Kearney-Nunnery

ADVANCING YOUR CAREER

Concepts of Professional Nursing

EIGHTH EDITION

F.A. DAVIS

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Rose Kearney-Nunnery, RN, PhD

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Dedication

To all the talented professionals who cared for patients and colleagues during the COVID-19 pandemic and all those we lost. Let us celebrate diversity, resilience, innovation, and inclusiveness in ongoing practice.

Preface

The nursing profession has undergone major changes in the past decades, and the pace of change seems to accelerate daily. We are redefining practice and basing this practice on evidence of efficacy. We have moved from a position of defending nursing as a profession to our current pivotal role in healthcare. Focusing on human beings in their respective environments with unique healthcare needs that are addressed through nursing care is vitally important with our rapidly expanding knowledge base and the dynamic changes continually occurring in healthcare. In essence, our quest in our nursing roles is to expand knowledge, become involved within the profession and in interprofessional healthcare, utilize evidence-based practice, promote equity and expanding technologies, and broaden the vision of professional practice.

This book is directed to the RN student returning to school. The intent is to provide you, the practicing RN, with professional concepts to advance your practice. These concepts build on your prior nursing education, and their application will greatly enhance your professional practice and growth. The aim is to engage you intellectually in an ongoing professional dialogue and journey with your peers, colleagues, and instructors; broaden your professional development; and build on your preexisting knowledge and experiences. You are challenged to delve further into professional education and conceptual practice. The book is written for the adult learner with the characteristics of self-direction, prior experiences, applicability to practice, and motivation to meet the challenge to expand his or her knowledge base.

The eighth edition has been updated in light of recent national reports and recommendations and is divided into four sections. As with the previous editions, each chapter contains chapter objectives, key terms, key points, and chapter exercises to assist in meeting each of the chapter objectives. Evidence-based practice challenges are provided in Chapters 5 through 19. References, a Bibliography, and Online Resources are located at the end of each chapter.

In Section I, the professional bases for nursing practice are introduced. This discussion is the start of *Advancing Your Career*. Chapter 1 focuses on the characteristics of nursing as a profession and as a unique professional discipline. A focus on the core competencies, for all healthcare professionals, challenges both professional and interdisciplinary practice. As a first step in your educational pursuit, you are challenged to review your learner characteristics to enhance your educational experience. Next, you focus on your concept of the profession via an analysis of your personal perspectives of professional nursing as a philosophy statement.

From a view of professional practice, Section I continues with a focus on theory as the basis for practice in Chapter 2. Dr. Jacqueline Fawcett addresses how unique nursing knowledge and nursology has evolved and been applied to individuals, families, and groups in Chapter 3. A discussion of health, illness, and holism in Chapter 4 delves further into models of health and illness with a focus on cultural, equity, and literacy considerations. Section I concludes with a review of the research process and the necessity for the application of evidence-based practice in Chapter 5. Use of known and evolving knowledge replaces tradition as healthcare focuses on guidelines and documented evidence for efficacy of care.

Section II examines selected critical abilities in professional nursing practice. The first of these critical components addresses communication skills as vital to professional practice and in constant need of refinement. The content is presented by Dr. Lynne Hutchison in Chapter 6, with a discussion of communication models, essential ingredients of effective communication, nonverbal communication forms, civility, and specific communication techniques,

including communication skills for interdisciplinary and interprofessional practice. Along with effective communication, critical thinking is essential to professional nursing practice. In Chapter 7, aspects of critical thinking in nursing, along with further development of critical thinking, analytic skills, and skills for clinical judgment are investigated. Effective communication, critical thinking, and clinical judgment are required in collaborative practice situations. Chapter 8 focuses on working with groups, including the characteristics and roles of groups and group leaders and the skills needed for collaboration, coordination, negotiation, and dealing with conflict and difficult people. The next critical component for professional practice is the teaching and learning process. Included in Chapter 9 is a discussion of learning theories and learning readiness, along with information on writing behavioral objectives, teaching skills and methods, and evaluating outcomes.

Leadership and management skills are essential in professional practice, especially in organizational settings and because nurses have a major involvement in leadership and management in interprofessional practice situations. Chapter 10 looks at organizational characteristics and presents the skills needed for effectively managing and leading in organizational settings, including a discussion of selected theories and delegation principles. Organizations continue to redefine themselves, so effectively dealing with change is critical. Chapter 11 includes theories on change and innovation, along with the characteristics of change agents for change in individuals, families, groups, and organizations. Section II concludes with Chapter 12, which examines ethical principles and making ethical decisions focusing on informed consent, advance directives, organ procurement and donation, genomics, impaired practice, and health equity.

Section III starts with a focus on quality and safety in Chapter 13 and the national initiatives that have driven this process. Theoretical models for quality are discussed, along with strategies for continuous quality improvement, safety, and efficacy in the healthcare environment. In Chapter 14, the focus is on population health. The progress of the *Healthy People* initiatives in the United States is presented, along with the current focus on the social determinants of health (SDOH). Special populations that are highlighted include the aging population, minorities, and those living in rural areas. In Chapter 15, we look at one of the core competencies for healthcare professionals, the use of informatics. Health information systems with the interoperable electronic health record are discussed, along with evolving technologies in machine language, artificial intelligence, and the growth of telehealth. Informatics competencies for nurses, informatics nurses, and informatics specialists are described in this disciplinary specialty in.

Quality care includes a focus on healthcare economics and policy, as presented in Chapter 16. Policy and the associated costs are changing dramatically as we focus on safe, effective, equitable, and value-based care for individuals, groups, and society. Stemming from a focus on healthcare policy are the political advocacy skills needed by the politically active nurse in Chapter 17. These skills include both understanding the legislative process and promoting policy improvements for the health of individuals and groups.

We conclude in Section IV with a look at the reality of the healthcare issues addressed throughout the book and the challenges to be addressed by nursing professionals in the future. In Chapter 18, Sister Rosemary Donley addresses global health, international health, and public health through the lens of social justice with applications seen in the COVID-19 pandemic, global conflicts and wars, and violence that have major implications for health and human well-being and health policy. Chapter 19, the final chapter, discusses challenges for your professional future in terms of expanding your vision and planning for the future. Topics include a look at the practice environment and the call for change, greater collaboration, demonstration of competence greater preparation for emergency situations, and resiliency in professional practice. You will be challenged to take the lead and demonstrate involvement in the profession for improved care and healthcare initiatives that equitably meet the needs of the population, considering economics, quality initiatives, and demonstration of effective and equitable outcomes.

This book is intended to advance your professional practice and continued professional development through further education. Online case studies are provided for each chapter to challenge you further in application of the concepts. Your personal characteristics of self-motivation, a thirst for information, and commitment to your patients and the profession will be enhanced as you develop a more conceptual and visionary approach and grow to lead in quality, safe, and equitable professional nursing practice.

—Rose Kearney-Nunnery

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—Rose Kearney-Nunnery

Contents

SECTION I

Professional Bases for Practice

This section introduces the professional bases for nursing practice to start the discussion of *Advancing Your Practice*. Chapter 1, "Your Professional Identity," focuses on the characteristics of professional nursing as a profession and as a unique professional discipline. A focus on the core competencies for all healthcare professionals challenges both professional and interdisciplinary practice and especially now with the focus on achieving health equity. As an ongoing step in your educational pursuit, you are challenged to review your learner characteristics to enhance your educational experience. Next, focus on your concept of professionalism and analyze your personal perspectives of professional nursing as a philosophy statement.

From a view of professional practice, Section I continues with a focus on theory in Chapter 2, "Theory as the Basis for Practice." We then continue with how unique nursing knowledge has evolved and been applied to the consumers of nursing in Chapter 3, "Evolution and Use of Formal Knowledge of Nursology," by Jacqueline Fawcett. As you will see in Chapter 4, "Health, Illness, and Holism," holistic practice delves further into models of health and illness with a focus on cultural, literacy, and health equity considerations.

Section I concludes with Chapter 5, "Evidence-Based Practice," which presents a review of the scholarship and the necessity of the application of evidence-based practice in professional nursing and the growth of translational science. Use of known and evolving knowledge replaces tradition as healthcare focuses on guidelines and documented evidence for efficacy of care.

CHAPTER 1

Rose Kearney-Nunnery

Your Professional Identity

> *The past cannot be changed. The future is yet in your power.*
>
> *Mary Pickford, 1893–1979*

CHAPTER OBJECTIVES

On completion of this chapter, the reader will be able to:

1. Relate the attributes of a profession to professional nursing practice.
2. Relate the core competencies for health professionals to professional nursing practice.
3. Describe the consumers of professional nursing practice with a focus on healthcare equity.
4. Discuss responsibility and accountability in professional nursing practice.
5. Discuss the attributes of professional nursing practice.
6. Consider personal learning attributes, including learning style, time management, and appropriate use of resources.
7. Develop a personal philosophy of professional nursing.

KEY TERMS

Theory
Paradigm
Metaparadigm
Human Beings
Environment
Health
Nursing
Authority
Community Sanction
Code of Ethics
Professional Culture
Professional Development
Professional Organizations
Ethics
Educational Background
Core Competencies
Evidence-Based Practice and Research
Quality of Practice
Healthcare Equity
Communication
Leadership
Collaboration
Professional Practice Evaluation
Self-Regulation
Resource Stewardship
Environmental Health
Roles
Learning
Knowledge
Skill
Ability
Learning Style
Resources
Philosophy

As a registered nurse (RN) student pursuing an advanced degree in nursing, you must evaluate your personal and collegial perspectives on what truly constitutes professional practice. You are at a gateway for advancing your practice and building a professional commitment. To advance in your professional career, you must broaden and build on your knowledge base. This involves Mezirow's (1991, 2000) theory of adult development and education as transformative learning. This theory proposes that the adult learns in one of four ways:

- By elaborating existing frames of reference
- By learning new frames of reference
- By transforming points of view
- By transforming habits of mind (Mezirow, 2000, p. 19)

Building on your knowledge base and your personal frame of reference, you will be adding and developing new perspectives. This process promotes critical analysis and will allow you as the adult learner to transform your views in new ways and create new ways of approaching the world and professional practice. Learning occurs through reflection and interpretation to work toward understanding perceptions of self and the world. This transformation provides an ongoing process in both personal and professional development, including your entry into interprofessional practice.

From the professional standpoint, armed with technical skills and expertise in the practice setting, we chart a course into the conceptual components that embody and expand professional practice. As a start, consider the concepts that characterize both a profession in general and professional nursing practice specifically.

CHARACTERISTICS OF A PROFESSION

Greenwood (1957) developed a classic work on professionalism in which he proposed five characteristics of a profession:

- Systematic Theory and Knowledge Base
- Authority
- Community Sanction
- Code of Ethics
- Professional Culture

These attributes were then applied to the social work discipline to defend its professional status, but they are applicable to any profession, including professional nursing practice.

Systematic Theory and Knowledge Base

Each profession is guided by systematic theory on which its knowledge base is built. The skills of professional nurses are not trial and error but are supported by a fund of knowledge that has been organized into an internally consistent system that is our theoretical basis for practice. This system includes theoretical foundations unique to the profession as well as those adapted from other scientific disciplines.

Kerlinger and Lee (2000) define a **theory** as "a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena" (p. 11). This theory base is also referred to as the paradigm used by professionals or the practitioners in a particular scientific community.

Kuhn (1970) has provided us with the well-established definition of a **paradigm** as "universally recognized scientific achievements that, for a time, provide model problems and solutions to a community of practitioners" (p. vii). The paradigm consists of the beliefs and the belief system shared by members of a particular scientific community. When the paradigm is no longer useful in explaining, practicing, and conducting research in that community, the paradigm shifts and a new belief structure is promoted, adopted, and used by its members.

The paradigm is merely the phenomenon of concern that guides nursing practice. In Chapter 3, Fawcett proposes that *conceptual model* and *paradigm* are interchangeable terms relative to the phenomena of nursing. Various nursing paradigms or conceptual models are currently used in practice. The selection is based on the belief structure of the particular nursing community—for example, care of people who are chronically ill and need major assistance with health needs versus the wellness initiatives applicable in occupational settings. The paradigm is determined by the type of nursing, because it meets the health needs of a particular group in a certain environment or setting.

The **metaparadigm** is the overall concern of nursing common to each nursing model, whether a conceptual model/paradigm or formal theory. Fawcett (1995, 2000, 2005) and Fawcett and DeSanto-Madeya (2013) have described the following four requirements for a discipline's metaparadigm: identity, inclusiveness, neutrality, and internationality. First, the metaparadigm must provide an identity for the profession that is distinctly different from that of others. Second, the metaparadigm must address all phenomena of interest to the profession in a manageable and understandable manner. Third, the metaparadigm must be neutral, so that all smaller practice paradigms can fit under the umbrella metaparadigm. And, finally, the metaparadigm must be "global in scope and substance" (Fawcett & DeSanto-Madeya, 2013, p. 4) to represent the profession across national, social, cultural, and ethnic

boundaries. With that in mind, the metaparadigm of professional nursing incorporates four concepts:

- ***Human beings*** represent the individual, family, group, or community receiving care, each with unique characteristics.
- The ***environment*** comprises the physical, social, cultural, spiritual, and emotional climate or setting(s) in which the person lives, works, plays, and interacts.
- ***Health*** is the focus for the particular type of nursing and specific care provisions needed.
- ***Nursing*** is defined by its activities, goals, and services.

In any area of professional nursing practice, we can evaluate who the person is as the patient or recipient of nursing care, where the person and the caregiver are seen and influenced by others, why the person needs professional nursing care, and how the professional nurse functions as a provider or manager of care. These concepts are present whether the patient is the frail elder in an acute care setting, the expanding family in a birthing center, or an employee group in an occupational setting. Investigate these concepts specific to your own practice setting for an initial view of the systematic theory and knowledge base of your disciplinary paradigm. Look at how the "patient" is defined in the environmental context. And consider the health actions: Are they perceived as emerging, maintaining, enhancing, or perhaps palliative? Now, how do the nursing actions address patients, in their environment, to meet the concept of health? In addition, the national initiatives of *Healthy People 2020* (Office of Disease Prevention and Health Promotion [ODPHP], 2021) and *Healthy People 2030* (ODPHP, n.d.) identified the critical elements of the **Social Determinants of Health** (SDOH): economic stability, educational access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

Authority

The next characteristic of a professional is authority, as viewed by the patient. This **authority** occurs through education and experience, which give the professional the knowledge and skills to make professional judgments. The patient perceives the professional as having the knowledge and expertise to assist the patient in meeting some need. The professional is therefore viewed as an authority in the area, and their judgments are trusted. Authority is the basis for the competence the patient perceives and the patient–professional relationship.

In the nurse-patient relationship, the nurse is perceived as the authority figure, whether providing a selected care technique or filling an informational need. The competence and skill demonstrated justify the patient's trust in the professional nurse. Benner (1984) has described the following five levels of competency in clinical nursing practice: novice, advanced beginner, competent, proficient, and expert (p. xvii). The higher the levels of competence or expertise patients perceive in any profession, the greater trust or authority they place in the practitioners of that profession. Patients and their significant others who see nurses as experts in providing needed healthcare view the profession as having more authority in healthcare judgments. On the basis of this perception of authority, society grants the profession and its practitioners certain rights, privileges, and responsibilities.

Community Sanction

Society grants each profession certain powers and obligations to practice the specific profession. *Nursing's Policy Statement: The Essence of the Profession* (American Nurses Association [ANA], 2010) attributes professional nursing's authority to a social contract with the community. The professional community is responsible for ensuring safe and effective practice within the discipline. Professional and legal regulation of nursing practice as a **community sanction** occurs through statutes, rules and regulations, definition of practice, and expectations for practitioners. Powers for entry and continuity in the profession are granted through licensure and professional practice parameters dictated in the state practice acts. These laws define a specific practice and provide regulatory powers at the state level for the board, licensing of professionals and protection of title (e.g., RN or advanced practice registered nurse [APRN]), general practice standards, approvals for educational programs, and disciplinary procedures.

