DISCURSIVE PAPER

The Careful Nursing philosophy and professional practice model

Therese C Meehan

Aims and objectives. To present the Careful Nursing philosophy and professional practice model which has its source in the skilled practice of 19th century Irish nurses and to propose that its implementation could provide a relevant foundation for contemporary nursing practice.

Background. Nursing models are widely considered not relevant to nursing practice. Alarming instances of incompetent and insensitive nursing practice and experiences of powerlessness amongst nurses are being reported. Professional practice models that will inspire and strengthen nurses in practice and help them to address these challenges are needed. Nursing history has been suggested as a source of such models.

Design. Discursive.

Methods. Content analysis of historical documents describing the thinking and practice of 19th century Irish nurses. Identification of emergent categories and subcategories as philosophical assumptions, concepts and dimensions of professional nursing practice.

Results. A philosophical approach to practise encompassing the nature and innate dignity of the person, the experience of an infinite transcendent reality in life processes and health as human flourishing. A professional practice model constructed from four concepts; therapeutic milieu, practice competence and excellence, management of practice and influence in health systems and professional authority; and their eighteen dimensions.

Conclusion. As a philosophy and professional practice model, Careful Nursing can engage nurses and provide meaningful direction for practice. It could help decrease incidents of incompetent and insensitive practice and sustain already exemplary practice. As a basis for theory development, it could help close the relevance gap between nursing practice and nursing science.

Relevance to clinical practice. Careful Nursing highlights respect for the innate dignity of all persons and what this means for nurses in their relationships with patients. It balances attentive tenderness in nurse–patient relationships with clinical skill and judgement. It helps nurses to establish their professional practice boundaries and take authoritative responsibility for their practice.

Key words: careful nursing, history, human dignity, Irish nursing, nursing philosophy, nursing professional practice model

Introduction

For over forty years, the nursing profession has debated the relevance of nursing models to nursing practice and it is clear that most nurses, particularly practicing nurses, continue to judge them to be not relevant (Risjord 2010). Whilst this situation undermines the idea of nursing as a professional discipline, it is becoming increasingly more ominous. Alarming reports are appearing of incompetent and insensitive nursing practice (Abraham 2011, Bradshaw 2011, Milton

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2011, Williams 2011) and of nurses finding themselves powerless to implement their professional values in some healthcare settings (MacKusick & Minick 2010, Georges 2011, Sellman 2011). Clearly, such failures must be addressed urgently. Nurses' practice and their ability to sustain their practice depend on relevant nursing knowledge; that is, relevant nursing models and the theories and research that they generate. The search must continue for nursing models that will engage and strengthen nurses and provide meaningful direction for them in their professional practice.

To this end, two cues present themselves. Bradshaw (2011) suggests nursing history as a source of a renewed vision of nursing. Lynaugh (1996) observes that nursing history is 'our source of identity, our cultural DNA' (p. 1). Likewise, Black (2005) proposes that serious shortcomings in patient care in hospitals in the United Kingdom (UK) can be most effectively reversed by a nurse-led transformation of hospitals, as occurred in the 19th century. Nurse-led transformation of hospitals is already occurring in the United States (US) through the highly regarded nursing Magnet Recognition Program (American Nurses Credentialing Center 2008). This leads to the second cue: The Magnet Recognition Program requires that nursing practice be based on a nursing professional practice model, that is, a nursing model that directly addresses the structure, processes and values that are inherent in professional nursing practice.

This study presents the Careful Nursing philosophy and professional practice model. Careful Nursing has its source in 19th century nursing history and a brief overview of its background is presented. The initial development of Careful Nursing as a conceptual model is described and its limitations identified. Further content analysis of historical documents is then outlined, followed by presentation and discussion of Careful Nursing as a philosophy and professional practice model.

Background

The history of nursing is marked by a long dark period in Britain and Ireland, beginning with Henry VIII's dissolution of the monasteries and termination of their nursing services in the 16th century and lasting into the 19th century (Dock & Stewart 1920). The reformulation of nursing as a public service began in Ireland as soon as circumstances allowed in the 1820s, led by Catherine McAuley and Mary Aikenhead. In accordance with the cultural and social mores of the time, they formed new organisations of mainly well-educated religious sisters who went out daily to nurse the sick, injured and vulnerable in their homes. Over 7 months in 1832, during the first great cholera epidemic, they provided crucial

nursing service in Dublin cholera hospitals, McAuley being given 'the fullest control' of patient care (Carroll 1883, p. 295). During this time, they further expanded their knowledge and skills in caring for critically ill patients through working closely with doctors and apothecaries. In 1833, Aikenhead sent three Sisters of Charity to hospitals in Paris for specialised training and in 1835 founded St. Vincent's hospital in Dublin, the first major hospital owned and operated by nurses in Britain and Ireland in modern times.

