

# CAREFUL NURSING NEWS

## CAREFUL NURSING PROFESSIONAL PRACTICE MODEL THEME FOR MARCH/APRIL 2016 ISSUE—CLINICAL REASONING AND DECISION-MAKING

Saint Clare's Health System Nursing has adopted Careful Nursing as the Professional Practice Model for nursing practice. Careful Nursing has three philosophical assumptions and four concepts: therapeutic milieu, practice competence and excellence, nursing management and influence in health systems, and professional authority. This issue of the *Careful Nursing News* will focus on **CLINICAL REASONING AND DECISION-MAKING** which is one of the eight dimensions of the Practice Competence and Excellence Concept. Meehan (2012) explains this theme of the newsletter as, "The cognitive processes and strategies used by nurses to understand patient data, choose between alternatives and make nursing diagnoses. Particular emphasis is placed on the importance of nursing diagnostic accuracy. These processes are also used to identify needs for assessment and intervention by other health professionals, especially in relation to actual or potential life-threatening situations." (p. 2911).

The Careful Nursing professional practice model has FOUR Nursing Concepts (Dimensions) and 19 accompanying Key Practice (Concepts) Dimensions.

- I. Therapeutic Milieu
  - a. Caritas
  - b. Inherent human dignity
  - c. Nurses' care for selves and one another
  - d. Intellectual engagement
  - e. Contagious Calmness
  - f. Safe and restorative physical environment
- II. Practice Competence and Excellence
  - a. Great tenderness in all things
  - b. Perfect' skill fostering safety and comfort
  - c. Watching -assessment-recognition
  - d. **Clinical reasoning and decision-making**
  - e. Patient engagement in self-care
  - f. Diagnoses, outcomes, interventions
  - g. Family, friends, community supportive participation in care
  - h. Health education
- III. Management of Practice and Influence in Health System
  - a. Support of nursing practice
  - b. Trustworthy collaboration
  - c. Participative-authoritative management

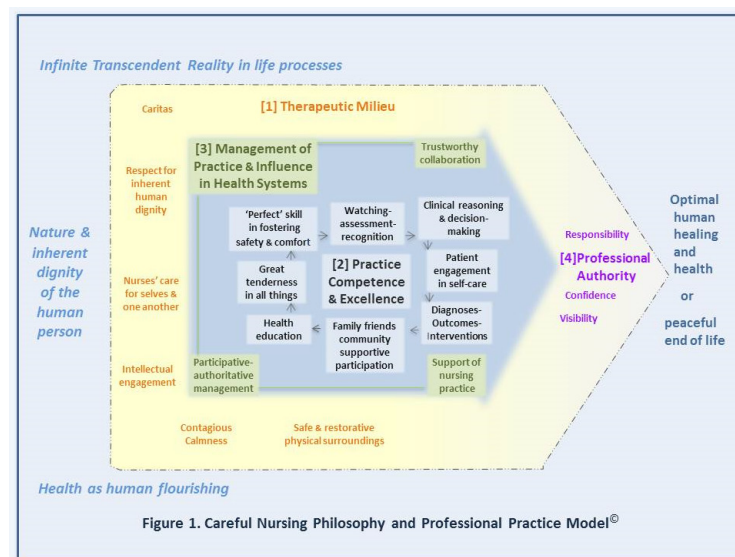
### IV. Professional Authority

- a. Professional self-confidence
- b. Professional Visibility

Meehan, T. (2012). The Careful Nursing philosophy and professional practice model. *Journal of Clinical Nursing*, 21, 2905–2916, doi: 10.1111/j.1365-2702.2012.04214.x

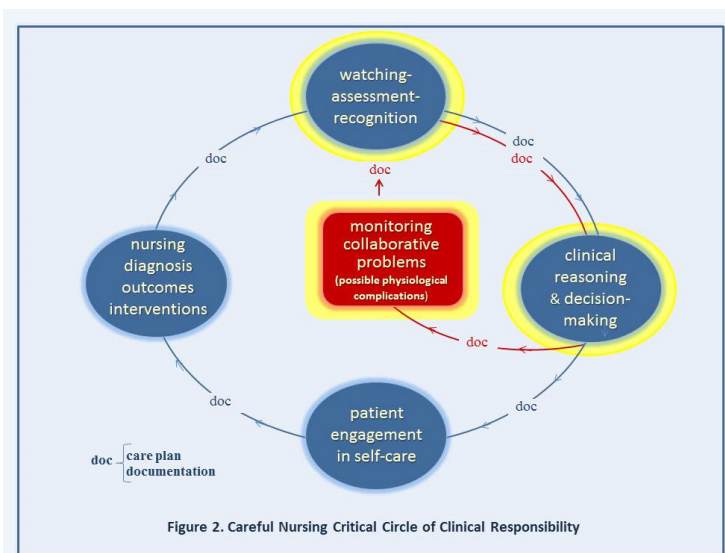
## CAREFUL NURSING PHILOSOPHY AND PROFESSIONAL PRACTICE MODEL®: PRACTICE COMPETENCE AND EXCELLENCE: CLINICAL REASONING AND DECISION-MAKING