Definition of practice and specific practice standards are further specified within the professional community through major nursing associations. The ANA has specified a variety of practice standards for the profession, both general and specific to certain practice areas. The ANA has prepared several specialty standards documents jointly with the particular specialty organization to reflect the expectations for specialized professional practice. These standards, which signify the sanction by the community of the nursing profession, are authoritative statements by which nurses practicing within the role, population, and specialty describe duties they are expected to competently perform and may be used as evidence of the standard of care governing the given context of nursing practice (ANA, 2021, p. 4). Other countries, such as Canada, publish similar standards, as with the Canadian Nurses Association.

The publication *Nursing: Scope and Standards of Practice* (ANA, 2021), for example, prescribes standards of practice and standards of professional performance. Standards of practice address safe and competent practice in general or specialty practice and use of the nursing process with the actions of assessment, diagnosis, outcome identification, planning, implementation (including coordination of care and health teaching and promotion), and evaluation (ANA, 2021). Standards of professional performance are expected professional roles and behaviors, including ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health (ANA, 2021).

Further standards of specialty practice are provided through the certification process with specialized education, testing, and ongoing learning requirements. Practice standards and expectations have also been developed by applicable specialty organizations. Check the websites listed in the Appendix for standards of practice expected in selected specialty practice areas included on various sites.

Another area in which the community grants a profession certain privileges on the basis of professional knowledge and expertise is in the education process of future clinicians and practitioners. Educational programs are both approved at the individual state level, as by the Board of Nursing, and accredited at the national level, as by the Commission on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in Nursing (ACEN). CCNE accredits baccalaureate, graduate, and residency/fellowship programs in nursing. ACEN accredits the clinical doctorate, master's, post-master's, baccalaureate, associate, diploma, and practical degrees; diploma; and certificate nursing program. Development, implementation, and evaluation of the organization, curriculum, faculty, students, graduates, facilities, and program resources are important considerations within the accreditation and reaccreditation process. The job of establishing and evaluating these standards falls to the professional accrediting groups. Here again, the profession is granted the power by the community and has the responsibility to provide the community with practitioners who are appropriately educated for safe, effective, and equitable practice.

Educational programs are also guided by professional nursing standards. The American Association of Colleges of Nursing (AACN) has specified core competencies and sub-competencies for nursing programs at the entry level and the advanced level of nursing education under 10 domains of nursing practice. See Box 1.1 for the 10 domains that AACN (2021) has identified as representative of professional nursing practice (p. 1). The domains, core competencies, and sub-competencies serve as core elements for educational programs and delineate expected outcomes for the nursing programs by educational level and into the practice environment. AACN (2021) also identified the following 10 concepts associated with professional practice: clinical judgment, person-centered care, population health, scholarship, quality and safety, interprofessional partnerships, systems-based practice, information and healthcare technologies, professionalism, and personal, professional, and leadership development (pp. 10–11). Further information on and description of these expected curricular elements can be found on the AACN website at https://www.aacnnursing.org/AACN-Essentials.

Confidentiality of patient information is one of the most important professional privileges. Professional nursing enjoys this privilege and conscientiously guards the confidentiality of patient information. As discussed in relation to ethical codes, confidentiality is a major consideration in professional nursing practice.

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American Nurses Association at
http://www.nursingworld.org

American Association of Colleges of Nursing at
http://www.aacnnursing.org

Canadian Nurses Association at
https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada

BOX 1.1 AACN Domains for Core Competencies for Nursing Practice

10 Domains for Nursing

- Knowledge for Nursing Practice
- Person-Centered Care
- Population Health
- Scholarship for the Nursing Discipline
- Quality and Safety
- Interprofessional Partnerships
- Systems-Based Practice
- Informatics and Healthcare Technologies
- Professionalism
- Personal, Professional, and Leadership Development

Source: American Association of Colleges of Nursing. (2021). *The essentials: Core competencies for professional nursing education*. https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Code of Ethics

A professional abides by a certain **code of ethics** applicable to the practice area. Developed within the profession, the code addresses general ethical practice issues as well as professional personal and practice values and colleague relationships. The ANA's Code of Ethics for Nurses is the ethical standard for professional nursing practice in the United States. It embodies both formal and informal ethical codes. The Code is "foundational to nursing theory, practice, and praxis in its expression of the values, virtues, and obligations that shape, guide, and inform nursing as a profession" (ANA, 2015, p. vii). The interpretative statements promote understanding for appropriate application of the code of ethics in professional practice. Adherence to this specific code may be regulated in your state's practice act. To view the ANA Code of Ethics with Interpretative Statements, go to https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/. However, there are other ethical codes, including the International Council of Nurses (ICN) *Code of Ethics for Nurses* (2021), which presents four elements associated with nurses: patients or other people requiring care or other services, practice, the profession, and global health. In addition, for each of the elements, the roles of nurses, nurse leaders and nurse managers, educators and researchers, and national nursing associations are illustrated.

Achieving professional status requires ethical standards for expected behaviors with patients, colleagues, and other professionals. And the high standards of nurses are recognized by the public as illustrated in the annual Gallup poll where nurses for the past two decades have led all professions in the consumer survey, being considered the most honest and ethical profession (Saad, 2020).

Professional Culture

The fifth characteristic of a profession is a professional culture. Greenwood (1957) described **professional culture** as the formal and informal groups represented in the profession. *Formal groups* refer to the organizational systems in which the professionals practice, the educational institutions that provide for basic and continued learning, and the professional associations. *Informal groups* are the collegial settings that provide for collaboration, stimulation, and sharing of mutual values. These informal groups exist within each formal group, providing further professional, collegial inclusiveness. These groups and the unique culture of nursing are reinforced in the *Code of Ethics for Nurses*.

Organizational systems in which professional nursing is practiced are diverse and multidimensional. As you will see in later chapters, hospital and home health agency settings are complex parts of a larger system. Professional nursing practice provides a unique culture with the values and norms expected of its practitioners and becomes increasingly influenced with interprofessional practice. Organizational philosophies and mission statements provide information on the expressed culture of these settings. Further expression of the professional culture is apparent in the behaviors of professional nurses who practice in these settings.

Formal educational settings for professional nursing practice occur in institutions of higher learning with liberal and specialized learning requirements. In addition, values and norms for continued learning and competency in practice are transmitted as expectations for professional practice. Beyond basic educational practice, **professional development** is provided through continuing education, specialty preparation, and continual competency as a professional.

Professional organizations or associations are a major component of the culture of professional nursing practice, but they vary in purpose or mission and membership. The purpose of some professional organizations, such as the ANA or the Canadian Nurses Association, is to represent the profession on a national basis. Specialty groups, with a more specific focus, promote education, skills, standards, and perhaps certification opportunities for a particular segment of the profession—for example, the American Association of Critical-Care Nurses. Each organization has a unique philosophy or mission directed at professional nursing practice.

Professional organizations communicate values and norms in official publications, position statements, and specified practice standards. These organizations promote professional parameters for clinical practice, education, administration, and research. They provide educational opportunities and foster expansion of the knowledge base of individual professionals and the discipline in general. Some organizations focus specifically on the science of the profession. Their purpose is to promote the scholarly aspects of the profession and to build professional and leadership skills through education, publications, and conferences. A more global view

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ANA Code of Ethics for Nurses with Interpretative Statements at
https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

ICN Code of Ethics for Nurses at
https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf

of practice can be seen in many professional organizations as they reach out to influence public policy. In addition, professional organizations often collaborate with each other on vital issues that enhance the impact and the influence on the professional and public communities.

Consider the organizations that represent professional nursing practice and education listed in Table 1.1. The ANA and its state and territorial associations focus mainly on the profession as an entity, with concern for the health of society as well as the welfare of professional nurses through standards,

TABLE 1.1 Characteristics of Professional Organizations

Organization	Focus, Mission, and Membership
American Nurses Association (ANA) and associated constituent state associations and organizational affiliate members Founded 1896 http://www.nursingworld.org	Focus: Professional nursing Mission: "Lead the profession to shape the future of nursing and health care" (ANA Enterprise, n.d., p. 1). Membership: Individual membership; professional nurses at the state and/or national level.
American Association of Colleges of Nursing (AACN) Founded 1969 http://www.aacnnursing.org/	Focus: Collegiate nursing education Mission: "As the collective voice for academic nursing, AACN serves as the catalyst for excellence and innovation in nursing education, research, and practice." (AACN, 2022, p. 1). Membership: Over 800 member schools with baccalaureate and higher-degree nursing programs
American Association of Critical-Care Nurses (AACN) Founded 1969 https://www.aacn.org/about-aacn	Focus: Specialty care Mission: "Patients and their families rely on nurses at the most vulnerable times of their lives. Acute and critical care nurses rely on AACN for expert knowledge and the influence to fulfill their promise to patients and their families. AACN drives excellence because nothing less is acceptable" (AACN, n.d., p. 1). Membership: Individual membership
International Council of Nurses (ICN) Founded 1899 http://www.icn.ch	Focus: Nursing internationally Mission: The ICN's mission is "to represent nursing worldwide, promote the wellbeing of nurses, and advocate for health in all policies" (ICN, 2022, p. 1). Membership: National nurses' associations representing nurses in more than 130 countries
National Council of State Boards of Nursing (NCSBN) Founded 1978 (previously a component of the ANA) http://www.ncsbn.org	Focus: Nursing regulation and public protection Mission: The "NCSBN empowers and supports nursing regulators in their mandate to protect the public." (NCSBN, 2022, p. 1). Membership: All state boards of nursing in the 50 states, the District of Columbia, and four U.S. territories. Associate members are from regulatory boards from around the world.
National League for Nursing (NLN) and associated constituent leagues Founded 1952 http://www.nln.org	Focus: Nursing education Mission: The NLN "promotes excellence in nursing education to build a strong and diverse nursing workforce to advance the health of our nation and the global community" (NLN, 2022, p. 1). Membership: Individuals, Schools of Nursing, Associate Supporter memberships
Sigma Theta Tau International Honor Society of Nursing and member chapters Founded 1922 https://www.sigmanursing.org	Focus: Excellence in scholarship, leadership, and service (international) Mission: "Developing nurse leaders anywhere to improve healthcare everywhere" (Sigma Theta Tau, 2022, p. 1). Membership: Individuals are invited to membership in chartered chapters with selection criteria as baccalaureate or higher-degree students, faculty members, or community leaders.

Note: Reference citations in table are excerpts from online resources of the respective nursing organizations.

official position statements, political action initiatives, and certification options for specialty practice. Specific to an area of specialty practice, the American Association of Critical-Care Nurses, with its worldwide membership, is the largest specialty organization. Also, more globally, the International Council of Nurses (ICN) is composed of professional associations from over 130 countries, including the ANA. The American Association of Colleges of Nursing focuses on collegiate education, serving member schools with baccalaureate and higher-degree programs through educational standards, programs, policies, research, accreditation, and legislative initiatives directed at high-quality professional education. This organization has published documents identifying educational essentials important for nursing education programs. The National League for Nursing (NLN) has individual and agency memberships for educational institutions and focuses on excellence in nursing education from practical nursing to graduate education. The National Council of State Boards of Nursing (NCSBN) is composed of the member regulatory boards for the 50 states, the District of Columbia, and four U.S. territories, as well as international regulatory bodies for nursing as associate members. Sigma Theta Tau, the international honor society for nursing, has a distinctly scientific focus. This organization promotes knowledge development through research, dissemination of scientific information, technology, education, interdisciplinary collaboration, and adaptability for the improvement of the health of people worldwide.

A comprehensive listing of professional organizations and their website addresses is located in the Appendix. In addition, useful links to additional resources may be discovered within these sites. Just one word of caution: website addresses change, as do physical addresses. Try to update your Internet "favorites" listing regularly with any changes and add new sites that you have found useful.

PROFESSIONALISM IN NURSING

We have viewed the profession of nursing according to general attributes. However, consider the specific practice attributes professionals have specified as standards for professional performance: ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health (ANA, 2021). In subsequent chapters we will consider specifics on ethical issues and advocacy, education, evidence-based practice, quality of practice, communication, leadership, and environmental health. But look further at the following expectations of professional nurses that are guideposts for professional development.

Ethics

Adherence to a code of **ethics** is expected in any profession. As discussed previously, the *Code of Ethics for Nurses with Interpretative Statements* (ANA, 2015) provides the broad guidelines. It is the responsibility of the practicing professional to know these guidelines and practice in accordance with the code. In 1993, Miller and associates reported that most professional nurse respondents did not have a copy of the ethical code, and many were unfamiliar with the document (p. 293). This problem occurred with the 1985 *Code of Ethics*. The question then becomes, how many nurses are aware of the current code as revised in 2015? To meet this criterion of professionalism, nursing professionals need to demonstrate greater knowledge and understanding of the official ethical code. Periodic review of the ethical provisions and their interpretative statements is an important responsibility for all professional nurses. This is especially true when the roles of nurses or patients change, but it is also important for nurses to appreciate fully their professional responsibilities, challenges, and talents when roles evolve.

Ethical considerations also involve personal and interpersonal actions, beyond those directly related to the individual situation, as with autonomy and self-regulation. Autonomy means independent judgment and self-governing within the scope of one's practice, which changes in response to people's healthcare needs. As key professionals in organizational settings, nurses make the time and commitment to ensure that high-quality care and standards are equitable, present, and upheld. This involves critical analysis, communication, collaboration, and leadership. Important concepts in this area are professional responsibility and accountability. In the *Code of Ethics for Nurses*, responsibility is defined as "an obligation to perform required professional activities at a level commensurate with one's education and in compliance with applicable laws and standards . . ." (ANA, 2015, p. 45), whereas accountability is being answerable to self and others for one's own choices, decisions and actions as measured against a standard . . ." such as the Code (ANA, 2015, p. 41). Nurses are accountable to both themselves and their patients for good clinical judgment and quality care. However, as we will see in later chapters, accountability is also extended to the broader population as the profession demonstrates involvement in social policy and a commitment to health equity.

Educational Background

The **educational background** required for professional practice is specified to ensure safe and effective practice. In nursing, the basic education required for entry into the profession varies, with differences

among baccalaureate, associate degree, diploma education, and entry-level graduate programs. But within each type of educational program, curricula and requirements are guided by general standards, and, as stated in two landmark national reports by the Institute of Medicine (IOM, 2011) on *The Future of Nursing: Advancing Health, Leading Change* and by the National Academies of Sciences, Engineering, and Medicine (NASEM, 2021) on *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity,* nurses should practice to the full extent of their education and training.

Although a school's curriculum is developed by its faculty members, certain standards are required for an educational program. Nursing curricula must contain essential content, practice opportunities, and hours as required by some state boards of nursing, higher education boards, professional associations, and national accrediting bodies. Consumers of nursing care can be confused by the different educational routes leading to the title of registered nurse. Numerous studies have reviewed the various health professions, their regulatory bodies, educational program requirements, and workforce needs with respect to the changing healthcare system. Consumer confusion and overlapping scopes of practice are key issues that must be addressed along with interprofessional collaboration. Ongoing clarification of these areas among professionals and consumers of nursing will have a beneficial effect on the view of nursing as a profession and of individual nurses as true professionals. However, some skills do cross professional boundaries and are important considerations in collaborative practice.

A 2003 report from the IOM following a Health Professions Education Summit led to the identification of five **core competencies** (Box 1.2) that are required of all health professions to advance a vision for the education of all health professionals "to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics" (Greiner & Knebel, 2003, p. 45). To address these competencies in nursing education programs, curricula must be constantly evaluated for currency, practice opportunities, and attainment of core competences. For example, most nurses will agree that providing patient-centered care is a component of our nursing programs. However, we need to assess carefully whether all programs foster interdisciplinary and evidence-based practice focused on quality improvement and the use of informatics.

