In this article...

- The humanising values theoretical framework
- How humanising care relates to key objectives in nursing competencies
- How to put humanising care into practice

Humanising values at the heart of nurse education

As qualified practitioners and student nurses, it is our responsibility to maintain the highest standards of care in our area of practice. In our previous article (Hemingway et al, 2012), we suggested that focusing care on what is important to us as human beings enables us to always put the person first. Working in this way, we can fulfil our responsibilities as nurses in developing person-centred practice (Department of Health, 2010), putting people at the core of health service delivery (DH, 2005; 2004).

Pre-registration nurse education clearly has a role to play in this. This article explores how the framework proposed by Todres et al (2009) could be used to ensure that humanising values are at the heart of nurse education.

Nurse education standards

The Nursing and Midwifery Council Standards for Pre-registration Nursing Education (NMC, 2010) were developed after consultation with many professional and lay stakeholders.

Putting them into practice is a shared responsibility involving university nursing departments and organisations that provide placements; this offers an excellent opportunity for genuine partnership working. It is important to have a shared underlying philosophy for the programmes and central to this should be a joint commitment to humanising values.

To recap, the humanising values framework describes eight key aspects of what it is to be human. These eight dimensions of humanisation and corresponding dehumanisation (described in full in part one) are listed in Box 1. This framework could be useful when considering the nature of nursing practice – that is, what nurses do and how they do it. In a similar way, the framework could provide a structure to learn about nursing.

Humanising dimensions and nurse education

The NMC competency framework (NMC, 2010) outlines the standards of competence that student nurses must acquire for entry to the nursing register. Four domains are identified (Box 2).

For each domain there is a generic standard and a field-specific standard. In
this article, the domains “professional values” and “communication and interpersonal skills” will be considered and related to adult nursing within the eight humanising dimensions.

**Insiderness/objectification**
As nurses we need to ensure we never make those we care for feel like objects. The generic professional values standard states that nurses must “be responsible and accountable for safe, compassionate, person-centred [care]”.

Patient-centred care is not a new idea; it has been the basis of many nursing curriculums since the 1970s. The ultimate way to objectify patients is to plan care around tasks such as “the obs round”, “the back round” or “bath days”, rather than focusing on the person in need. It might be assumed that such practice has long gone but old habits die hard – students quickly learn to conform to what they see going on around them (Melia, 1984).

**What can we do?** Reflective practice should be built into education programmes to enable students to consider their actions and the impact of these on the patients for whom they care. Students need to learn how to speak up in a constructive manner when concerned about care, rather than simply conform. Mentors must encourage this and respond empathetically, taking concerns forward for objective discussion.

**Agency/passivity**
We need to offer and enable choice and freedom for patients. Nurses are expected to “work in partnership with other health and social care professionals and agencies, service users, their carers and families in all settings, including the community, ensuring that decisions about care are shared” (professional values domain).

Many students come into nursing with the idea that they will always be working with people who are ill and that their job is to provide care. The dominance of a medical model in western culture can reinforce the idea that patients take a passive role in their health and wellbeing (communication domain).

As nurses we need to ensure we offer support to, and the opportunity to build relationships and friendships with, those people for whom we care.

Many older people maintain good health for most of their lives, while some develop long-term health conditions. Nurses need to be equipped “to respond warmly and positively to people of all ages who may be... facing problems with their health and wellbeing” (communication domain).

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**What can we do?** Excellent assessment skills are fundamental to good nursing care. Nurse education needs to ensure the student sees beyond the assessment checklist in order to truly perceive the person. A patient may be coping alone at home with considerable health needs, but when they become unable to access their usual place of worship, for example, the loss of their social contacts results in a crisis. Students learn so much from mentors who role model empathetic communication skills and proactive interagency working.

**Sense making/Loss of meaning**
We explain what is happening and ensure patients and relatives understand fully...
their situation in their context.

The NMC (2010) envisages that the voice of the service user will be prominent in all aspects of nurse education, thereby grounding the nursing programme in the experience of care. Teaching nurses good interpersonal skills is essential and, while this is not new, the emphasis has shifted from solely “talking to” towards “talking with” and developing “the ability to listen with empathy” (communication domain).

What can we do? Service user and carer groups need to be embedded in nursing departments in universities and respected as a vital part of the team. The assessment of students in practice has to involve feedback from service users, although for mentors this can represent an ethical and practical challenge. A potential way forward is for mentors to pick up on verbal/non-verbal cues from patients when working alongside students over the period of the placement and feeding these back to the student.

Personal journey/loss of personal journey
When we deal with patients they are often outside of what is familiar to them. We need to acknowledge and value their concerns and help them to adapt.

Going into hospital represents a significant disruption and is likely to provoke anxiety and vulnerability (NMC, 2002). Working with patients with a cognitive impairment such as dementia is challenging, as they may have difficulty in understanding and adjusting to their new environment. Nurses need “to respond... positively... to all... who may be anxious or distressed” (communication domain). Helping people to retain a sense of their identity and history helps them to adapt to disruptions such as a hospital admission. The use of resources, such as life books (McKeown et al, 2006) that describe a person’s earlier life, can help staff identify the interests of an individual with dementia, making a familiar connection in an unfamiliar environment.

What can we do? In universities we need to ensure we do not simply teach about conditions. Despite the fact that biological and pathophysiological knowledge is essential, it needs to be taught in the context of the person and their personal history. This can be achieved through the use of comprehensive case studies or having service users share their experiences with students to highlight the wider implications of living with a disease.

Sense of place/dislocation
Healthcare environments can be frightening and depressing places. We need to ensure we do the best we can to mitigate against this.

Adult nurses are expected “to promote the rights, choices and wishes of all” (professional values domain). One of our human rights is to feel safe and secure and this is often embodied in the place we call home. A care home is an interesting environment as, for most residents, it constitutes home, yet it is also a small institution. It is important for students to consider what “home” means to them personally and then to “step into the shoes” of the resident. While residents need nursing care, their personal space has to be respected so they feel “at home”.

What can we do? Universities often categorise placements as belonging to hospital or community care. This leaves care homes and indeed other provision as “other”. Our sense of what constitutes community is being challenged as services are restructured but if community is in part about caring for people in their own homes then care homes form a part of this. Viewing care homes in this way is more inclusive and helps students see such environments as a legitimate and positive place to learn about nursing as well as promoting an individual’s rights and choices regarding the way in which they live.

Embodiment/reductionism
Every person is equally unique and valuable; through our behaviour as nurses, we need to ensure we treat everyone with respect and dignity.

Personal identities are complex and evolving, yet we often judge others based on what those around us think or what we see in the media. This can be reductionist; for example, a belief that all old people are slow or deaf. We also tend to see the things with which we are familiar as better – this can lead us to patronise those who we perceive to be less physically or mentally able or those who have a different lifestyle, skin colour or nationality to ourselves (Scammell and Olumide, 2012). The professional values standard requires us to practise “nursing that respects and maintains dignity and human rights”. To do this we need to relate to people as people first and avoid making assumptions.

What can we do? Universities need to ensure students have a good awareness about the effect of stereotyping, both in relation to patients as well as colleagues. It is not enough to say our code of conduct prevents discrimination. Clearly lecturers and mentors need to role model this, but it is equally important that we teach students how to challenge discriminatory practices (Thompson, 2003).

Conclusion
Nurse education plays a vital role in preparing the future workforce for employment in the field. Those of us who are already nurses working either in clinical practice or universities will shape the nature of nurse education, through what we do as much as through what we say.

The humanising values framework could prove a useful tool – it could help us step back from our work with students, think about what it means to be human and to try to make our practice reflect this.

References
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