Nursing models and contemporary nursing 2: can they raise standards of care?

Patients benefit from a holistic assessment of their needs. Nursing models help to promote this and also encourage nurses to take a systematic approach.

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This two part series explores the value of nursing models and suggests that nurses should reconsider their use. It outlines that the fundamental concepts, beliefs, and values about nursing in these models have relevance to current policy debates about the future of nursing.

The first article gave an overview of what nursing models are, how, and why they were developed, and some of the main criticisms made of them. This second article examines their relevance to contemporary practice with particular reference to recent policy initiatives designed to modernise nursing and to raise standards of care.

INTRODUCTION

Identification of the core aspects of the nurse’s role remains at the centre of contemporary policy debates. Although the NHS is subject to much change in its organisation and management, the one constant is the need for health professionals to provide care. We suggest that theoretical models of nursing can provide a platform for re-examining and reasserting the essence of nursing and its contribution to healthcare.

There have been important criticisms of nursing models, which were summarised in the first article. These include intrinsic criticisms that relate to the model itself, such as the jargon used and the perceived irrelevance to practice, and extrinsic factors external to the model such as the approach to implementing the model into practice.

However, despite these criticisms, there are aspects of contemporary policy debates, such as compassionate care, nursing accountability and career flexibility that may have relevance to the theoretical concepts, values and beliefs originally proposed within the early nursing models.

CONTEMPORARY POLICY

During the past decade in the UK, there has been a major drive to introduce policies to support modernisation and reform of the NHS – a drive in which nurses have been identified as key players (Department of Health, 2006a; 2000; Welsh Assembly Government, 2005).

Although political devolution has led to different approaches by each country within the UK to modernisation and reform, the general thrust of health policy across the UK seems to be focused on common themes designed to improve the quality of care. These include concepts around empowering patients and staff, increasing patient information and choice, workforce redesign and improving clinical accountability through clinical leadership.

The launch of the NHS Plan by the Department of Health (DH, 2000) provided the platform for these reforms. It identified societal and demographic changes, such as technological advances, the ageing population, and increased incidence of chronic disease as the main drivers for change. In addition, it highlighted the need for the provision of individualised care based on core values of patient safety, respect, privacy, dignity and caring.

The NHS Plan also set out proposals to redefine traditional role boundaries between medicine and nursing to meet these challenges and respond to financial and legislative constraints.

Against this policy backdrop, occupational standards of competencies have been developed. These are enshrined within the NHS Knowledge and Skills Framework (Royal College of Nursing, 2005). Competency assessment forms a major part of both the preregistration and postregistration educational programmes.

Despite this, it seems there is growing dissatisfaction about what nurses are capable of doing in practice and there has been uncritical acceptance of the need to develop competencies for nursing (Watson et al, 2002).

Nursing models were heavily criticised for their use of jargon, but some of the competency statements contained within nursing curriculums and occupational standards within the NHS Knowledge and Skills Framework are also vulnerable to that criticism, being infinitely more complex and lacking precise definitions of key terms (Watson et al, 2002).

The DH campaign Dignity in Care (DH, 2006b) and the national service frameworks for older people in England (DH, 2001a) and Wales (WAG, 2006), all feature recommendations for addressing issues relating to privacy, dignity and choice, and attempt to stress the importance of patient centred care.

Earlier publications, such as The Essence of Care (DH, 2001b) and Fundamentals of Care (WAG, 2003), were also attempts to address quality issues relating to aspects of caring.

These documents identify benchmarks for practice that most nurses would recognise immediately as being almost identical to the activities of living outlined by Roper et al (1990). The language used is similar, which suggests that the language of this model,

PRACTICE POINTS

● NHS policy focuses on measuring the nursing contribution and increasing the flexibility of the nurses’ role.
● Discussions have also covered the delivery of high quality, individualised, holistic care that supports patient empowerment and choice.
● Nursing models are relevant to modern nursing as they address these issues central to current nursing policy.
● Nursing models can provide a useful framework for nursing practice.
practice in depth

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CONTRIBUTION OF NURSING MODELS
Delivering compassionate, patient centred, individualised care
The DH (2008) has highlighted the need for the provision of personalised or individualised care and identified six core elements of high quality care from the patients' perspective. Of greatest importance is the holistic, patient-centred approach. Use of a nursing model can help to achieve this. The starting point of many nursing models was an assumption about the nature of people, focusing on aspects of physiology, behaviour, and the socioenvironmental factors that may impinge on health. Aggleton and Chalmers (2000) suggest this detracts from the idea of individualism. It means models are founded on assumptions about the commonalities between people. However, it could be argued that, although these models begin with common assumptions about people, nurses are directed towards assessment of the whole person as an individual. That may differ according to either the theorist or the individual nurse's interpretation.

