obtained from well-designed controlled trials without randomization.
- Level II-2: Evidence obtained from well-designed cohort studies or case-control studies, preferably from more than one center or research group.
- Level II-3: Evidence obtained from multiple time series designs with or without the intervention. Dramatic results in uncontrolled trials might also be regarded as this type of evidence.
- Level III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Another example are the CEBM Levels of evidence published by the Centre for Evidence-Based Medicine. First released in September 2000, the Oxford CEBM Levels of Evidence provides 'levels' of evidence for claims about prognosis, diagnosis, treatment benefits, treatment harms, and screening, which

most grading schemes do not address. The original CEBM Levels was Evidence-Based On Call to make the process of finding evidence feasible and its results explicit. In 2011, an international team redesigned the Oxford CEBM Levels to make it more understandable and to take into account recent developments in evidence ranking schemes. The Oxford CEBM Levels of Evidence have been used by patients, clinicians and also to develop clinical guidelines including recommendations for the optimal use of phototherapy and topical therapy in psoriasis and guidelines for the use of the BCLC staging system for diagnosing and monitoring hepatocellular carcinoma in Canada.

In 2000, a system was developed by the GRADE (short for Grading of Recommendations Assessment, Development and Evaluation) working group and takes into account more dimensions than just the quality of medical research. It requires users of GRADE who are performing an assessment of the quality of evidence, usually as part of a systematic review, to consider the impact of different factors on their confidence in the results.

Authors of GRADE tables grade the quality of evidence into four levels, on the basis of their confidence in the observed effect (a numerical value) being close to what the true effect is. The confidence value is based on judgements assigned in five different domains in a structured manner.

The GRADE working group defines 'quality of evidence' and 'strength of recommendations' based on the quality as two different concepts which are commonly confused with each other.

Systematic reviews may include randomized controlled trials that have low risk of bias, or, observational studies that have high risk of bias. In the case of randomized controlled trials, the quality of evidence is high, but can be downgraded in five different domains.

- Risk of bias: Is a judgement made on the basis of the chance that bias in included studies has influenced the estimate of effect.
- Imprecision: Is a judgement made on the basis of the chance that the observed estimate of effect could change completely.
- Indirectness: Is a judgement made on the basis of the differences in characteristics of how the study was conducted and how the results are actually going to be applied.
- Inconsistency: Is a judgement made on the basis of the variability of results across the included studies.
- Publication bias: Is a judgement made on the basis of the question whether all the research evidence has been taken to account.

In the case of observational studies per GRADE, the quality of evidence starts off lower and may be upgraded in three domains in addition to being subject to downgrading.

- Large effect: This is when methodologically strong studies show that the observed effect is so large that the probability of it changing completely is less likely.
- Plausible confounding would change the effect: This is when despite the presence of a possible

confounding factor which is expected to reduce the observed effect, the effect estimate still shows significant effect.

- Dose response gradient: This is when the intervention used becomes more effective with increasing dose. This suggests that a further increase will likely bring about more effect.

Meaning of the levels of quality of evidence as per GRADE:

- High Quality Evidence: The authors are very confident that the estimate that is presented lies very close to the true value. One could interpret it as "there is very low probability of further research completely changing the presented conclusions."
- Moderate Quality Evidence: The authors are confident that the presented estimate lies close to the true value, but it is also possible that it may be substantially different. One could also interpret it as: further research may completely change the conclusions.
- Low Quality Evidence: The authors are not confident in the effect estimate and the true value may be substantially different. One could interpret it as "further research is likely to change the presented conclusions completely."
- Very low quality Evidence: The authors do not have any confidence in the estimate and it is likely that the true value is substantially different from it. One could interpret it as "new research will most probably change the presented conclusions completely."

Categories of recommendations

In guidelines and other publications, recommendation for a clinical service is classified by the balance of risk versus benefit and the level of evidence on which this information is based. The U.S. Preventive Services Task Force uses:

- Level A: Good scientific evidence suggests that the benefits of the clinical service substantially outweigh the potential risks. Clinicians should discuss the service with eligible patients.
- Level B: At least fair scientific evidence suggests that the benefits of the clinical service outweighs the potential risks. Clinicians should discuss the service with eligible patients.
- Level C: At least fair scientific evidence suggests that there are benefits provided by the clinical service, but the balance between benefits and risks are too close for making general recommendations. Clinicians need not offer it unless there are individual considerations.
- Level D: At least fair scientific evidence suggests that the risks of the clinical service outweighs potential benefits. Clinicians should not routinely offer the service to asymptomatic patients.
- Level I: Scientific evidence is lacking, of poor quality, or conflicting, such that the risk versus benefit balance cannot be assessed. Clinicians should help patients understand the uncertainty surrounding the clinical service.

GRADE guideline panelists may make strong or weak recommendations on the basis of further criteria. Some of the important criteria are the balance between desirable and undesirable effects (not considering cost), the quality of the evidence, values and preferences and costs (resource utilization).

Despite the differences between systems, the purposes are the same: to guide users of clinical research information on which studies are likely to be most valid. However, the individual studies still require careful critical appraisal.

Statistical measures

Evidence-based medicine attempts to express clinical benefits of tests and treatments using mathematical methods. Tools used by practitioners of evidence-based medicine include:

- Likelihood ratio
- Main article: Likelihood ratios in diagnostic testing
- The pre-test odds of a particular diagnosis, multiplied by the likelihood ratio, determines the post-test odds. (Odds can be calculated from, and then converted to, the [more familiar] probability.) This reflects Bayes' theorem. The differences in likelihood ratio between clinical tests can be used to prioritize clinical tests according to their usefulness in a given clinical situation.
- AUC-ROC The area under the receiver operating characteristic curve (AUC-ROC) reflects the relationship between sensitivity and specificity for a given test. High-quality tests will have an AUC-ROC

approaching 1, and high-quality publications about clinical tests will provide information about the AUC-ROC. Cutoff values for positive and negative tests can influence specificity and sensitivity, but they do not affect AUC-ROC.

- Number needed to treat (NNT)/Number needed to harm (NNH). Number needed to treat or number needed to harm are ways of expressing the effectiveness and safety, respectively, of interventions in a way that is clinically meaningful. NNT is the number of people who need to be treated in order to achieve the desired outcome (e.g. survival from cancer) in one patient. For example, if a treatment increases the chance of survival by 5%, then 20 people need to be treated in order to have 1 additional patient survive due to the treatment. The concept can also be applied to diagnostic tests. For example, if 1,339 women age 50–59 have to be invited for breast cancer screening over a ten-year period in order to prevent one woman from dying of breast cancer, then the NNT for being invited to breast cancer screening is 1339.

Quality of clinical trials

Evidence-based medicine attempts to objectively evaluate the quality of clinical research by critically assessing techniques reported by researchers in their publications.

- Trial design considerations. High-quality studies have clearly defined eligibility criteria and have minimal missing data.

- Generalizability considerations. Studies may only be applicable to narrowly defined patient populations and may not be generalizable to other clinical contexts.
- Follow-up. Sufficient time for defined outcomes to occur can influence the prospective study outcomes and the statistical power of a study to detect differences between a treatment and control arm.
- Power. A mathematical calculation can determine if the number of patients is sufficient to detect a difference between treatment arms. A negative study may reflect a lack of benefit, or simply a lack of sufficient quantities of patients to detect a difference.

Limitations and criticism

There are a number of limitations and criticisms of evidence-based medicine. Two widely cited categorization schemes for the various published critiques of EBM include the three-fold division of Straus and McAlister ("limitations universal to the practice of medicine, limitations unique to evidence-based medicine and misperceptions of evidence-based-medicine") and the five-point categorization of Cohen, Stavri and Hersh (EBM is a poor philosophic basis for medicine, defines evidence too narrowly, is not evidence-based, is limited in usefulness when applied to individual patients, or reduces the autonomy of the doctor/patient relationship).In no particular order, some published objections include:

- Research produced by EBM, such as from randomized controlled trials (RCTs), may not be

relevant for all treatment situations. Research tends to focus on specific populations, but individual persons can vary substantially from population norms. Since certain population segments have been historically under-researched (racial minorities and people with co-morbid diseases), evidence from RCTs may not be generalizable to those populations. Thus EBM applies to groups of people, but this should not preclude clinicians from using their personal experience in deciding how to treat each patient. One author advises that "the knowledge gained from clinical research does not directly answer the primary clinical question of what is best for the patient at hand" and suggests that evidence-based medicine should not discount the value of clinical experience. Another author stated that "the practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research."

- The theoretical ideal of EBM (that every narrow clinical question, of which hundreds of thousands can exist, would be answered by meta-analysis and systematic reviews of multiple RCTs) faces the limitation that research (especially the RCTs themselves) is expensive; thus, in reality, for the foreseeable future, there will always be much more demand for EBM than supply, and the best humanity can do is to triage the application of scarce resources.
- Research can be influenced by biases such as publication bias and conflict of interest in academic publishing. For example, studies with conflicts due

to industry funding are more likely to favor their product.
- There is a lag between when the RCT is conducted and when its results are published.
- There is a lag between when results are published and when these are properly applied.
- Hypocognition (the absence of a simple, consolidated mental framework that new information can be placed into) can hinder the application of EBM.
- Values: while patient values are considered in the original definition of EBM, the importance of values is not commonly emphasized in EBM training, a potential problem under current study.

