

FOUNDATIONS OF ADULT NURSING

EDITED BY

Dianne Burns

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Editorial assistant: Jade Grogan
Assistant editor, digital: Chloe Statham
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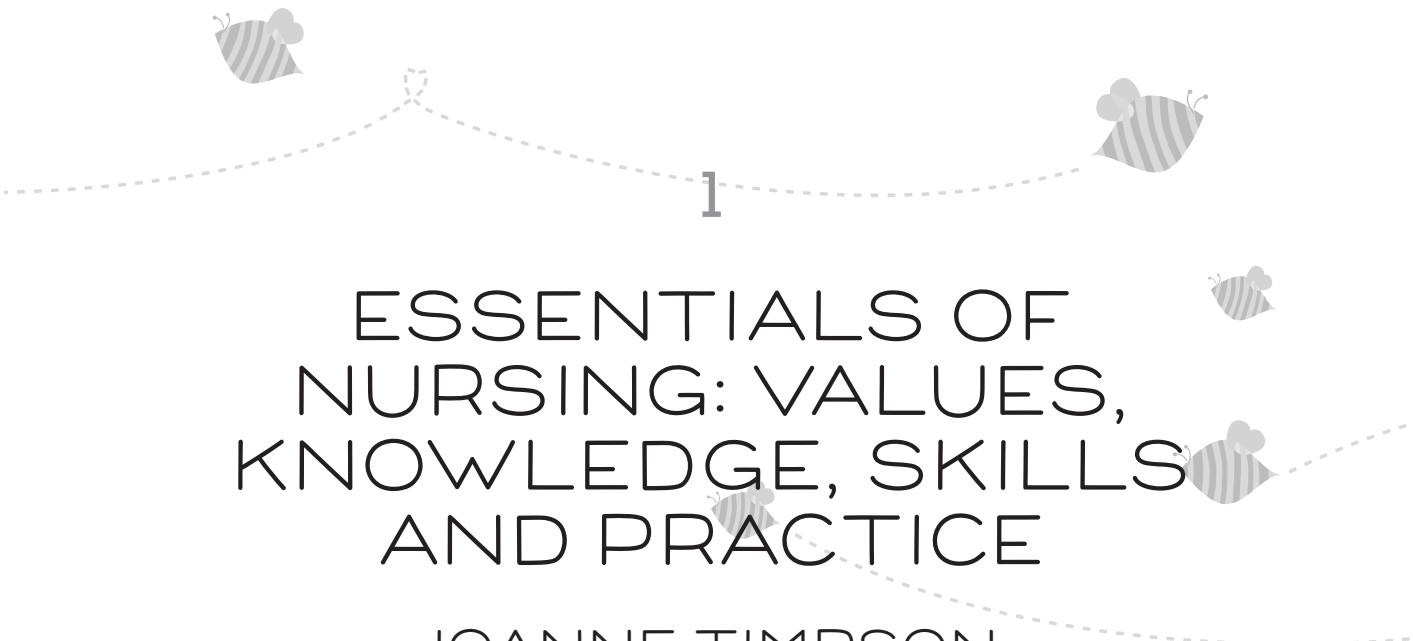
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1

ESSENTIALS OF NURSING: VALUES, KNOWLEDGE, SKILLS AND PRACTICE

JOANNE TIMPSON,
ELIZABETH LEE-WOOLF
AND JANE BROOKS

CHAPTER OBJECTIVES

- Outline the landmarks of nursing history and highlight how these have influenced nursing practice across the UK;
- Explain how legal and ethical principles provide a core framework for our professional practice;
- Define the core values that underpin nursing and recognise their application to practice;
- Understand the principles of *The Code* (Nursing and Midwifery Council or NMC, 2018a) by which we practise and how these define our fitness to practise;
- Highlight the challenges to modern nursing and relate these to our professional values in regard to cultural competence, emotional IQ and resilience.

As you begin your studies in nursing we hope that you will be as full of questions, as you are enthusiasm, for your chosen profession and trust that you are prepared for the challenge ahead. Our aim is to engage you with our passion for nursing and instil an ethos of nursing as a privilege. Together, we will review the essentials of nursing knowledge and values, exploring how these will underpin your practice in a way that we hope will excite your professional imagination, intelligence and curiosity.

Related NMC proficiencies for registered nurses

The overarching Nursing and Midwifery Council (NMC) requirement is that all nurses act in the best interests of people, putting them first and providing nursing care that is person centred, safe and compassionate. They should act professionally at all times and use their knowledge and experience to make evidence-based decisions about care. They communicate effectively, are role models for others and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care (NMC, 2018b).



To achieve entry to the nursing register
you must be able to

- Understand and act in accordance with *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* and fulfil all registration requirements (NMC, 2018a);
- Act as an ambassador, upholding the reputation of your profession and promoting public confidence in nursing, health and care services;
- Understand and apply relevant legal, regulatory and governance requirements, policies and ethical frameworks to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom;
- Demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences your judgements and decisions in routine, complex and challenging situations;
- Understand and maintain the level of health, fitness and wellbeing required to meet people's needs for mental and physical care;
- Understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in yourself or your colleagues and the action required to minimise risks to health;
- Understand and apply the principles of courage, transparency and the duty of candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes;
- Demonstrate an understanding of and the ability to challenge discriminatory behaviour;
- Take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop your professional knowledge and skills.

(Adapted from NMC, 2018b)

Background

To understand the role of the contemporary adult nurse in the UK, it is useful to know a little of nursing's history and to recognise key landmarks over the last 150 years that signal the development towards the professional nursing practice we have today. However, it is not our intention to provide a detailed history of nursing here and you are advised to explore the Further Reading section at the end of this chapter, which illustrates in more detail the historical threads that bring us to this point.

Although caring, and the role of carer, has existed throughout history, nursing in its modern sense is a relatively recent concept. It is recognised that the words 'nurse' and 'nursing' are derived from the Old French *nourice* and the Late Latin *nutrire*, meaning to nourish and care (*Oxford English*

Dictionary, 2014a), but their use in today's sense has occurred only from the seventeenth century onwards. It is often suggested that nursing can be traced back through history to its earliest times. If you accept that this reflects the act of carer and caring then this is undoubtedly true. The themes that run through the earliest annals of history involve those who provided succour (i.e. assistance and support in times of hardship or distress) for families, communities or for those injured in battle, for example. What is perhaps more important here for modern notions of nursing are those involved with what Reverby, O'Brian D'Antonio, and Mann Wall have called 'professed-nursing', namely the care of sick strangers (Reverby, 1987; O'Brien D'Antonio, 1993; Mann Wall, 1998). This distinction is crucial because, if we understand modern professional nursing as caring for those people who are not our friends or family, this means that it is a very different undertaking from caring for those who are. Nevertheless, often the carers who nursed 'sick strangers' were influenced by religious values and altruism, believing that it would be wrong to gain monetarily from their work. There was, however, a more insidious ideology at work: once a lady worked for money, she was no longer considered a lady. To cite historian Hawkins, 'they forfeited their respectability' (Hawkins, 2010: 29). Given that nursing reformers in the nineteenth century wished to increase the number of educated middle-class women in the occupation this was clearly a problem. Hence the vocation or calling to nurse has been the province of those who had a desire to care with little thought of reward or perhaps, more pertinently, were felt not to want such financial reward because they were respectable. Either way, whilst philanthropy may indeed be admirable, such notions influenced the status of the nurse and, perhaps, some might argue, limited the evolution of nursing as a highly skilled profession (Helmstadter, 1993, 1996).

Throughout the eighteenth century we can see the appearance of what might be termed the 'modern hospital' in Britain. This was also the Age of Enlightenment – a movement made up of intellectuals who wished to see development in many areas of life through reasoned argument and science rather than adhering to traditions without thought. This influence can be seen in the funding of modern 'voluntary hospitals' by wealthy benefactors such as Thomas Guy who funded Guy's Hospital in London (1719), followed by the Edinburgh Royal Infirmary (founded in 1729), St Bartholomew's Hospital (opened in 1730, funded by public subscription), the Middlesex Hospital (opened in 1745, funded by public subscription) and the Manchester Royal Infirmary (in 1752). These hospitals had a charitable remit to provide treatment for the poor which was recognised by an Act of Parliament in 1836. However, they needed to provide care only for the 'deserving poor', and all voluntary hospitals tended to focus on acute illnesses that could be treated and would therefore provide excellent advertisements for future possible benefactors. This system excluded the chronically sick, the elderly and infirm, the mentally ill and those with learning disabilities. The last two types of patients were cared for in separate 'asylums for the insane' whereas the elderly and chronically sick were cared for in Poor Law Hospitals. The Poor Law Hospitals were described as 'murderous pesthouses' into which 'the dense mass of living creatures were crammed' (cited in White, 1978: 18).

- How do people today consider the work carried out by nurses in intensive care units in acute hospitals?
- How do people view the nursing of older people with dementia?
- What sort of facilities do we offer to each of these groups of patients?
- The thing about history is that there are often reasons in our past that go some way to explaining the ways in which services develop over time.
- Are you able to identify any links with history for the care of older people that exist today?



Modern nursing has its roots in the nineteenth century (please note, we do not wish to ignore the notion that there were significant examples of nursing-type activities in earlier times, but it would be difficult to present their importance here without sounding superficial). As the Industrial Revolution changed the face of our national landscape the need to care and manage the sick faced equal challenges. The choices surrounding who did what were primarily influenced by industry and the developing urban communities employed therein, but also by gender role. As a result, those individuals who nursed tended to be women. Living conditions were often crowded, unsanitary and polluted. Disease flourished and work-based accidents were common.