Our topic for this issue of *Careful Nursing News* (CNN), clinical reasoning and decision-making, brings us to our distinctively human capacity to reason. Naturally, reasoning is central to our purposeful application of nursing knowledge; to how our thinking guides our practice. In reasoning we draw on all relevant knowledge but are concerned particularly with knowledge related to the Careful Nursing philosophical principles and professional practice concepts.



You will recall that clinical reasoning and decision-making is a concept of the practice competence and excellence dimension of the professional practice model, shown in Figure 1, and one of a subgroup of concepts called the critical circle of clinical responsibility, shown in Figure 2. In the figures the concepts appear distinct, although linked. But we know from implementing them in practice that they are wholly interrelated. For example, in the previous issue of CNN (2016, 8(1), p.14-19) we discussed watching-assessment-recognition, a three-fold knowledge gathering concept. As we continue in this issue with clinical reasoning and decision-making we will find the two concepts naturally weaving themselves together in our mind.

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In fact, watching-assessing-recognition and clinical reasoning and decision-making woven together can be thought of as the *modus operandi* of our practice. They give rise to how we decide to act in relation to the other concepts, particularly collaborative problems, patients' engagement in their care and nursing diagnoses, outcomes and interventions.

You may be wondering: if clinical reasoning and decision-making is all about thinking, knowing and applying knowledge, where in this process is the therapeutic milieu concept of intellectual engagement? Actually, the critical circle of clinical responsibility is intellectual engagement in action. But because our philosophy of the human person tells us that intellectual engagement is deeply part of *how* we are in ourselves as nurses, it is located conceptually in the therapeutic milieu along with the other concepts that describe the 'relational doing' of nursing.

Recall that intellectual engagement has its source in our inward life of mind and spirit and is thereby linked intimately to the substance of our being. It acts together with the other therapeutic milieu concepts to define the nursing-created, nursing-led surrounding and atmosphere in which all patient care takes place (CNN, 2015, 7(2), pp.10-19). In this article, intellectual engagement was described thus:

Much may be said about the heart and hands of nursing, but surely it is in the mind of nursing that our greatest treasure is to be found. Through our mind we are intimately linked to the first principle of our being. We can also say that our mind, our thinking, our intellectual engagement, is the first principle of our practice as professional nurses.

In our day-to-day practice with its many pressures that demand our *doing* as much as possible we may not always fully appreciate that it is our intellectual engagement that enables us to be who we are and do what we do. . . . As we practice we might tend to overlook how nimbly our mind choreographs our myriad of sense impressions, streaming them to our imagination, memory, and reasoning power to provide

the rich ground for our insight, understanding, knowledge, judgements, and actions (p. 10).

Intellectual engagement leads us directly to clinical reasoning and decision-making. We will begin with the nature of reasoning itself. This will provide a philosophical landscape against which to consider clinical reasoning, its critical thinking component, and clinical decision-making. We will then consider a very important correlate of both watching-assessment-recognition and clinical reasoning and decision-making, namely identifying and monitoring for collaborative nursing-medical potential patient problems. Finally, we will reflect on how these concepts concern our fundamental responsibility as nurses; to protect sick, injured and vulnerable people from harm; in other words, to guard patient safety.

## Reasoning

In simple terms, reason is defined as the power of the mind to think and understand in a logical way. Reasoning is defined simply as "the process of thinking about something in a logical way in order to form a conclusion or judgment" (Reasoning, 2016). However, philosophical definitions concerning the nature of reasoning vary significantly.

## Scientific philosophy of reasoning

Philosophers of science argue that reasoning concerns the rational consideration of objective facts and that this alone provides all that is necessary to form judgements. Any role for subjective experiences in this process, such as intuition, imagination or faith, is firmly rejected (Honderich, 2005). We know this view very well as the scientific method. Other philosophers argue from the somewhat broader position that reasoning is any process of drawing a conclusion from a set of ideas where the ideas can be shown to verify the conclusion (Blackburn, 2016). Again, verification must be objective.