Beyond the basic education, competent practice requires ongoing learning, continuing education, and continued competency. These attributes are crucial to safe, effective, and ethical professional practice. Ongoing improvement and knowledge are the goals of continuing education, which is required for relicensure in some states and recertification in specialty areas. But continuing education involves more than obtaining required credits, in-service hours, and formal degrees. Remaining current with ideas presented in the nursing and scientific literature is an important component of continued competency as a professional and to incorporate evidence-based information into practice. And more so now, as we focus more broadly to achieve health equity for all.

The Internet has made remaining current on issues of concern to the profession more convenient. Yet, a word of caution is in order: It is important to evaluate the source of information and its validity. Consider whether the information is provided by an organization, an agency, or social media and personal perspective.

Identifying your own learning and developmental needs is an expectation and a continual process for competent professional practice. In essence, continuing education for competency involves self-assessment, ongoing learning, and self-evaluation. The focus is on discovery, as in baccalaureate and graduate education. Ongoing learning means that your mind is challenged every day with new ideas, building on a professional knowledge base and skills. Opportunities for continuing education abound through a variety of formal programs as well as through professional journals and online resources. Many professional organizations have special online services for their members, such as reviews of current literature and care products, continuing education programs, and forums. Publishers also have online resources with special discounts, e-mail updates, associated websites, discussion groups, and interactive continuing education offerings. The ongoing challenge is developing new knowledge, and it is the responsibility of the professional to maintain currency for the specific practice area and to document their professional efforts and progress.

BOX 1.2 Core Competencies for Health Professionals

- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

Source: Greiner, A. C., & Knebel, E. (Eds.). (2003). *Health professions education: A bridge to quality*. Institute of Medicine (p. 48). Reproduced by permission from the National Academies Press.

Evidence-Based Practice and Research

Nursing research is much more than leading or participating in a research study. We now look to the core competency of **evidence-based practice and research** to guide the way we practice. Greiner and Knebel (2003) define evidence-based practice as the integration of the best research with clinical expertise and the patient's values for optimal care, as well as participation in learning and research activities (pp. 45–46). As found in the interpretative statements of the *Code for Nurses*, "All nurses must participate in the advancement of the profession through the knowledge development, evaluation, dissemination, and application to practice" (ANA, 2015, p. 27).

In the revised standard of professional performance, "scholarly inquiry requires that "the registered nurse integrates scholarship, evidence, and research findings into practice" (ANA, 2021, p. 100). This standard includes identification of researchable questions, using findings, sharing knowledge with others, participating in an investigation, protecting human subjects, and searching the literature for demonstrated innovations in practice. It adds to our knowledge base, enhances our practice, promotes improved outcomes for our patients and fosters practice based on evidence of efficacy rather than tradition or trial and error. Collaborating with others and sharing new knowledge is critical in this process. We will focus further on evidence-based practice and research in Chapter 5.

Quality of Practice

The effectiveness of nursing care to address appropriate, equitable, and measurable patient outcomes is an expectation of the professional nurse. In addition, recall that improvement in the **quality of practice** is a core competency of all health professionals. It is not just a matter of determining whether a nursing intervention was appropriate and effectively addressed the healthcare need. Now, questions are raised about further improvements that can be made based on the evidence presented in the current case and through documented evidence of practice effectiveness with concerted efforts on healthcare equity. Quality improvement is the goal for making refinements in practice that are based on efficacy, equity, and efficiency. Efficacy in meeting the patient outcomes is not sufficient for professional practice. The activities must be acceptable for the patient population in addressing our metaparadigm concepts of human beings, health, environment, and nursing. The patient is the focus, and equity and efficiency are vital considerations to preserve resources, both personal resources (such as energy of both the patient and the nurse) and the material and physical healthcare resources for patients in the environment. But notice our present quality focus on healthcare equity. **Healthcare equity** is defined as "the state in which everyone has the opportunity to attain full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance" (NASEM, 2017, p. 32). So, the question becomes, how can practice in the future be made safer, more effective, and equitable? This question can lead to innovative and changed practices for improved patient outcomes, considering human needs, the environment, the concept of health, and care techniques and technologies.

Communication

Effective **communication** has long been a focus and characteristic of professional nursing. In a subsequent chapter, we will review this important content, as it is an area that needs constant reevaluation in different situations and with different individuals. And effective communication skills are essential with patients as well as nursing colleagues and other members of the healthcare team. Consider communication as more than a verbal encounter with another individual, but rather an interaction involving all the interpersonal and cultural facets. Appropriate verbal messages must be communicated into the plan of care, be documented appropriately, be shared through a variety of channels and media, and lead to quality improvements for the equitable care of patients. Dissent, debate, conflict, and negotiation are natural outcomes and, again, must focus on quality and equitable healthcare. And think further about evolving technologies, as in the case of telehealth, with patients and providers interacting at a distance. Effective communication skills are in constant refinement for the professional nurse who is on the front line managing and leading the team for quality patient outcomes. We will consider refinement of interpersonal and professional communication skills in Chapter 6.

Leadership

Leadership is an expectation for the professional nurse, both in the practice setting and in the profession. Nurses must project a positive image as well as the vision and actions needed for effective patient outcomes on a daily basis and in an effective working environment. Managing care effectively and leading others in the process is more than a job requirement but also a commitment to patients, colleagues, and the profession. And leadership extends beyond the care environment to involvement in the institution or agency, as with shared governance or committee involvement, and in the profession at large.

Nurses also assume leadership positions in the community through service activities using their

unique knowledge, skills, and abilities. Nurses are well equipped and talented in this area because of their orientation of service to patients and society at large. Nurses frequently lead health-promoting activities in their employment role, their professional community, and among their family members and acquaintances. Consider how residents in a defined community always seem to know who the nurses in the area are and how frequently those nurses are approached with questions or requests to become involved in projects or serve on committees. Also consider how nurses reach out to others with information on healthcare issues or ideas to foster wellness in their communities. This vision of the community also leads to involvement in healthcare policy and changes needed for health equity and improved outcomes in the community.

Collaboration

Each of the standards of professional performance requires **collaboration** in practice. The ANA Standard of Performance on Collaboration includes the healthcare consumer and other key stakeholders in the conduct of nursing practice (ANA, 2021, p. 95). Professional interactions and behaviors should be ethical, equitable, and patient-centered, based on the information and needs of the colleagues who influence patients and on the quality of practice. These interactions require excellent communication and leadership skills focused on effective practice and quality outcomes. The healthcare team is focused on the patient and promoting positive outcomes, which do not occur in isolation by the efforts of one individual but through interprofessional collaboration. This professional performance standard requires that colleagues assist each other and include the patient in the plan of care to promote long-term positive outcomes. Trust, openness, knowledge, skills, various professional abilities, and commitment are necessary parts of all interactions toward this aim of safe, equitable, and effective patient-centered care.

Professional Practice Evaluation

The *Scope and Standards of Practice* (ANA, 2021) specifies practice competencies in this area as "engag[ing] in self-reflection and self-evaluation of nursing practice on a regular basis, identifying areas of strength as well as areas in which professional growth would be beneficial" (p. 103). **Professional practice evaluation** requires self-regulation by both the professional and the profession that sets the standards. The ANA's *Nursing's Policy Statement: The Essence of the Profession* (2010) describes **self-regulation** as both personal accountability for the knowledge base for practice and participation in the peer review process (pp. 30–32). Professional responsibility and accountability involve upholding quality standards as well as developing and critically analyzing those standards and the outcomes. The regulation of nursing practice includes both self-regulation beyond a limited job description and professional regulation through the defined scope of practice, further education, certification, and adherence to the code of ethics.

Professionals are responsible and answerable to patients and their significant others for nursing care outcomes. And performance feedback from patients as well as professional colleagues should be included in a practice evaluation. Nurses are actively involved in supervising, delegating, and evaluating others. But reflection on professional performance assists in practice improvement as an important component of the peer review process and as part of an annual performance evaluation. The peer review process is a time for professional development for both the reviewer and the person being evaluated. The process is a learning opportunity and much more than a checklist and narrative comment provided on an annual basis.

Resource Stewardship

Recall the concept of efficiency related to quality care. Innovative and changed practices for improved patient outcomes must address human needs, the environment, the concept of health, and care techniques and technologies. Identification, procurement, and the judicious use of healthcare resources are requirements of the professional role. The *Scope and Standards of Practice* (ANA, 2021) describes **resource stewardship** as not only the appropriate use of resources but also the assurance that nursing care be "safe, effective, financially responsible, and used judiciously" (p. 105). The focus continues to be on outcomes and the vital role of the nurse in promoting successful and equitable outcomes. In the healthcare environment, the focus is on safety and obtaining appropriate resources, supplies, and care provision. However, understanding cost factors and patient concerns and resources is essential. And think further than resources in the healthcare environment, especially when assisting the patient and family to prepare for care in the home and community. Assess carefully those social determinants of heath: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Will they have sufficient resources at home for safe healthcare practices? This includes the knowledge for safety at home and the value for the treatments needed, as well as the financial and environmental resources to obtain needed medication or treatment. Think about the individual with asthma and whether they will, in the long term, have short-term rescue and controller

medications, understand their proper use and care, and make the environmental adjustments needed for successful management of this chronic condition. The professional nurse is concerned with safe, equitable, and effective care beyond the treatment facility with a focus on human beings, the environment, and health as part of effective nursing care for positive outcomes.

Environmental Health

With nursing's focus on the centrality of the environment in individuals' health and care, concerns over safety and health risks require constant attention and vigilance. Health professionals and consumers of healthcare were alarmed by the release of reports from the IOM of the National Academies on the high incidence of medical errors. These reports started in 1998 and led to ongoing efforts for improving patient safety in both the hospital and community settings. The IOM (now the National Academies of Sciences, Engineering, and Medicine) is a nonprofit organization designed to provide science-based advice as a public service. The 2001 report from the IOM, *Crossing the Quality Chasm*, proposed 10 rules for quality healthcare in the 21st century (Box 1.3). The six overall aims—that care should be safe, effective, patient-centered, timely, efficient, and equitable—underlie these ten rules (Corrigan et al., 2001). Health equity has received additional attention in light of health disparities identified during the COVID-19 pandemic.

Achieving health equity has become a major national objective and has directed additional attention to nursing, especially since the release of *The Future of Nursing 2020–2030: Charting a Path to Health Equity* (NASEM, 2021). From the report a decade earlier (IOM, 2011), nursing has been urged to take a leadership role toward improving health equity with subsequent initiatives from the American Association of Retired Persons (AARP) and the Robert Wood Johnson Foundation (RWJF). The vision shared is a healthcare system where nurses contribute to the full extent of their capabilities with initiatives focused on the following issue areas: improving access to care, interprofessional collaboration, nursing leadership, nursing education, nursing workforce data, diversity in nursing, and building healthier communities (RWJF, n.d.).

Research by the Agency for Healthcare Research and Quality (AHRQ) also continues to expand the knowledge base on how the quality of the healthcare workplace affects the quality of the healthcare provided, especially in the areas of workload and working conditions, effects of stress and fatigue, reduction of adverse events, and the organizational climate and culture. Patient outcomes are viewed and investigated, along with nursing-sensitive indicators and factors that promote safe and effective practice.

Nurses play an essential role in their constant attention to the environment and the factors that could place patients and healthcare providers at risk. These include product defects, risky or improper medication practices, environmental artifacts like noise, other potential hazards, abusive behaviors, and the SDOH. Attention to the environment is necessary for care to be safe, effective, patient-centered, timely, efficient, and equitable. As stated in one of the competencies for environmental health, the nurse is responsible for reducing "environmental health risks to self, colleagues, healthcare consumers, and the world" (ANA, 2021, p. 107).

Fulfilling the characteristics described in standards of professional performance is the challenge to you in your educational pursuit and your daily practice. Professionalism is an attribute in constant refinement. The degree to which professionals demonstrate professionalism in nursing is apparent in their professional practice and how they define nursing. But have you prepared all your resources for this ongoing professional development?

BOX 1.3 Rules for the 21st Century Health System

- Care is based on continuous healing relationships.
- Care is customized according to patient needs and values.
- The patient is the source of control.
- Knowledge is shared, and information flows freely.
- Decision making is evidence based.
- Safety is a system property.
- Transparency is necessary.
- Needs are anticipated.
- Waste is continuously decreased.
- Cooperation among clinicians is a priority.

Source: Corrigan, M. S., Donaldson, M. S., Kohn, L. Y., Maguire, S. K., & Pike, K. C. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academy Press (pp. 61–62). Reproduced by permission from the National Academies Press.

RETURNING TO SCHOOL

This is a time to celebrate the talents you bring with you to your continuing knowledge development. It is a time for discovery, reflection, and professional development. You have had many experiences in educational settings. Unlike a child in school, the adult learner brings a wealth of experiences to the learning environment. Experiences of the adult learner may

be varied, but they occurred in a certain environment or context and have meaning to the individual. To understand this meaning requires careful examination of your situation.

First, consider the reasons you have returned to school. You may think that the recognition for your work or the pay differential on your career ladder is the reason. These may be considerations, but you are embarking on a journey of professional development that will further your knowledge, skills, and abilities, compared with a quick fix to a limiting situation. You will be facing challenges of competing roles and addressing priorities in time management.

Competing Roles

As an adult, you are already engaged in multiple roles. **Roles** are organized behavioral patterns and expectations. VandenBos (2013) defined a role as "a coherent set of behaviors expected of an individual in a specific position within a group or social setting" (p. 503). Now consider the multiple roles and positions in your unique circumstance.

You are probably employed as a registered nurse. The expectations for your work are written in the state law for practice and in the job description at your place of employment. There are also the less formal expectations of your supervisors and colleagues at work. However, there are many role opportunities in professional nursing. The American Association of Colleges of Nursing (AACN, 2021) states that entry-level nursing programs prepare graduates for generalist practice across the lifespan with diverse populations in four spheres of care: wellness/disease prevention, chronic disease management, regenerative/restorative care, and hospice/palliative care (p. 19). Advanced nursing education builds on competencies from entry-level education with additional competencies for an advanced nursing specialty or practice role (AACN, 2021, p. 26). Advanced practice nurses (APRNs) are prepared at the graduate level in nursing within one of four roles and function in a specialty area as a nurse practitioner, clinical nurse specialist, nurse anesthetist, or nurse midwife. Nurses prepared at the master's or doctoral level in nursing also function in role specialties such as nursing education, administration, informatics, research, public health, and other specialties.

Your future practice will be in one of these multiple roles of RN. However, your current situation has another role: adult learner. And this new role of student will influence your current career and personal roles. For example, how are your coworkers and supervisors reacting to your return to school? Consider the apparent and hidden behaviors, all of which have an impact on your progress. Align yourself with positive influences and try not to be drawn into negativity.

Consider also your varied personal roles. You are also a member of a family—whether it is an extended family with intergenerational considerations, a single partnership, a single-parent family, or even a social or religious group. Your roles and responsibilities for caregiving occur by virtue of your membership in this unique group. You may be a parent concerned about your child's progress in elementary school or your teenager's involvement with a particular social group. You may be living close to extended family members or be isolated by miles or situations. These are all considerations of your unique situation as an RN pursuing additional education.

You have now thought about both your family and work-related roles and responsibilities. Now, what about you? What are your deeply held wishes and desires—personal, career-related, and family-inspired? This is where competition and conflict can occur. Think about the questions posed in Box 1.4 and add others that apply to your personal situation. You made the right decision to return to school.

BOX 1.4 What Are Your Competing and Multiple Roles?