By the time of the Crimean war of 1853–1856, they had developed a distinctive nursing system. They were recognised as skilled nurses and had attained 'brilliant prestige in nursing' (Dock & Nutting 1907, p. 86). The British government looked to Ireland for nurses to assist Florence Nightingale. Twelve Irish nurses, Sisters of Mercy, served at the war over a 16-month period. Mary Clare Moore, who had 'trained' with McAuley during the 1832 cholera epidemic, worked closely with Nightingale (Meehan 2005). Cultural and political conflicts precluded their public recognition, but Nightingale acknowledged privately her reliance on their nursing knowledge and skill, particularly that of Moore. 'You were far above me in fitness for the General Superintendency' Nightingale wrote to Moore, 'what you have done for the work no one can ever say' (Letter, 29 April 1856), and in a later recollection, 'how I should have failed without your help' (Letter, 21 October 1863). Moore has been recognised as one of the greatest influences on Nightingale in nursing matters (Baly 1997). Beginning in 1843, the Irish nursing system also spread internationally as the nurses accompanied the Irish Diaspora, founding and operating hospitals and schools of nursing in many countries.

Careful Nursing as a conceptual model

Careful Nursing was initially developed as conceptual model (Meehan 2003). A preliminary content analysis of historical documents was conducted. Primary sources were documents written by the 19th century Irish nurses and other nurses, surgeons, army officers and purveyors who worked with them or observed them working. These included journals, letters, convent annals, British army records, loose papers and published books, which were identified through an extensive search of convent and national archives in Ireland and the UK. Genuineness of documents was checked to every possible extent by the comparison of handwriting and consultation with other historians familiar with the documents. Authenticity of document content was verified by the comparison of events reported across documents from different sources. Specific documents included McAuley's guide to the

visitation of the sick (1832), a compilation of McAuley's letters (Neumann 1969), a compilation of letters and manuscripts of McAuley's closest nursing associates (Sullivan 1995), the nurses' Crimean war journals (Bridgeman MF, Archives of the Sisters of Mercy, Dublin, unpublished manuscript, Croke 1854–1856a, Croke 1854–1856b, Doyle 1897), descriptions by a fellow nurse (Taylor 1856, 1857) and related British army correspondence (Codrington 1856). Secondary sources were biographies of McAuley (Moore 1841/1995, Harnett 1864, Carroll 1866) and published second-hand descriptions of the nurses' practice (Murphy 1847, Carroll 1883). Documents were read and reread in depth. Content was categorised and classified according to Weber (1985) and mapped onto the nursing metaparadigm concepts of human being, environment, health and nursing proposed by Fawcett (2000). Most content related to nursing and was summarised in a conceptual model composed of ten practice concepts grouped under four headings, as shown in Fig. 1.

The name, Careful Nursing, was selected from a letter sent by the nurses to the British War Office in 1854 in which they wrote; 'Attendance on the sick is, as you are aware, part of our Institute; and sad experience amongst the poor has convinced us that, even with the advantage of medical aid, many valuable lives are lost for want of careful nursing' (Whitty to Yore 18th October 1854).

The structure and utility of the model was assessed and critically analysed by nurses in education and practice in Ireland (Meehan 2006, McMullin *et al.* 2009) and the US

Nurses' therapeutic capacity
Nurses' care for themselves

The therapeutic milieu
Disinterested love
Contagious calmness
Creation of restorative environment

Clinical competence & expertise
'Perfect' skill fostering safety & comfort
Nursing interventions
Health teaching

**Management of practice
& influence on health system**
Participatory-authoritative management
Trustworthy collaboration
Power derived from service

Figure 1 Careful Nursing as a conceptual model.