This approach to reasoning dominates contemporary thinking because it is very useful. The evidence it provides is objective so it can be considered probably true; and it can be measured. As nurses we use it to develop theory, conduct research, and support evidence-based practice. But at the same time we are faced with the reality that it is inadequate for understanding the human complexity encountered when reasoning in nursing practice.

## Holistic philosophy of reasoning

Nursing's theoretical claim that human beings are in essence unitary beings (holistic) together with our subjective experience of holism in practice, require an encompassing philosophical understanding of reasoning: one which addresses the unitary (holistic) nature of human persons and the complexity of human thinking and human relationships. The neo-Aristotelian philosophy of Aquinas, which informs Careful Nursing, is one such philosophy. It throws a broad light on the process of reasoning.

Aquinas (1265–1274/1948, I Q 76) argues that human persons are in essence unitary beings and that reasoning is their defining characteristic: that we are by nature rational (reasoning) beings. Therefore, reasoning cannot be confined to objective, factual evidence of the senses. Rather, it includes everything that is humanly knowable. In keeping with this view, objective logical reasoning is only one process of reasoning. Reasoning also takes place by analogy, a method of reasoning long known to be fun-



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damental to human thought (Bartha, 2013). Aquinas also differentiates somewhat between theoretical reasoning and practical reasoning, which concerns work done in a particular situation to achieve a good outcome (Osborne, 2012).

Jacques Maritain, an influential 20<sup>th</sup>-century interpreter of the philosophy of Aquinas, argues that a natural, semi-conscious, intuitive reasoning is deeply embedded in human persons. As a fundamental human quality:

“... reason possess a life both deeper and less conscious than its articulate logical life. For reason indeed does not only articulate, connect, and infer, it also *sees*; and reason's intuitive grasping, *intuitus rationis*, is the primary act and function of that one and single power which is called intellect or reason. In other words, there is not only logical reason, but also, and prior to it, intuitive reason” (Maritain, 1953, p.75).

While this understanding of reasoning is not commonly recognized and could not be considered scientifically valid, it is part of a philosophical argument that offers insight into subjective types of knowledge that nurses draw on in clinical practice.

## Implications for clinical reasoning and decision-making

Drawing on previous research and analysis, Koharchik *et al.* (2015) define clinical reasoning as applying formal and informal nursing knowledge and other related knowledge to experience in practice. Its purpose is to analyze and understand as accurately as possible a patient's condition. Such reasoning leads directly to timely and effective decision-making.

Drawing on a concept analysis of decision-making in nursing, Johansen and O'Brien (2016) define it as a complex process of applying knowledge, analytical and critical thinking, intuition, experience, clinical reasoning and applying rules of thumb. It is influenced by a number of contextual factors including situation awareness and values. Its purpose is to make sound decisions about patient care. Only some of these can be touched on here.

**Critical thinking.** The cognitive process of critical thinking is central to how we draw on and use knowledge developed according to the scientific philosophy of reasoning (Zuriguel Pérez, *et al.*, 2015). Because we use scientific knowledge so widely in decision-making about risks to patient safety and in making precise judgements about patient care, it is vital that we evaluate it as we use it. However, in their scoping review of critical thinking in nursing, Zuriguel Pérez, *et al.*, found that its use in practice, as opposed to educational settings, is limited. This limitation surely requires our attention.

**Intuition and experience.** It is well established that, in addition to using objective ways of reasoning, we use a multiplicity of subjective ways of reasoning, particularly intuition. In a concept analysis of intuition in clinical nursing practice, Robert, *et al.*, (2014) concluded that many nurses experience intuition spontaneously and use in clinical reasoning. The holistic philosophy of reasoning provides insight into the nature of intuition and also supports our use of other experiential types of clinical reasoning, such as narrative and aesthetic reasoning.

Further, the holistic philosophy of reasoning proposes that intuition is, in fact, the fundamental form of reasoning. It offers a structure for rethinking clinical reasoning, with Maritain's “intuitive grasp” proposed as the source of what emerges as both objective logical reasoning and subjective analogical reasoning. This philosophy suggests that it is misleading to separate clinical reasoning and intuition as two separate phenomena, as occurs in much of the nursing literature. In addition, the more wide-ranging light it throws on reasoning could help address the concern that little is actually known about nurses' clinical reasoning processes (Simmons, 2010).

**Situational awareness.** Of particular interest for our clinical reasoning and decision-making is that Maritain, in *The Range of Reason* (1952), emphasizes that how human persons interact with one another and the context in which they interact has an important influence on their perception and understanding. He suggests that reason's *seeing* and intuitive grasp is enhanced by what we would call attending to patients with loving kindness. This suggests the importance of the therapeutic nurse-patient relationship, and the therapeutic milieu of the practice setting, as the context for clinical reasoning and decision-making. They could enhance our capacity to experience ‘reason's *seeing*’ and our ‘intuitive grasp’ of key elements of patients' condition in order to best inform our clinical reasoning and decision-making.