- Will your employer adjust your work schedule for you to complete a required practice activity or use the library?
- How did your coworkers react (certified nursing assistants [CNAs], licensed practical nurses [LPNs], RN peers, supervisors, others) when they found out you were taking this course?
- Have you taken the prerequisite courses, such as statistics, for the nursing program?
- What study materials do you have readily available?
- How are your computer skills?
- What expectations do your partner, family, or child(ren) have for your returning to school: high/low/none? Are they supportive or unsupportive?
- What are your expectations?
- What will you do to ensure you have the time needed for each of your roles?
- Do you have resources for childcare or elder-care, if needed?
- If needed, did you apply for tuition assistance through your employer or at the college?
- Do you have any outstanding loans? Are they a worry?
- Do you have reliable transportation to get to work as well as to school requirements?
- Did taking this course seem like a good plan at the time but now you are having second thoughts?
- Others?

Now relax and prepare. Plan to streamline your life (work, school, and family) and prepare for dealing with your competing roles and responsibilities. This situation is another form of multitasking—a more complex one than encountered in daily practice. You are advancing your career and professional practice through additional learning and building on your knowledge, skills, and abilities.

Learning as Empowerment

Learning is the perception and assimilation of the information presented to us in a variety of ways. Learning leads to knowledge and encompasses the following characteristics:

- Perception of new information
- Reaction to the information
- Ability to recall or repeat the information
- Understanding as rejection or acceptance of the information
- Use of the information in a similar situation
- Critical analysis of the information
- Incorporation of the information into the value system
- Use of the information in various situations and combinations

An increasing complexity emerges here as the learner moves from receiving and recalling information through understanding, application, analysis, and evaluation, to the point of creating new applications.

There are also three domains, or categories, of learning: affective, cognitive, and psychomotor. The affective domain includes attitudes, feelings, and values—for example, how you feel about returning to school. Your perception and value of the positive effects on your life will influence your progress. The cognitive domain involves knowledge and thought processes within an individual's intellectual ability. This cognitive domain involves your understanding of the information received about pathophysiology, theory, and the other areas for knowledge acquisition. The psychomotor domain is probably the one you are most comfortable with. This domain involves the processing and demonstration of behaviors, as with the performance of a skill like changing a dressing or starting an IV infusion.

Learning activities can be very different for the three domains, but continued learning leads to empowerment. Remember, to achieve a lasting change in observed behavior (psychomotor domain), the value of that change (affective domain) and the intellectual capacity to understand and process the information for behavioral changes (cognitive domain) must first be present. What are some of your individual learning needs?

Building Knowledge, Skills, and Abilities

Your plan for professional practice should be tailored to your situation and learning needs, taking into account your knowledge, skills, and abilities. **Knowledge** is the accumulation of appropriate information through learning and experience. **Skill** is the ability to retrieve this knowledge through mental and psychomotor activities and apply it appropriately to a situation. **Ability** refers to your competence and proficiency in the demonstration of that knowledge and skill. Your personal plan needs to address your knowledge, skills, and abilities for success in your nursing program. Consider the particular factors in your own situation.

First, look at your educational goals. Think about your timeline for program completion and determine whether adjustments may be needed to accommodate additional time commitments. Given your personal timeline, consider the factors that will promote your success. Consider the time required for the program. If you are employed, what adjustments to your schedule will need to be made? Do you have to factor in travel for classes or library research? Or is the program online and do you have all the technology needed to navigate the courses, including the computer skills, equipment, and broadband necessary? Some nursing programs require a certain number of courses arranged in a specific semester plan with classes, laboratory or clinical sessions, online activities, and library research. What is your computer access and how are your skills with presentation graphics and attaching files? Have you completed some of the prerequisite work? And what about other courses required in the program—have you plotted them into your timeline?

There may be areas in which you want to do some enhancement work. Consider your resources and materials for review. Your program may offer review or tutorial requirements to allow you to refresh certain content areas or to learn about areas that were not known at the time of your program, such as genomics competencies and informatics. If review opportunities are available, take advantage of them and take them seriously. Review and refreshment opportunities can add to your supply of personal knowledge, skills, and abilities.

Look further at your present job. Will the schedule permit you to stay in that job, perhaps on a reduced schedule, or will you need to find another job? How will your peers at work react to you once you are really progressing through the program? You may experience unanticipated reactions, including hostility.

Another consideration is unanticipated costs. You may be evaluating the cost of tuition, books, and materials, but what about additional travel to a clinical site, reduced salary due to a reduced working

schedule, and added costs for childcare and perhaps prepared meals? Is your tuition assistance available only after you have successfully completed a course? Are there delays that must be factored into your plan? What other costs will be unique to your situation?

Now, consider your family and significant others. What support systems are available, and what other ones may be needed by you and your family members? You need to differentiate educational commitments that are required during a semester from family activities that can become prominent during semester breaks. This may be the opportunity to have a "family meeting" to discuss the situation. Nurses often do not like to ask for help, but perhaps family members can be enlisted to take on some of the household chores. You may get to a point down the road when your son or daughter scolds you, telling you that you had better get *your* schoolwork done before you can play!

Your own health is also a consideration. Remember, to effectively care for others, you must take good care of yourself. All of this requires prioritization of needs, roles, activities, and, especially, time management skills. This is especially true in times of staffing shortages, increased acuities, additional responsibilities, challenging patients and colleagues, along with returning to school.

ADDRESSING TIME MANAGEMENT

Now look at your time management skills. What do you do well and what can be further developed? Identify your "time wasters" and your "time enhancers." Much reflection on your part will be involved in this activity—it is not a one-size-fits-all situation. You are unique as is your environment and the people around you. Someone once asked me how I had the time to do a particular activity. My first response was, "I make the time." Then I thought about it and added, "I get up an hour earlier, and that seems to work best." It's all about reflecting on the activity and planning ahead, as with a dressing change, to set aside the time and have all the materials at hand. Remember, no one has yet figured out how to add more minutes to the day. So, within any given 24-hour period, you must determine the most efficient use of time. Look at the factors identified in Box 1.5. Depending on your roles and unique situation, you will likely need to add other factors for effective time management, whether at work, at home, at school, in the library, or online. Be honest and realistic, but do not get lost in the details.

Your Learning Style

Learning styles and associated inventories have been discussed with varied research for over 50 years in an attempt to improve teaching and learning outcomes (see Box 1.6). The research and discussion continue as we seek to understand better how individuals acquire meaning and knowledge. Increasingly we are concerned with the active involvement of the learner in the process. Your **learning style** is simply the ways you best perceive, think, organize, use, and retain knowledge. To understand this concept, merely recall colleagues in the same learning environment—those who take a lot of notes, those who just listen,

BOX 1.5 Factors to Consider for Efficient Time Management

Family
- Meals
- Homework
- Laundry
- Relationships
- Social obligations

Work
- Work schedule
- Hours and fatigue
- Coworkers and colleagues
- Practices to refine
- Scope of practice

School/College
- Costs
- Transportation
- Learning needs
- Course requirements
- Academic schedule and timeline

Personal
- Health and fitness
- Hope and aspirations
- Spirituality
- Knowledge, skills, and abilities
- Individual needs

BOX 1.6 Myers-Briggs Inventory

The Myers-Briggs Inventory is used widely in education and business applications. A classification system of four scales identifies 16 personality types that can be further classified for learning preferences:
- Introversion—Extroversion
- Sensing—Intuition
- Thinking—Feeling
- Judging—Perceiving

Source: Myers & Briggs Foundation. (2022). *MBTI basics*. http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/

and those who make notes or drawings on what they interpret the message in the presentation to be. Understanding differences in learning styles can help teachers and learners make more informed decisions about which learning activities will be useful or productive to them as individuals and as members of learning groups or communities. And this also applies to online learning.

Individuals with different learning styles vary in their preferences for how they absorb and assimilate information:

- Visual learning (reading or watching)
- Auditory learning (listening or talking)
- Kinesthetic learning (doing or participating)

For example, some learners are highly visual in the way they perceive information and derive meaning. For these learners, a structured lecture with few visual aids is a less desirable learning environment than one enhanced by visual aids. Others learn better through the written word, by either reading or taking notes. Learners who are highly auditory in their learning preference derive greater meaning from just listening to the information. One of the exercises at the end of this chapter is the identification of your particular learning style.

The learning environment for health professionals has changed. The explosion of knowledge that continues on a daily basis no longer allows for the memorization of discrete facts. Health professionals must understand the underlying concepts, discover new information, reflect on applications, and apply relevant knowledge to their situation. Reflection and critical analysis are important parts of this process. The learner is now active in the process, no longer considering the teacher as the "sage on the stage" but rather as the facilitator of learning. You, as the learner, are the active one, seeing how information fits with facts and perceptions. Recall that in Mezirow's (2000) view of transformative learning, adults learn by elaborating on existing frames of reference, learning new frames of reference, transforming points of view, or transforming habits of mind (p. 19). Building on your knowledge base and your personal frame of reference, you will learn new perspectives. This process will further allow you as the adult learner to transform your views and create new ways of approaching the world and nursing practice.

Learning occurs through reflection and interpretation to understand perceptions of the self and the world. But you also need to identify and organize your resources.

GARNERING RESOURCES

Perhaps the initial things that come to mind are books, a stethoscope, a computer, and perhaps a car to get to a class meeting or clinical site. Look beyond supplies and reliable transportation. **Resources** are tools or means of support. Consider those things and people that can help you study, prepare assignments, succeed on examinations, and thrive in your education.

Studying

Once you understand your learning style, you can look to the resources needed to capitalize on your assets. Remember, once you know your style, you will still be in a group with individuals with varying styles, including the instructor—even in the online environment. If you learn best through participation in discussions, you may want to find a compatible study group. But a word of caution: Study groups are not for everyone and can be time wasters if the group is not focused, compatible, and committed to ground rules of preparing on the topic prior to the meeting. In addition, some individuals are more solitary and need to think about something for a while and work it out in their frame of reference before being put on the spot in a discussion.

Your environment is another area you need to carefully consider, with regard to where you best think and concentrate. Do you prefer a completely quiet environment or soft background music? Think about what helps you to understand information and see relationships. Do you have a favorite place in the house, either a cozy corner or a clean kitchen table after the children are in bed? Maybe it is in a special chair with the cat in your lap. Or perhaps it is at the library where additional resources are available without other distractions. Again, you must determine your best environment to concentrate and be open to new information.

Preparing Assignments

This is an area feared by many returning students, as they face a blank piece of paper or computer screen. First, write or type the expectation. It may help to see it isolated from the distraction of other course expectations and grading criteria. Make sure you have sufficient access to a reliable computer for document preparation, sending and receiving e-mail, accessing the Internet, and preparing presentation graphics. Competing with your spouse or children for time online does not count! And your phone is too small for large documents or graphics. Locate the dictionary tool and make sure you have the spelling and grammar checking tools activated to assist you in the composition process. You will also need to become comfortable with the publication style required by your school or instructor. One popular style is by the American Psychological Association, and you may be required to use this resource. These basic tools and your development of skill in these

areas will facilitate your ease in making your case as you address the requirements of an assignment, whether a case study or a scholarly paper.

Another valuable resource is a professional librarian, especially one who can help you effectively search for materials, teach you how to access databases, and provide you with interlibrary loan materials. A librarian can show you how to access the library remotely to help with your time management and cut down on travel to the library during certain hours. But be sure to use all your time management skills when searching online to avoid getting distracted or lost in the sea of information.

Sooner or later in your program of study you will have a group assignment in which the group, not each individual, earns the grade. This type of activity can be accomplished in person or online and may be a wonderful team experience—or a disaster with an uncooperative member. Peer pressure is warranted; if that is not effective, consult your instructor. Remember, teams are an important part of collaborative practice and we need to continually refine our skills in this area.

Taking Examinations

The thought of taking tests is one of the most threatening to the adult learner. Stress management techniques such as deep breathing may help. Some of the most important considerations are adequate rest and being confident in your preparation and understanding of the content. Understanding the information is critical, especially since test questions in nursing focus on critical analysis and rarely involve the simple recall of isolated facts. Beyond simple memorization of facts such as the bones and muscles of the leg, more complexity is added for application of this information to a patient situation. And then grades are an issue, with the adult learner trying to do "the best" or else experience a personal sense of failure. Remember, a grading scale is just that: a scale that varies. There are certain acceptable numbers on your bathroom scale, just as there should be acceptable numbers or letters on a grading scale. There will be times when you excel and others when you succeed but do not achieve an A—and that is acceptable. Give yourself permission to be human and not always receive the top grade in the course. Understanding, retention, and application of knowledge are the more important considerations.

Thriving

One of the most important actions you can take as you pursue your nursing degree is to thrive on the acquisition of your new knowledge, skills, and abilities. Lifelong learning is a component of professional nursing. From your practice, armed with technical skills and experience in the practice setting, we advance to critical analysis and clinical judgment that embody professional practice. You have taken the first step in your ongoing learning. Now, what is your view of professional nursing?

YOUR PHILOSOPHY OF NURSING

Virginia Henderson (1897–1996) was an outstanding leader in nursing. Her classic definition of nursing embodied her view of the unique role of the professional nurse as:

> *[a]ssisting the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966, p. 15)*

This concrete definition was expanded and applied to nursing practice, education, and research. Henderson's philosophy of nursing was one of caring, assisting, and supporting the person. In her writings, she encouraged every nurse to develop a personal concept of nursing—in essence, a philosophy of nursing.

A **philosophy** of nursing presents a particular professional nurse's belief system or worldview of nursing—the nurse's personal definition of nursing. Recall that the first component on the structural hierarchy of contemporary nursing knowledge was the metaparadigm, followed by the influence of the belief system or philosophy. Fawcett and DeSanto-Madeya (2013) describe the function of a philosophy as communication of what the members of a discipline believe to be true relative to the phenomena of interest, how knowledge is developed, and the values with regard to actions and practices (p. 8).

As discussed previously, the metaparadigm concept of human beings relates to the people of concern for nursing. Nurses in different settings define patients uniquely within their practice—for example, as individuals versus families. The nurse's practice area and patient populations also influence the environment—for example, an intensive care unit in an acute care setting or a rural healthcare clinic located in a community school or modular building. The concept of health also varies, being different for the professional who provides care for trauma victims and the nurse involved with health initiatives in an employee group. Specific nursing roles, and the services provided, influence the concept of nursing. Now is the time to describe your unique belief systems by crafting your own definitions for the metaparadigm concepts: human beings, environment, health, and nursing. And don't forget to address the Social Determinants of

Health (SDOH): economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

In addition to the metaparadigm concepts in a personal philosophy of nursing, certain other values and beliefs are generally apparent as one's beliefs about nursing are illustrated. Consider the following essential features of professional nursing definitions identified in the ANA's *Nursing's Policy Statement: The Essence of the Profession* (2010):

- Provision of a caring relationship that facilitates health and healing
- Attention to the range of human experiences and responses to health and illness within the physical and social environments
- Integration of objective data with knowledge gained from an appreciation of the patient or the group
- Application of scientific knowledge to the processes of diagnosis and treatment using judgment and critical thinking
- Advancement of professional nursing knowledge through scholarly inquiry
- Influence on social and public policy to promote social justice
- Assurance of safe, quality, and evidence-based practice (p. 9)

Along with these criteria are interwoven ethical principles, standards of practice, and professional performance expectations. Now, reflect on your values and beliefs related to these statements. What are your priority areas?

At this point, you should critically analyze your belief system and express your views of nursing. We all have prior experiences that influence our thinking and actions. Try to place those aside and begin to craft your unique philosophy of nursing. Using these definitions and criteria, develop your views into a personal philosophy of nursing. Periodically reflect on your philosophy to analyze how your professional practice is enhanced in your ongoing quest for knowledge and expertise in your profession. This is your unique professional identity.