SOME EARLY NURSING PIONEERS IN BRITAIN

Florence Nightingale was born in 1820 to a wealthy family. She was encouraged and taught to think and question in a way that was unusual for a girl of those times. Her parents did not approve of her wish to nurse which they deemed unconventional. However, in 1851 she travelled to Kaiserswerth for three months to learn to be a nurse and two years later Nightingale became superintendent of a hospital for gentlewomen in Harley Street. The outbreak of the Crimean War, and the plight of wounded soldiers in terrible conditions, saw her initiate a campaign to take a team of nurses to military hospitals in Turkey where, despite relentless opposition, she improved the care and conditions for patients. Even before her return to Britain in 1856 the Nightingale Fund – which the grateful public of Britain had established in her name following her work in the Crimea – had accrued significant monies. Although initially not enthused by the project, in 1860 the Nightingale Training School for nurses at St Thomas's Hospital in London was established in her name (Baly, 1997; Bostridge, 2008). The purpose of the school was to train nurses who would then establish similar schools based on her principles. By 1867 probationer nurses were able to pay to attend and this facilitated a two-tier system of nurses where, by the turn of the twentieth century, only those who had paid for their training would be offered a post as Sister.

Mary Seacole was another Crimean pioneer (Alexander and Dewjee, 1984; Griffon, 1998). Born in Jamaica in 1805 (her father was a Scot and her mother Jamaican), Seacole was well travelled and had gained perspectives on medicines and care wherever she went. Like Florence Nightingale, in 1854 Seacole asked the British government to send her to the Crimea to assist in the army hospital. In her autobiography, Seacole recalled being turned down. However, she did then fund her own travel to the Crimea, where she cared for soldiers. On returning to the UK her health was poor and she had little money and no family to support her. She achieved a great deal but died in 1881 and thus did not live to see the achievement of nurse registration.

Ethel Gordon Manson (who later became known as Mrs Bedford Fenwick) was passionate about the improvements to nursing and nurse training. She trained as a nurse at the Nottingham Children's Hospital and then at Manchester's Royal Infirmary between 1878 and 1879. She became the matron of St Bartholomew's Hospital in London at the age of only 24 years. In 1888 she married Dr Bedford Fenwick, retired from nursing, and devoted her life to national and international nursing matters. As the founder of the Royal British Nurses' Association (1887) and the International Council of Nurses (1899), and editor of the first professional nursing journal *The Nursing Record/The British Journal of Nursing*, from 1893 to 1946, she staunchly advocated that nursing should be regulated and every nurse should be registered. She is considered to have contributed to phenomenal achievements in nursing's development (Griffon, 1995). She died on 13 March 1947.



ACTIVITY 1.1

Find out more about the pioneers of nursing practice and identify their contribution to the development of nursing and nurse education.

You can start by accessing the UK Association for the History of Nursing at <http://ukahn.org/wp/>

We should not deny the fact that, while nursing was struggling for recognition, this aspect also reflects an earlier period in medicine where doctors had little recognisably organised training as such. The Medical Act of 1858 responded to a need for the public to be able to determine whether or not a doctor was qualified to practise and resulted in the inauguration of the General Medical Council. This professional body was (and remains to this day) charged with registering practitioners and ensuring that the public have access to that information (although this is now governed under the Medical Act of 1983). Following on from this, many recognised the logic for nurses to be registered in a similar fashion. The debate and will for this became more organised, especially after the beginnings of nurse training in 1860.

By 1880 the Hospitals' Association (HA) was in agreement that some form of nurse registration was a necessity and therefore voluntary registration was introduced. Ethel Bedford Fenwick (a member of the Matrons' Committee) passionately believed in professionalism and that nurses should be registered in a similar fashion to doctors. She set up the British Nurses' Association, which provided an alternative voluntary register that noted completion of a programme of study, but also more importantly aligned itself with a remit to protect the public.

The First World War provided the pivotal impetus for registration. Many women had answered a call to go and nurse which had, incidentally, raised the profile of nursing with the public. Women's role in society was changing and their contribution to working life while soldiers were away was generally noted and applauded. Meanwhile the College of Nursing was founded in 1916 (later to become the Royal College of Nursing). This organisation led and supported initiatives to further develop and raise nursing's profile and the need for a nursing register. In 1919 one MP (Major Barnett) was persuaded to propose a Private Members Bill which resulted in the Nurse Registration Act. This called upon the General Nursing Council to maintain and monitor a nursing register, as well as provide central guidance to inform nurse training programmes. It was replaced by the United Kingdom Central Council in 1983 and subsequently by the Nursing and Midwifery Council in 2002. All had similar duties in their role to maintain the register, provide educational guidance and ensure protection of the public. It is interesting to note that women still had no right to vote and nursing would not be officially recognised as a profession for almost another 100 years but at least they had registration and regulation.

The NHS was born in 1948 which again reflected the changes that war had brought to society. However, and despite the work of many groups, nurse education and the role of the nurse were slow to evolve. Graduate education for nurses was embryonic although several university medical schools began offering some form of nurse education at degree level. The University of Edinburgh offered the first degree in nursing in 1960 and the University of Manchester's Bachelor of Nursing degree soon followed. It was at the University of Manchester that the first Professor of Nursing was appointed – Jean Kennedy McFarlane, later to become Baroness McFarlane of Llandaff. Other 'experimental' courses were tried throughout the 1960s and 1970s, with some at degree and some at diploma level.

The birth of modern nursing

Several reports during the twentieth century culminated in the Briggs Committee's remit to consider various concerns surrounding the methods, content and quality of nurse education and its interface with the NHS. Margaret Scott Wright was an influential member of this committee and the report that followed in 1972 recommended a step change: a move away from training towards professional education and the development of research into all aspects of education and nursing practice. After much wrangling the Nurses, Midwives and Health Visitors Act (passed in 1979) saw the beginnings of a modern-day nurse education.

Project 2000 was introduced in 1988 and diploma education for nurses was piloted in a number of schools prior to it being rolled out across Britain. Student nurses now had student status and were no longer employees of the hospital in which the School of Nursing was based. This created some challenges for nursing practice, but these were not insurmountable and many nurses at all levels engaged with this new approach to education with enthusiasm. Between 1990 and 2010 diploma and degree courses in nursing ran side by side, but in 2010 legislation was enacted to ensure that every nurse in England would be educated to degree level, reflecting previous changes already effected in Scotland, Northern Ireland and Wales, for both nursing and other allied health professions such as physiotherapy, radiography and occupational therapy.

TWENTIETH-CENTURY PIONEERS IN NURSING

Lisbeth Hockey was born Lisbeth Hochsinger on 17 October 1918 in Graz, Steiermark, Austria. In 1936, at the age of 18, she commenced her medical studies at the Karl-Franzens University of Graz. However, following the Nazi occupation of Austria in 1938 she left for England. Hockey was not able to recommence her medical studies in England for three reasons: she was a woman (and few British women went to university at that time); she did not speak English; and she had no money. British friends recommended nursing as an alternative and so Hockey began her training at the London Hospital in Whitechapel in 1939 (Mason, 2005: 2–5). Her importance to the nursing profession came from her natural desire to ask questions. However, during her training this was to cause her problems with those in authority:

What intrigued me or alarmed me was the number of pressure sores and bed sores of course in those days. But what interested me more, was why some people did not get bed sores ... And I went to the sister one day and said, 'please explain to me why some patients have got bed sores and others didn't' seeing as I was interested in the ones that didn't, and she said, 'it's not your place to ask questions, go back and do your work'. (Hockey, 2001)

She was not put off, and after qualifying as a nurse she trained as both a district nurse and then a health visitor before becoming a tutor at the Royal College of Nursing. In 1971, Hockey became the Director of the first Nursing Research Unit at the University of Edinburgh (Weir, 2004). She was awarded her PhD on 3 December 1979 and on 4 December the same year was invested Order of the British Empire in recognition of her contribution to nursing research (Mason, 2005: 2). She died on 15 June 2004.

Baroness Jean McFarlane of Llandaff (Jean Kennedy McFarlane) was born on 1 April 1926. The youngest child of a large family, she did well at school and went to study sciences at London University. However, her voluntary work with people experiencing difficult life situations led her to undertake a

nursing course at Manchester Royal Infirmary, and then later she qualified as both a midwife and health visitor. Her career in nursing saw her lead a project, sponsored by the then Department of Health and Social Security and the RCN (1967), to research nursing care in depth and provide evidence for quality care. McFarlane's role was to summarise the project and produce a literature review on 'The proper study of the nurse' (McFarlane, 1970). She returned to Manchester in the early 1970s to work with the Department of Community Medicine, her vision being that nurses' education should be of graduate standing and prepare them to work equally in a hospital or a community setting. This resulted ultimately in the development of a Bachelor's degree in Nursing with additional health visiting and district nursing qualifications. Her work was renowned on both the national and the international stage. McFarlane was awarded a chair in nursing at Manchester in 1974 – the first in England – and her subsequent work for the Royal Commission on the NHS led to her parliamentary seat in the House of Lords and further influence on a number of select committees. Although Baroness McFarlane died in 2012, her influence on people and undergraduate nurse education continues to evolve and respond to the dynamic world of healthcare provision.

Margaret Scott Wright (a contemporary of both Jean McFarlane and Lisbeth Hockey) enjoyed significant nursing and nurse management roles at St George's and the Middlesex Hospitals in London before embarking on a challenging career as a nursing researcher in both Edinburgh and several Canadian universities. Her clinical work spanned a period of immense development of the nursing role in care, the advance of technology in diagnostics and treatment, and a stronger dialogue between medical practitioners and nurses, which would evolve into clinical specialist nursing opportunities. Scott Wright was passionate about the development of nursing research because she believed it would enhance the quality of care provision by adding an academic rigour to the clinical nurse's expertise. She was also one of the first UK nurses to study for a Doctorate of Philosophy (1961) and in 1971 was awarded the first chair of nursing studies in Europe while at Edinburgh University. Her desire to see nursing research as a central theme in nurse education was helped by her role in the influential Briggs Committee which reported to government in 1972 and strongly supported the development of nursing research units across the UK. Her career finally took her to Canada where she continued to have international influence on the development of nursing research.

So, what can we learn from our nursing history?

We can learn that nursing has, at its roots, nurture, caring, comfort and compassion, ministered by those committed to humanitarian values and often enduring significant hardship in the process. Several conflicts have given rise to ground-breaking innovations and discoveries in medical technology and treatment (as necessity has driven invention), and the evolution of nursing has taken place alongside these. As a result, advances in nursing practice, and more recently nursing research, have often followed the development of medical practice. One thing that we can be absolutely sure of is that as a nursing student you will study, learn, practise and develop your knowledge and skills in the light of new discoveries and treatments. Indeed, nursing in the future will surely be different from what it is today. However, in this regard we must advise some caution: we must be careful not to live in our history because this can distract us from the importance of our present and the potential for nursing's future. A healthy interest in events that have shaped the profession will often provide the impetus and courage to ensure that our nursing practice continues to evolve and can meet the needs of service users in a dynamic world.