The purpose of a nursing model is to guide rather than to prescribe practice. When used in conjunction with the nursing process, it can help nurses to formulate a view of the patient's experience of ill health from the patient's own perspective.

As an example, Orem (1991) saw the assessment process as a method of history taking tailored to the specific needs of the individual patient. This is, again, extremely relevant in the current climate where patient choice and autonomy are seen as paramount.

More specifically, the benchmarks for high quality care identified by the UK health departments have many parallels with Roper et al's (1990) activities of living, as well as to the universal self care requisites identified by Orem (1991) (Table 1).

It is worth noting that early criticisms of nursing models focused on their tendency to adopt a checklist approach to assessment rather than being jargonistic, is uncomplicated and transcends fashions and trends in nursing and healthcare.

Current issues highlighted in the report commissioned by the chief nursing officer for England, Nurses in Society (Maben and Griffiths, 2008), relate to falling public confidence in nursing and the profession's contribution in the NHS, suggesting that "nursing has lost its way". The report calls for the reiteration of the centrality of caring to nursing and robust measurement of the nursing contribution.

So, from looking at contemporary policy and concerns, four main areas for nursing have become apparent:

- Delivery of compassionate, patient centred, individualised care;
- The management of chronic disease and empowering patients to self care;
- The need to measure and account for the nursing contribution to healthcare;
- The need to develop a flexible career structure for nurses.

Table 1: Comparison between quality benchmarks for England and Wales and the main components of two models of nursing

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<td>Safety Environment Promoting health</td>
<td>Ensuring safety</td>
<td>Maintaining a safe environment</td>
<td>Prevention of hazards to human life, human functioning and wellbeing</td>
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<td>Communication</td>
<td>Communication and information</td>
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<td>Balance between solitude and social interaction</td>
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<td>Rest and sleep</td>
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<td>Relationships</td>
<td>Expressing sexuality</td>
<td>Working and playing</td>
<td>Promotion of human functioning and development within social groups, in accordance with human potential, limitations and the desire for normalcy</td>
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<td>Ensuring comfort, alleviating pain</td>
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of predominantly physical needs and problems (Tierney, 1998). This may be compounded if these discrete elements are used in isolation and without full appreciation of the theoretical frameworks underpinning the models.

Revisiting the underpinning theories for nursing models can help nurses to understand the relationship between the elements of each model and to adopt a more holistic and individualised view of their patients’ needs. In this way, nurses are arguably better equipped to produce comprehensive, holistic plans of care.

Care planning systems in current practice appear to be fragmented and disease-specific. For example, integrated care pathways focus on specific disease processes and progression. It is conceivable that, for patients with multiple pathologies, several sets of paperwork could exist relating to each disease or condition.

Anthony et al (2008) identified more than 40 different risk assessment tools. Arguably, this leads nurses to examine these different aspects of the person in isolation and may even compound the checklist approach to care. It is also by no means clear whether their use improves patient outcomes or whether sound clinical judgement is sufficient (Anthony et al, 2008).

A re-evaluation of the use of a nursing model together with the nursing process and clinical judgement to produce a complete plan of care could help to reduce the proliferation of documentation and reduce fragmentation in approach to patient assessment.

Empowering patients to self care
While the concept of self care as described by Orem (1991) may have been at odds with the UK NHS philosophy and culture of two decades ago, contemporary issues of demographic change, economic pressures, and the rise in chronic disease renders this concept now highly applicable to the needs of service users.

Timmins (2008) pointed out that self care is correlated with age and that older people were generally more motivated to self care than the general population and that identifying clients’ self care behaviours was useful in clarifying individual needs. Similarly, Roper et al (1990) believed the central goal of nursing is to provide interventions that will help people to acquire, maintain, or restore maximum independence in activities of daily living. These strengthen the case for a renewed consideration of the models of Orem and Roper et al in contemporary nursing.

Accounting for the nursing contribution
Nursing models attempted to articulate beliefs about what nursing is and what the role of the nurse should be. For example, Roper et al (1990) saw the nurse as a helper in solving, alleviating, coping with or preventing actual or potential problems, identified through the framework of activities of living.

Arguably, this does at least give a focus to the areas in which nursing activity could be concentrated and which might be measured via care plans. Yet, historically, accounting for the nursing contribution has been problematic due to uncertainty about what comprises the nursing role and the responsibilities of nursing in relation to medicine (Doherty, 2009).

Attempts were made to link the nursing role to the concept of caring, as reviewed by Morse et al (1990), who identified 35 definitions of caring. This could be part of the difficulty in articulating exactly what the nursing role should encompass.

Davison and Williams (2009) posit that the terms “caring” and “compassion” may be interchangeable. They suggest that there are two elements involved in professional caring: those that relate to technical competence (caring for); and those that relate to the emotional aspects of the nurse-patient relationship (caring about). These technical and emotional aspects seem to cause conflict for modern nurses and it appears that the future of nursing is being pulled in opposing directions.