(Roemer 2006). Further elaboration of the model was required to provide more specific direction for practice and theory development. However, reflection on the mapping of the documents' content onto Fawcett's (2005) metaparadigm concepts showed that they were inadequate for full explication of the documents' content. Important philosophical principles inherent in the documents were obscured and at odds with Fawcett's proposed world views. Fawcett's approach to knowledge development was put aside and a second more comprehensive, content analysis was undertaken wherein the documents were given the freedom to speak for themselves.
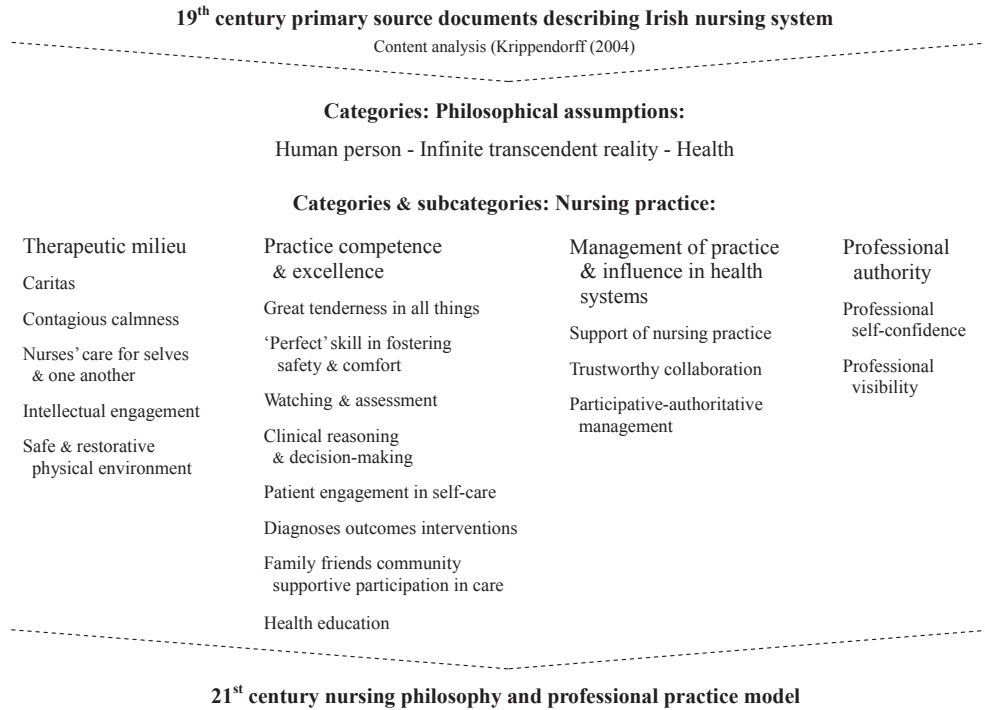
Methods

The document search and verification procedures described for the preliminary analysis were repeated. Additional primary sources were identified and examined (Barrie 1854, 1855a,b, Moore 1854–1856, 1855, Fitzgerald 1855) as were additional secondary sources (Atkinson 1879, Terrot 1898, Doona 1995, Sullivan 2004). Again, documents were read and reread in depth. Following Krippendorff (2004), primary sources were analysed for manifest and latent content. Textual units, each relating to the same central meaning, were identified and hand coded and sorted into categories and subcategories. Secondary sources provided background information.

Seven broad categories emerged. Three categories, human person, an infinite transcendent reality and health, were judged to primarily concern philosophical assumptions underlying nursing practice. Four categories, with a total of eighteen subcategories, were judged to primarily concern attitudes and actions of skilled nursing as a public service. This process, as shown in Fig. 2, was used to reformulate a 19th century nursing system into a 21st century nursing philosophy and professional practice model.

Results

Careful Nursing philosophy

Data giving rise to the philosophical assumptions markedly matched the thinking of Thomas Aquinas (1256–1259/1953, 1265–1274/1948), as he built on and extended the thinking of Aristotle (Ross 1915). Thus, the thinking of Aquinas was drawn upon in elaborating these assumptions, shown in Table 1. They provide the foundation for how nurses think about themselves as nurses, the patients they care for, the nurse–patient relationship and the attitudes and actions they engage in to protect patients and foster their healing and health.

19th century primary source documents describing Irish nursing system

Content analysis (Krippendorff (2004)

Categories: Philosophical assumptions:

Human person - Infinite transcendent reality - Health

Categories & subcategories: Nursing practice:

Therapeutic milieu	Practice competence & excellence	Management of practice & influence in health systems	Professional authority
Caritas	Great tenderness in all things	Support of nursing practice	Professional self-confidence
Contagious calmness	'Perfect' skill in fostering safety & comfort	Trustworthy collaboration	Professional visibility
Nurses' care for selves & one another	Watching & assessment	Participative-authoritative management	
Intellectual engagement	Clinical reasoning & decision-making		
Safe & restorative physical environment	Patient engagement in self-care		
	Diagnoses outcomes interventions		
	Family friends community supportive participation in care		
	Health education		

21st century nursing philosophy and professional practice model

Figure 2 Reformulation of a 19th century nursing system into a 21st century nursing philosophy and professional practice model.