- Are you able to identify your reasons for becoming a nurse?
- What is it that you wish to achieve?
- What skills and attributes do you feel you can offer the profession?

Keep a note of your answers to these questions because we shall revisit this topic later in the chapter.

Where are we now?

Today, those aspiring to be professional nurses can access the benefits of established educational pre-registration programmes which are both validated and monitored by a professional body, the Nursing and Midwifery Council (NMC), and the Higher Education Institution (HEI) in which the course takes place. As new registrants launch their careers, learning continues. Nurses grow in knowledge and skill while experience, reflective practice, and professional discussion facilitate effective, compassionate care for patients and colleagues alike. Several strategies support this development: *Modernising Nursing Careers* (Department of Health, Social Services and Public Safety or DHSSPS, 2006) and *Preceptorship Frameworks* (Department of Health or DH, 2010a; NHS Wales, 2012; Willis Commission, 2012; Northern Ireland Practice and Education Council, 2013; NHS Employers, 2014; Cummings, 2016).

The role of the nurse has extended and nurses are now significant partners with other health professionals and service users in care provision. Increasingly, specialist nurses are the leaders of care and take on additional responsibilities in areas such as prescribing, implementing complex care interventions, and performing minor surgery and other invasive treatments. It is clear that as a profession we are facing an unprecedented rate of change. This is partly in response to the changing face of healthcare itself as we move towards a more community-based focus of care. However, it is also as a result of improvements in treatments and emergent technologies. We face targets and the competitive aspects of a free-market economy, which has been introduced to the NHS where it is almost impossible to put a price on the time you spend with a frightened patient waiting for uncertain news in an A&E, for example. We continue to face increased scrutiny from our service users and those who provide carer support. Increased media coverage has led to an atmosphere of alarm, ambiguity and a perception of neglect, especially in the context of ongoing chronic disease and end of life care. This lack of compassion and kindness was highlighted in its starkest form in the Francis Reports (DH, 2010b, 2013), which provoked a necessary period of professional introspection, an avowed reclaiming of our core values and the emergence of the seven principles of the NHS Constitution (NHS England, 2015), which will be explored and discussed in more detail later in the chapter.

It is our hope that as a registered nurse you will develop the knowledge, skills and confidence to enable you to provide high-quality, evidence-based nursing in a variety of settings. Furthermore, we hope that you will always be sensitive to the needs of those in your care, their families and/or carers, and to your multidisciplinary colleagues with whom you work and communicate in the provision of holistic care.

The parameters for your programme of study are laid down by the NMC in *Future Nurse: Standards of Proficiency for Registered Nurses* (NMC, 2018b). These standards provide a framework to which your university or higher educational institution (HEI) will add the appropriate knowledge and experience that will help you meet these essential requirements (see the Introduction to this book). During your studies you will undoubtedly learn about nursing theory and practice, anatomy and physiology in health and illness, psychology and communication,

sociology, pharmacology, microbiology, health promotion and education, law and ethics. When applied to nursing these topics will form the building blocks that will then inform your practice. As you move through a number of practice placements you will begin to appreciate the diverse nature of adult nursing and the various specialist roles of those who work within it. There may well be some aspects that you will find more difficult to learn than others and some areas of practice where you will feel more at home. The point here is that you will be exposed to an essential variety of care settings that will facilitate your development and help you make decisions about where you will want to focus your practice when registered.

Your student experience will also be influenced by both local and national developments in policy and practice, for example National Service Frameworks, Clinical Guidelines or Plans for Care and/or Care Pathways (which will be referred to regularly throughout the chapters that follow).

Essentially then, wherever you undertake your learning, your placement will reflect the fact that contemporary adult nursing takes place in various settings where care is often delivered to a diverse client group. This might seem a tall order if you are new to a nursing programme, but you will bring knowledge and experience with you as you start a course of study, and gradually you will be encouraged and guided to build and extend that knowledge and understanding over the three years of your programme and beyond, thereby embarking on a lifelong learning journey.

This is where a professional portfolio or profile and your skills of reflective practice will prove invaluable. Completing a programme of study in a practice discipline such as nursing is akin to learning to walk up hills and mountains. When you first begin doing so the terrain is unfamiliar and you will find yourself concentrating on your feet so you don't fall over. Sometimes you will get out of breath if you try to climb too quickly or if you are trying to keep up with colleagues. At some point you will stop to catch your breath, turn around and admire the view, just in time to realise how far you have actually come. This then gives you the confidence to look up and out rather than down as the terrain has become more familiar. You will build sufficient stamina to keep going and face each new challenge. Occasionally, you will have to walk round or even down to be able to carry on climbing.

Professional practice can, on occasion, feel very similar to climbing a mountain, reliant as it is on self-awareness, resilience, resourcefulness and courage. All are necessary attributes in the pursuit of safe, self-aware nursing practice. Your professional portfolio or profile is a comprehensive record of your professional achievements and developing reflective skills. It is a requirement of registration with the Nursing and Midwifery Council that every nurse is able to demonstrate that they have met the requirements for practice and continuing professional development (NMC, 2017). Keeping a professional portfolio or profile will help you adopt a 'lifelong learning' approach to both your professional and your personal development in addition to supporting the revalidation process.

Within any profile it is important to provide evidence of that development. This evidence will help you demonstrate to others that you have achieved the required learning outcomes in practice. During your studies you will acquire both study and practice skills to prepare you for your role as a qualified nurse. These skills will include those that are necessary to become a reflective practitioner, i.e. a professional individual who challenges practice in a constructive and helpful way.

Hence your profile is a record of your development as a nurse throughout every aspect of your course. It is a means of demonstrating your ongoing achievement and recording your development throughout your course and beyond. It is also a tool to help you develop the skills of critical awareness, reflective practice, rational decision making and clinical judgement. In summary, your portfolio or profile is your showcase. It gives value to both the practical and the academic work you have completed.

Reflection is a process by which you can think about and achieve better knowledge and understanding of your practice, learning from your own experiences in order to improve the care you

provide to patients. Reflecting on our experiences and interactions with others enables us, as caring professionals, to establish what we have learnt and the influence we may have had on others. The key message about reflection here is that it is purposeful and has meaning when it is undertaken and, just as with nursing practice, is constantly evolving. Reflection is often also referred to as reflexivity, acting as an internal monitor or check for an individual's ever-changing self (Todd, 2002: 62). As individuals we learn and evolve through education and a range of professional, personal and third-party experiences; this then influences our behaviours and actions. Reflexivity is an integral part of developing as an effective nurse and is crucial whether we are caring for a dying patient, someone who is suffering from an acute illness or a patient who is in need of additional support to manage a chronic condition.

Schön (1983) suggests that there are two types of reflective practice, reflection in action (in the moment) and reflection on action (looking back on the moment), and purports that experienced nurses are able to reflect while in action and if necessary change and adapt, whereas the novice reflects retrospectively. However, in reality it is likely that these actions occur simultaneously, partly due to the evolution of nurse training since the 1980s. Nursing students are now introduced to the concept of reflection and are encouraged throughout their course and professional life to apply reflexivity to their practice. Reflection is an active, purposeful act intended to make us challenge the nursing world around us. It is a lifelong process of learning about ourselves and how things that happen to us can be thought about, deliberated and acted on. This does not have to be a significant life-changing episode that you may have witnessed with patients (for example a terminal diagnosis); it may be something that has made you stop and consider the impact this has had on you.

There are many different models of reflection that can be used depending on your individual learning style and personal preference. One such example, is the Gibbs reflective cycle (Gibbs, 1988) illustrated in Figure 1.1 which describes reflection as a process with distinct steps, i.e. as a description of what happened and the feelings evoked, followed by your evaluation and analysis of the situation, concluding with a review of the situation, including consideration of what you might do differently and the provision of an action plan based on your learning and aspirations for your future practice.

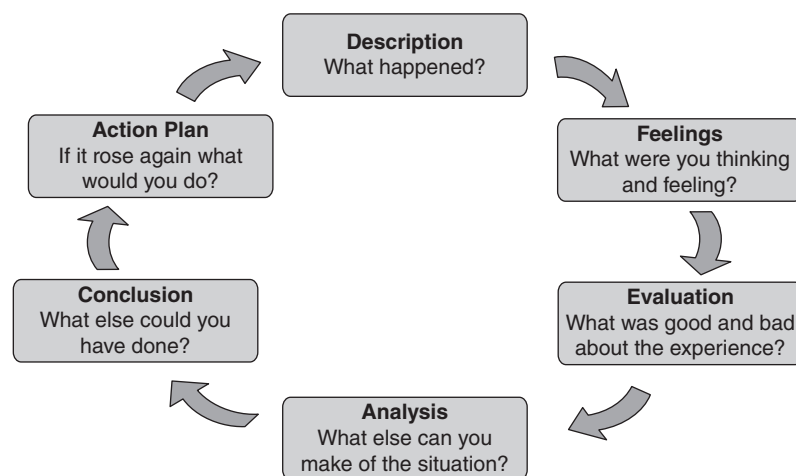


Figure 1.1 The Gibbs reflective cycle (1988)

By documenting in your student profile the things you have learned, the challenges you have faced (both the good and bad experiences encountered) and the wide range of people you have met in possibly heart-breaking circumstances, you will not only make a record of your student journey and provide evidence of your achievements, but also build your reflexive aptitude and a capacity for self-awareness which should help you engage more effectively in order to improve patient outcomes. The important thing is that you are able to learn from your experiences and apply what you have learnt to your future practice. By using reflective practice and your profile in this way you should be able to trace the development of your knowledge base and skills for practice, your clinical judgement and decision making, and your leadership and management approaches as you prepare to nurse adults irrespective of their age, health status, culture or disability. The ability to reflect upon practice in this way is something that we will revisit in subsequent chapters.