Nurses are being directed to be more compassionate and caring and to deliver, lead and account for fundamental aspects of nursing care (Maben and Griffiths, 2008). Simultaneously, they are being directed towards role extension and expansion with a focus on technical aspects of caring created to meet political and financial drivers for change (Doherty, 2009).

However, it is care that is not formally recorded or measurable such as empathy, gentleness and engagement with patients that is most valued and described as a marker of high quality care by patients themselves (Attree, 2001).

Doherty (2009) suggests that policy initiatives to move away from physical nursing tasks have not resulted, as envisaged, in empowerment for nurses but have, instead, limited them to performing technical tasks, largely as a result of the perceived subordinate role of nursing to the medical profession. This is compounded by the continued uncertainty of what constitutes proper nursing tasks.

Tierney (1998) saw the activities of living model (Roper et al, 1990) as central to reframing the relationship of nursing with the medical profession, by placing emphasis on nurse-initiated areas of practice while retaining links with the medical model and the relationships between the two.

The dilemma for nurses wishing to develop the scope of their role and professional practice is the perception that hands-on delivery of nursing care is increasingly being undertaken by healthcare support staff. Registered nurses are withdrawing from their traditional bedside role, resulting in compromises to the safety and quality of care (McKenna et al, 2004).

One of the earliest nursing theorists, Henderson (1966), saw physical nursing tasks as fundamental to the nursing role, providing vital opportunities for patient assessment and warning against the handing over of these tasks to unqualified staff. However, this handover has happened and has done so in the absence of regulation, clear boundaries or systematic education and training (McKenna et al, 2004).

Models for nursing can still provide a robust framework for practice that incorporates the importance of comprehensive and holistic assessment and emphasises fundamental, core beliefs about nursing and the caring role of the nurse.

Theoretical models for nursing, when applied alongside the nursing process, provide nurses with the necessary framework for practice and a way to articulate the nursing contribution.

Perhaps modern interpretations should encompass aspects of risk assessment and could also include more direction in relation to the adoption of national standards and guidance such as the national service frameworks and metrics for nursing. More importantly, though, the model could provide a philosophy for nursing and a value base for care delivery to support assessment planning, delivery, and evaluation of care.

Nursing assessment is a skilled task requiring interpretation and application of this underpinning philosophy and value base and therefore should be within the remit of registered nurses, not least because this requires critical thinking, professional judgement and decision making.

The Nursing and Midwifery Council (2008) identifies competence in these skills as vital components of registered nurses’ essential skills clusters. It is explicit that registered nurses are able to “make holistic and systematic assessment of physical, emotional, psychological, social, cultural and spiritual needs, including risk, and creates a comprehensive plan of nursing care in
partnership with the patient/client, carer, family or friends”. There is a need however, to develop programmes of research to find out whether the use of a nursing model facilitates the process of assessment and helps to highlight the nursing contribution.

It has been suggested that nursing models are most useful in supporting learner or novice nurses and are of less value to experienced nurses. Wimpenny (2002) suggests they are used in practice in such a way that nurses amalgamate the theoretical version with their own model that is modified according to practice experience. This suggests that the theoretical model is adapted by the user as experience is gained. What may serve as a practical guide for the practice of nursing for the novice nurse is transformed into a guide for “thinking” about practice for the expert practitioner.

REFERENCES


Department of Health (2006b) Dignity in Care Campaign. tinyurl.com/digicare-camp


CONCLUSION

Many of the fundamental concepts inherent to nursing models such as the nature of caring, the explicit role of the nurse, individualised care and patient empowerment are still relevant to contemporary nursing. It could be argued that they actually underpin present day nursing policy (Maben and Griffiths, 2008; DH, 2006b; WAG, 2006).

Models lead nurses to focus on a holistic assessment of patients’ needs from patients’ perspectives. They also direct the nurse towards meeting the needs of the individual in a systematic and organised manner.

Current concerns expressed by both the public and the profession centre on the need to enhance the caring and compassionate aspects of care delivery and it is recognised that this is seen as a marker of quality from patients’ perspectives (Attree, 2001).

Nurses are also being directed to undertake more flexible roles that may require them to move away from providing direct physical care at the bedside to deliver more technical care previously provided by medical staff (Mckenna et al, 2004).

Theoretical models for nursing can provide a platform for highlighting the nursing contribution to healthcare.

Tierney (1998) saw nursing models as crucial to emphasising the unique and valuable contribution nursing makes to healthcare and making the profession distinct from other disciplines such as medicine.

In the current climate, where registered nurses are likely to be at a premium, it is vital that these frameworks for practice are reconsidered, embraced and utilised to articulate the nursing voice.

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