KEY POINTS

- The following are characteristics of a profession: (1) systematic theory and knowledge base, (2) authority, (3) community sanction, (4) an ethical code, and (5) a professional culture.
- Kerlinger and Lee (2000) define a theory as "a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena" (p. 11).
- A paradigm used by professionals in a scientific community consists of the beliefs and the belief system shared by members of that particular community to explain phenomena, practice the profession, and conduct research.
- The metaparadigm of nursing is the overall concern of nursing common to each nursing model, whether a conceptual model/paradigm or formal theory, and it includes the concepts of human beings, environment, health, and nursing.
- The *Code of Ethics for Nurses* (ANA, 2015) is the ethical standard for professional nursing practice. It identifies expected professional practice behaviors with patients, colleagues, and other professionals within nine provisions with interpretative statements.
- Autonomy involves judgment and self-governing within one's scope of practice. This self-governing requires ongoing evaluation of both responsibility and accountability in professional practice. In the ANA's *Code of Ethics for Nurses*, responsibility is defined as "an obligation to perform required professional activities at a level commensurate with one's education and in compliance with applicable laws and standards . . ." (ANA, 2015, p. 45), whereas accountability is "being answerable to oneself and others for one's own choices, decisions and actions as measured against a standard . . ." such as the Code (ANA, 2015, p. 41).
- The ANA (2021) *Standards of Professional Performance* are ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health.

KEY POINTS—cont'd

- The five competencies for health professionals are providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and using informatics (Greiner & Knebel, 2003).
- Roles are organized behavioral patterns and expectations.
- Learning is the perception and assimilation of the information presented to us in a variety of ways.
- Knowledge is the accumulation of the appropriate information through learning and experience. Skill is the ability to retrieve this knowledge through mental and psychomotor activities and apply it appropriately to the situation. Ability is your competence and proficiency in the demonstration of the knowledge and skill.
- Learning style or preference is simply the ways you best perceive, think, organize, use, and retain knowledge.
- Resources are tools or means of support.
- A personal philosophy of nursing presents the belief system or worldview of nursing for a particular professional nurse. Incorporated into such a philosophy are definitions, values, and assumptions about the metaparadigm concepts of human beings, environment, health, and nursing.

THOUGHT AND DISCUSSION QUESTIONS

1. Be prepared to participate in a discussion to be scheduled by your instructor on how you demonstrate the five core competencies of health professionals.
2. Explain your views on professional responsibility and accountability, especially with attention to health equity.
3. Describe how you demonstrate and document your continued competence.
4. Reflect carefully and identify your reasons for continuing your nursing education.
5. Consider your responsibilities.
   - Identify all your current roles. Which ones can be streamlined?
   - What resources can you classify as readily available, sometimes available, or in need of locating?
   - What strategies can you identify for improved time management for your new role as a student?
6. Review the Chapter Thought located on the first page of the chapter and discuss it in the context of the contents of the chapter.

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ONLINE RESOURCES

American Association of Colleges of Nursing
http://www.aacnnursing.org/

American Nurses Association
http://www.nursingworld.org

ANA Code of Ethics for Nurses
https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

Canadian Nurses Association Code of Ethics
https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics

ICN Code of Ethics for Nurses
https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf

Rose Kearney-Nunnery

CHAPTER 2

Theory as the Basis for Practice

> *"Theory and research should not be solely the province of academics, just as practice is not solely the concern of practitioners."*
>
> *(Glanz et al., 2008, p. 24)*

CHAPTER OBJECTIVES

On completion of this chapter, the reader will be able to:

1. Define key terms in theory development and utilization.

2. Discuss Maslow's theory of motivation with the hierarchy of basic needs.

3. Describe the components of developmental theories and their application to individuals across the life span.

4. Describe the components and application of systems theory.

5. Discuss the impact of theory on practice.

KEY TERMS

Theory
Model
Framework
Conceptual Model or Framework
Concept
Construct
Variable
Proposition
Theory Description and Evaluation
Hierarchy of Needs
Developmental Theories
General System Theory
Quantum Theory

One characteristic of a profession is that it is built on a theoretical base. This base includes theoretical foundations unique to the profession, as well as those borrowed or adapted from other scientific disciplines. Chapter 1 discussed paradigms and the metaparadigm concepts of nursing. Recall that Kuhn (1970) described a paradigm as "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners" (p. vii). When the paradigm is no longer useful in explaining phenomena, practice, and research in that particular scientific community, a paradigm shift occurs, and a new structure evolves.

In 1957, Merton used a paradigm to analyze sociological theory. He viewed the paradigm as a "field glass" to illuminate and view concepts and interrelationships and to make assumptions clear on the body of knowledge for analysis and testing. Merton (1957) identified the purposes of a paradigm as providing for the following:

1. Parsimonious arrangement of concepts and propositions showing interrelationships
2. A logical guide showing derivations and avoiding hidden assumptions and concepts
3. Culmination in theory development as a building process
4. Systematic arrangement and cross-tabulation of concepts for analysis
5. Codification of qualitative research methods (pp. 13–16)

From a cultural perspective, Leininger (2006) defined *worldview* as "the way an individual or group looks out on and understands their world about them as a value, stance, picture, or perspective about life or the world" (p. 83). In the professional culture of nursing, these are the values, attitudes, beliefs, and practices unique to the profession. Thus, a scientific community has the tools to create and test a theory for knowledge development and the use of this knowledge in practice. The worldview furnishes the philosophical assumptions that are considered "givens" by the theorist or the scientific community. In nursing, this provides us with the process: the metaparadigm concepts to various paradigms, and the development of theories on which to base research, practice, administration, and education.

TERMINOLOGY IN THEORY AND DEVELOPMENT ANALYSIS

Professions such as nursing are based on unique theory. Kerlinger and Lee (2000) defined a **theory** as "a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena" (p. 11). This definition provides us with the components and aims of a theory, which must initially be described and then evaluated for potential use in practice, education, and research in a discipline. Some theorists, however, believe this definition is too narrow and excludes descriptive theories; descriptive theories, which focus on factor naming, are abundant in professional nursing and are often a first step for further research and development.

Before moving to the components of a theory, we need to address three similar terms frequently associated with theory: model, framework, and conceptual model (or conceptual framework). A **model** is a graphic representation of some phenomenon. It may be a mathematical model (such as A + B = C) or a diagrammatic model that links words with symbols and lines. A theoretical model provides a visual description of a theory using limited narrative and displaying components and relationships symbolically. A **framework** is another means of providing a structural view of the concepts and relationships proposed in a theory. Again, use of words and narrative is limited, but the structure of the theory is presented as the framework and allows translation, interpretation, and illumination of the narrative or text.

A **conceptual model or framework** is similar to a theory in that it represents some phenomenon of interest and contains concepts and propositions. However, with a conceptual model or framework, the concepts and especially the propositions are broader in scope, less defined, and less specific to the phenomenon of concern. As Fawcett and DeSanto-Madeya (2013) note, "the concepts of a conceptual model are so abstract and general that they are not directly observed in the real world, nor are they limited to any particular individual, group, situation, or event" (p. 13).

A theory can evolve from a conceptual model or framework as concepts are further defined, specified, tested, and interrelated to represent some aspect of reality. Fawcett (1995, 2000, 2005) and, subsequently, Fawcett and DeSanto-Madeya (2013) have described the structural hierarchy of contemporary nursing knowledge (Fig. 2.1) with its components, from the most abstract metaparadigm, influenced by different philosophies, to conceptual models that further evolve into theories and specific empirical indicators for testing. They further define the function of conceptual models "to provide a framework to organize and visualize abstract and general phenomena and relations between various phenomena encompassed by the model" (Fawcett & DeSanto-Madeya, 2013, p. 13). Then, the function of a theory is "to narrow and more fully specify the phenomena contained in a conceptual model" (Fawcett & DeSanto-Madeya, 2013, p. 16). Concepts become less abstract, and the population of interest is identified. This increase in specificity is evident in the examples proposed by

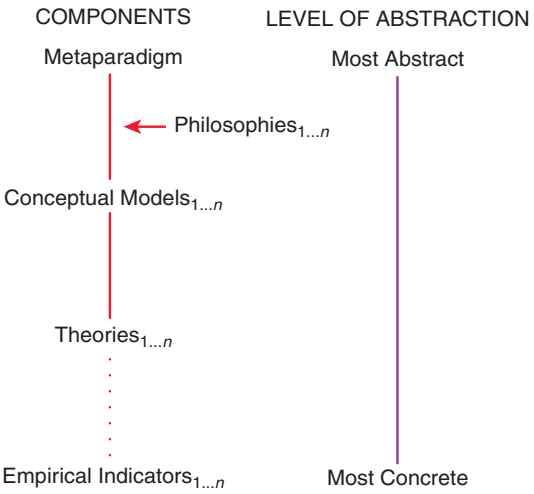

Figure 2.1 The structural hierarchy of contemporary nursing knowledge: Components and levels of abstraction. *(From Fawcett, J., & DeSanto-Madeya, S. [2013]. Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories [3rd ed., p. 4]. F. A. Davis, with permission.)*

Alligood (2018b), who, on the basis of Fawcett's structural hierarchy of nursing knowledge, correlated examples in theoretical structures by different nursing theorists as follows:

- Metaparadigm: Person, environment, health, and nursing
- Philosophies: Nightingale, Watson, Benner
- Conceptual Models: King, Levine, Neuman, Orem, Rogers, Roy, Johnson
- Theories: Leininger, Newman, Parse, Pender, Meleis, Husted and Husted, Boykin and Schoenhofer
- Middle-Range Theories: Mercer, Mishel, Wiener and Dodd, Kolcaba, Swanson, Beck, Rutland and Moore (p. 45)

As more is known about the phenomenon, this knowledge can be used in specific, meaningful patient applications.

As knowledge about some phenomena increases, a theory is proposed to address the phenomena or reality within the discipline. The components of a theory are the constructs (concepts), with their specific definitions, and the propositions that describe or link those constructs (concepts). At the simplest level, a **concept** is a view or idea that we hold about something. It can be something highly concrete, such as a pencil, or something highly abstract, such as quality. The more concrete the concept, the easier it is understood and consistently used. For instance, we are comfortable envisioning a pencil and can easily describe it to others. This ability to describe something directly in the concrete world shares the "concept." But the concept of quality is more abstract, and ensuring that all individual definitions are the same is difficult, often requiring indirect measures.

We strive to define a concept in operational terms—that is, how we view a specific entity and how it can be measured so that others know exactly what we mean. To meet the criteria of a theory, we need to define the concepts. Consider the concept of a pencil. We think of a pencil as a writing implement. This is the theoretical or conceptual definition of a pencil we read in a dictionary. But what do we truly mean by *pencil*? It is a yellow-painted, wooden-covered graphite instrument that we use to make marks on a paper. Does it have an eraser? Does a mechanical pencil fit into this definition? An operational definition narrows the definition to precisely what we view and how it can be measured for use in practice or research as a measurable, empirical indicator. In addition, concepts are broadened to constructs, such as with quality or identity, which can be multidimensional and difficult—if not impossible—to break down into component parts.

A **construct** is a more complex idea package of some phenomenon that contains many factors but cannot be truly isolated or confined to a more concrete concept. The construct of *identity*, for example, contains many pieces, such as personal perception, role expectations, and status. However, we must still provide an operational definition of a construct by specifying certain elements it contains (as indirect measures), such as self-image, ideal image, group image, role expectations, and status. The same multidimensionality occurs when we assess the quality of healthcare.

In research, we often see the term *variables*, referring to some concept in the theory under study. A **variable** is a concept that can change and that contains a set of values that can be measured in a practice or research situation. For example, a patient's cholesterol reading is a variable. The concept of blood cholesterol has been operationally defined within certain parameters, and the level of the reading is the value for the variable.

Whether concepts, constructs, or a combination of the two are included in a specific theory, they are the building blocks of the theory. Definitions are provided to help us understand the nature and characteristics of each block in the construction. We then need to relate these building blocks to each other. Describing and stating the relationships between or among the constructs (or concepts) provides the propositions of a theory. Also called relational statements, **propositions** show how the concepts are linked in the theory and how they relate to one another and to the total theoretical structure. They define how the structure is held together. In nursing theory,

propositions refer to how the individual is characterized with specific abilities, knowledge, values, and traits and how these factors interrelate with the characteristics of health, the environment, and nursing.

Research is a means of supporting the concepts and relationships proposed in a theory. It provides supportive evidence and suggests further study and possible gaps or revisions needed in the theoretical structure. We can see this in the next chapters, which cover refinement of nursing and other health models, such as the health-belief model revision. Research can be qualitative and inductive, for generating theory, or more quantitative, for deductively testing hypotheses as theoretical propositions.

As stated previously, Kerlinger and Lee (2000) defined the aims or purpose of theory as describing or explaining some phenomena of interest. In nursing, theory is further differentiated into levels that describe, explain, predict, and control. Dickoff and James (1968) developed a classic position paper proposing four levels of nursing theory (Box 2.1). All levels may be present as a practice theory evolves (factor-isolating and then factor-relating), is subjected to further research, and is refined, becoming predictive and prescriptive. In application, testing, and refinement, a theory is a continuum as long as the content meets the intent of the discipline and metaparadigm.

In addition, theories are classified according to their scope as grand, middle-range, or limited in scope or practice. This is the breadth of coverage of some phenomena. General system theory is an example of a grand theory, or one with a broad scope. This theory, discussed later in the chapter, has been used in development, testing, and application in many scientific disciplines.

Merton (1957) was the first theorist to suggest "theories of the middle range: theories intermediate to the minor working hypotheses evolved in abundance during the day-by-day routines of research, and the all-inclusive speculations comprising a master conceptual scheme from which it is hoped to derive a very large number of empirically observed uniformities of . . . behavior" (pp. 5–6). As you will see in the next chapter, middle-range theories are narrower in scope, with a limited view of a phenomenon, and contain concepts and propositions that are measurable and can be empirically tested. Some of our traditional nursing theories meet the characteristics of a middle-range theory, as described in Chapter 3. Other middle-range theories include the developmental theories reviewed later in this chapter. Although these theories address psychosocial, cognitive, and moral development, they apply across disciplines as continual, incremental knowledge and skills developed by individuals. More limited nursing practice theories are evolving as hypotheses derived from middle-range theories are tested, clarified, and made specific to certain practice areas or types of patients. Chapter 4 shows examples of limited nursing practice models that are being tested and refined into theoretical frameworks, including Pender's health promotion model. Even more narrow in scope are practice theories, which focus on measurable variables and propositions that are based on empirical research and now may be refined further, perhaps to a specific population or group of individuals with a common characteristic.

You can also enter "middle-range nursing theory" in your Internet search engine to locate additional sources of information from a variety of nursing programs.

To understand theories for use and application in practice, we use certain criteria to describe and evaluate them. Theory development is both an inductive and a deductive process. An inductive process is used to generate concepts and make inferences by stating interrelationships (propositions) within a framework to view phenomena. From observations of phenomena, we can name concepts and enumerate proposed relationships. Once the theory is generated, it is applied, in whole or in part, for testing as a deductive process. For nursing **theory description and evaluation,** we consider the following three sets of criteria proposed by nursing scholars Chinn, Kramer and Sitzman, Barnum, and Fawcett.

BOX 2.1 Dickoff and James (1968): Four Levels of Nursing Theory

1. Factor-isolating (naming) theories
2. Factor-relating (situation-depicting) theories
3. Situation-relating (predictive or promoting/inhibiting theories)
4. Situation-producing (prescriptive) theories

Source: Dickoff, J., & James, P. (1968). A theory of theories: A position paper. *Nursing Research, 17*, 197–203.

THEORY DESCRIPTION AND EVALUATION

Chinn and colleagues (2022) differentiate between theory description and critical reflection of empiric theory. The theory is described by answering questions in the following areas: purpose, concepts, definitions, relationships and structure, and assumptions. This process provides an understanding of the components and aims of the theory. Once the theory has been described, five issues are addressed in critical reflection:

- Clarity and consistency in presentation
- Simplicity and meaningfulness of relationships
- Generality or scope

- Accessibility as potential for use with empirically identifiable phenomena
- Importance or significance as leading to the values in practice, education, and research (Chinn et al., 2022, pp. 169–176)

This differentiation allows us to discriminate between understanding the theoretical structure and evaluating the theory's soundness and usefulness in practice, education, or research. Alligood (2018b) refers to these five areas for theory analysis as clarity, simplicity, generality, accessibility, and importance (p. 46).