‘Profession’, ‘professional’ and ‘professionalism’

Throughout this chapter we use the words ‘profession’ and ‘professional’ quite liberally. However, it is important to understand the difference between the two.

- What does being professional mean to you?
- Can you describe what professionalism means?



Entering or belonging to a profession means that you have undertaken a specific area of study (mainly at degree level), and the way in which you carry out your work is governed by a set of codes and standards that is regulated by legislation (law). As a professional, you have a certain level of autonomy and you are both responsible and accountable for all of your actions. Belonging to a profession affords a status; being professional describes how you conduct yourself in that status. ‘Professionalism’ describes a set of values and behaviours that influence not just what you do but also how and when you do it. Professionalism is also framed in terms of awareness, attitudes and behaviours and relates to having sufficient professional judgement to identify the attitude and type of behaviour that are appropriate in any given situation. This is a distinction that may sometimes be missed. In all of the caring professions, professionalism includes the ability to demonstrate the following values:

- Integrity;
- Honesty;
- Transparency;
- A sense of duty;
- Decency.

These are the values that will dictate how you should behave as a professional and therefore will have a direct impact on patient care. Indeed, being an accountable professional is the first platform of the NMC (2018b) proficiencies.



ACTIVITY 1.2

1. Go to the Scottish Government website and access and read the Chief Nursing Officer (CNO) for Scotland's report below which focuses on professionalism: CNO for Scotland (2012), 'Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the Coordinating Council for the NMAHP Contribution to the Healthcare Quality Strategy for NHS Scotland' (available at: www.gov.scot/Publications/2012/07/7338).

Write down the key elements that are thought to be important and keep these handy. You will need to compare these later.

2. Now access the Health and Care Professions Council UK (HCPC) website and download the latest report focusing on 'Fitness to practise' cases referred to professional regulators (available at www.hcpc-uk.org.uk/publications/reportsindex).
3. Make a list of the type of cases the HCPC is likely to consider.
4. Access a copy of the subsequent study commissioned as a result of these findings by going to www.hpc-uk.org and go to 'research publications'. Download the *Professionalism in Healthcare Professionals* document (HCPC, 2011).

In the study outlined in the report on the Scottish Government's website above, you may notice a trend in cases linked to a broad range of behaviours which were distinct from technical capability and generally termed 'professionalism'. The subsequent study carried out by Durham University included students and educators from three different regulated health professions (paramedics, occupational therapists and podiatrists/chiropractors) and provides an excellent summary of what professionalism entails. It also puts this in the context of healthcare in terms of relevant examples.

The key findings of the study were that:

1. The concept of what professionalism is remains common regardless of the professional group, status or training route;
2. Regulations are considered to be basic guidance and signposting on what is appropriate and what is unacceptable behaviour (acting as a baseline for behaviour rather than a specification) (HCPC, 2011).

An appropriate set of moral values and personal qualities must be the foundation to which we would add specialist knowledge and clinical skills. The above study supports the view that it is both possible and desirable to 'be professional' before acquiring the necessary knowledge and skills to become a registered professional. This is particularly crucial in the context of healthcare students who, unlike many other undergraduate students, must be professional from day one because they must interact with patients, families and qualified healthcare professionals while on placements. Professionalism is the consequence of qualities that an individual brings to the profession – indeed many of those questioned in the study felt that this was an essential part of themselves. Yet how does this manifest itself?

Consider the examples in the following 'Stop and Think'.

The way in which we present ourselves is significant because it is the first impression people will get. What does it say about you if:



- You regularly turn up on time for lectures or shifts?
- You respond to a text during your first meeting with your practice assessor or supervisor?
- You often appear dishevelled and unkempt?
- You turn up to pre-arranged meetings with your supervisor or assessor having undertaken some preparation beforehand?
- You are sometimes rude or brusque?
- You listen carefully and act upon feedback?

How might a patient interpret each of the above behaviours in terms of the standard of care they will receive?

Obviously, there will always be the odd occasion when we are running late and even with the very best of intentions our plans can sometimes go wrong. However, turning up on time to meetings, lectures or shifts in practice is one way of demonstrating our ongoing commitment – to patients, colleagues and other professionals. Similarly, being rude to or about our colleagues gives a very poor impression to patients and their families, not only of ourselves as individuals but of the whole team providing care. Faulkner (1998) argues that those who find it difficult to communicate effectively with each other are less likely to be effective when interacting with patients and families. This is also demonstrated by HCPC UK (2011) who found that individuals who are professional have an innate sense of decency towards others and suggest that they are polite, courteous, non-condescending, and act honestly and with integrity.

How do legal and ethical principles underpin our professional practice?

The law may be broadly defined as:

The system of rules which a particular country or community recognises as regulating the actions of its members and which it may enforce by the imposition of penalties. (*Oxford English Dictionary*, 2014b)

This is clearly reflected in *The Code* (NMC, 2018a: 18) where it states that, as a nurse:

- You should uphold the reputation of your profession at all times;
- You should display a personal commitment to the standards of practice and behaviour set out in *The Code*;
- You should be a model of integrity and leadership for others to aspire to.

This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

As our professional roles develop alongside innovations in healthcare knowledge and practice, associated technologies and increasing public demand, Wheeler (2012: 3) reminds us that ‘moral

values guide our thinking and behaviour and impact on our ethical decision making in relation to caring'. Therefore, as a student of nursing you are a developing professional and it is essential that you understand *The Code* (NMC, 2018a) to which you ultimately aspire and how this relates to all aspects of your everyday life and work.



ACTIVITY 1.3

Access and read the latest copy of the NMC *Code*, available at www.nmc.org.uk/standards/code.

- What do you consider to be the aims of *The Code*?
- Which elements do you consider to be the most important and why?

The Code (NMC, 2018a) is designed to ensure that your practice is safe and that you do not leave your actions open to challenge. However, you are also expected to explore topics such as moral values, ethical theories, attitude development, accountability, confidentiality, integrity and trust, to mention but a few. Each of these will underpin the relationships you form with service users, colleagues, the profession and society in general. Developing your knowledge base to include these aspects will help you increase your appreciation of how legal requirements affect your work and also be alert to situations where you should gain further advice and support.

If an understanding of the law helps us to have better understanding of what is considered to be legally right and wrong within the parameters of our nursing practice, then an appreciation of ethical principles helps us determine, through a process of structured reasoning, the morally 'good' course of action from the 'bad'. In both cases the perception of what is right and what is good will be influenced by your personal beliefs and values. For example, in a previous Stop and Think when asked to reflect on why you want to become a nurse, you may have considered that your desire is driven by your own moral compass, including your personal beliefs and values. Is this perhaps related to a belief in the centrality of integrity, compassion and a willingness to be kind and caring, and a wish to empathise with those in need? However, what happens if your impulse is not based on a willingness to care? What if you are not empathic or non-judgemental?

It is important for nurses to be open-minded and able to care equally for all individuals, irrespective of their illness, age, sexuality, race or religion. As an adult nurse you will be required to adhere to the ethical principles enshrined within *The Code* (NMC, 2018a), including the intention to do good, the insight to do no harm, the capacity to ensure justice, and the competence to promote dignity by respecting autonomy and affording participation and choice (Beauchamp and Childress, 2013). This is a complex and complicated process that relies on commitment and conviction, and will require discipline and an enduring capacity to explore your own impulses. You will need to foster an ability to justify and articulate your choices in terms of both your actions and your omissions. You will often be called on to balance your private understandings against public expectations and professional requirements, and to promote the best interest of individuals, society and the profession. You will need to accept shared professional parameters and role model professional values. You will also need to understand and be able to articulate your obligations to clients and colleagues alike.

It is vital to your own development – and more specifically to those in receipt of your care – that you are sure of the moral basis of your impetus to nurse. You may remember the answers you gave to the previous Stop and Think above. However, we would invite you to expand on these here and reflect upon the following questions:



- What informs your impulse to care?
- Why have you deliberately opted to work with individuals experiencing illness?
- How would you define nursing?
- What makes a good nurse and what kind of nurse do you want to be?
- As a conduit through which caring is facilitated, what skills do you possess/would you like to foster in order to best enact your nursing role?
- How might these skills be best secured and articulated?
- How can you give yourself the best chance of success?
- What are your goals?
- What are your sources of motivation and inspiration?

When reflecting upon how you might define nursing you may wish to consider the three definitions of nursing that have evolved over the last 150 years:

Nature alone cures ... and what nursing has to do ... is to put the patient in the best condition for nature to act upon him. (Nightingale, 1859)

The unique function of the nurse is to assist the individual – sick or well – in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as help him gain independence as rapidly as possible. (Henderson, 1960)

Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems and to achieve the best possible quality of life – whatever their disease or disability until death. (RCN, 2014)

As a registered nurse you will inevitably face a range of ethical dilemmas during the course of your studies and indeed throughout your professional life. As the conduit of care, your moral compass will dictate your actions and inform your choices. Patients deserve to be nursed at all times by someone who is careful, compassionate and considerate. This calls for purposeful moral engagement combined with emotional intelligence based on a deliberate intention to place patients at the centre of all your care, a personal philosophy of nursing as privilege and the facilitation of candour in terms of truthfulness and transparency. We work in partnership with those we care for, fostering a deliberate shared-care ethos whereby we recognise the autonomy and inner resources of those we nurse.

The concept of moral engagement arises from social cognitive theory (Bandura, 1986, 1991) and requires you to stand firm in your moral behaviour, despite the possibility of peer or social pressure to act differently. This takes moral courage. Bandura suggests that a sure way to demonstrate this concept is through empathy. This means that you must accept responsibility for your behaviours and demonstrate a humane concern for others at all times. This ability to self-govern our behaviours ensures that we are able to consider best practice and best interest for those in our care.

In April 2015, the Criminal Justice and Courts Act made it an offence for ‘an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual’. It relates to the conduct of the individual and applies to healthcare workers (such as nurses, doctors, dentists and the like) and exposes what that person did, or did not do, for the patient rather than specifically any harm caused. Offences under this and associated legislation extend to all patients irrespective of mental capacity or age. Griffith (2015) reports that neglect is said to occur where a healthcare worker does not do what is expected of them in relation to patient care provision, and can include omission of medication, incorrect recording of care or failing to assist a patient in difficulty. It is clear that nurses must be honest and truthful at all times and meet the standards of law and the NMC by understanding the need to follow good practice. Nurses must be able to justify the reasons for their actions and duty of care, and all verbal engagement and records must reflect their precise involvement in any care provision.