**Practical issues.** Situational awareness raises the importance of practical reasoning, that is, deliberating on the best course of action attainable in a given clinical practice situation where there is lack of clarity, uncertainty, and likelihood of on-going change based on particular concrete realities. Practical reasoning also influences how research findings are implemented in practice (French 2005). Knowledge underlying practical reasoning is usually accumulated from experience over time in aiming to make the best possible practical decisions. Practical reasoning is contrasted with theoretical reasoning and often linked back to Aristotle's virtue theory, which we discussed it in relation to promoting health as human flourishing CNN (2014 5(2), pp. 6-8).

**Values.** Values enter our clinical reasoning and decision-making as ethical reasoning. In ethical reasoning we deliberate on values held by patients, ourselves and others related to what is right or wrong, good or bad, for patients, in deciding which actions will best foster their health. Our reasoning is guided by a national nursing professional code of ethics. In *Careful Nursing*, ethical reasoning is especially concerned with inherent human dignity, natural justice, and health as human flourishing. Ethical reasoning is widely recognized as an especially complex and difficult process often made more so by competing values in practice settings (Goethals *et al.*, 2010).

## Reflection on reasoning in nursing in nursing practice

Consideration of different philosophies of reasoning provides us with a broad intellectual landscape against which to think about clinical reasoning and decision-making in nursing practice. The scientific philosophy of reasoning which guides our use of vitally important objective forms of reasoning is of central importance in decision-making and requires that we always approach our practice in a critical thinking mode. In *Careful Nursing* terms it relates to our outward lives of body and senses.

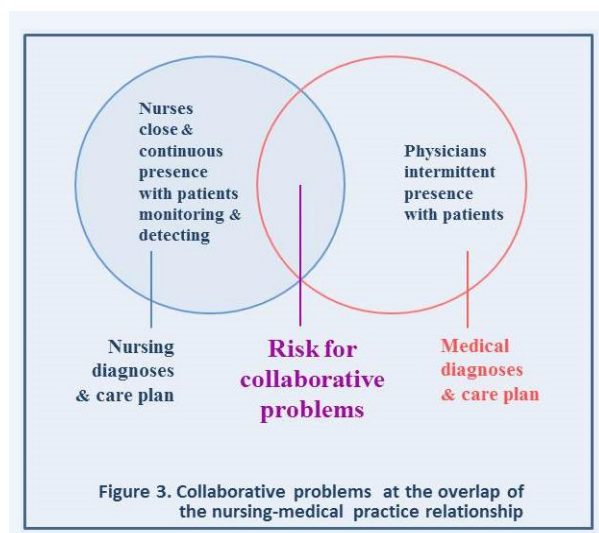
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But, the high value accorded to this approach to reasoning in contemporary society and health care can serve to overshadow the long-standing holistic philosophy of reasoning, which is generally not so valued. Aquinas's explanation of human reasoning and that of Maritain following him are detailed and complex and further discussion of their meaning for nursing practice is beyond the scope of this article. (But even an attempt to read them or read about them will produce an "oh, yes" response because they explain what we see and experience in nursing practice every day but find it hard to describe and explain). This approach supports the multiplicity of subjective and situation-based ways of reasoning that we engage in on a daily basis in our nursing practice. In Careful Nursing terms it relates to our inward lives of mind and spirit and our essential nature as unitary beings.

Considering the distinctive nature of our profession, particularly our close and continuous relationship with patients and our special responsibility to guard them from harm, we are bound to draw on both philosophies of reasoning. Doing so will enhance our capacity to engage in the most insightful, accurate and effective clinical reasoning and decision-making.

## Collaborative problems

The concept of collaborative problems is not part of Careful Nursing as such, but is very close to it. It addresses an area of risk to patients where nursing and medical responsibilities overlap, as shown in Figure 3. Collaborative practice in relation to collaborative problems is vital to minimizing the risk. Although the term 'collaborative problems' is new, such collaboration between nursing and medicine reaches back to antiquity. In Greek mythology Asclepius, a personification of medicine, is often portrayed in a close relationship with Hygieia and her companions, personifications of nursing. In fact, Asclepius's appears to have been dependent on the nurses' presence for his therapeutic effects (Connell, 1984).



Today this closeness is vital to patient safety. As you will be aware, Carpenito (2013) defines collaborative problems as "Certain physiologic complications that nurses monitor to detect onset or changes in status.