A 2018 study, "Why all randomised controlled trials produce biased results", assessed the 10 most cited RCTs and argued that trials face a wide range of biases and constraints, from trials only being feasible to study a small set of questions amenable to randomisation and generally only being able to assess the *average* treatment effect of a sample, to limitations in extrapolating results to another context, among many others outlined in the study.

Application of evidence in clinical settings

Despite the emphasis on evidence-based medicine, unsafe or ineffective medical practices continue to be applied, because of patient demand for tests or treatments, because of failure to access information about the evidence, or because of the rapid pace of change in the scientific evidence. For example, between

2003 and 2017, the evidence shifted on hundreds of medical practices, ranging from whether hormone replacement therapy was safe to whether babies should be given certain vitamins to whether antidepressant drugs are effective in people with Alzheimer's disease. Even when the evidence is unequivocally that a treatment is either not safe or not effective, it may take many years for other treatments to be adopted. In other cases, significant change can require a generation of physicians to retire or die, and be replaced by physicians who were trained with more recent evidence.

Physicians may also reject evidence which conflicts with their anecdotal experience or because of cognitive biases – for example, a vivid memory of a rare but shocking outcome (the availability heuristic), such as a patient dying after refusing treatment. They may overtreat to "do something" or to address a patient's emotional needs. They may worry about malpractice charges based on a discrepancy between what the patient expects and what the evidence recommends. They may also overtreat or provide ineffective treatments because the treatment feels biologically plausible.

Education

Training in evidence based medicine is offered across the continuum of medical education. The Berlin questionnaire and the Fresno Test are validated instruments for assessing the effectiveness of education in evidence-based medicine. These questionnaires have been used in diverse settings.

Chapter 6

Notable Nursing Theorists and Theories

Dorothea Orem

Dorothea Elizabeth Orem (June 15, 1914 – June 22, 2007), born in Baltimore, Maryland, was a nursing theorist and creator of the self-care deficit nursing theory, also known as the Orem model of nursing.

Education

Orem received a nursing diploma from Providence Hospital School of Nursing in Washington, DC. She also attended Catholic University of America, earning a Bachelor of Science in Nursing Education in 1939 and a Master of Science in Nursing Education in 1945.

Orem has been awardedhonorary doctoral degrees from Georgetown University, Incarnate Word College and Illinois Wesleyan University.

Self-care deficit nursing theory

Orem'snursing theory states self-care as a human need, and nurses design interventions to provide or manage self-care actions for persons to recover or maintain health.

Nursing diagnosis

Orem was a member of the group of nurse theorists who presented *Patterns of Unitary Man (Humans)*, the initial framework for nursing diagnosis, to the North American Nursing Diagnosis Association in 1982.

Awards

- 1980: Alumni Achievement Award for Nursing Theory, Catholic University of America

Death

Orem died on June 22, 2007 in Savannah, Georgia, where she had spent the last 25 years of her life as a consultant and author. She was 92.

Faye Glenn Abdellah

Faye Glenn Abdellah (March 13, 1919 – February 24, 2017) was an American pioneer in nursing research. Abdellah was the first nurse and woman to serve as the Deputy Surgeon General of the United States. Preceding her appointment, she served in active duty during the Korean War, where she earned a distinguished ranking equivalent to a Navy Rear Admiral, making her the highest ranked woman and nurse in the Federal Nursing Services at the time. In addition to these achievements, Abdellah led the formation of the National

Institute of Nursing Research at the NIH, and was the founder and first dean of the Graduate School of Nursing at the Uniformed Services University of the Health Sciences (USUHS). A few of Abdellah's more passionate interests in public health included the importance of long-term care planning for elderly patients; the need to strengthen nursing school infrastructure; and the necessity of patient-centered approaches in nursing. In 2000Abdellah was inducted into the National Women's Hall of Fame. During her acceptance speech, Abdellah made the following quote: "We cannot wait for the world to change . . . Those of us with intelligence, purpose, and vision must take the lead and change the world . . . I promise never to rest until my work has been completed!" Abdellah donated a collection of her papers to the National Library of Medicine in November 1988. Abdellah died on February 24, 2017 at the age of 97.

Education

- PhD in education psychology, Masters of Arts, and Bachelors of Science degrees from the Teachers' College at Columbia University in New York, NY
- Liberal arts and chemistry specializations at Douglass Residential College, a division of Rutgers University, in New Brunswick, NJ
- RN diploma from Fitkin Memorial Hospital (later named Ann May School of Nursing) in Neptune, NJ

Career

Abdellah was a professor of nursing arts, pharmacology, and medical nursing at the Yale University School of Nursing from

1945 until 1949. From 1950 until 1954 she served in active duty during the Korean War, where she earned a distinguished ranking equivalent to a Navy Rear Admiral, making her the highest ranked woman and nurse in the Federal Nursing Services at the time. Following the war, she served as a visiting professor at the University of Washington; the University of Colorado, Boulder; and the University of Minnesota. In 1981, she was appointed deputy to Surgeon GeneralC. Everett Koop, making her the first nurse and woman to serve as Deputy Surgeon General of the United States. As Deputy Surgeon General, she frequently served as an alternate ex-officio member of the Board of Regents at the United States National Library of Medicine (NLM), and contributed to policies that shaped NLM programs, services, and NLM's Long-Range Plan for 1986-2006. She served as Deputy Surgeon General until her retirement in 1989. Following her retirement, Abdellah taught as a professor at the College of Nursing at the University of South Carolina; and established and served as the acting dean of the first federal graduate school of nursing at the Uniformed Services University of the Health Sciences (USUHS).

Perspectives on nursing education

Abdellah was passionate in the effort to improve nursing education. Early in her career, while working for Yale University, she became frustrated by the lack of scientific basis in the National League of Nursing guidelines, and proceeded to burn a stack of the curriculum guides in the Yale courtyard. She mentioned with some humor that it took well over a year for her to pay for the destroyed books.

Throughout her career, Abdellah advocated for the strengthening of nursing school infrastructure. Specifically, she called for cross-disciplinary collaborations in nursing education; the teaching of specialized and budgeting skills in nursing graduate education; increased admittance of nursing students from minority backgrounds; and fostering humanistic skills in future nurses, such as compassion for patients. She was also a proponent of the teaching the teacher method, where graduate students are taught specialized skills so that they may teach the skills to future students.

Abdellah created a typology of twenty-one areas of focus for the nurse. These problems were divided into three classes: physical, sociological and emotional needs of the patient; the types of nurse-patient interpersonal relationships; and common elements of patient care.

Select awards and achievements

- 2012: Inductee, American Nurses Association Hall of Fame
- 2000: Inductee, National Women's Hall of Fame
- 1994: Living Legend, American Academy of Nursing
- 11 honorary degrees
- 152 publications
- Over 50 academic awards and recognitions

Helen Erickson

Helen Lorraine (Cook) Erickson (born 1936) is the primary author of the modeling and role-modeling theory of nursing.

Her work, co-authored with Evelyn Tomlin and Mary Ann Swain, was published in the 1980s and derived from her experience in clinical practice. In 2006 she edited a book that provides additional information describing the relationships among soul, spirit, and human form.

Career

Erickson was the first president of the Society for the Advancement of Modeling and Role-Modeling (SAMRM). The organization was established in 1986 at the University of Michigan.

She holds the title of Professor Emeritus at The University of Texas at Austin. She has served on the Board of Directors for the American Holistic Nurses Certification Corporation.

Personal

Erickson was married to Lance Erickson in 1957 in Clare, Michigan. Together they live in Cedar Park, Texas.

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Hildegard Peplau

Hildegard E. Peplau (September 1, 1909 – March 17, 1999) was an American nurse and the first published nursing theorist since Florence Nightingale. She created the middle-range nursing theory of interpersonal relations, which helped to revolutionize the scholarly work of nurses. As a primary

contributor to mental health law reform, she led the way towards humane treatment of patients with behavior and personality disorders.

Biography

Early life

Hildegard was born in Reading, Pennsylvania to immigrant parents of German descent, Gustav and OtylliePeplau. She was the second daughter born of six children. Gustav was an illiterate, hard-working father and Otyllie was an oppressive, perfectionist mother. Though higher education was never discussed at home, Hilda was strong-willed, with motivation and vision to grow beyond traditional women's roles. She wanted more out of life, and knew nursing was one of few career choices for women in her day. As a child, she was watcher of people's behaviours. She witnessed the devastating flu epidemic of 1918, a personal experience that greatly influenced her understanding of the impact of illness and death on families. She witnessed people jumping from windows in delirium caused by the flu.

In the early 1900s, the autonomous, nursing-controlled, Nightingale era schools came to an end – schools became controlled by hospitals, and formal "book learning" was discouraged. Hospitals and physicians saw women in nursing as a source of free or inexpensive labor. Exploitation was not uncommon by a nurse's employers, physicians, and educational providers.