Emotional intelligence (EI) is defined by Vitello-Cicciu (2002) as the ability to perceive and regulate your own emotions and those of others in a way that positively influences communication, motivation and team work. Snowden et al. (2015) comment that, although elements of EI may be trait based, it can also be learned. The concept has gained popularity in a nursing context and appears to have links with quality of care provision, supports reflective practice and thus facilitates an increase in nurse resilience. Fernandez et al. (2012) explored the notion that higher levels of EI might link to increased performance and, although there are limited available studies as to whether EI can influence academic intelligence, Codier and Odell (2014) found a positive correlation between academic performance and EI in Year 1 student nurses. According to Goleman (1995) there are five integrated EI domains: self-awareness, self-regulation, motivation, empathy and social skills. An interesting longitudinal study from Snowden et al. (2015) found that previous caring experiences did not mean that EI was heightened but rather that over time specific strategies to support the development of EI were helpful. Most recently, Carragher and Gormley (2016) have explored the link between EI and leadership, demonstrating the importance of this quality to the promotion of effective and supportive leadership. We will be revisiting the importance of EI again in subsequent chapters.

Resilience is defined as an ability to adapt to, or recover from, change or challenging situations (McAllister and McKinnon, 2009) and where you learn new skills to address similar situations in the future. It originates from the Latin, *to rebound*. Nurses meet both joy and grief in their everyday work and must be able to respond to and support patients in joy and adversity. In addition, they must manage the demands of professionals working alongside the current constraints on the care provision workforce and regulatory changes. These challenges are complex and Hart et al. (2014) link the lack of resilience to increased stress, dissonance and the likelihood that healthcare workers will leave their profession for work of lesser emotional and ethical challenge. This requires nurse educators to be proactive in the facilitation of your learning and to include resilience as part of your professional and personal development. You may ask why this is important but, as Stephens (2013) suggests, you will inevitably meet new situations that challenge your existing views and beliefs, such that you must review the basis of your existing knowledge and be prepared to explore further. You will learn these skills, not just from a theoretical perspective but also during your practice learning together with clinical colleagues and via your reflections. Thomas and Revell (2016) suggest that this aspect of development will not just benefit you in the longer term but will help to create an environment in which your wish to learn will flourish.

The 10 commitments of nursing: from 6 to 10

We have established that caring and compassion have been fundamental aspects of a nurse's role since nursing's inception, and that good moral values and personal qualities are central to who a person is and will ultimately directly impact on their behaviour towards others. You will note that the title of this chapter begins with values and is followed by knowledge and skills, which, in their entirety, underpin nursing practice and ultimately give rise to the best possible patient outcomes. Without the appropriate set of values and personal qualities, there is no foundation on which to add the building blocks of clinical skills, education, professional standards, codes and ethics.

In 2012, and in recognition of the importance of these values, the Chief Nursing Officer of England and the Director of Nursing at the Department of Health launched a new strategy (DH, 2012b) based on six core values (the 6Cs), which were adopted as a means to determine effective care. This followed similar standards previously outlined in Northern Ireland (DHSSPS, 2006, 2008). These include moral values, professionalism and aspects of dedication that are used to define the basis of good quality nursing care.

The key elements identified within this framework are outlined below (Figure 1.2):

- *Care*: the care we deliver helps the individual person and improves the health of the whole community. Caring defines us in our work. The people receiving care expect it to be right for them consistently throughout every stage of their life.
- *Compassion*: this is how the care is given through relationships based on respect.

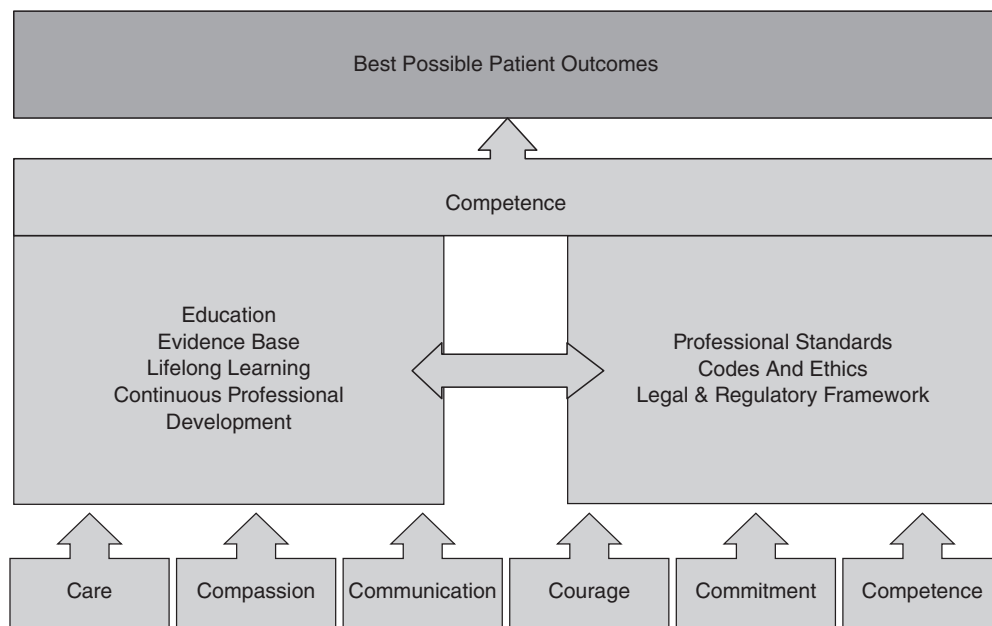


Figure 1.2 The 6Cs: the foundations of professional nursing practice

- *Communication*: this is central to successful caring relationships and effective team working. All successful interactions between individuals are based on good communication, which comes in many formats and encompasses multiple means, such as non-verbal, verbal and written.
- *Courage*: this relates to us as nurses having the courage to do the right thing for the people we care for, to speak up when we have concerns, and to have the personal strength and vision to embrace new ways of working.
- *Commitment*: commitment to our patients and populations is the cornerstone of what we do and we need to build on this to improve the care and experience of our patients.
- *Competence*: all those in caring roles must have the ability to understand an individual's health and social needs, and have the clinical expertise and technical knowledge to deliver effective care and treatments based on research and evidence. In 2015, 'candour' was an additional C added by the NMC and relates to 'a professional responsibility to be honest with patients when things go wrong'.

In 2016 Cummings, in her role as CNO for England, played a key role in the publication of *Leading Change, Adding Value*, which enhanced her concept of the 6Cs and introduced the 10 commitments as described here:

1. We will promote a culture where improving the population's health is a core component of the practice of all nursing, midwifery and care staff (health improvement);
2. We will increase the visibility of nursing and midwifery leadership and input in prevention;
3. We will work with individuals, families and communities to equip them to make informed choices and manage their own health;
4. We will be centred on individuals experiencing high value care;
5. We will work in partnership with individuals, their families, carers and others important to them;
6. We will actively respond to what matters most to our staff and colleagues;
7. We will lead and drive research to evidence the impact of what we do;
8. We will champion the use of technology and informatics to improve practice, address unwarranted variations and enhance outcomes;
9. We will have the right education, training and development to enhance our skills, knowledge and understanding;
10. We will have the right staff in the right places and at the right time.

As you may realise, the six core values and ten commitments, as outlined here, are not really new. They are based on the key fundamental principles of what have always been considered vital to the role of nurse. Florence Nightingale, for example, always tried to strive for accessibility and simplicity of expression and to stress the importance of enacting core values. However, perhaps there is now a need to be more specific and explicit in terms of what these are and how they underpin practice.

The 7Cs and 10Cs highlighted above resonate with the values needed to support the development of a therapeutic relationship. You will notice that all the elements enshrined in both are framed within *The Code* (NMC, 2018a), and all are used by nurses in tandem to help them refine their appreciation of the complexity that is nursing.

Remember, nothing you will ever do as nurses should be considered basic. Nursing is a complex and purposeful endeavour that relies on you as the conduit of care to meet your patients' needs. Everything you do as a nurse relies on a myriad of technical and interpersonal skills, which are themselves underpinned by multiple intelligences, including intellectual, moral, social and aesthetic ways of knowing and seeing the world.



ACTIVITY 1.4

Compare the 6Cs Framework and the 10 commitments outlined above with the principles outlined by the CNO for Scotland in Activity 1.2, the NHS Constitution (NHS England, 2015) and the Royal College of Nursing's *Principles of Practice* (RCN, 2011).

You can access the NHS Constitution document at the following website: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Upholding the professional reputation of nursing

Thus far we have outlined the fundamental values and principles of nursing practice. However, let's now stop and think about contemporary nursing practice.

- What is the image of nursing today?
- How is the nursing profession perceived by patients, carers and/or members of the general public?



Follow the link as detailed below which will take you to the personal account of Christina Patterson, a well-known and respected journalist: www.bbc.co.uk/programmes/b010mrzt (this highlights a programme recorded for BBC Radio 4 (2011), entitled 'Care to be a nurse?', in which she describes her experiences while undergoing six operations for breast cancer over a period of eight years at different hospitals).

While listening consider the following questions and make a note of your answers:

- What were the key issues here?
- Why do you think this happened?
- How did Christina feel?
- How does this account make **you** feel?
- As a nurse involved in Christina's care what would you have done differently?
- Were there any barriers – and if so – how might you have overcome them?
- What were the key positive nursing actions important to her?