Nurses manage collaborative problems using physician-prescribed and nursing-prescribed interventions to minimize the complications of the events" (p. 19). Our watching-assessment-recognition and clinical reasoning and decision-making in relation to collaborative problems, as indicated in the highlighted inner red circle shown above in Figure 2, take on a special significance.

Carpenito (2013) emphasizes that the physiologic complications do not include complications that we can prevent, such as pressure ulcers, deficient fluid volume, or aspiration. (These would be risk-related nursing diagnoses which we will discuss in a future issue of CNN). They do include complications nurses cannot prevent, such as bleeding, cardiac arrhythmias or electrolyte imbalances. Both physicians and nurses treat collaborative problems. For example, physicians may use medications or surgery and nurses may use physiological positioning, and education or calming interventions to reduce anxiety.

It is not the intention here to discuss collaborative problems in detail, but to stress the vital importance of our responsibility to identify collaborative problems and monitor patients closely to detect onset or changes – as early as possible. Our responsibility arises from the inherently protective function of our profession and, in acute care settings, our close and continuous, 24/7 presence with patients.

Because collaborative problems can arise in relatively slow and subtle ways but then become life-threatening very quickly, watching-assessment-recognition and a holistic understanding of reasoning are of key importance. For example, the first hint of a postoperative collaborative problem, such as bleeding, is not always detected from changes in vital signs. Rather, it may be detected intuitively by a nurse as 'something is not right' (Brier, et al., 2014 p. 833). Both are 'red circle' signals, as portrayed in Figure 2, for high priority watching-assessment-recognition, sharp clinical reasoning, and confident decision-making to ensure the earliest possible collaborative confirmation and treatment.

## Summary

The central role of clinical reasoning and decision-making in our application of nursing and other knowledge is a complex and vital component of our practice. Empowered by intellectual engagement and together with watching-assessment-recognition, it directs how we implement the other concepts of the Careful Nursing critical circle of clinical responsibility. In this article its importance in our monitoring to detect onset or changes in status of patients' risk for potentially life-threatening deterioration is highlighted. Consideration of this concept against different but complementary philosophies of reasoning can enhance our understanding of how we can attain excellence, as often as possible, in understanding and applying nursing and related knowledge to provide the best possible patient care.

You are invited to contribute to the development of this concept in its Careful Nursing context by commenting on and critically evaluating how it is presented in this article. Does this article enhance your understanding of a concept that you are already very familiar with? As you read it, what limitations in its information and scope occur to you?



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Do send your thoughts about it to Sue Weaver, the editor of *Careful Nursing News*, [sueweaver@primehealthcare.com](mailto:sueweaver@primehealthcare.com) or send a message to the 'Contact' section of the Careful Nursing webpage: [http://www.careful-nursing.ie/go/about/contact\\_us](http://www.careful-nursing.ie/go/about/contact_us). We look forward to hearing from you.

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## KUDOS

Congratulations to Saint Clare's nurses who presented the following poster presentations at the 2016 Pathway to Excellence conference in Philadelphia:

- ❖ Crucial conversations: Improving communication among multidisciplinary teams utilizing role play for crucial conversations by **Rosemary Russo, MSN, RN, CNOR, RNFA** and **Grace Carcich, MSN, RN**
- ❖ A Multidisciplinary Approach to Promote a Culture of Safety during Clinical Orientation by **Rosemarie Rocchio, BSN, MS, RNC-NIC, Grace Carcich, MSN, RN, and Diane Hassa, MSN, RN**
- ❖ Pathway to Excellence: Maintaining a positive practice environment during a time of transition by **Kristina Felix BSN, RN** and **Sue Weaver PhD, RN, CRNI, NEA-BC**
- ❖ Workplace Violence: Taking Action to Prevent Harm to Healthcare Workers by **Susanne Graham, MA, RN-BC, MaryAnn Piro, BSN, RN, CARN, and Sandy Clark, RN, NE-BC**

Congratulations to **Susan Fox, BSN, RN, CEN**, Clinical Educator Emergency Department, who recently became certified as a Certified Emergency Nurse through the Board of Certification for Emergency Nursing.

Congratulations to **Rebecca Thomlinson, BSN, MICN, CTRN, SCTU** nurse, who recently became certified as a Certified Transport Nurse through the Board of Certification for Emergency Nursing.

Congratulations to **Sue Weaver PhD, RN, CRNI, NEA-BC**, Education Specialist, who:

- ❖ Had the article "Administrative Supervisors: A Qualitative Exploration of their Perceived Role" published in the April - June 2016 issue of *Nursing Administration Quarterly*.