Career

Peplau began her career in nursing in 1931 as a graduate of the Pottstown Hospital School of Nursing in Pottstown, Pennsylvania. She then worked as a staff nurse in Pennsylvania and New York City. A summer position as nurse for the New York University summer camp led to a recommendation for Peplau to become the school nurse at Bennington College in Vermont. There she earned a bachelor's degree in interpersonal psychology in 1943. At Bennington, and through field experiences at Chestnut Lodge, a private psychiatric facility, she studied psychological issues with Erich Fromm, Frieda Fromm-Reichmann, and Harry Stack Sullivan. Peplau's lifelong work was largely focused on extending Sullivan's interpersonal theory for use in nursing practice.

From 1943 to 1945, she served in the Army Nurse Corps, and was assigned to the 312th Field Station Hospital in England, where the American School of Military Psychiatry was located. Here she met and worked with leading figures in British and American psychiatry. After the war, Peplau was at the table with many of these same men as they worked to reshape the mental health system in the United States through the passage of the National Mental Health Act o 1946.

Peplau held master's and doctoral degrees from Teachers College, Columbia University. She was also certified in psychoanalysis by the William Alanson White Institute of New York City. In the early 1950s, Peplau developed and taught the first classes for graduate psychiatric nursing students at Teachers College. Dr. Peplau was a member of the faculty of the College of Nursing at Rutgers University from 1954 to

1974. At Rutgers, Peplau created the first graduate level program for the preparation of clinical specialists in psychiatric nursing.

She was a prolific writer, and was well known for her presentations, speeches, and clinical training workshops. Peplau was a tireless advocate for advanced education for psychiatric nurses. She thought that nurses should provide truly therapeutic care to patients, rather than the custodial care that was prevalent in the mental hospitals of that era. During the 1950s and 1960s, she conducted summer workshops for nurses throughout the United States, mostly in state psychiatric hospitals. In these seminars, she taught interpersonal concepts and interviewing techniques, as well as individual, family, and group therapy.

Peplau was an advisor to the World Health Organization, and was a visiting professor at universities in Africa, Latin America, Belgium, and throughout the United States. A strong advocate for research in nursing, she served as a consultant to the U.S. Surgeon General, the U.S. Air Force, and the National Institute of Mental Health. She participated in many government policy-making groups. She served as president of the American Nurses Association from 1970 to 1972, and as second vice president from 1972 to 1974. After her retirement from Rutgers, she served as a visiting professor at the University of Leuven in Belgium in 1975 and 1976.

Personal life

Peplau was attractive and liked to go on many dates, though generally she was careful, due in part to the severe social

stigma at the time regarding pregnancy out of wedlock. In 1944Peplau met an American army psychiatrist who was also briefly stationed at the 312th Field Hospital in England. With the psychiatrist somewhat perturbed by post combat stress, and Peplau herself unsettled by the unexpected death of her mother shortly after the couple met, their relationship got out of hand, leading to a pregnancy. As the psychiatrist was married, Peplau went on to raise their daughter as a single mother. She rarely talked about the father to others, though she spoke highly of him shortly before her death. Letitia Anne Peplau was born in 1945 - she would later grow up to be a psychology professor at UCLA, and an influential contributor to the scientific literature. After Letitia's birth, Peplau had no more serious romances, dedicating her energies to her daughter and to her career.

In 1999, Peplau died peacefully in her sleep at her home in Sherman Oaks, California.

Theoretical work

In her interpersonal relationship theory, Dr. Peplau emphasized the nurse-client *relationship*, holding that this relationship was the foundation of nursing practice. Her book, *Interpersonal Relations in Nursing*, was completed in 1948. Publication took four additional years, mainly because Peplau had authored a scholarly work without a coauthoring physician, which was unheard of for a nurse in the 1950s. At the time, her research and emphasis on the give-and-take of nurse-client relationships was seen by many as revolutionary. The essence of Peplau's theory was creation of a *shared experience* between nurse and client, as opposed to the client

passively receiving treatment (and the nurse passively acting out doctor's orders). Nurses, she thought, could facilitate this through observation, description, formulation, interpretation, validation, and intervention. For example, as the nurse listens to her client she develops a general impression of the client's situation. The nurse then validates her inferences by checking with the client for accuracy. The result may be experiential learning, improved coping strategies and personal growth for both parties.

Peplau's model

Peplau's Six Nursing Roles

Peplau describes the six nursing roles that lead into the different phases:

- **Stranger role**: Peplau states that when the nurse and patient first meet, they are strangers to one another. Therefore, the patient should be treated with respect and courtesy, as anybody would expect to be treated. The nurse should not prejudge the patient or make assumptions about the patient, but take the patient as he or she is. The nurse should treat the patient as emotionally stable unless evidence states otherwise.
- **Resource role**: The nurse provides answers to questions primarily on health information. The resource person is also in charge of relaying information to the patient about the treatment plan. Usually the questions arise from larger problems,

therefore the nurse would determine what type of response is appropriate for constructive learning. The nurse should provide straightforward answers when providing information on counseling.

- **Teaching role**: The teaching role is a role that is a combination of all roles. Peplau determined that there are two categories that the teaching role consists of: Instructional and experimental. The instructional consists of giving a wide variety of information that is given to the patients and experimental is using the experience of the learner as a starting point to later form products of learning which the patient makes about their experiences.
- **Counseling role**: Peplau believes that counselling has the biggest emphasis in psychiatric nursing. The counselor role helps the patient understand and remember what is going on and what is happening to them in current life situations. Also, to provide guidance and encouragement to make changes.
- **Surrogate role**: The patient is responsible for putting the nurse in the surrogate role. The nurse's behaviors and attitudes create a feeling tone for the patient that trigger feelings that were generated in a previous relationship. The nurse helps the patient recognize the similarities and differences between the nurse and the past relationship.
- **Leadership role**: Helps the patient assume maximum responsibility for meeting treatment goals in a mutually satisfying way. The nurse helps the patient meet these goals through cooperation and active participation with the nurse.

Peplau's Developmental Stages of the Nurse-Client Relationship

Orientation Phase

The orientation phase is initiated by the nurse. This is the phase during which the nurse and the patient become acquainted, and set the tone for their relationship, which will ultimately be patient centered. During this stage, it is important that a professional relationship is established, as opposed to a social relationship. This includes clarifying that the patient is the center of the relationship, and that all interactions are, and will be centered around helping the patient.

This phase is usually progressed through during a highly impressionable phase in the nurse-client relationship, because the orientation phase occurs shortly after admission to a hospital, when the client is becoming accustomed to a new environment and new people. The nurse begins to know the patient as a unique individual, and the patient should sense that the nurse is genuinely interested in them. Trust begins to develop, and the client begins to understand their role, the nurse's role, and the parameters and boundaries of their relationship.

Identification Phase

The client begins to identify problems to be worked on within relationship. The goal of the nurse is to help the patient to recognize his/her own interdependent/participation role and promote responsibility for self.

Exploitation Phase / Working Phase

During the Working Phase, the nurse and the patient work to achieve the patient's full potential, and meet their goals for the relationship.

A sign that the transition from the orientation phase to the working phase has been made, is if the patient can approach the nurse as a resource, instead of feeling a social obligation to the nurse (Peplau, 1997). The client fully trusts the nurse, and makes full use of the nurse's services and professional abilities. The nurse and the patient work towards discharge and termination goal.

Resolution Phase/Termination Phase

The termination phase of the nurse client relationship occurs after the current goals for the client have been met. The nurse and the client summarize and end their relationship. One of the key aspects of a nurse-client relationship, as opposed to a social relationship, is that it is temporary, and often of short duration (Peplau, 1997).

In a more long term relationship, termination can commonly occur when a patient is discharged from a hospital setting, or a patient dies. In more short term relationships, such as a clinic visit, an emergency room visit, or a health bus vaccination visit, the termination occurs when the patient leaves, and the relationship is usually less complex. However, in most situations, the relationship should terminate once the client has established increased self-reliance to deal with their own problems.

Imogene King

Imogene King (January 30, 1923 – December 24, 2007) was a pioneer of nursing theory development. Her interacting systems theory of nursing and her theory of goal attainment have been included in every major nursing theory text. These theories are taught to thousands of nursing students, form the basis of nursing education programs, and are implemented in a variety of service settings.

Education

King's educational achievements began with a nursing diploma in 1945. She attended St. Louis University, earning a Bachelor of Science in Nursing in 1948 and a Master of Science in Nursing in 1957. She subsequently earned a Doctor of Education from Teachers College, Columbia University.

Academic appointments

King was on the faculty at Loyola University from 1961-1966 and 1972-1980. She directed the nursing program at Ohio State University between 1968 and 1972. She taught at University of South Florida from 1980 to 1990.

Awards and honors

- 2004: Hall of Fame Inductee, American Nurses Association
- 2005: Living Legend, American Academy of Nursing

Isabel Hampton Robb

- **Isabel Adams Hampton Robb** (1860–1910) was an American nurse theorist, author, nursing school administrator and early leader. Hampton was the first Superintendent of Nurses at the Johns Hopkins School of Nursing, wrote several influential textbooks, and helped to found the organizations that became known as the National League for Nursing, the International Council of Nurses, and the American Nurses Association. Hampton also played a large role in advancing the social status of nursing through her work in developing a curriculum of more advanced training during her time at the Johns Hopkins School of Nursing.