The Code (NMC, 2018a) requires us to 'be open and honest, act with integrity and uphold the reputation' of our profession, and therefore it would be disingenuous if we did not acknowledge the gravity and extent of the challenges to the nursing profession's reputation over the last few years. Although it is important to recognise that in some areas there are excellent standards of nursing care we have to acknowledge the evidence that demonstrates that in other areas current opinion of the nursing profession is low. At this point should we perhaps look at events that have brought into question the professional reputation of nurses over the last few years? We need to try to work out why and how these events have been allowed to happen and then create a strategy of both reform and support to ensure that they will not do so again. One of the key aspects that Christina focuses on is a lack of care, compassion and 'basic human kindness'. Crucially, before Christina went into hospital the first time she wasn't worried about her care since she didn't think she would

have to. Yet she experienced poor care consistently throughout her patient journey. Why was this? Where was the effective communication, care and compassion for her situation, the competence and commitment to provide the best evidence-based care and the courage to ensure that the nurses who worked with her understood her personal journey through ill health? As her case clearly demonstrates, somewhere along the way the nurses involved in the delivery of her care seemed to have lost sight of the art of nursing. This example indicates that vulnerability and patient status constitute universal features of the illness experience. Hallett (2012) considers a range of potential factors that may have contributed to Christina's poor experience, including:

- The changing emphasis towards more technical skills and knowledge;
- The shift in roles between what doctors used to have sole responsibility for and the extended role of the nurse;
- The professionalisation of the nursing role;
- The delegation of primary care to healthcare assistants;
- Bureaucracy and box ticking given priority over compassion;
- The wider social, economic and political factors.

Christina's account also adds to revelations from the Care Quality Commission's (CQC's) inspection of over 150 hospitals and care homes (CQC, 2013), the events at Winterbourne View Hospital (BBC, 2012; DH, 2012a), the Princess of Wales and Neath Port Talbot hospitals (Andrews and Butler, 2014) and the publication of the Francis Reports (DH, 2010b, 2013) leading to the abuse and 'appalling suffering of many patients' between 2005 and 2008 at the Mid Staffordshire Foundation NHS Trust.



ACTIVITY 1.5

Access and read the following documents:

1. The Francis Report.
You can find this information on the Executive Summary and recommendations at: www.midstaffspublicinquiry.com/report
2. Care Quality Commission (CQC), Nursing and Midwifery Council (NMC) and NHS Wales responses to the Francis Report.

You can find this information at the following websites:

- www.cqc.org.uk/content/care-quality-commission-response-francis-report
- www.cqc.org.uk/content/cqc-highlights-changes-following-francis-report
- www.nmc-uk.org/About-us/Our-response-to-the-Francis-Inquiry-Report

Make a list of all factors identified in each report.

The original report into events at Mid Staffs (DH, 2010b) noted that 'It was striking how many accounts related to basic nursing care as opposed to clinical errors leading to injury or death'. Jane Cummings (Chief Nursing Officer for England) noted that 'such poor care is a betrayal of all that

we stand for' (DH, 2012b: 7). The Francis Report (DH, 2013) went on to highlight 290 recommendations for stakeholders to consider across a wide and enduring spectrum of concern including the neglect, negligence and abuse of individuals, along with a wide range of associated factors including organisational structures, staff shortages, management policies, bonus payments for managers and the imposition of targets devoid of any research evidence base. Nor did the CQC emerge from the Francis Report unscathed because it was clear that their criteria for inspection were not sufficiently robust. A response issued by the CQC (2013) acknowledged these shortcomings, highlighting a schedule of changes including the appointment of an Inspector of Hospitals, a more searching assessment process in profiling institutions and an expert base for their inspection teams. They also reaffirmed their remit to monitor the quality of healthcare environments for the people who matter most – service users.

Although the vast majority of nurses would find these behaviours and actions to be as abhorrent as they are incomprehensible, you will by now have recognised that nurses have a personal duty of care that includes obligations and promises to adhere to the standards as espoused within *The Code* (NMC, 2018a). This means that we are personally and collectively responsible and accountable for the decisions we make and the actions we take, regardless of the pressures or environment within which we are working. This therefore calls upon us to display courage and commitment, acting as advocates for our patients to ensure that we always act in their 'best interest'.

The challenges to contemporary practice

At the outset of this chapter we outlined the challenges faced by nurses, whether they be in the nature of some of the very personal aspects of the work, the issues of gender, the fight for recognition as a profession, the emotional labour involved or the hardships of nursing during wartime. Some of these challenges remain ever present whereas others will change and evolve. Many of these are covered in more depth in later chapters but this chapter highlights some of the key issues facing nurses today. Perhaps the most significant challenge is that of public perception, namely the image of nursing and the prevailing culture of care within our profession.

Advances in technology and the changing emphasis in recent years on nurses becoming more technically specialised have been blamed in a number of quarters for the loss of care and compassion (Hallett, 2007; Pearcey, 2008; Law and Aranda, 2010). However, we should consider whether these two must be mutually exclusive. We would be failing ourselves and our profession if we did not maintain our competence and continue to develop as techniques and technology improve. Hallett (2007) also suggests that core values are constants whereas technology is a tool to be wielded in the services of health.

When people require any kind of medical intervention, it is the level of empathic and compassionate care they receive that makes the difference between a good and a bad experience: it is good communication (especially listening carefully), kindness, caring and empathy and not the technical intervention (which is almost taken as a given) that really make the difference. It is also clear that such values, qualities and behaviours are crucial to good nursing. In one study, Smith (2012) found that 44 different words or phrases were used by patients to describe 'ideal' and 'real' nurses. Interestingly, only six of these related to functional attributes such as efficient, observant and capable of doing their job. The caring and emotional aspects of nursing were clearly seen as distinct but complementary to and, more importantly, underpinning the functional aspects of everything we do as nurses. Kindness, helpfulness and patience were the attributes most frequently used. Talking,

listening, showing interest and sympathy also featured heavily as aspects of the ideal nurse. It is clear how these attributes align closely with *The Code* (NMC, 2018a), 7Cs and subsequent 10 commitments (DH, 2012b; GMC/NMC, 2015; Cummings, 2016), but perhaps all of this is best expressed by one patient who concluded:

A nurse has to be aware of the patient's condition and how to tackle it. She has to have a nursing manner which requires a lot of patience and forethought and to try and relieve pain and suffering not by medical means but by compassion. (Smith, 2012: 27)

Furthermore, perhaps as a result of wider access to the internet, the public are much better informed and have access to a huge amount of information and related data about their health. They will often have high expectations in terms of openness and transparency, and the right to be included and informed. As a result, as nurses we must work hard to keep our own knowledge up to date and ensure that our practice is firmly based on sound evidence. We must also demonstrate care and compassion not only in how we treat our patients and their families, but also in respecting their right to be involved in all the decisions affecting them. Respect, privacy and dignity should feature strongly in every aspect of our care delivery. We must ensure that we listen to their concerns, needs and wants, acting as patient advocates when required. This requires commitment to ensure that we are continually updating our knowledge and that we maintain our competency. It also requires good communication to ensure that we listen to people's concerns and answer their questions, making sure that we explain ourselves clearly and that we have been understood (a topic that will be focused on in more detail in subsequent chapters).

Fitness to practise

Part of the NMC's role as a professional regulator is to maintain the professional register and ensure that the public are protected from poor practice. The NMC takes these aspects of their work most seriously in order to maintain the reputation of the profession and promote public confidence that nurses on the register meet the necessary standards of a competent practitioner. There are procedures in place to guide employers, colleagues and the public who wish to raise concerns about any nurse's fitness to practise and the NMC investigates these concerns thoroughly.

So, what does the term 'fitness to practise' mean? The current NMC guidance (NMC, 2016) states that a nurse who is fit to practise is one who has successfully completed an approved pre-registration education programme, is registered with the NMC and thereafter maintains that ability to practise safely and independently while following the professional code of practice as set out in *The Code* (NMC, 2018a). In practical terms this means that, as a nurse, you maintain appropriate standards of proficiency, ensure that you are of good health and good character, and that you adhere to the principles of good practice that are set out in the various standards, guidance and advice.

The notion of being suitably prepared by your educational programme to undertake the nurse registrant's role, and that you should have valid and current registration with the regulatory body, is really quite straightforward. Demonstrating that you are of good health and good character is closely linked to the ways in which you work and live and ensuring that these are aligned to *The Code* (NMC, 2018a).



ACTIVITY 1.6

Follow the links on the NMC website and read the current version of *The Code* and the information related to fitness to practise and good health and good character.

Make a note of any questions that occur to you as you read this and consider where or to whom you might go for help in answering your questions.

Some of your questions may well be ‘How do I prepare for this responsibility?’ or ‘What happens if something occurs that means I question my own fitness to practise?’.

It is important that we explore this concept of ‘fitness to practise’ with you and what it means to be of good health and good character. You will soon appreciate that during your programme of study you will normally be well prepared to face the challenges of professional life and demonstrate the knowledge, skills, behaviours and standards of care that the public would expect from nurses.

During your programme of study there will be information and opportunities for discussion which will enable you to develop a better understanding of these concepts and recognise the implications for student nurses who fail to study appropriately and/or fail to abide by *The Code* (NMC, 2018a) to which you aspire. Although you are not expected to enter your pre-registration education with all the required professional attributes, it is important to ensure that you are made aware of these concepts, that you understand them, and that you grow in competence and confidence with regard to these skills alongside other areas of your development.

We will start with the concept of good health. You may wonder why demonstrating good health is an essential component of a nurse’s fitness to practise. Clearly, if we are able to demonstrate that we lead a healthy lifestyle then the benefits of this are that we may be better able to guide those in our care. However, there will be occasions for all of us where we become temporarily incapacitated such that we are unable to work or study. In these circumstances our professional behaviour is to follow the relevant sickness and absence policies. There may be some conditions that challenge our ability to undertake our role safely and competently. At these times it is vital that we seek appropriate support in a timely way to make certain that we have the right help and that we do not endanger our colleagues or service users. Often it is not the event or incidence of ill health that becomes an issue but rather what we have done about it. Have we been honest with ourselves and others? Have we sought appropriate professional support and guidance?

The NMC (2018b: 8) proficiencies state that nurses must ‘understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people’s needs for mental and physical care’. How does this proficiency relate to the situations highlighted above?

How are we to interpret this competency perhaps in relation to going to work even though we are not really well enough?; a nurse living with diabetes not taking regular breaks for food or medication; a student who feels that they never have a hangover so they can drink heavily before going on duty. All these actions demonstrate a lack of insight into our health, wellbeing and professional obligations. Health issues can catch us all out.