Barnum (1998) proposed two categories of theory: descriptive theory and explanatory theory. *Descriptive theory* is a factor-naming and factor-relating theory developed initially to characterize some phenomena. *Explanatory theory* brings us to the situation-relating and situation-producing levels of theory, looking at the "how," the "why," and the interrelationships in the theory (Barnum, 1998). Theory description is delineated as theory interpretation, with questions addressing the following areas:

- Major elements of the theory and their definitions
- Relationships among the elements
- Differentiation between descriptive and explanatory theory
- How the theory addresses, defines, and differentiates nursing
- The focus on the patient, nurse, action, or relationship
- Unique language used and defined by the theorist (Barnum, 1990, 1994, 1998)

For critical analysis, internal criticism and external criticism are differentiated. *Internal criticism* is used to evaluate how the theory components fit together: the clarity, consistency, adequacy, logical development, and, sometimes, level of theory development (Barnum, 1998). *External criticism* deals with real-world issues such as reality convergence, usefulness, significance, and discrimination from other healthcare disciplines (Barnum, 1998). This process allows us to discriminate between understanding the theoretical structure (internal criticism) and evaluating the soundness and usefulness of the theory for application in practice, education, or research (external criticism).

Fawcett and DeSanto-Madeya (2013) have proposed criteria for theory analysis and evaluation that have undergone several revisions. They further differentiate between analysis and evaluation of nursing conceptual models and theories. Recall that conceptual models are more abstract than theories. As described by Fawcett and DeSanto-Madeya (2013), a theory is more concrete and more specific and is restricted to a more limited range of phenomena than is a conceptual model; the purpose of middle-range theories is to describe, explain, or predict concrete and specific phenomena (p. 20).

Analysis refers to the description of the theory. Fawcett and DeSanto-Madeya (2013) have described an analysis as "a nonjudgmental examination" of the nursing model, while an evaluation requires judgments to be made about the extent to which a nursing model satisfies certain criteria (p. 442). Theory analysis is followed by theory evaluation, which requires thoughtful interpretation of the theory. Fawcett and DeSanto-Madeya (2013) have identified a series of questions for analysis and evaluation of nursing theories appropriate to their level of abstraction as compared with conceptual models. In this revision, Fawcett and DeSanto-Madeya (2013) have proposed steps in a framework for the analysis and the evaluation of the theory, as follows:

Theory Analysis	Theory Evaluation
Step 1: Model Origins	*Step 1:* Explication of origins
Step 2: Unique Focus	*Step 2:* Comprehensiveness of content
Step 3: Content	*Step 3:* Logical congruence
	Step 4: Generation of theory
	Step 5: Legitimacy (social utility, congruence, and significance)
	Step 6: Contributions to nursing knowledge and the discipline

Application of this framework for theory analysis and evaluation will be evident in Chapter 3, which deals with specific grand and middle-range nursing theories. Each of these sets of criteria involves a careful identification of the components and evaluation for determination of applicability to nursing practice.

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Nursing Theories at
http://nursing-theory.org

THEORIES FROM OUTSIDE OF NURSING

Nursing and other healthcare disciplines have long used a variety of theories to guide practice. Some are discipline specific, such as the nursing theories reviewed in Chapter 3. For example, Fawcett and DeSanto-Madeya (2013) differentiate between theories developed unique to nursing (Newman, Orlando, Parse, Peplau, and Watson) and models borrowed from other disciplines (stress, coping, and

self-efficacy) (p. 17). Early nursing theories were described by Barnum (1990) as follows:

> *As an applied science, much of nursing's theory is "borrowed" from other disciplines. Every discipline has similar boundary ambiguities, where the inquiry and answers in one field overlap those in another. . . . Nursing's uniqueness in this respect does not lie in boundary overlap but in the number of boundary overlaps with which it must contend. A high number of overlaps occur in the discipline of nursing because it often attempts to deal holistically with a phenomenon (man) that has previously been dealt with in compartmentalized ways by other disciplines. (p. 218)*

Nursing theory has come a long way since that time. In her description of the development of nursing theory from the Curriculum Era in the early 20th century, through the Research and Graduate Education Eras in the middle 20th century, and the Theory Era in the latter part of the 20th century, into the 21st century and the Era of Theory Utilization, Alligood (2018a) described the process resulting in theory as not just to know but to use with the growth of the discipline (pp. 4–5). As noted by Chinn et al. (2022), "the shift toward a concept of nursing knowledge as predominantly scientific began in the 1950s and took a stronghold in the 1960s" (p. 33). And, as proposed by Fawcett (2014), nurses must embrace nursing knowledge in the form of explicit nursing conceptual models and theories; indeed, "the use of discipline-specific nursing knowledge to guide nursing practice is the hallmark of professional nursing" (p. 427). Recall the metaparadigm concepts. Borrowed theories may address human beings, health, and the environment, but what of nursing? With collaborative practice, however, these theories provide a common ground and the opportunity for the application and sharing of middle-range theories. They also enable us to understand human nature, motivation, and development. But, as noted by Chinn et al. (2022), always consider significant factors that influence a nursing situation (p. 35).

Several classic theories have been applied in nursing to view the person, family, community, and group. We use Maslow's hierarchy of needs to view human beings and basic human needs. Developmental theories have been applied across the human life span as we seek to understand the complexity of human behavior. In looking at the person or group, we have applied systems theory to understand the interaction of human beings with their environment. The following section briefly describes selected theories that are applied in certain areas and have been used in the evolution of nursing models more specific to our metaparadigm concepts.

Maslow's Theory of Human Motivation and Hierarchy of Basic Needs

A theory widely used in many disciplines is Maslow's theory of human motivation. In his original 1954 book, *Motivation and Personality*, Maslow described how his work emerged. The book begins by presenting Maslow's philosophy as an approach to science. Human values are prevalent in the philosophy, and Maslow's worldview is described as holistic, functional, dynamic, and purposive. In his 1970 revised edition, Maslow reinforced his worldviews and described his theory as holistic-dynamic. He supported his original 16 propositions on motivation, on which his theory was based (see Chapter 9 on motivation in the teaching-learning process). This theory views the complexity of human behavior, especially in relation to motivation of behavior. The theory of motivation is based on clinical and experimental data from psychology, psychiatry, education, and philosophy. It does not address specific nursing concerns except as they relate to human behavior with environmental influences.

Maslow's theory includes a hierarchical structure for human needs. This **hierarchy of needs** can be visualized as a pyramid (Fig. 2.2). At the base of the pyramid are the physiological drives. Higher needs progress upward as safety, love and belonging, esteem, and self-actualization needs. Maslow (1954, 1970) described this as a "hierarchy of prepotency" to explain that the individual first concentrates on the physiological drives. The physiological drives are considered the most powerful, but as physiological needs are satisfied, the individual focuses on emerging higher needs. This is the general structure for the hierarchy.

Individual differences are provided for in this theory. Some individuals have altered placement of needs in the hierarchy. Maslow (1970) described differences among individuals in placement of some of the higher needs such as a reversal of esteem and love/belonging needs. In addition, individuals may have different levels of need satisfaction. For example, one person might meet the physiological drives at a 75 percent level, whereas another person's level for satisfaction is 85 percent. Individual differences also apply to the emergence of higher needs. Maslow (1970) regarded this as a gradual process; one person's safety needs may begin to emerge when his or her physiological needs are being met at 25 percent, whereas another person may not begin to satisfy his or her safety needs until 30 percent of his or her physiological needs are met. Levels of satisfaction and emergence of higher needs therefore occur at different points in different people, as do pain thresholds in different people.

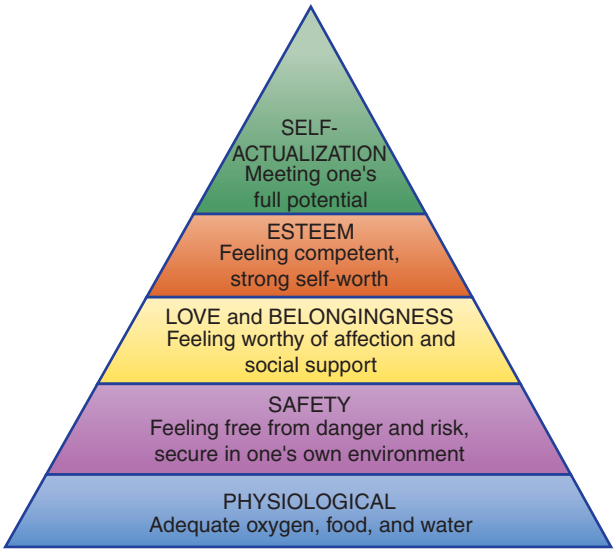

Figure 2.2 Maslow's hierarchy of human needs.

Looking again at the theoretical hierarchy, we see at the bottom level of the pyramid the physiologic drives, including the need to maintain homeostasis and the needs of satisfying hunger and thirst, sleep and rest, activity and exercise, sexual gratification and sensory pleasure, and maternal responses (Maslow, 1970). Meeting the physiological hunger drive is very different from meeting one's nutritional requirements or treating anxiety or depression with a chocolate bar. When the individual is truly hungry or thirsty, not merely satisfying an appetite for food or drink, all energies and thoughts are directed to satisfying that drive for food or water. Consider the physiological need of an individual with a chemical dependency. The person will focus all efforts on attaining the drug or addictive substance at the required level of satisfaction—while ignoring other needs, including the physiological need for food or the next level of safety needs. When the physiological drives and needs are relatively satisfied, higher-level needs emerge.

Safety needs are the next level of the hierarchy. Safety, both physical and emotional, must be achieved. Threats to a person's safety can become all consuming. Think of an isolated person in an inner-city apartment whose fear for his safety motivates him to place bars on his windows and multiple chains and deadbolt locks on his door. This person fears for his physical safety from a threat, real or imagined, of bodily harm. This is the main concern, not whether access is impeded in the case of a fire or accident. He places all focus on the quest for freedom from perceived danger.

Perceived safety can also be related to health, as with the fear of the patient with chronic obstructive pulmonary disease (COPD) to be near anyone who is coughing or sneezing. This person's safety need is to avoid a respiratory infection that could lead to pneumonia or even diminished oxygenation in an already compromised respiratory system. Even if the other person in the room is experiencing symptoms of a seasonal allergy, the individual with COPD seeks immediate escape from that environment because of the perceived danger of infection. Maslow (1954, 1970) also viewed safety needs more broadly in the need for the familiar and spiritual, religious, or philosophical meaning in life. He describes the use of rituals and ceremonial behaviors in children and individuals with psychological disorders as examples of focusing on safety needs.

Once the person satisfies safety needs, the focus turns to the need for love and belonging. Inclusion and affection are important needs, as contrasted with the isolated sex act, which is a physiological drive. Maslow (1970) described the normal person as having a hunger and striving for affectionate relations and a place in a group, as opposed to the maladjusted person (pp. 43–44). Love and affection are manifested in many ways and are individually defined.

Satisfying the need for belonging and love brings us to the next level, esteem needs. Esteem needs involve a sense of dignity, worth, and usefulness in life. Maslow (1970) described two sets of esteem needs: (1) the sense of self-worth, including perceptions of strength, achievement, competence, and confidence, and (2) the esteem of others, including perceptions of deserved respect, status, recognition, importance, and dignity (p. 45). Satisfying the sense of self-worth and respect allows the next, and highest, level of basic needs to emerge.

The need for self-actualization, at the top of the pyramid, is the desire for self-fulfillment. This is the sense of being able to do all that a person can to answer the "why" of his or her existence. Maslow (1970) defined self-actualization as "the full use and exploitation of talents, capacities, potentialities, etc., such [that] people seem to be fulfilling themselves and . . . developing to the full stature of which they are capable" (p. 150). Originally, Maslow (1954) proposed that self-actualized people include both older people and college students and children. But when he further examined the concept of self-actualization, he separated psychological health from self-actualization, which he limited to older people whose human potentialities have been realized and actualized (Maslow, 1970).

Maslow then developed support for his theory of basic needs and human actions using case studies and other research. Through observation of people, he proposed specific phenomena that are determined by basic gratification of cognitive-affective, cognitive, character traits, interpersonal, and miscellaneous needs. He cited characteristics of people in relation to the hierarchy. For example, the following characteristics of self-actualized people emerged from Maslow's (1970) research and analysis of historical figures, public people, selected college students, and children:

1. More efficient and comfortable perceptions of reality
2. Acceptance of self, others, and nature
3. Spontaneity, simplicity, and naturalness in thoughts and behaviors
4. Problem centered rather than ego centered
5. Desire for detachment, solitude, and privacy
6. Autonomy with independence of culture and environment
7. Continued freshness of appreciation
8. Mystic and oceanic feelings with limitless horizons
9. Genuine desire to help people
10. Deeper and more profound interpersonal relationships
11. Democratic character structure
12. Strong ethical sense that discriminates means/ends and good/evil
13. Philosophical and unhostile sense of humor
14. Creativeness
15. Resistance to enculturation with an inner detachment (pp. 203–228).

Maslow created further hypotheses for testing. He described cases that diverged from his theory, such as the martyr who ignores survival needs for a principle. He called for further research, hypothesizing that satisfying basic needs earlier in life allows the individual to weather deprivation easier in later life (Maslow, 1954, p. 99). Maslow's work continued until his death in 1970. His hierarchy of needs has endured, and its applications have been extended in healthcare, education, industry, and marketing to understand people and their motivators. Needs related to individual, environmental, and health concerns are applicable to the nursing discipline. However, this theory does not address the specific domain of nursing.

Developmental Theories

A group of theories widely used in healthcare and education are the **developmental theories.** Some of these middle-range theories address personality (Erikson), cognitive (Piaget), and moral (Kohlberg) development using a life-span perspective. This perspective is based on progression and complexity in motor, personal-social, cognitive, or moral behavior. A brief review of each of the theories demonstrates how the theorist moved from a philosophy or worldview to identify concepts, propositions, and a model or theory based on observations, existing research, or case study presentations. Common to the developmental theories are predictable steps or stages through which the individual progresses during the life cycle. This is a building process. These theories are based largely on research through observation or case studies. Subsequent applications and research have been guided by the use of these theories to explain more specific phenomena or to test hypotheses.

Personality Development

Erikson's (1963) eight ages of man represents a theory of psychosocial personality development in which the individual proceeds through critical periods in a step-by-step or epigenetic process (Fig. 2.3). This theory has been and continues to be used widely in healthcare and psychology. In offering the theory, Erikson presented his philosophy and case studies with Freudian and neo-Freudian applications. Each stage has positive and negative aspects that are defined and described. The basic goal is for the individual to develop a favorable ratio of the positive aspects for a healthy ego. Erikson (1963) further described basic virtues and essential strengths for each of his "ages" or stages of development. These strengths and basic virtues define the positive aspects of ego development required in each stage.

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Learn more about Maslow and his work at **http://www.maslow.com**

	AGES	STRENGTHS & VIRTUES	DEVELOPMENTAL STAGE
8.	Ego Integrity vs. Despair	Renunciation & Wisdom	Older Adulthood
7.	Generativity vs. Stagnation	Production & Care	Middle Adulthood
6.	Intimacy vs. Isolation	Affiliation & Love	Young Adulthood
5.	Identity vs. Role Confusion	Devotion & Fidelity	Adolescence
4.	Industry vs. Inferiority	Method & Competence	School Age
3.	Initiative vs. Guilt	Direction & Purpose	Preschool
2.	Autonomy vs. Shame & Doubt	Self-control & Will Power	Toddler
1.	Trust vs. Mistrust	Drive & Hope	Infancy

Figure 2.3 Erikson's (1963) eight ages of man.