Early life and career (1859-1889)

Isabel Hampton was born in Welland, Ontario, on August 26, 1859. At 17, she became a public school teacher in Merritton, Ontario. She attended a collegiate institution after high school, but a significant part of her early education was attained through independent study. Hampton enrolled in the Bellevue Hospital Training School for Nurses in 1881 and graduated in 1883. After graduation, she briefly worked as a nurse in New York and later went to work in Rome at St. Paul's House. Here, she worked for a hospital that served American and European travelers.

Upon returning the United States, she worked as a private duty nurse for the Conover family in New Jersey. In 1886, Hampton

went to Chicago and assumed the role of superintendent of Illinois Training School for Nurses at the Cook County Hospital. During her time in Chicago, she implemented reforms, many of which are still followed today. One of her most notable contributions to the system of nursing education was the implementation of a grading policy for nursing students. Students would need to prove their competency in order to receive qualifications. Before Hampton's reforms, nursing had been largely taken up by lower-class women who were unable to hold other jobs.

Career at Johns Hopkins (1889-1894)

Early impact on Hopkins Nursing

In 1889, Hampton was appointed the superintendent of nurses and principal of the training school at the new Johns Hopkins School of Nursing. Hampton's strong leadership and educational background was immediately recognized by the chairman of the Johns Hopkins Hospital, William Osler, after he said the following during the interviewing process: "Miss Isabel Hampton entered the room looking like an animated Greek statue...we knew that all was settled...Her certificates were looked at...and all was settled in a few minutes." She continued to suggest reforms, participate in teaching, and publish textbooks. Right from the beginning, Hampton extended the nursing program's length from 2 to 3 years, while also establishing eight-hour workdays for nurses. She also

eliminated stipends, began a Nurses' Alumnae Association, and created a Nurses' Journal Club.

Nursing: Its Principles and Practice

It was during her time at Hopkins that Hampton wrote the famous *Nursing: Its Principles and Practice*. The textbook was published in 1893 and, as a review of the second edition of the textbook that appeared in the Journal of the American Medical Association stated, the textbook "stands without a competitor." This text was not only unique, but critical to a better understanding of nursing as a whole because it included in-depth analyses of topics including: an outline for a 3-year long nursing curriculum, economics of hospital wards, proper hygiene protocol in hospitals, and protocol for bacteriological notes and proper bed making. Such comprehensive detail in one foundational text brought about a sense of structure in nursing and demonstrated its crucial role in the hospital environment. As Hampton said, herself: "This arrangement at the same time will relieve the nurses of much of the domestic side of their work and thus enable them to devote more time to actual nursing, with the result that the patients will receive better care."

Her book is known for "standardizing the education for nursing in the United States and abroad."

Further impact on the nursing field

In 1893 at the World's Fair in Chicago, Hampton organized the nurses section of the International Congress of Charities, Correction and Philanthropy. This laid the foundation for

Hampton and Lavinia Dock to found the American Society of Superintendents of Training Schools for Nurses of the United States and Canada, a precursor to the current National League for Nursing Education. Hampton later served as the president of this organization.

Hampton stated that she had shown so much interest in Johns Hopkins because the institution "would be the first in this country to have a primary interest in education, research, and health care."

Later life and career (1894-1910)

In 1894, Hampton left Johns Hopkins to marry Dr. Hunter Robb, who was an obstetrician/gynecologist at Johns Hopkins. Hampton and Robb moved to Ohio, where Robb had a new position as professor of gynecology at Case Western Reserve University. Hampton and her husband had two children, in 1895 and 1902.

In 1896, Hampton became the first president of the American of the Nurses' Associated Alumnae of the United States and Canada, which has since become the American Nurses Association. Hampton also played roles in both establishing the American Journal of Nurses and a course on Hospital Economics at the Teachers College, Columbia University in 1899. Hampton, M. Adelaide Nutting, and Lavinia Dock were among the first professors for this course. They offered their services pro bono.

She was a key figure in the development for curriculum for the Lakeside Hospital Training School for Nurses, the nucleus for

Case Western's future School of Nursing, as a member of the Lady Board of Governors. Lakeside's program became one of the first schools to implement the teachings of Florence Nightingale.

Hampton was an active member of the Matrons Council, a small international group of nurses concerned with professional development. A committee to establish the International Council of Nurses was created in 1899. Hampton served as an American representative.

Hampton also authored *Nursing Ethics* in 1900 and *Educational Standards for Nurses* in 1907. In a 1901 review of *Nursing Ethics*, the *Baltimore American* said, "This text-book differs from any other on the market at the present time, in that it deals simply with the principles and practice of nursing, and omits the usual smattering of teaching on a great variety of subjects. The author books, each dealing with a single subject, such as anatomy, physiology, materiamedica, massage, bandaging and invalid cookery, particularly insists that for thorough training in nursing it is necessary that each nurse should be supplied with various additional which are quite distinct from, although supplementary to, the principles of nursing."

Death

Hampton died on Friday, April 15, 1910 while walking on Euclid Avenue in Cleveland. She was on the way to her son's dance class with a friend. She stepped between two streetcar tracks to avoid being hit by a rapidly approaching automobile. Two streetcars passed on the tracks on either side of her and

she was instantly killed. She is buried in St. Mary's Cemetery of Burlington, New Jersey.

Awards and legacy

In 1976, Hampton was posthumously inducted to the American Nurses Association Hall of Fame.

The following awards and funds carry on Isabel Hampton's legacy by promoting leadership, perseverance, and innovation in the nursing field. They are among the most prestigious nursing commendations one can receive today.

- **Isabel Robb Memorial Fund** - supports the Graduate Nurses' Association and nursing school scholarships
- **Isabel Hampton Robb Leadership Award** - presented to a Student Nurses' Association state president whose leadership characteristics best resemble those of Isabel Hampton Robb
- **The NLN Isabel Hampton Robb Award for Outstanding Leadership in Clinical Practice** - awarded to he/she who best reflects the ideals of Isabel Hampton Robb in the clinical setting

Works

- *Hampton, Isabel Adams (1894). Nursing: Its Principles and Practice for Hospital and Private Use. W.B. Saunders.*
- *Robb, Isabel Hampton (1900). Nursing Ethics. Cleveland: E.C. Koeckert. isabelhampton.*

- *Robb, Isabel Hampton (1907). Educational Standards for Nurses. Cleveland: E.C. Koeckert.*

Kari Martinsen

Kari Martinsen (born 1943) is a Norwegiannurse and academic, whose work focuses on nursing theory. After competing nursing training and working as a psychiatric nurse, she returned to school to earn a bachelor's, master's and PhD degree. Developing ideas about the philosophy involved in taking care of other people, she moved away from practicing nursing and turned toward academia. She taught at various universities in Norway and Denmark and was recognized as a Knight 1st Class of the Order of St. Olav for nursing by the Norwegian crown in 2011.

Early life

Kari Marie Martinsen was born in Oslo, Norway in 1943. The older of two sisters, she grew up in a home composed of her parents, who were both economists and had formerly been part of the Norwegian resistance movement during World War II, her sister and her grandmother. After completion of her high schooling, Martinsen enrolled in Ullevål College of Nursing and graduated in 1964.

Career

Upon her graduation, Martinsen completed a clinical practice at Ullevål University Hospital through 1965 and then worked

as a psychiatric nurse at Dikemark Psychiatric Hospital for two years. During her work, she began to question the policy of objectifying patients by focusing on the technology of care and disease, rather than the patient. The idea led her to further her education, enrolling in psychology at the University of Oslo, from where she obtained a bachelor's degree in 1968. Going on to further her education, Martinsen enrolled at the University of Bergen (UB) to study philosophy and phenomenology. She completed her Master of Arts degree in 1974 with her thesis, *Philosophy and Nursing: A Marxist and Phenomenological Contribution* (1975), which was the first critical analysis in Norway evaluating the profession from a philosophical and social perspective.

From 1976 to 1977, Martinsen served as dean of the Nursing Teacher's Training faculty, which had been established as a joint venture by county authorities, three nursing colleges and the University of Bergen. At the time in Norway, debate was on-going over the educational requirements for nurses. Martinsen favored a four-year program, attained through a 2-year care assistant certification, followed by another two years of study to attain a nursing degree. Her stance that the social aspects of care were equal to the technical aspects, were viewed as provocative and she was asked to withdraw from the Norwegian Nursing Association (NSF). In 1978, Martinsen took a position at the University of Oslo in the history department as a lecturer on socio-political history and worked to develop the social history of nursing in Norway under a grant she had received from the General Science Research Council.

Martinsen returned to the University of Bergen in 1981 as a scientific assistant in the history department, lecturing on

feminist history. Her research focus from 1976 to 1986 evaluated the social history of women and caring, evaluating when the shift from care of the sick shifted from "women's work" and charitable activities to professionally trained nurses. She completed her PhD in philosophy from UB in 1984 with her work *History of Nursing: Frank and Engaged Deaconesses: A Caring Profession Emerges 1860–1905*. Promoted to associate professor in 1986, Martinson lectured in the Department of Health and Social Medicine at UB. *Caring Nursing and Medicine: Historical-Philosophical Essays* (1989) marked a turn in her research to a philosophical phase and evaluated the impact of Martin Heidegger's theories on the development of a concept of caring. In her philosophical studies, Martinsen makes a distinction between the activities of observing and classifying and perception, or the way one emotionally reacts to the patient.