- Should a nurse smoke or be over- or underweight?
- Should nurses at all times role model healthy behaviour?
- Are nurses policing or promoting health?

There are four main areas from which an individual's fitness to practise can be called into question. These are criminal behaviour, dishonesty, unprofessional behaviour and ill health (Ellis et al., 2011). Here you will see that honesty and integrity figure highly in the professional equation, i.e. our ability to know right from wrong and thus act appropriately.

In considering these four areas again it may be that some activities feel easier to identify than others: for example, harm to another person; stealing; misuse of or dealing in illegal substances; fraudulent activity; and the abuse of vulnerable people. These are unacceptable behaviours and ones that do not adhere to *The Code* (NMC, 2018a). However, by reading this chapter you should also be aware that unprofessional behaviours (e.g. ongoing poor time management, rudeness to service users or colleagues, breach of confidentiality, examination cheating or plagiarism, and bullying) are equally relevant.



ACTIVITY 1.7

Visit the NMC website and find a case presented to the Fitness to Practise Committee that related to out-of-work activities compromising their professionalism.

- How do you feel about these circumstances?
- Which circumstances were work related and which occurred in their own personal time?

Perhaps what is particularly significant here is the notion that what happens in your personal life is just as important as events in your professional, registrant and/or student life.



Whether you are a student or a registrant, sit back for a minute and think about the things you do in terms of email correspondence, being out with friends or engaging in online social media:

- How do you speak to people?
- Does this vary depending on who it is?
- Do you use a form of shorthand in text or on social media?
- Is this appropriate?
- Does it matter?

These are the sorts of questions you must be able to answer. Perhaps you can discuss this with fellow colleagues, teachers or line managers. As students we are able to seek advice and feedback from teachers and mentors to support our professional development and, since 2004, we have been asked as students to affirm that we are of good health and good character in line with the NMC Quality Assurance (QA) Framework requirements for pre-registration courses (NMC, 2017).

As registrants we also affirm our good health and character each year when our registration is renewed, and it is clearly stated in *The Code* (NMC, 2018a) that we have a duty to inform both our employer and the NMC of any concerns we have about our ability to practise safely or any involvement with the police as soon as possible after a concern has been highlighted. Do remember that any caution or conviction recorded by the police remains on your personal record for life and is viewed by employers through the Disclosure and Barring Service (further information about this service can be accessed at the following website: www.gov.uk/government/organisations/disclosure-and-barring-service).

What are the processes for investigating 'fitness to practise' in your school of nursing and how are these issues addressed in your programme of study?



Now visit www.nmc.org.uk/concerns-nurses-midwives/hearings and compare your university process with that of the NMC when investigating allegations of professional misconduct.

- What differences have you highlighted?
- Does your university process mirror that of the NMC?

Most students and registrants do not have their fitness to practise challenged in such a way that requires investigation and possible sanction. David and Bray (2009) acknowledge that the percentage of students investigated via these procedures is thought to be low. The reason for this is that, although each university is charged with having a 'fitness to practise' procedure for students, there is no central collation of the number of students investigated or the outcomes of such investigations. However, from half a million registered nurse and midwives less than 1% of registrants had concerns raised against them, meaning that a total of 5476 cases were investigated by the NMC in 2016–17 (NMC, 2017).

David and Lee-Woolf (2010) also point out that student nurses are still learning and therefore the seriousness of any given situation may vary dependent on the stage reached in the programme of study. However, it is necessary that you are aware of the potential pitfalls that can sometimes catch you unawares and you must not close your eyes to the subject. You should be careful to be self-aware and not self-righteous in respect of this concept, ensuring that by safe practice and reflective development you are able to recognise any problems or challenges to your practice and act appropriately. Similarly, as a registrant, although there is an expectation that you will adhere to *The Code* (NMC, 2018a), there is also an acknowledgement of varying degrees of experience that may impact on any allegation that questions your fitness to practise as a nurse.

Both student and registrant processes that examine fitness to practise have a number of sanctions that can be applied to any given situation. These can range from there being no case to answer, through varying levels of supervision or suspension, to a student's place on their course being withdrawn or a registrant removed from the register permanently. Whatever the outcome in relation to the sanctions applied, there must be robust evidence in support of any allegations made and the probability of the event reoccurring must be balanced against the sanction chosen.

In most cases – as either student or registrant – there will be evidence of mitigation to be considered alongside an allegation. It is important to realise that such mitigation can never condone an unprofessional action but it may be used to determine the outcome and level of sanction imposed.



ACTIVITY 1.8

Explore the summary on professional behaviour which you will find on the NMC website <https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/enabling-professionalism.pdf>

Are you ready to be a professional?

Now visit the section of the NMC website where professional practice hearings are recorded, then continue with the activity as it was. What do you think?

The importance of evidence-based practice

We have acknowledged growing public awareness and the perennial challenge that nurses should be able to justify their actions. *The Code* (NMC, 2018a) also tells us to ensure that our nursing practice should be based on the best available evidence. Therefore, as adult nurses we must learn how to find this evidence and ascertain whether or not it is good.

Good, evidence-based, patient-centred care is vital to modern healthcare and will underpin the expertise and sensitivity of care strategies, thus demonstrating the quality of care provision (Emanuel et al., 2011). Evidence-based practice is an essential component in defining the efficacy of our nursing practice, though it is perhaps worthwhile realising that we will not find a research base for every aspect of care. However, the increasing breadth of knowledge and technology available to inform our decisions adds weight to the explanations of why we do what we do. Our knowledge base for nursing is influenced by knowledge from other disciplines such as the physical and social sciences, law and ethics. We must be able to work with these different elements and apply them to all the clinical situations we encounter.

The capacity to know what is the right thing to do in any nursing situation relies on our ability to explore the relevant and current knowledge in a certain area, to understand what that is trying to tell us, and for us to utilise our research appreciation skills to distil whether or not this knowledge can be applied to a particular situation. Although this is a tall order, we as professional nurses are committed to lifelong learning that will facilitate our clinical development over our working lives.

Therefore, during your programme of study or as a registrant you will be expected to learn and develop the skills of research appraisal (see Chapter 6). These will enable you to reflect critically on research worthiness and not only to understand the implications of research for nursing care but also to play your part in ensuring that appropriate research-based care strategies are implemented in practice.

Developing your nursing skills

We all enter nursing with different levels of life experience and emotional maturity, and these can differ widely regardless of age. The concept of emotional intelligence is often associated with experiential learning and learning from the lessons of life, and this will evolve as we are exposed to more such experiences and gain experience in the nursing context (Bulmer Smith et al., 2009).

- Are you ready to practise nursing?
- Are you fit to practise?



Pause for moment and reflect on whether these questions are asking the same thing.

- How would you answer these questions if asked?

Chapter summary

Throughout this chapter we have introduced you to the complexity of the nursing role and hopefully posed challenging questions that will help you to scrutinise your impulse to nurse and aspirations for your future nursing practice. We have drawn your attention to the evolution of nursing by highlighting significant events and people who have helped to shape the profession we have today. In so doing, we have asked you to reflect upon your motivation to nurse and your own philosophy on caring, and to that end we have explored some of the legal, moral and ethical issues that can challenge our fitness to practise. We have also discussed some of the challenges faced by nurses today and the tension that exists between the technical expertise of caring and its softer, yet vital skill counterpart – compassion.

As you begin your lifelong journey in the profession we trust that this chapter has helped you to share our passion for nursing, and has stimulated your interest to read and explore the concepts and issues highlighted in subsequent chapters of this book.

Further reading

- Cullum, N., Ciliska, D., Haynes, B. and Marks, S. (2013) *Evidence Based Nursing: An Introduction*. Chichester: Wiley.
- Dimond, B. (2015) *Legal Aspects of Nursing*. Harlow: Pearson Education.
- Goleman, D. (1995) *Emotional Intelligence*. New York: Bantam.
- Hallett, C. (2014) *Veiled Warriors: Allied Nurses of the First World War*. Oxford: Oxford University Press.
- Rafferty, A.M., Philipou, J., Fitzpatrick J.M. and Ball, J. (2015) ‘Culture of Care’ Barometer, National Nursing Research Unit, London, Kings College.
- Timmins, F. and Duffy, A. (2011) *Writing Your Nursing Portfolio: A Step by Step Guide*. Maidenhead: Open University Press.

References

- Alexander, Z. and Dewjee, A. (1984) *The Wonderful Adventures of Mary Seacole in Many Lands*. Bristol: Falling Wall Press.
- Andrews, A. and Butler, M. (2014) *Trusted to Care. An Independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Boards (Executive Summary)*. Available at: <http://gov.wales/topics/health/publications/health/reports/care> (last accessed 8 April 2018).
- Baly, M. (1997) *Florence Nightingale and the Nursing Legacy*. London: Whurr.
- Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, NJ: Prentice Hall.