Table 1 Careful Nursing philosophical assumptions

Human person	A unitary, rational being encompassing two explicit realities, a bio-physical reality and a psycho-spiritual reality. Is not composed of these realities but is a unitary being in whom these realities can he distinguished (Aquinas 1265–1274/1948, I Q76)[1]. Life is experienced as twofold: an outward life of the body and senses and, simultaneously, an inward life of the mind, spirit and communion with an infinite transcendent reality (II, II Q23). The outward life predominates in consciousness. The inward life; experienced mainly during inner reflection, contemplation, meditation or prayer; encompasses awareness, or potential awareness of the love, purposefulness and healing presence of an infinite transcendent reality, which the person has an actual or potential desire to search for and to know (1 Q12). Each person is unique and possesses intrinsic order and beauty, inestimable dignity and worth, distinctive creative potential, a meaningful purpose in life, inalienable rights; and if able to reason, has certain responsibilities. While persons in essence are not inconsiderate or malevolent, they can experience inconsiderate and malevolent influences which can, in turn, generate in them inconsiderate and malevolent ideas and intentions and attitudes and actions (I Q49).
An infinite transcendent reality	The abundantly loving source of all creation, unitary wholeness and healing in the universe (Aquinas 1265–1274/1948, I Q2). Infuses human persons with boundless love and goodness that they can apprehend through their psycho-spiritual reality or inward life during inner reflection, contemplation, meditation or prayer; or through sensitive perception of splendid beauty, for example, in nature or a musical symphony. Is experienced as the spiritual aspect of life.
Health	Human flourishing; the person's unitary experience of personal dignity, harmony, relative autonomy, contentedness and sense of purpose in life. Has its source in an infinite transcendent reality and in nature and can be fostered by restorative psycho-spiritual, bio-physical and social influences in the person and the person's environment (Aquinas 1256–1259/ 1953, Q11). Is ideally associated with the relative absence of disease but can still be fully experienced in states of disability or chronic illness. Includes the ability, or potential, to experience a personal relationship with an infinite transcendent reality through inner reflection, contemplation, meditation or prayer; and to express this experience in loving relationships with others and in seeking to fulfill a perceived purpose in life. It includes the ability to accept with equanimity influences and circumstances which are seemingly unjust but may be very difficult to alter.

[1]The standard method of referencing Aquinas's publications is by parts [I, II, II II or III, questions (Q) and sometimes articles (Art.)].

Attention to the nature of the person is especially important because nurse–patient relationships are central in nursing practice. The inherent dignity of all persons is emphasised. In their relationships with patients and with one another, nurses are guided to be conscious of their own unitary nature, inward and outward lives, intrinsic order and beauty and

dignity and worth, as well as their own potential for inconsiderate attitudes and actions. Aquinas's elaboration of the person's unitary nature and simultaneously distinguishable explicit realities provides a practical perspective for nurses in their commitment to provide holistic care. As Risjord (2010) observes, attention to the unitary person and the person's 'parts' is not conceptually inconsistent. This perspective can help nurses to be more easily mindful of the unitary nature of patients and themselves, whilst at the same time attending to distinguishable and very real bio-physical and psycho-spiritual needs.

Historically, the experience of an infinite transcendent reality has been central to nursing in the Western world and is widely known to have been fundamental to Nightingale's experience of herself as a nurse. Following Aristotle, Aquinas refers to this reality as the 'first mover' or 'first efficient cause, to which everyone gives the name of God' (1265–1274/1948, I Q2 Art.3), whose existence is supported by natural reason and reflection on the data of sense experiences of familiar features of the world. Both Nightingale and the 19th century Irish nurses were inspired and strengthened by their awareness of an infinite transcendent reality in their work as nurses, in the lives of the people they served and in their understanding of healing and health (Sullivan 1999).

Health as human flourishing (DeYoung *et al.* 2009) is reflected in the descriptions of the nurses' ideas and their practice attitudes and actions. They shared with Nightingale the assumption that nature heals patients and that the purpose of true nursing is 'to put the patient in the best condition for nature to act upon him' (Nightingale 1859/1970, p. 133). Aquinas (1256–1259/1953 Q11) also argued that it was the natural power within the sick person that brought the person to health and that the role of health professionals and their treatments was to act as instruments to aid nature in healing.