The following year, Martinsen moved to Denmark to develop master's degree and PhD programs in nursing at Aarhus University. Soon after she arrived, Heidegger's ties to Nazism became public knowledge and Martinsen reevaluated her previous work based on his philosophy. In *From Marx to Løgstrup: On Morality, Social Criticism and Sensuousness in Nursing* (1993), she confronted the issues with Heidegger and introduced the philosophy of KnudEjlerLøgstrup, as it related to a discussion of care. While in Aarhus, she simultaneously worked as an adjunct professor at the University ofTromsø (UT) from 1994 to 1997. She moved to Tromsø in 1997 when she was offered a full professorship at UT, but remained only one year. Between 1998 and 2002, Martinsen worked as a free-lance researcher and lecturer before returning to the University of Bergen as a full professor of nursing science. In

2007, she accepted a full professorship at Harstad University College in Troms County northern Norway.

Martinsen's work has been influential in developing a concept of care in nursing in Nordic countries and has been used as a comparison point for nursing ethics in Anglo-American thought and practice. In 2011, Martinsenwas recognized as a Knight 1st Class of the Order of St. Olav for nursing by the Norwegian crown.

Selected works

- *Martinsen, Kari (1989). Omsorg, sykepleieogmedisin: historisk-filosofiske essays (in Norwegian). Oslo, Norway: TanoAschehoug. ISBN 978-8-251-82654-9.*, later editions 1991, 2003
- *"Omsorgogmakt, ordogkroppisykepleien" [Care and power, words and body in nursing]. Sykepleien (in Norwegian). Oslo, Norway: Norske Sykepleierforbund.* ***2****: 2–11, 29. 1991. ISSN 0039-7628.*
- *Martinsen, Kari (1993). Den Omtenksommesykepleier (in Norwegian). Oslo, Norway: TanoAschehoug. ISBN 978-8-251-83096-6.*
- *Martinsen, Kari (1993). Fra Marx tilLøgstrup: ometikogsanselighedisygeplejen (in Danish). Copenhagen, Denmark: MunksgaardDanmark. ISBN 978-8-762-80043-4.*, later editions 1997, 1998, 2000, 2002, 2005, 2006, 2010
- *Martinsen, Kari (1996). Fenomenologiogomsorg: tredialoger (in Norwegian). Oslo, Norway: TanoAschehoug. ISBN 978-8-251-83309-7.*, later edition 2003

Katharine Kolcaba

Katharine Kolcaba (born December 28, 1944 in Cleveland, Ohio) is an American nursingtheorist and nursing professor. Dr. Kolcaba is responsible for the Theory of Comfort, a broad-scope mid-range nursing theory commonly implemented throughout the nursing field up to the institutional level.

Education

Kolcaba earned a nursing diploma from St. Luke's Hospital School of Nursing in 1965. Kolcaba completed graduate work at Case Western Reserve University, earning a Master of Science in Nursing in 1987 and a PhD with a specialization in Gerontology in 1997.

Career

Kolcaba's career includes nursing practice in the operating room, medical/surgical nursing, home health, and long-term care. Kolcaba is an Associate Professor Emeritus at University of Akron and holds an adjunct position at Ursuline College.

Awards and honors

2007: Distinguished Alumni Award, The Cleveland General and St. Luke's Nurses' Alumni Association 1994–Present: Who's Who in American Nursing

Nursing Theory of Comfort

During Kolcaba's graduate studies at Case Western Reserve University she became interested in comfort as a theoretical construct while concurrently working as a head nurse on a unit for dementia patients. While the concept of comfort is as old as the nursing profession, Kolcaba's theory allowed for objective measurement of comfort and defined features central to the concept of comfort. The Theory of Comfort considers the concepts of relief, ease and transcendence across four dimensions - physical, psychospiritual, sociocultural and environmental. The juxtaposition of the three levels of comfort and four contexts of comfort is referred to as the “Taxonomic Structure of Comfort”. Using the taxonomic structure as a tool allows researchers to easily apply the theory in their specialty to operationalize the idea of comfort and apply it to experimental research rather than a reliance on observational research.

Scope of Theory

The Comfort Theory (CT) is a broad-scope middle range theory because it contains concepts and relationships, is adaptable to a wide range of practice settings and experiences, can be built from many sources and it can be tested and measured. It also qualifies as a middle range theory because of its direct applicability to nursing practice. It is broad in the sense that it also considers nursing practice holistically, however the concepts of the theory can be used separately or in combination with each other in nursing practice settings.

White Paper

"Integration of Insights about the Human Perception of Comfort," for Magna Corporation, a leader in specialized automotive seating, January 2018. Recruited by Idea Connection.

Books and Chapters in Books

- Kolcaba, K. (2004, 2008, 2010, 2013, 2017). "Comfort." Chapter in *Middle Range Theories: Application to Nursing Research* (&Bredow, Eds). Phila, PA: Lippincott Williams & Wilkins.
- Kolcaba, K. (2010, 2012 & 2015) Katharine Kolcaba's Comfort Theory. In M. Parker & M. Smith (Eds.). Nursing Theories & Nursing Practice. (3rd edition, P. 389-401).
- Kolcaba, K. (2010, 2012. 2015.) Impaired Comfort. In B. Ackley & G. Ladwig (Eds.). Nursing Diagnosis Handbook: An evidence-based guide to planning care. (9th edition, P. 222-225), (10th edition, P. 210-213).
- Schuiling, K., Sampselle, C., &Kolcaba, K. (2011) Using comfort theory as a framework for research on childbirth. In R. Bryar& S. Sinclair , (2011) Theory for midwifery practice (2nd ed.). UK: Macmillan.
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- Kolcaba, K. &Kolcaba, R. (2010). Integrative Theorizing: Linking Middle-Range Nursing Theories

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- Mitzel, A., &Kolcaba, K. (2008). Two chapters: Hand Massage; Simple Massage. In Ackley, Ladwig, Swan & Tucker (Eds.), A clinical guide to evidence-based practice in nursing (402-407; 504-508). Philadelphia: Elsevier.
- Dowd, T. (2001 & 2005). Chapter 24: Katharine Kolcaba: Comfort Theory. In Nursing theorists and their work (Alliggod&Tomey, eds, 56h Ed., pp. 430–442). St. Louis, MI: Mosby.
- Kolcaba, K. (2003 and 2007). The theory of comfort [Peterson S. &Bredow, T., Eds.] Middle range theories: Application to nursing research. Philadelphia: Lippincott, Williams, & Wilkins. Pgs. 254-272.
- Kolcaba, K. (2003). *Comfort theory and practice: A vision for holistic health care and research.* Springer Publishing Co.
- Kolcaba, K. (2001). Sub-Chapter entitled "Kolcaba's Theory of Comfort" in Core concepts for advanced nursing practice (pp. 418–422). St. Louis: Mosby.
- Kolcaba, K. (2001). Chapter 5: Holistic care: Is it feasible in today's health care environment? In H. Feldman (Ed.), Nursing leaders speak out (pp. 49–54) and formula for the outside. NY: Springer.

Significant Citations

D. Robinson, & C. Kish (2001). Core concepts in advanced practice nursing, Section VI, Theoretical foundations: Kolcaba's theory of comfort (pp. 418–422).

B. Kozier, G. Erb, A. Berman, & K. Burke (2000). Fundamentals of nursing: Concepts process, and practice (6th Ed.). Chapter 25: Caring, comforting, and communicating (pp. 430–431). New York: Prentice Hall.

Phillips, L., & Ayres, M. (1999). Supportive and nonsupportive care environments for the elderly. In. A. Hinshaw, S. Feetham, & J. Shaver (Eds.), Handbook of Clinical Nursing (pp. 600–603). Newbury Park, CA:Sage.

Kolcaba's Theory of Comfort

Kolcaba's theory of comfort explains comfort as a fundamental need of all human beings for relief, ease, or transcendence arising from health care situations that are stressful. Comfort can enhance health-seeking behaviors for patients, family members, and nurses. The major concept within Katharine Kolcaba's theory is the comfort. The other related concepts include caring, comfort measures, holistic care, health seeking behaviors, institutional integrity, and intervening variables.

Kolcaba's theory successfully addresses the four elements of nursing metaparadigm. Providing comfort in physical, psychospiritual, social, and environmental aspects in order to reduce harmful tension is a conceptual assertion of this

theory. When nursing interventions are effective, the outcome of enhanced comfort is attained. This theory was derived from Watson's theory of human care and her own practice. Kolcaba was a head nurse asked to define her job as a nurse outside of specialized responsibilities.

She realized the lack of written knowledge on the subject of comfort being important in patient care. The first publication was in 1994, then expanded in an article in 2001, and further developed in a book written in 2003.