- Bandura, A. (1991) 'Social cognitive theory of self-regulation', *Organizational Behavior and Human Decision Processes*, 50: 248–87. Available at: www.uky.edu/~eushe2/Bandura/Bandura1991OBHDP.pdf (last accessed 18 May 2018).
- BBC Radio 4 (2011) *Four Thought Series 2: Christina Patterson: Care To Be A Nurse?* Available at: www.bbc.co.uk/programmes/b010mrzt
- BBC (2012) *The Hospital That Stopped Caring*. Available at: www.bbc.co.uk/programmes/b01nqn4d
- Beauchamp, T. and Childress, J. (2013) *Principles of Biomedical Ethics*, 6th edn. Oxford: Oxford University Press.
- Bostridge, M. (2008) *Florence Nightingale: The Woman and Her Legend*. London: Penguin.
- Bulmer Smith, K., Profetto-McGrath, J. and Cummings, G.G. (2009) 'Emotional intelligence and nursing: an integrative literature review', *International Journal of Nursing Studies*, 46: 1624–36.
- Care Quality Commission (2013) *Care Quality Commission Response to Francis Report*. Available at: www.cqc.org.uk/content/care-quality-commission-response-francis-report (last accessed 18 May 2018).
- Carragher, J. and Gormley, K. (2016) 'Leadership and emotional intelligence in nursing and midwifery education and practice: a discussion paper', *Journal of Advanced Nursing*, 73(1): 85–96.
- Codier, E. and Odell, E. (2014) 'Measured emotional intelligence ability and grade point average in nursing students', *Nurse Education Today*, 34(4): 608–12.
- Cummings, J. (2016) *Leading Change, Adding Value: A Framework for Nursing, Midwifery and Care Staff*. London: NHS England.
- David, T.J. and Bray, S.A. (2009) 'Healthcare student fitness to practise cases: reason for referral and outcomes', *Education Law Journal*, 196–203.
- David, T.J. and Lee-Woolf, E. (2010) 'Fitness to practise for student nurses: principles, standards and procedures', *Nursing Times*, 106(39): 23–6.
- Department of Health (2010a) *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals*. London: DH.
- Department of Health (2010b) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust, January 2005–March 2009*. London: HMSO. Available at: www.midstaffspublicinquiry.com (last accessed 18 May 2018).
- Department of Health (2012a) *Transforming Care: A National Response to Winterbourne Hospital*. London: HMSO. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf (last accessed 18 May 2018).
- Department of Health (2012b) *Compassion in Practice: Nursing, Midwifery and Care Staff: Our Vision and Strategy*. London: HMSO.
- Department of Health (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: HMSO. Available at: www.midstaffspublicinquiry.com (last accessed 18 May 2018).
- Department of Health, Social Services and Public Safety (2006) *Modernising Nursing Careers: Setting the Direction*. Belfast: DHSSPS.
- Department of Health, Social Services and Public Safety (2008) *Improving the Patient and Client Experience*. Belfast: DHSSPS.
- Ellis, J., Lee-Woolf, E. and David, T. (2011) 'Supporting nursing students during fitness to practise hearings', *Nursing Standard*, 25(32): 38–43.
- Emanuel, V., Day, K. and Diegnan, L. (2011) 'Developing evidence-based practice amongst students', *Nursing Times*, 107(49/50): 21–3.
- Faulkner, A. (1998) 'The ABC of palliative care: communication with patients, families and other professionals', *British Medical Journal*, 316(7125): 130–2.
- Fernandez, R., Salamonsen, Y. and Griffiths, R. (2012) 'Emotional intelligence as a predictor of academic performance in first-year accelerated graduate entry nursing students', *Journal of Clinical Nursing*, 21: 3485–92.
- Gibbs, G. (1988) *Learning by Doing, A Guide to Teaching and Learning Methods*. Oxford: Further Education Unit, Oxford Brookes University.
- GMC/NMC (2015) *Openness and Honesty When Things Go Wrong: The Professional Duty of Candour*. London: GMC/NMC.

- Goleman, D. (1995) *Emotional Intelligence*. New York: Bantam.
- Griffith, R. (2015) 'Patient protection: ill-treatment and wilful neglect', *British Journal of Nursing*, 12 June 24(11). Available at: www.magonlinelibrary.com/doi/abs/10.12968/bjon.2015.24.11.600 (last accessed 15 May 2018).
- Griffon, D.P. (1995) "'Crowning the edifice": Ethel Fenwick and state registration', *Nursing History Review*, 3: 201–12.
- Griffon, D.P. (1998) "'A somewhat duskier skin": Mary Seacole in the Crimea', *Nursing History Review*, 6: 115–27.
- Hallett, C.E. (2007) 'Editorial: a "gallop" through history: nursing in social context', *Journal of Clinical Nursing*, 16(3): 429–30.
- Hallett, C.E. (2012) *Nursing: the lost art?*. Conference paper presented at the International History of Nursing Conference, Kolding, Denmark, 11 August.
- Hart, P.L., Brebban, J.D. and Chesney, M. (2014) 'Resilience in nursing: an integrative review', *Journal of Nursing Management*, 22(6), 720–34.
- Hawkins, S. (2010) *Nursing and Women's Labour in the Nineteenth Century*. London: Routledge.
- Health and Care Professions Council UK (2011) *Research Report: Professionalism in Healthcare Professionals*. London: HCPC. Available at: www.hpc-uk.org/publications/index.asp?id=s11 (last accessed 15 May 2018).
- Helmstadter, C. (1993) 'Old nurses and new: nursing in the London teaching hospitals before and after the mid-nineteenth century reforms', *Nursing History Review*, 1: 43–70.
- Helmstadter, C. (1996) 'Nurse recruitment and retention in the 19th century London teaching hospitals', *International History of Nursing Journal*, 2(1): 58–69.
- Henderson, V. (1960) *Basic Principles of Nursing Care*. London: International Council of Nurses.
- Hockey, L. (2001) *Oral history interview by Jane Brooks in Edinburgh on 8 August 2001*. UK Centre for the History of Nursing and Midwifery, School of Nursing, Midwifery and Social Work, University of Manchester.
- Law, K. and Aranda, K. (2010) 'The shifting foundations of nursing', *Nurse Education Today*, 30: 544–7.
- Mann Wall, B. (1998) 'Called to a mission of charity: the sisters of St Joseph in the Civil War'. *Nursing History Review*, 6: 85–113.
- Mason, K. (2005) *Dr Lisbeth Hockey, 1918–2004: Biography*. Available at: www.bmh.manchester.ac.uk/research/nursing-groups/uk-centre-for-the-history-of-nursing/publications (last accessed 18 May 2018).
- McAllister, M. and McKinnon, J. (2009) 'The importance of teaching and learning resilience in the health disciplines: a critical review of the literature', *Nurse Education Today*, 29(4): 371–9. <http://dx.doi.org/10.1016/j.nedt.2008.10.011>
- McFarlane, J.J. (1970) *The Proper Study of the Nurse*. London: Royal College of Nursing.
- McGann, S. (1992) *The Battle of the Nurses: A Study of Eight Women Who Influenced the Development of Professional Nursing, 1880–1930*. London: Scutari.
- NHS Employers (2014) *Simplified Knowledge and Skills Framework (KSF)*. Available at: www.nhsemployers.org/Simplified (last accessed 18 May 2018).
- NHS England (2015) *The NHS Constitution*. London: DH.
- NHS Wales (2012) *Preceptorship Foundation Policy for Newly Qualified Nurses*. Available at: www.wales.nhs.uk/sitesplus/documents/862/112PreceptorshipFoundationPolicyForNewlyQualifiedNursesv1.pdf (last accessed 18 May 2018).
- Nightingale, F. (1859) *Notes on Nursing: What It Is and What It Is Not*. London: Harrison.
- Northern Ireland Practice Education Council (NIPEC) (2013) *Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing*. Belfast: NIPEC.
- Nursing and Midwifery Council (2016) *Health and Character Guidance for AEs*. Available at: www.nmc.org.uk/education/what-we-expect-of-educational-institutions/good-health-and-good-character-for-aeis (last accessed 30 April 2018).
- Nursing and Midwifery Council (2017) *Quality Assurance Framework*. Available at: www.nmc.org.uk/education/quality-assurance-of-education/qa-framework-for-education (accessed 30 April 2018).

- Nursing and Midwifery Council (2018a) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. Available at: www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (last accessed 30 April 2018).
- Nursing and Midwifery Council (2018b) *Future Nurse: Standards of Proficiency for Registered Nurses*. London: NMC.
- O'Brien D'Antonio, P. (1993) 'The legacy of domesticity: nursing in early nineteenth-century America', *Nursing History Review*, 1: 229–46.
- Oxford English Dictionary* (2014a) Available at: <http://dictionary.reference.com/browse/nurse> (last accessed 15 May 2018).
- Oxford English Dictionary* (2014b) Available at: www.oxforddictionaries.com/definition/english/law (last accessed 15 May 2018).
- Pearcey, P. (2008) 'Shifting roles in nursing: does role extension require role abdication?', *Journal of Clinical Nursing*, 17(10): 1320–6.
- Reverby, S. (1987) *Ordered to Care: The Dilemma of America Nursing*. New York: Cambridge University Press.
- Royal College of Nursing (2011) *Principles of Nursing Practice*. Available at: www.rcn.org.uk/professional-development/principles-of-nursing-practice (last accessed 2 May 2018).
- Royal College of Nursing (2014) *Defining Nursing*. London: RCN. Available at: www.rcn.org.uk (last accessed 2 May 2018).
- Schön, D. (1983). *The Reflective Practitioner: How Professionals Think in Action*. London: Temple Smith.
- Smith, P. (2012) *The Emotional Labour of Nursing Revisited*, 2nd edn. Basingstoke: Palgrave Macmillan.
- Snowden, A., Stenhouse, R., Young, J., Carver, H., Carver, F. and Brown, N. (2015) 'The relationship between emotional intelligence, previous caring experience and mindfulness in student nurses and midwives: a cross sectional analysis', *Nurse Education Today*, 35(1): 152–8. Available at: www.sciencedirect.com/science/article/pii/S0260691714003025 (last accessed 2 May 2018).
- Stephens, T. (2013). 'Nursing student resilience: a concept clarification', *Nursing Forum*, 48(2), 125–33.
- Thomas, L.J. and Revell, S.H. (2016) 'Resilience in nursing students: an integrative review', *Nurse Education Today*, 36: 457–62.
- Todd, G. (2002) 'The role of the internal supervisor in developing therapeutic nursing'. In: D. Freshwater (ed.), *Therapeutic Nursing*. London: Sage, pp. 58–82.
- Vitello-Cicciu, J.M. (2002) 'Exploring emotional intelligence: implications for nursing leaders', *Journal of Nursing Administration*, 32(4): 203–10.
- Weir, R.I. (2004) *Educating Nurses in Scotland: A History of Innovation and Change, 1950–2000*. Penzance: The Hypatia Trust.
- Wheeler, H. (2012) *Law, Ethics and Professional Issues for Nursing: A Reflective and Portfolio Building Approach*. London: Routledge.
- White, R. (1978) *Social Change and the Nursing Profession: A Study of the Poor Law Nursing Service, 1848–1948*. London: Henry Klimenton.
- Willis Commission (2012) *Quality with Compassion: The Future of Nursing Education*. Available at: www.macmillan.org.uk/documents/newsletter/willis-commission-report-macmail-dec2012.pdf (last accessed 1 May 2018).