Propositions are developed for each of the stages. This theory is supported mainly by case study, with suggestions and encouragement of further hypotheses for research and testing. Erikson's theory has been used widely in nursing to foster positive ego development and empowerment in individuals. Although this theory does not specifically address the domain of nursing, common concerns include human beings, the environment, and psychosocial health.

Havighurst was another theorist who focused on personality development as developmental tasks and education. His theory from the mid-20th century included principles of cognitive and moral development in which the individual proceeded through six stages, accomplishing critical tasks. Havighurst (1972) described his philosophy, including the origins of the concept, and proposed a method for analyzing individual developmental tasks based on his defining criteria as well as biological, psychological, and cultural bases. He also provided educational implications for each of the developmental periods. Although descriptions of the tasks represent some gender bias and cultural limitations in our current global society, the biological and psychological bases are applicable. The tasks represent major milestones in biological, psychological, emotional, and cognitive functioning or development that individuals must negotiate as they progress through life. As with Erikson's theory of personality development, concerns about the human being, the environment, and health promotion are apparent in Havighurst's life-span perspective. The age-specific tasks represent activities of daily living during specific life stages, along with cognitive development.

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Learn more about psychosocial development and Erikson's Eight Ages (or Stages) at
https://www.verywellmind.com/erik-erikson-biography-1902-1994-2795538

Cognitive Development

Piaget's theory of cognitive development focuses on the development of the intellect. Piaget was truly an example of a self-actualized person. He described himself as a naturalist and biologist by training, without formal training in psychology (Flavell, 1963, p. vii). Moving from the publication of his first monograph on birds at the age of 10, he detailed the development of the intellect in children through observations. His techniques were sometimes criticized by the scientific community, but his theory has since been accepted and used in practice and research by many students and professionals. Piaget's theory looks at innate and environmental influences on the development of the intellect. This theory has four major periods of cognitive development: sensorimotor, preoperational thought, concrete operations, and formal operations (Table 2.1).

Within his theory, Piaget provided us with the concepts of schema, object permanence, assimilation, and accommodation. *Schema* are patterns of thought or behavior that evolve into more complexity as more information is obtained through assimilation and accommodation. *Object permanence*, the knowledge that something still exists when it is out of sight, develops when the child is between 9 and 10 months of age. *Assimilation* is the acquisition and incorporation of new information into the individual's existing cognitive and behavioral structures. *Accommodation* is the change in the individual's cognitive and behavioral patterns based on the new information acquired. Piaget's theory has been translated and applied worldwide and across disciplines. His work continued until his death in 1980, and further research and theory are still evolving from his contributions.

Piaget's work concentrated on cognitive development in children, including views on moral development. As such, it is more limited but has provided major insight into working with children. Applications are seen in health teaching, especially in chronic or terminal illness situations. But with these limitations on cognitive development for some environmental influences, it can address only a portion of the domain of concern to nursing.

TABLE 2.1 Piaget's Theory of Cognitive Development

Period of Cognitive Development	Age	Stage Description
Sensorimotor Stages		
Reflexive	Birth–1 month	Use of primitive reflexes, such as sucking and rooting
Primary circular reactions	1–4 months	Repeating an event for the result, such as thumb in mouth
Secondary circular reactions	4–10 months	Combining events for a result, such as kicking mobile over crib
Coordination of secondary schema	10–12 months	Creating a behavior for some result, such as standing in crib to reach mobile
Tertiary circular reactions	12–18 months	Looking for similar results from varying behaviors, such as shaking crib and jumping to observe movements of mobile
Representational thought begins	18–24 months	Symbolic representation in thought such as hanging objects to create mobile
Preoperational	2–7 years	Making overgeneralizations, such as all cats are named Tiger; egocentric
		Focuses only on one concrete attribute
		Magical thought and symbolic play present
Concrete Operations	7–11 years	Logical and reversible thought appears; conservation of matter and numbers
Formal Operations	After 11 years	Theoretical and hypothetical thinking now possible; higher-order mathematics and reasoning

Moral Development

Kohlberg's theory of moral development was an outgrowth of Piaget's work on moral development in children. Kohlberg's extensive work on moral development (Kohlberg, 1984; Kohlberg et al., 1987) is based on research with children who were given scenarios to describe reactions and make judgments. He initially studied boys 10 to 16 years old from Chicago, later adding research with children of both genders and different backgrounds. Kohlberg's theory (Table 2.2) consists of six stages grouped into three major levels: preconventional, conventional, and postconventional (Kohlberg, 1984).

Kohlberg's theory confers major insight into moral development. He provided the theoretical structure, supportive research, and applications in educational practice. The individual progresses through the levels and stages, not as a natural process, but through intellectual stimulation with a central focus on moral justice. This requires thinking about moral problems and issues. Further research and practices have been based on this theory and are ongoing. Consider the usefulness of this theory when you are working with a child or adolescent whose parent was recently diagnosed with a terminal illness.

As with Piagetian theory, Kohlberg's theory is limited to a specific area of development. The focus is on human beings, such as the child, with ramifications for adult life. Environmental (e.g., social and cultural) factors provide insight for social and psychological health. The limitation to moral development addresses only a portion of the domain of concern to nursing.

Many developmental models are used and applied in nursing. Examine the conceptual models and theories presented in Chapter 3 for their application of developmental concepts. Several nursing theories have a decidedly developmental focus, whether as a main component, as in Watson's theory, or with specific concepts included, defined, and built on, as in King's model.

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Learn more about cognitive development and Piaget's stages of development at **https://www.webmd.com/children/piaget-stages-of-development#1**

TABLE 2.2 Kohlberg's Theory of Moral Development (Kohlberg, 1981; Kohlberg & Lickona, 1990)

Level	Stage	Stage Description
Level I: Preconventional morality	1. Heteronomous morality	Egocentric and applies a fixed set of rules from authorities, e.g., parents
	2. Individualism, purpose, and exchange	Sees that different individuals have different rules, e.g., parents and teachers
Level II: Conventional morality	3. Interpersonal expectations, relationships, and conformity	Motives of other person now emerge when considering right and wrong; use of the Golden Rule
	4. Social system and conscience	The good of society as a whole now emerges
Level III: Postconventional morality	5. Social contract and individual rights	Believes in upholding laws and legal contracts
	6. Universal ethical principles	Principles of justice and human rights as an ethical system

A life span, developmental, or life processes focus has major relevance for nursing, because we view human beings in the context of environment and effects on health status. The interrelationships with health and nursing are complex and must be specified for their applicability to the domain of nursing.

Systems Theory

Perhaps the most widely used theory in multiple disciplines is systems theory. Systems have been in existence for ages, but in the late 1930s, Bertalanffy introduced systems theory to represent an aspect of reality. Thus, **general system theory** was incorporated in the paradigms of many scientific communities. This is a grand theory that is wide in scope and that has generated numerous theories in many disciplines. Bertalanffy (1968) explained the wide applicability in many scientific communities as the various disciplines became concerned with "wholeness"—that is, not just focusing on isolated parts, but dealing with the interrelationships among them and between the parts and the whole. A system generally contains the following basic components: input, output, boundary, environment, and feedback. Figure 2.4 illustrates a basic view of a simple system.

The initial step in understanding and applying systems theory is to view the grand theory. Bertalanffy (1968) defined a *system* as a complex of interacting elements and proposed that every living organism is essentially an open system. The general system theory applies the following principles to human and organizational systems:

1. *Wholeness:* This indicates that the whole is more than merely the sum of its parts. To understand the whole, one must understand the components and their interactions with each other and the environment.
2. *Hierarchical order:* Some form of hierarchy exists in the system's components, structure, and functions.
3. *Exchange of information and matter (openness):* In an open system, there is an exchange and flow of information and matter with the environment through some boundary that surrounds the system. Inputs come through the boundary from the environment, are transformed through system processes (throughputs), and are sent as outputs through the boundary back into the environment. This exchange of information and matter is goal-oriented, whether to maintain the steady state or to fulfill the functions of the system. An important component of this process is feedback from the environment.
4. *Progressive differentiation:* Differentiation within the system leads to self-organization. Applying the laws of thermodynamics, entropy is a measure of order or organization in the system in the process of seeking equilibrium or some final goal. In an open system, entropy is decreased or negative, allowing for differentiation and self-organization.
5. *Equifinality:* In open systems, the final state can be reached from different initial conditions and in different ways. Initial conditions do not necessarily determine the final state or outcome of the system.

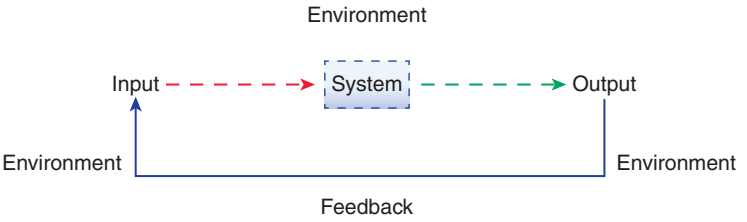

Figure 2.4 General systems model: A simple, open system.

6. *Teleology:* Behavior in the system is directed toward some purpose or goal, as a human characteristic.

Environmental influences are a major consideration in healthcare. Systems theory provides a useful framework with which to visualize some phenomenon (the system), focusing on the components, structure, and functions as the internal environment (throughputs), and influenced by (inputs and feedback) and influencing (outputs) the environment. It is important to analyze the system carefully for all component parts, structures, and functions. Recall that the basis for general system theory is that "the whole is greater than the sum of the parts." This brings us to the need for a precise analysis of interrelationships among components and between the parts and the entire system. In addition, an open system has permeable boundaries receiving input and feedback from the environment. Problems occur when environmental factors are unknown, unclear, or ignored. Consider the broad health-service system. Since the Institute of Medicine (now the National Academies of Science, Engineering, Medicine, NASEM) began issuing a series of reports in 1998, we have been greatly concerned about safety in healthcare. Systems issues have been a major focus but moving from a culture of blaming individual practitioners, the challenge became one of improving components in the system, input, feedback, and outputs. In addition, the broader healthcare environment and societal influences are included and visualized as crossing the system boundaries of an individual hospital setting.

In nursing, systems theory and various applications have been used to explain organizations, nursing and healthcare delivery, and groups of people. Several nursing models are based on systems theory. Johnson's Behavioral Systems conceptual model views the person as a behavioral system and nursing as an external force. It exemplifies how a grand theory (general system theory) from another scientific community provided a basis for developing the conceptual model of nursing (Johnson's Behavioral Systems). Specificity to the metaparadigm concepts and interrelationships unique to nursing have provided the basis for the nursing conceptual framework. Further delineation of concepts and propositions leads to more specific nursing theory. Neuman's Healthcare Model, Roy's Adaptation Model, and King's conceptual framework and Theory of Goal Attainment are examples of nursing conceptual models and theories based on systems models. Other nursing models use various components of general systems theory. Further applications of systems theory are evident in subsequent sections on management and leadership in organizations and change.

THEORETICAL CHALLENGES AND A PARADIGM SHIFT

Galbraith (1984) identified conventional wisdom as the structure of ideas that is based on acceptability, and to the people as their reality as they see and articulate it (p. 16). These ideas, which people generally consider as "truths," can be obstacles to new theories and to the development of new knowledge. Conventional wisdom may be that the current paradigm is on the brink of change. We must be open to new theories with new technology. Knowledge expansion can proceed at a much greater rate, as we have now seen with quantum physics or quantum mechanics.

For years, Newtonian physics provided the conventional wisdom of the three laws of motion: (1) inertia (objects in motion tend to stay in motion, and objects at rest tend to stay at rest unless there is interference from an outside force), (2) net force (the force on an object is mathematically equal to its mass times acceleration), and (3) reciprocal actions (for every action there is an equal and opposite reaction).

Based on the work of Galileo and others, Newton's theories from the 17th century prevailed until the 20th century, with the addition of Einstein's theory of relativity and the discovery of **quantum theory.** As Nobel Laureate Robert Laughlin (2005) points out, although applicable to the macroscopic world, Newton's laws are incorrect at the atomic scale (p. 31). How we formerly pictured an atom, as a Newtonian-like solar system, is outdated and

incorrect. Researchers and theorists have moved from classical physics to the era of the quantum.

We hear a good deal about the "quantum" nature of our world and universe. But it is all evolving as we develop new insight into the makeup of matter and how particles behave. A quantum is merely an energy bundle at the atomic and subatomic level—neutrons, protons, and electrons. The measurement of the quantum requires high-level mathematical computations looking at statistical probabilities of matter and waves. Hence, the discoveries from classic mechanics to quantum mechanics have occurred in areas of physics, chemistry, computers, and biology. This has provided the basis for certain transformations in healthcare, such as the introduction of the laser and magnetic resonance imaging (MRI). Biotechnology and advances in physical science will continue with our quest for discovery and knowledge. Laughlin (2005) notes, however, that we have experienced a paradigm shift, moving from a reductionist view of science to one of emergence, and that, "as in all other human activities, it is necessary in science to take stock now and then and re-evaluate what one deeply understands and what one does not" (p. 13).

The language and concepts of quantum theory extend beyond the atom as we look at issues of holism, duality, uncertainty, causality, and probabilities in daily life and practice. Recognition and understanding of the paradigm shift are essential for the health sciences as we seek new knowledge and improvements in patient-care outcomes.

THE IMPACT OF THEORY ON PRACTICE

Alligood (2018a) proposes that professional nursing practice "requires a systematic approach that is focused on the patient, and the theoretical works provide the perspectives of the patient" (p. 8). We use theory every day in our personal and professional lives, from learning the basic principles of asepsis in hygiene and standard precautions, to understanding the complex communication channels of the organizational system in which we practice.

Theory, practice, and research are interrelated and interdependent. We need theory to guide practice predictably and effectively. We need research to support the significance and usefulness of the theory, because the dynamic nature of our metaparadigm concepts of human beings, environment, health, and nursing makes theories tentative and subject to refinement and revision. Professional practice provides the questions for study based on problems and phenomena relevant to the discipline. Again, recall that nursing is a profession and a scientific community. We practice using principles provided by our metaparadigm and theoretical bases. This furnishes us with the tools for critical thinking, provision of care, education, administration, research, and interdisciplinary collaboration. We have a paradigm that provides the models for problems and solutions in our knowledge base and practice community in line with Kuhn's (1970) descriptions of a paradigm. Our paradigms and theories are designed to address problems and solutions in practice; otherwise, we need to shift to a new structure with different theories and paradigms to explain our concerns for people, environments, health, and nursing.

The theory on which we base practice must be compatible with and must correspond to the phenomena of professional nursing practice. To ensure that the goals of theory and practice are consistent, Alligood (2014) has recommended the following considerations for selecting a framework for practice:

1. Evaluate your values and beliefs held true about nursing.
2. Establish your philosophy statement of beliefs on the metaparadigm concepts.
3. Evaluate definitions of the metaparadigm concepts in selected models.
4. Select two to three frameworks that are consistent with your beliefs.
5. Look at the assumptions of the models.
6. Apply the models to your practice area to see if they work in the practice setting.
7. Compare the frameworks, looking at patient focus, nursing action, and outcomes.
8. Review the literature on applications of the selected models to practice.
9. Select the best framework appropriate to your practice and implement it. (p. 57)

But recall that conventional wisdom can be an obstacle to the discovery of new knowledge. Practice models are subject to change as new information is discovered and as patients' needs change. And will change further as we incorporate new concepts like health equity and the Social Determinants of Health (SDOH). The paradigm concepts must be in a constant state of evaluation to ensure that the model of practice is current and based on nursing science.

In the next chapter, conceptual models and theories unique to nursing are discussed. These models guide practice in our highly complex profession. Implementing models for practice, whether unique to nursing or adapted, is a necessary but arduous and time-consuming task. The process is worth the effort to ensure quality care for recipients, but it requires many of the skills addressed in subsequent chapters.