Kolcaba's theory became so popular that it was tested in multiple studies such as: women with early stage breast cancer going through radiation therapy conducted by Kolcaba and Fox in 1999, persons with urinary frequency and incontinence conducted by Dowd, Kolcaba, and Steiner in 2000, and persons near end of life conducted by Novak, Kolcaba, Steiner, and Dowd in 2001.

Madeleine Leininger

Madeleine Leininger (July 13, 1925 – August 10, 2012) was a nursing theorist, nursing professor and developer of the concept of transcultural nursing. First published in 1961, her contributions to nursing theory involve the discussion of what it is to care.

Biography

Leininger was born on 13 July 1925. She earned a nursing diploma from St. Anthony's Hospital School of Nursing,

followed by undergraduate degrees at Benedictine College and Creighton University. She received a Master of Science in Nursing at Catholic University of America. She later studied cultural and social anthropology at the University of Washington, earning a PhD in 1966. Leininger held at least three honorary doctoral degrees.

Dr. Leininger held faculty positions at the University of Cincinnati and the University of Colorado, followed by service as a nursing school dean at both the University of Washington and the University of Utah.

She was Professor Emeritus of Nursing at Wayne State University and an adjunct faculty member at the University of Nebraska Medical Center in Omaha. Leininger died at her home in Omaha, Nebraska on 10 August 2012.

Honors and awards

- 1998: Living Legend, American Academy of Nursing
- 1998: Distinguished Fellow, Royal College of Nursing (Australia)

Cultural care theory

The cultural care theory aims to provide culturally congruent nursing care through "cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with individual's, group's, or institution's cultural values, beliefs, and lifeways" (Leininger, M. M. (1995). Transcultural nursing: Concepts, theories, research & practices. New York: McGraw Hill, Inc.5, p. 75) This care is

intended to fit with or have beneficial meaning and health outcomes for people of different or similar cultural backgrounds.

Components of culturalogical assessment

- communication and language
- gender considerations
- sexual orientation
- ability/disability
- occupation
- age
- socioeconomic status
- interpersonal relationships
- appearance
- dress
- use of space
- foods
- meal preparation and related life ways

Leininger proposes that there are three modes for guiding nursing care judgements, decisions, or actions to provide appropriate, beneficial, and meaningful care:

(a) preservation and/or maintenance

(b) accommodation and/or negotiation

(c) re-patterning and/or restructuring

"These modes have substantively influenced nurses' ability to provide culturally congruent nursing care and have fostered the development of culturally-competent nurses."

Theoretical assumptions and orientational definitions

- Care is the essence of nursing and a distinct, dominant, and unifying focus.
- Care (caring) is essential for well being, health, healing, growth survival, and to face handicaps or death.
- Culture care is the broadest holistic means to know, explain, interpret, and predict nursing care phenomena to guide nursing care practices.
- Nursing is a transcultural, humanistic, and scientific care discipline and profession with the central purpose to serve human beings worldwide.
- Care (caring) is essential to curing and healing, for there can be no curing without caring.
- Culture care concepts, meanings, expressions, patterns, processes, and structural forms of care are different (diversity) and similar (towards commonalities or universalities) among all cultures of the world.
- Every human culture has lay (generic, folk, or indigenous) care knowledge and practices and usually some professional care knowledge and practices which vary transculturally.
- Cultural care values, beliefs, and practices are influenced by and tend to be embedded in worldview, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethnohistorical, and environmental context of a particular culture.
- Beneficial, healthy, and satisfying culturally based nursing care contributes to the well being of

individuals, families, groups, and communities within their environmental context.

- Culturally congruent or beneficial nursing care can only occur when the individual, group, community, or culture care values, expressions, or patterns are known and used appropriately and in meaningful ways by the nurse with the people.
- Culture care differences and similarities between professional caregiver(s) and client (generic) care-receiver(s) exist in any human culture worldwide.
- Clients who experience nursing care that fails to be reasonably congruent with their beliefs, values, and caring lifeways will show signs of cultural conflicts, noncompliance, stresses and ethical or moral concerns.
- The qualitative paradigm provides new ways of knowing and different ways to discover the epistemic and ontological dimensions of human care transculturally. (Leininger, M. M. (1991). The theory of culture care diversity and universality. New York: National League for Nursing., pp. 44–45)

Leininger focused on two types of knowledge that were present in every culture.

- Emic Knowledge was the folk, lay or generic knowledge that was present in a culture

- Etic Knowledge was the professional or medical knowledge present within the culture and from the outsider perspective

These two types of knowledge intertwined to determine how culture was viewed within the indigenous society and how outside providers would react to it. It was imperative to Leininger that nurses understand specifically the Emic knowledge to have a better understanding of what could be done to tailor nursing care to be more culturally appropriate.

"Leininger defined nursing as a learned scientific and humanistic profession and discipline focused on human care phenomena and caring activities in order to assist, support, facilitate or enable individuals or groups to maintain or regain their health or well-being in culturally meaningful and beneficial ways, or to help individuals face handicaps or death." (Leininger, M. M., & McFarland, M. R. (2002). Transcultural nursing:Concepts, theories, research & practice. New York: McGraw Hill., p. 46)

Leininger provides a visual aid to her theory with the Sunrise Model.

Transcultural Nursing

While Leininger initially started with the creation of the cultural care theory she would later build the theory into a nursing specialty called Transcultural Nursing. In Leininger's own words Transcultural nursing is:

"a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs and practices of individuals or groups of similar or different cultures. Transcultural nursing's goal is to provide culture specific and universal nursing care practices for the health and well-being of

people or to help them face unfavorable human conditions, illness or death in culturally meaningful ways."

Combining her nursing experience with the doctorate in Anthropology she had received, Leininger wanted to have nursing look at patients with a cultural perspective, utilizing the indigenous perspective from the patient's own culture and how the outside world would perceive them.

Empowered Holistic Nursing Education

Empowered Holistic Nursing Education - Mid-range Nursing Theory

The Empowered Holistic Nursing Education (EHNE) nursing theory is a middle range nursing theory that was developed between 2008 and 2014 by Dr. Katie Love. It is particularly used In undergraduate level nursing education, where students are first being socialized into nursing professional practice

Central philosophy

The nursing theory is based upon the philosophy that students need to experience holism and empowerment in the classroom to not only have a positive learning experience, but to integrate holism and empowerment in their own professional practice. Examination of power structures and cultural perspectives is supportive of diverse student populations, and therefore diverse patient populations.

EHNE principles

EHNE principles are the basis of the theory as Love identified. They are described as:

Prior knowledge: Knowledge and experience the student brings is the foundation from where learning begins.

Meet them where they are: Making teaching responsive to the diverse learning needs of students, and where the teacher learns from the student.

Interconnectedness: Experiencing our connection to one another, being present, and growing together. *Self-Care*: Nurturing ourselves so we may nurture others.

Contextual Teaching and Learning: Addressing the environmental factors that influence readiness to learn, such as mind-body-spirit imbalance, values and beliefs, with culturally appropriate education and holism.

Support modalities

Nurse educators are encouraged to integrate 1) complementary and alternative modalities (CAM) into their classrooms and 2) Praxis: Reflection and Action:

1) All CAM can be used to start class, before/after exams, or as a whole class to experience directly. These modalities have been used in nursing classrooms for this purpose:

- Guided imagery
- Meditation

- Progressive muscle relaxation
- Tapping
- Aromatherapy
- Drumming
- Belly dancing
- Yoga
- Breathing

2) Reflection of personal bias, world view, experiences, and values is done as a part of experiential learning experiences. Supporting students from diverse backgrounds such as race, class, religion, and the LGBT community leads to the diversification of the profession and socializes nursing students how to support diverse patient populations.

Marie Manthey

Education

Manthey received a diploma in nursing from St. Elizabeth Hospital in Chicago, Illinois in 1956. After passing the Illinois State Boards, she joined the University of Chicago Medical Center as a staff nurse, and then became an assistant head nurse and then head nurse on a twenty-bed surgical floor there.

She received her Bachelor of Science in Nursing Administration in 1962 and her Master of Science, Nursing Administration in 1964, both from the University of MinnesotaSchool of Nursing in Minneapolis. Mantheywas awarded an honorary doctorate from the University of Minnesota in 1999.

Primary Nursing

Primary Nursing emphasizes continuity of care and acceptance of responsibility for care over a period of time by the patient's Primary Nurse - usually a registered nurse (RN). The care team consists of the Primary Nurse and additional staff - a licensed practical nurse (LPN) and/or nursing assistant (NA) - and together they provide complete care for a group of patients within a hospital unit or department.

While serving as Assistant Director of Nursing at the University of Minnesota Hospital, Manthey was head of a team of nurses that implemented Primary Nursing in 1968-1969 on Unit 32, an acute medical care ward. Mantheywas later named Associate Director of Nursing at the University of Minnesota.

In 1968 Primary Nursing evolved from the work of a team of direct care providers on Unit 32 at the University of Minnesota Medical Center who were experiencing extreme frustration with their chaotic work environment. The result was a nursing delivery system that was "too fragmented and diffuse -- one in which 'everybody's responsible for everything and nobody's responsible for anything'."