KEY POINTS

- Kerlinger and Lee (2000) define a theory as "a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena" (p. 11).
- A model is a graphic representation of some phenomena. A theoretical model provides a visual description of the theory using limited narrative and displaying components and relationships symbolically. A framework is another means of providing a structural view of the concepts and relationships proposed in a theory.
- A concept is a view or idea we hold about something, ranging from something highly concrete to something highly abstract. A construct is a more complex idea package of some phenomena. Definitions of concepts and constructs are theoretical or conceptual. An operational definition states precisely what we view as phenomena and how they can be measured as variables in a practice or research situation.
- Propositions in a theory are the descriptions and relationships among the constructs (or concepts) that propose how the concepts are linked and relate to each other and to the total theoretical structure.
- Dickoff and James (1968) developed a classic position paper proposing four levels of nursing theory: factor-isolating, factor-relating, situation-relating, and situation-producing theories.
- Theories are classified as grand, middle-range, or practice on the basis of their scope or breadth of coverage of phenomena.
- Theory description is a careful, nonjudgmental analysis of the component parts of a theory—its assumptions, concepts, definitions, propositions, context, and scope.
- Theory evaluation requires thoughtful interpretation relative to the clarity, significance, consistency, empirical support, and usefulness in explaining a phenomenon of concern.
- Maslow's theory of human motivation proposes a hierarchical structure for basic human needs.
- Developmental theories are widely used in nursing and other healthcare disciplines and include Erikson's (1963) eight ages of psychosocial development, Piaget's theory of cognitive development, and Kohlberg's theory of moral development.
- A system generally contains the following basic component parts: input, output, boundary, environment, and feedback. Bertalanffy's (1968) general system theory is a grand theory applied to many disciplines.
- Quantum theory, based on quantum physics, uses statistical probabilities for the actions of atomic and subatomic matter and waves and has provided some of the basis for advances in technology.
- Theory, practice, and research are interrelated and interdependent. When we are selecting a theory on which to base practice, the theory must be compatible with and correspond to the phenomena of professional nursing practice.

THOUGHT AND DISCUSSION QUESTIONS

1. Consider the following statement by Barnum (1990) describing early nursing theories: "A high number of [boundary] overlaps occur in the discipline of nursing because it often attempts to deal holistically with a phenomenon (man) that has previously been dealt with in compartmentalized ways by other disciplines" (p. 218). What does she mean by "holistically"? How do you think other disciplines may deal with the human being in a compartmentalized way?
2. Identify individuals who you think are self-actualized and explain why.
3. Identify a theory used in your practice setting. Identify the concepts (constructs), how the component concepts are defined, the propositions that link the concepts, and the aims of the theory.
4. Describe how theory is used in your practice setting and propose how it could be used further.
5. Review the Chapter Thought located on the first page of the chapter and discuss it in the context of the contents of the chapter.

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ONLINE RESOURCES

Books by A. H. Maslow
http://www.maslow.com

Jean Piaget Society
http://www.piaget.org

Nursing Theories
www.nursing-theory.org /

Nursology
https://nursology.net/

CHAPTER 3

Jacqueline Fawcett

Evolution and Use of Formal Knowledge of Nursology

Nursology is the proper name for our discipline and all members are nursologists.

CHAPTER OBJECTIVES

On completion of this chapter, the reader will be able to:

1. Describe the meaning of formal knowledge of nursology as the basis for the professional practice of nursology.
2. Identify the definitions and different functions of conceptual models and theories.
3. Discuss the advantages of using explicit conceptual models of nursology and nursological theories to guide the professional practice of nursology.
4. Discuss the use of practice guidelines as evidence-based health policies.
5. Apply a conceptual model of nursology or nursological theory to a particular practice situation.

KEY TERMS

Nursology Defined
Formal Knowledge of Nursology
Conceptual Models of Nursology
Johnson's Behavioral System Model
King's Conceptual System
Levine's Conservation Model
Neuman's Systems Model
Orem's Self-Care Framework
Rogers' Science of Unitary Human Beings
Roy's Adaptation Model
Synergy Model
Nursological Grand Theories
Leininger's Theory of Culture Care Diversity and Universality
Newman's Theory of Health as Expanding Consciousness
Parse's Theory of Humanbecoming
Nursological Middle-Range Theories
Peplau's Theory of Interpersonal Relations
Watson's Theory of Human Caring
Orlando's Theory of the Deliberative Nursing Process
Transitions Theory
Nursological Situation-Specific Theories
Practice Guidelines as Evidence-Based Health Policies

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This chapter presents a discussion of the evolution of knowledge of nursology—as it has been formalized—in conceptual models of nursology and nursological theories as well as a discussion of how that knowledge has influenced the professional practice of nursology.

NURSOLOGY DEFINED

Nursology is the proper name for our discipline and profession, and as such, will be used in this chapter instead of the more commonly used term *nursing*. Similarly, the proper name for members of the discipline of nursology is *nursologist*; this name will be used in this chapter instead of the more commonly used term *nurse*. The adjective for *nursology* is *nursological*. Although these terms may seem strange at first, you most likely will soon discover that the terms are so similar to terms such as *sociology* or *psychology*, *sociologist* or *psychologist*, and *sociological* or *psychological* that they no longer seem strange. The terms *nursing* and *nurse* are retained only when specific to the vocabulary of a particular conceptual model or theory or when crucial to the content of a quotation.

I have defined *nursology* as "the knowledge of the phenomena of interest to nursologists, which are [what, why, when, where, and how] nursologists collaborate with other human beings as they experience wellness, illness, and disease, within the context of their environments" (Fawcett, 2019, p. 919).

Fawcett and colleagues (2015) traced the origins of nursology as the name for our discipline. They explained:

> *The term, nursology, comes from the Latin, Nutrix, nurse; and from the Greek, Logos, science (O'Toole, 2013, p. 1303). The first mention of nursology apparently is by Paterson in her 1971 journal article. She claimed that she coined the term, nursology, "to designate the study of nursing aimed towards the development of nursing theory" (p. 143). . . . Roper (1976), a Scottish nurse, explained that her search for a word for the discipline led to her (apparently independent) selection of nursology. She stated, "It could be that nursing might develop as a discipline without using a word to describe its characteristic mode of thinking, but it will have to make the mode explicit and it will have to have the same meaning for nurses anywhere. Should the nursing profession require to use a word, I propose the word nursology for the study of nursing, so that the logical pattern of derivation of an adverb could be followed. (p. 227)*

Fawcett and colleagues (2015) went on to point out that a review of literature revealed that the term *nursology* is regarded not only as the proper name for our discipline but also is a research method and a practice methodology. The phenomenological research method, which emphasizes synthesis of individuals' lived experiences, is an appropriate research method for the generation of knowledge of nursology (Paterson, 1971; Paterson & Zderad, 1976/1988). As we think about what it means to call our discipline nursology, we most likely will identify other appropriate research methods that focus on collection of qualitative and quantitative data. For example, it may be that mixed method designs are the most appropriate research method for the development of knowledge of nursology; these designs combine and/or integrate qualitative data (data that are collected as words) and quantitative data (data that are collected as numbers) to produce theories about people's experiences of wellness and illness (Fawcett, 2015).

The practice methodology for nursology is humanistic nursing (Paterson & Zderad, 1976/1988), which requires the nursologist

> *to interact with the patient in an "authentic" way, without aloofness and the distance of professionalism; the [nursologist] must take the risk of caring. As a [practice] method, nursology requires that the [nursologist] cut through the defenses and fears that prevent self knowledge. The [nursologist] tries to know the patient on an intuitive, subjective level and then, using reflection, on an objective, scientific level. The [nursologist] recognizes that each person has an "angular view" of the whole truth. Comparison of the views of others is necessary for a perspective that allows a synthesis, often paradoxic but closer to the truth than any one person's angular view. (O'Toole, 2013, pp. 1303–1304)*

This practice methodology implies attention to both qualitative and quantitative information from patients and, therefore, is consistent with mixed method research designs.

THE FORMAL KNOWLEDGE OF NURSOLOGY

Before articulation of formal nursology knowledge, it is likely that one or more persons in a community practiced what we now know as nursology care for others in the form of informal knowledge or what Polanyi (1962) referred to as personal or tacit knowledge. This "informal nursologist" was in prerecorded history the primitive mother or wise woman (Dock & Stewart, 1938). Formal nursology knowledge has developed and evolved to its current form as presented in this section of the chapter at least since the time of Florence Nightingale (1859/1992),

Conceptual models of nursology and nursological theories represent the **formal knowledge of nursology.** That knowledge was organized by several

nursologist scholars who devoted a great deal of time to observing people's experiences of wellness and illness, thinking about what is important to all nursologists and the discipline of nursology in those experiences, and then testing their thoughts by conducting research. **Knowledge of nursology** continues to evolve as nursologists who are researchers and practitioners of nursology use conceptual models and theories to guide their research and practice, and then report the results at conferences and in publications. Consequently, all nursologists can contribute to the evolution of the knowledge of nursology.

CONCEPTUAL MODELS

For our purposes, the terms *conceptual model, conceptual framework, conceptual system*, and *paradigm* have the same definition and functions and may be used interchangeably.

Definition

A **conceptual model** is defined as a set of relatively abstract and general concepts that address the phenomena of central interest to a discipline, the statements that broadly describe those concepts, and the statements that assert relatively abstract and general relations between two or more of the concepts (Fawcett & DeSanto-Madeya, 2013).

Each conceptual model presents a particular perspective about the phenomena of interest to a particular discipline, such as nursology. Conceptual models of nursology present diverse perspectives of human beings—including individuals, families and other groups, and communities—who are participants in nursological practice; the environment of the nursing participant and the environment in which the practice of nursology occurs; the health condition of the practice participant; and the definition and goals of nursological practice as well as the practice methodology—typically referred to as the nursing process—used to assess, label, plan, intervene, and evaluate.

Functions

One function of any conceptual model is to provide a distinctive frame of reference or "a horizon of expectations" (Popper, 1965, p. 47). Another function of each conceptual model is to identify a particular "philosophical and pragmatic orientation to the service [nursologists] provide patients—a service which only [nursologists] can provide—a service which provides a dimension to total care different from that provided by any other health professional" (Johnson, 1987, p. 195). Conceptual models of nursology provide explicit orientations not only for [nursologists] but also for the general public. Johnson (1987) explained, "Conceptual models specify for [nursologists] and society the mission and boundaries of the profession. They clarify the realm of [nursology] responsibility and accountability, and they allow the practitioner and/or the profession to document services and outcomes" (pp. 196–197).

Conceptual Models of Nursology

Currently, the works of several nursologist scholars are recognized as broad **conceptual models of nursology** that can be used in many different practice situations. Among the best known of those conceptual models are Johnson's (1990) Behavioral System Model, King's (2006) Conceptual System, Levine's (1991) Conservation Model, Neuman's Systems Model (Neuman & Fawcett, 2011), Orem's (2001) Self-Care Framework, Rogers' (1990) Science of Unitary Human Beings, and Roy's (2009) Adaptation Model. An overview of each of these nursological models is presented in the next section, along with the implications of each one for the professional practice of nursology.

Dorothy Johnson's Behavioral System Model

Johnson's Behavioral System Model focuses on the person as a behavioral system, made up of all the patterned, repetitive, and purposeful elements of behavior that characterize life. Seven subsystems carry out specialized tasks or functions needed to maintain the integrity of the whole behavioral system and to manage its relationship to the environment. The subsystems and their functions are as follows:

1. *Attachment or affiliative:* The security—in terms of social inclusion, intimacy, and formation and maintenance of social bonds—that the individual needs for survival.
2. *Dependency:* The succoring behavior that calls for a response of nurturance as well as approval, attention or recognition, and physical assistance.
3. *Ingestive:* Appetite satisfaction—when, how, what, how much, and under what conditions the individual eats—all of which are governed by social and psychological considerations as well as biological requirements for food and fluids.
4. *Eliminative:* Elimination—when, how, and under what conditions the individual eliminates wastes.
5. *Sexual:* Procreation and gratification, with regard to behaviors dependent on the individual's biological sex and gender role identity, including but not limited to courting and mating.
6. *Aggressive:* Protection and preservation of self and society.
7. *Achievement:* Mastery or control of some aspect of self or environment, with regard to intellectual, physical, creative, mechanical, social, and caretaking (of children, partner, home) skills.

The structure of each subsystem involves four elements:

1. *Drive or goal:* The motivation for behavior.
2. *Set:* The individual's predisposition to act in certain ways to fulfill the function of the subsystem.
3. *Choice:* The individual's total behavioral repertoire for fulfilling subsystem functions, which encompasses the scope of action alternatives from which the person can choose.
4. *Action:* The individual's actual behavior in a situation. Action is the only structural element that can be observed directly; all other elements must be inferred from the individual's actual behavior and from the consequences of that behavior.

The three functional requirements listed below are needed by each subsystem to fulfill its functions:

1. *Protection* from noxious influences with which the system cannot cope
2. *Nurturance* through the input of appropriate supplies from the environment
3. *Stimulation* to enhance growth and prevent stagnation

Implications for the Practice of Nursology

The practice of nursology is directed toward the restoration, maintenance, or attainment of behavioral system balance and dynamic stability at the highest possible level for the individual. Johnson's practice methodology, which is called the Nursing Diagnostic and Treatment Process, encompasses the four steps listed in Box 3.1. Each step is discussed in detail below.

Determination of the Existence of a Problem

The nursologist obtains the following:

- Past and present family and individual behavioral system histories through interviews, structured and unstructured observations, and objective methodologies
- Data about the nature of behavioral system functioning in terms of the efficiency and effectiveness with which the patient's goals are obtained
- Information to determine the degree to which the behavior is purposeful, orderly, and predictable
- Information on the condition of the subsystem structural components to draw inferences about (1) drive strength, direction, and value; (2) the solidity and specificity of the set; (3) the range of behavior patterns available to the patient; and (4) the usual behavior in a given situation

The patient's behavior is compared with the following indices for behavioral system balance and stability, as well as the reorganization and integration of the subsystems:

- The behavior achieves the consequences sought.
- The behavior reveals the patient's effective use of motor, expressive, or social skills.
- The behavior is purposeful—actions are goal directed, reveal a plan, cease at an identifiable point, and are economical in sequence.
- The behavior is orderly—actions are methodical and systematic, build sequentially toward a goal, and form a recognizable pattern.
- The behavior is predictable—actions are repetitive under particular circumstances.
- The amount of energy expended to achieve desired goals is acceptable.
- The behavior reflects appropriate choices—actions are compatible with survival imperatives and the social situation.
- The behavior satisfies the patient sufficiently.

Diagnostic Classification of a Problem

A problem might occur in two areas:

- *Internal subsystem problems:* Functional requirements are not met, inconsistency or disharmony among the structural components of subsystems is evident, and/or the behavior is inappropriate in the ambient culture.
- *Intersystem problems:* The entire behavioral system is dominated by one or two subsystems, or a conflict exists between two or more subsystems.

Management of Nursing Problems

The general goals of action are to restore, maintain, or attain the patient's behavioral system balance and stability and to help the patient achieve an optimum level of balance and functioning when this goal is possible and desired. The nursologist determines what they are to accomplish on behalf of the behavioral system by determining who makes the judgment regarding the acceptable level of behavioral system balance and stability. Nursologists' actions may occur in three areas:

- *Temporary external regulatory or control mechanisms*, by setting limits for behavior by either permissive or inhibitory means, inhibiting ineffective behavioral responses, helping the patient acquire new responses, and reinforcing appropriate behaviors

BOX 3.1 Johnson's Behavioral System Model: Diagnostic and Treatment Process

- Determination of the Existence of a Problem
- Diagnostic Classification of a Problem
- Management of Nursing Problems
- Evaluation of Behavioral System Balance and Stability