At the time, it was quite revolutionary to allow the nurse providing care for the patient to determine the amount and type of nursing care the patient would receive. Nurses had been expected to follow policies and orders rather than making decisions based on their own professional judgment. Nurses providing direct care also did not generally communicate with physicians. Instead, patient information was communicated by the unit manager or nurse in charge. These individuals served

as a go between, transmitting patient information/messages and orders between the nurses providing patient care and the patient's physician.

"The change to primary nursing eliminated one level of nursing supervision, the traditional team leader, and flattened the well-worn hierarchical structure. Each registered nurse on Station 32 assumed 24-hour responsibility and accountability to plan nursing care for a small group of patients.

The results were positive, totally unplanned and nearly palpable. The staff nurse instantly earned, and claimed, the power to make nursing decisions. Almost overnight, communication changed to a direct, person-to-person pattern; physicians discussed patients with the nurse caregiver, not the head or charge nurse."

The Primary Nursing model, which emphasizes 'relationship-based care' is based on 'one nurse taking responsibility for one small group of patients, delivering individualized care for the duration of the stay.' "The essence ..is that primary nursing is really a generic term that simply means one nurse accepting responsibility for managing the care of a small number of patients. Who delivers the care, what the ratio mix is, what the skill level is, what the staffing level is, what the care plans look like, none of those things make a difference. What makes a difference is whether the nurse accepts responsibility for managing the care of the patients."

At the core of Primary Nursing is an empowered staff led by empowering leaders. "It [Primary Nursing] not only put a relationship focus on the nurses' role, it also had the effect of decentralizing power and empowering the individual at the

bedside... Nurse managers and directors and vice presidents had to really make a considerable shift in their job focus -- from control to development."

The principles of Primary Nursing were later expanded to include people in all health care disciplines and departments, and clinicians seeing themselves as the "primary" caregiver or service provider to each patient and family became the core of the Relationship-Based Care Model of care delivery (Koloroutis, 2004). Marie Manthey's leadership has allowed the work started by the nurses on Unit 32 at the University of Minnesota Medical Center to be expanded and shared worldwide.

Later career

After leaving the University of Minnesota, Manthey became Assistant Administrator and Director of Nursing at Miller Hospital as it merged with St. Lukes to become United Hospitals of Saint Paul, Minnesota.

Manthey moved to New Haven, Connecticut in January 1976, and served as the Vice President of Patient Services at Yale New Haven Hospital. During that time in Connecticut she also served as associate professor at the University of Connecticut and associate clinical professor at Yale School of Nursing.

In 1978, she founded a consulting firm specializing in the organization and delivery of health care services. Originally named Creative Nursing Management, now known as Creative HealthCare Management since 2002, headquartered in Eden Prairie, Minnesota, USA.

Manthey provided technical guidance to the U.S. Department of Health and Human Services for their study of Primary Nursing, published in 1983.

Manthey has also remained active with the University of Minnesota School of Nursing, including serving as the President of the Nursing Alumni Society from 1999 to 2003.

Throughout her career, Manthey has continued to nourish and support the profession of nursing as it continues to evolve.

"The profession of nursing must continue to define itself. .. Nurses must ask themselves some important questions..in short, what is the nursing imperative? I would ask you to mount your own inquiry, and come up with your own answers. Here are mine:

"The nursing imperative is a two-sided coin. On one side there is the imperative to be clinically competent in both technical skills and clinical judgement. The other side is the willingness to step in to *being with* the human being for whom the nurse in caring. In healthcare, people experience vulnerability at every level of their being: mental, emotional, physical, and spiritual. The privilege of nursing is having the knowledge and skill, the position and relationship, to interact with a vulnerable human being in a way that alleviates pain and increases mental, emotional, physical, and spiritual comfort. This is the privilege of nursing -- the *being with* a vulnerable human being. If this privilege is ignored or overlooked, nursing isn't happening. No matter what is happening in a care environment, authentic human connection with the vulnerable human beings in our care can and must happen. That, to my mind, is the nursing imperative."

Awards and honors

- 1994 - Marie Mantheywas elected a fellow in the Royal College of Nursing in the United Kingdom, one of only four American nurses at that time.
- 1998 - Marie Mantheywas elected a fellow of the American Academy of Nursing.
- 1999 - The All-University Honors Committee of the University of Minnesota awarded Marie Manthey an honorary Doctor of Laws degree by unanimous endorsement.
- 2015 - Marie Mantheywas presented with the American Academy of Nursing Living Legend Award.

Published works

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Primary nursing

Originated in 1969 by staff nurses at the University of Minnesota, **Primary Nursing** is a system of nursing care delivery which emphasizes continuity of care and responsibility acceptance by having one registered nurse (RN), often teamed with a licensed practical nurse (LPN) and/or nursing assistant (NA), who together provide complete care for a group of patients throughout their stay in a hospital unit or department. While the patient is on the nurses' unit, the primary nurse accepts responsibility for administering some and coordinating all aspects of the patient's nursing care, with the support of other members of the nursing staff. This results in the nurse having greater insight into the patient's condition, both medical and emotional.

This is distinguished from the practice of team nursing, functional nursing, or total patient care, in that primary nursing focuses on the therapeutic relationship between a patient and a named nurse who assumes responsibility for a

patient's plan of care for their length of stay in a particular area. The patient is aware of who their nurse is in Primary Nursing, and can communicate to the entire hospital staff through that nurse. The nurse accepts responsibility for the patient's care.

Primary Nursing description

A delivery system is a set of organizing principles that is used to deliver a product or service and generally consist of four elements: decision-making, work allocation, communication, and management. Primary Nursing moves decision-making to the Primary Nurse, giving the Primary Nurse responsibility for the care of the patient. Results include shorter hospital stays, increased patient satisfaction, fewer medical complications, and less staff absenteeism. Work is allocated by the Primary Nurse to other staff in their absence, accountability remains with the Primary Nurse. Communication between the patient, the physician and the nurse is improved because the Primary Nurse is the central hub, and responsible for all communications. "All a good phsysician wants is quality care for his patient, and if Primary Nursing is the way to get it they are all for it", says Lawrence J. Donnelly, RN, Director of Nursing at Glendale Memorial Hospital.

Effect on Nursing Retention

Shortages of qualified nurses and nursing retention issues are long-standing challenges for hospitals. Reasons for nursing turnover including dissatisfaction with the way they are required to practice nursing, in team nursing environments.

Primary Nursing grew out of a group of nurses and nurse supervisors working together to address that dissatisfaction. Charlotte Dison of Baptist Hospital of Miami stated that primary nursing increased nursing retention because "the nurse is more satisfied with her environment. Absenteeism tends to be less, and there is a greater commitment to the patient." Dick Otswald, Vice President Nursing at Wausau Hospitals, believed that returning nurses to direct patient care versus administrative duties would increase retention because the reason people go in to nursing is to give patient care.

Patient experience

In team nursing, "the tasks got done, but patients often went home poorly taught (to take care of themselves) and the caring aspect of nursing wasn't carried out" said Karen Ciske, a former staff nurse and nursing instructor and a member of the University of Minnesota Hospitals' primary-nursing project. Ciske said that the one-to-one communication between nurse and patient is .. "where you form a relationship and patients open up to you.

Not back with the charts and the pills." Patients reported satisfaction with the system because care is personalized to them. The trust relationship between the nurse and the patient is critical. "Gaining a patient's trust means they will tell me about any discomfort to changes going on in their body that the monitors might not pick up."

That patient-nurse relationship carries over to the family, and helps the nurse with discharge planning, as they're able to assess the patient's support system outside of the hospital.

The patient-focused continuity of care of Primary Nursing also affects the patient's family. Penni Weston, primary nursing project coordinator at St. Alexius explained, "The family knows which nurse to talk to" when they have questions or anxiety about the patient's recovery. In a University of Michigan study, two groups of kidney-transplant patients were compared, one under primary nursing, the other under team nursing. The patients under team nursing experienced an average of four complications after the operation. The patients under primary nursing experienced an average of one complication after the operation, and so were able to be discharged from the hospital sooner.

The team nursing model is where the RN gives the patient a pill, the practical nurse changes the patient's bed linens, and the nurses' aide brings the bed pan - the RN only saw the patient that one time, when they gave the patient the pill. In primary nursing, the primary nurse gives the pill, teaches the patient about what the effects of the medication are, and monitors the patient's reaction to the medication.

On discharge, the primary nurse can recommend the best time of day for the patient to take the pill, based on what they've seen during the patient's hospital stay. The primary nurse is also more alert to medication errors, because of their greater awareness of patient medication outcomes.

In the total patient care system (or modified primary nursing), the responsibility aspect of primary nursing is not implemented. However RN's do still provide more patient care than under team nursing, and have less supervisory duties over other caregivers.

History

Primary Nursing is a return to the relationship between the nurse and patient being primary, with the nurse bringing all of her professional knowledge and expertise to her care of the patient.

In the 1920s and earlier, nearly all nursing was home care nursing, in which the nurse alone managed the patient's care. Hospitals trained nurses, and those student nurses provided the care in hospitals. Once the student nurse graduated and became a professional nurse, they would be on their own professionally, managing themselves as a business with clients who required care at home. In World War II, registered nurses (RN's) were drawn into care of the wounded.

The staffing available to hospitals was limited to Licensed Practical Nurses (LPN's) and Nurses Aides, so the functional model of nursing was implemented. In functional nursing, each person is assigned tasks limited by their qualifications. After the war, hospitals were built all over the US to continue to provide care to the wounded, and expand the health of the population. Functional nursing remained in place as demand for nurses constantly was greater than the supply of nurses, so the work was assigned out to various roles: orderlies, technicians, nursing assistants, practical nurses, and aides - and the Registered Nurse had oversight over all of them, rarely seeing a patient themselves. Nursing dissatisfaction and turnover was a continual problem throughout the 1950s and 1960s. The return of primary nursing started in 1969 on Unit 32 at the University of Minnesota Hospital.

The first seminar presenting primary nursing to the nursing community took place in 1970, and the first article was published that same year in *Nursing Forum*. A second article, "A Dialogue on Primary Nursing", was published in the journal *Nursing Forum* in October 1970. Throughout the 1970s, hospitals started to see the benefits of a primary nursing care delivery system to patients and nurses. In the Twin Cities, hospitals that implemented Primary Nursing in the 1970s included Hennepin County Medical Center, United Hospital, Bethesda Lutheran Medical Center, the Veterans Administration hospital and the University Hospital. St. Alexius implemented Primary Nursing in the early 1980s, crediting it with improved outcomes. The nursing staffs at Boston Beth Israel led by Joyce Clifford and Evanston Hospital led by June Werner were early adopters of primary nursing and were recognized for their outstanding work in fully implementing this professional nursing model.

Hospitals' attempts to implement primary nursing were hindered by the initially-higher costs of a more professional staff. Some hospitals initially implemented a modified version in which responsibilities are moved toward a patient focus.

Implementation

As implementation of Primary Nursing continued, patients reported satisfaction with the system because care is personalized to them. Hospital-level resistance to Primary Nursing comes from the difficulty of integrating the Primary Nursing process within usual hospital processes. Changes required may include the nurse-doctor relationship, staffing patterns and nursing supervision practices. Changes are also

required to the technical support systems underlying nursing practice. Marie Manthey asserts that a nursing system can support either professional (nursing) values or bureaucratic (hospital) values as it either focuses on caring for people or tending to the needs of an organization. “Primary Nursing is a delivery system for nursing at the station level that facilitates professional nursing practice despite the bureaucratic nature of hospitals. The practice of any profession is based on an independent assessment of a client’s needs which determines the kind and amount of service to be rendered: services in bureaucracies are usually delivered according to routine pre-established procedures without sensitivity to variations in needs.” Manthey also stated that primary nursing is sometimes rejected because the nursing leader is afraid of losing authority.

The implementation of Primary Nursing outside of the U.S. started in England, where the term 'named nurse' was used in the National Health Service. John Major announced the Patient's Charter in 1991, one component of which was that "a named qualified nurse, midwife, or health visitor ..will be responsible for your nursing or midwifery care." In making this policy change, he stressed that Nursing was being recognized as a key component of medicine, that well-trained nurses' greater responsibilities were a benefit for the health system and for patients. While the Royal College of Nursing supported this greater role for nursing, cost challenges were also acknowledged. Stephen Wright at Tameside promoted primary nursing's benefits, while also acknowledging the challenges. The benefits Wright identified of primary nursing include reduced patient complaints, fewer medical complications, and less staff absenteeism. The discomfort of doctors working with

different primary nurses, rather than one specific head nurse/ward sister is a challenge. Also, for the Primary Nurse, taking responsibility for the patient's care from admission to discharge requires an adequate support system. Wright said, "It can be pretty scary if you are totally responsible for a patient's care. The bus stops with you." Wright also stressed the need for adequate funding of the new system. Imperfect conditions meant that at times the ward sister (similar to Head Nurse in the U.S.) was treated as a primary nurse in some cases, meaning that Patient was given her name as their nurse. The Royal College of Nursing stated that since the named nurse concept meant "qualified staff having responsibility for designated patients", the ward sister assignment as named nurse was not realistic. Possible cost savings to support the hiring of additional qualified nurses were identified to include reducing shift change from two hours down to one, reducing supervision costs, and moving clerical and housekeeping tasks from nursing to other hospital staff members.

In the 1990s, industry consultants led a movement of hospitals into restructuring and re-engineering in the name of cost-cutting, that had the effect of reducing professional nursing autonomy and judgment by use of multi-skilled team members. The term primary nursing fell out of use, and the concepts were modified. Other changes included de-emphasis of the nurse-patient relationship. This had a negative effect on nursing satisfaction with the care they were able to provide to patients.

In the UK, hospital restructuring had the effect of spreading skilled work among a wider variety of staff. This 'changing skill mix' had the effect of increasing the managerial, medical and

therapeutic work of nursing, and assigning bedside care to non-nursing staff. This grew out of 'total patient care' which involved nurses taking on additional clinical roles such as occupational therapy tasks, their work load increased accordingly. Nurses reported being concerned about qualitative differences in patient care that weren't being measured, as well as increased pressure and uncertainty due to extensive changes.

Current terminology for this practice model - 'Relationship-Based Care' - applies the original concepts of Primary Nursing to all functions and relationships within the hospital setting.

Martha E. Rogers

- **Martha Elizabeth Rogers** (May 12, 1914 – March 13, 1994) was an American nurse, researcher, theorist, and author. While professor of nursing at New York University, Rogers developed the "Science of Unitary Human Beings", a body of ideas that she described in her book *An Introduction to the Theoretical Basis of Nursing*.

Early life and education

She was born in Dallas, Texas, the oldest of four children of Bruce Taylor Rogers and Lucy Mulholland Keener Rogers. She began college at the University of Tennessee, studying pre-med (1931-1933) and withdrew due to pressure that medicine was an unsuitable career for a woman. She received a diploma from the Knoxville General Hospital School of Nursing in 1936. The

following year she received an undergraduate degree in public health nursing at George Peabody College in Nashville, Tennessee. She received an M.A. in public health nursing from Teachers College, Columbia University in 1945, an M.P.H. in 1952 and a Sc.D. in 1954, both from Johns Hopkins School of Public Health.

Career

She specialized in public health nursing, working in Michigan, Connecticut, and Arizona, where she established the Visiting Nurse Service of Phoenix, Arizona. Between 1952 and 1975, she was Professor and Head of the Division of Nursing at New York University; she became Professor Emeritus in 1979.

Death

Rogers died March 13, 1994, and was buried in Knoxville, Tennessee. In 1996, she was posthumously inducted into the American Nurses Association's Hall of Fame.

Nursing theory

Rogers' theoryis known as the Science of Unitary Human Beings. Its primary tenets include the following:

- Nursing is both a science and art; the uniqueness of nursing, like that of any other science, lies in the phenomenon central to its focus.

- Nurses' long-established concern with the people and the world they live is a natural forerunner of an organized abstract system encompassing people and their environments.
- The irreducible nature of individuals is more than the sum of the parts.
- The integralness of people and the environment that coordinate with a multidimensional universe of open systems points to a new paradigm: the identity of nursing as a science.
- The purpose of nursing is to promote health and wellbeing for all persons wherever they are.

A form of energy medicine, the Science of Unitary Human Beings is based on the idea that "human beings and environment are energy fields" that are characterized by "four-dimensionality", a "nonlinear domain without spatial or temporal attributes"; postulates that physicist Alan Sokal describes as "pseudoscientific verbiage" and "perfectly meaningless". JefRaskin wrote that Rogers' writings were filled with contradictions, "fuzzy physics," and vagaries. "Unlike science, nursing theory has no built-in mechanisms for rejecting falsehoods, tautologies, and irrelevancies."

Publications

- *Educational Revolution in Nursing* (1961)
- *Reveille in Nursing* (1964)
- *An Introduction to the Theoretical Basis of Nursing* (1970)

Ramona T. Mercer

Ramona Thieme Mercer (born October 4, 1929) is the author of a mid-range nursing theory known as maternal role attainment. Mercer has contributed many works to the refinement of this theory and is credited as a nurse-theorist. She was the Nahm Lecturer 1984 at the University of California.

Career

Mercer earned a diploma from St. Margaret's School of Nursing in Montgomery, Alabama. She earned an undergraduate degree in nursing with distinction from the University of New Mexico in 1962, followed by a master's degree in maternal child nursing from Emory University in 1964. For ten years, she worked as a staff nurse, head nurse and instructor. She was a faculty member at Emory University for five years until she left to pursue doctoral studies in maternity nursing at the University of Pittsburgh.

Honors and awards

1988: Distinguished Research Lectureship Award, Western Society for Research in Nursing (inaugural award)

2003: Living Legend, American Academy of Nursing

2004: Distinguished Alumni Award, University of New Mexico College of Nursing

Works

- *Mercer, Ramona (1980). "Teenage motherhood: The first year". Journal of Obstetric, Gynecologic, and Neonatal Nursing.* ***9*** *(1): 16–27. doi:10.1111/j.1552-6909.1980.tb01301.x. PMID 6898708.*
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