Careful Nursing professional practice model

The four categories concerned with the attitudes and actions of skilled nursing as a public service were used to construct the nursing professional practice model, as shown in Fig. 3. To construct the model, the four categories were viewed as interrelated concepts, and their subcategories as interrelated dimensions of the concepts: the therapeutic milieu with five dimensions, practice competence and excellence with eight dimensions, nursing management and influence in health systems with three dimensions and professional authority with two dimensions. The names and definitions of the concepts and dimensions were derived from the historical data

Figure 3 Careful Nursing professional practice model.

but expressed in contemporary language. The positions of the concepts and their dimensions shown in the model represent a preliminary proposal of relationships amongst them. Thus, the model provides a conceptual foundation for the subsequent development of nursing theories and contribution to the development of nursing science.

Definitions of the model concepts and their dimensions are presented in Tables 2–5. Although the term 'therapeutic milieu' emerged independently from the historical data as a clear and compelling conceptual impression, it has been evident in the mental health nursing literature for some time and its importance recently emphasised by Mahoney *et al.* (2009).

The definition of the therapeutic milieu dimension of caritas follows Aquinas's description of the type of love, which was commonly translated in Latin as *caritas* from the Greek *agapē* during the 1st century (Batten 1948). The term caritas is used because its English translation as charity has lost its original meaning. Caritas is also included in other nursing models where it is equated with caring (Eriksson 2002, Watson 2006). However, the term caring is not used in

Careful Nursing because its common use as a synonym for nursing is confusing. Watson defines caritas as a loving consciousness related to deeper dimensions of human experience. Eriksson defines caritas more specifically as unconditional love united with charity and related to 'a god or abstract other' (p. 63), which is similar to the Careful Nursing definition. As a quality of caritas, nurses' experience of true empathy with patients is the insightful, practical approach to empathy in nursing suggested by Määttä (2006) based on the philosophical research of Edmund Husserl's assistant Edith Stein (1916/1989).

Definitions of the dimensions of the practice competence and excellence concept that incorporate standardised nursing languages (Flanagan & Jones 2007) and emphasise accuracy (Lunny 2009) clinical judgement (Thompson & Dowding 2009) and monitoring collaborative problems (Carpenito-Moyet 2010) may seem unlikely analogues to 19th century practice. Nonetheless, they reflect in contemporary terms the precise, innovative and efficient practice activities of the 19th century nurses.

Table 2 Therapeutic milieu concept and its five dimensions

Therapeutic milieu	**The nursing-created surrounding and atmosphere that provides the context within which clinical practice and management take place. It is more than an environment. It is a culture rich in healing interpersonal relationships, cooperative attentiveness to patients and physical features which sooth patients and provide for optimum safety. It is further defined by its five dimensions.**
Caritas	Nurses' experience and expression of love for patients as the benevolent affection of one human person for another that flows through nurses' inner awareness of their sharing in the infused love of an infinite transcendent reality. It is a love given irrespective of the characteristics of the person who is loved. It is impartial; unbiased by personal interest or desire for advantage. It disposes nurses to attend to patients with kindness, compassion, great tenderness and a joyous spirit and to experience moments of true empathy with patients. These qualities arise in the inward life and reside in the will, not in transient emotions.
Contagious calmness	Nurses' ability to preserve and project an inner sense of calm even under the most adverse circumstances. It is closely associated with the experience and expression of caritas and characterised by a gentle manner, soothing voice and impression of quiet dependability. Reflected in nurses' attitudes and actions, it is communicated naturally to patients and others in the therapeutic milieu. It sets the emotional tone of the practice setting and counters anxiety that can arise in response to stressful situations. It engenders in nurses an attitude of composed self-confidence and alertness to the ever-changing needs of patients and practice situations.
Intellectual engagement	Nurses' ability to conceptualise, think creatively and critically, and theorise about nursing practice using nursing and other related knowledge and to do this in relation to knowledge of the social, political and economic context of their practice. Because the life of the mind is linked partly to the creative influence of an infinite transcendent reality, it includes using contemplation and empathy as well as natural reason, logical analysis and scientific research to guide, implement and evaluate nursing practice and health care.
Nurses' care for selves and one another	Nurses' attentiveness to their own health and the health of one another. This is essential to supporting and augmenting their therapeutic capacity. It includes them nourishing their inward lives through the creative use of their minds and spending at least a short time each day in inner reflection, contemplation, meditation or prayer. It also includes them nourishing their outward lives in relation to aspects such as nutrition, rest, relaxation and exercise, enjoyment of social activities and having a sense of humour.
A safe and restorative physical environment	The result of actions nurses take to protect patients from physical harm and promote healing. It is meticulously clean and orderly, free from potentially harmful physical factors, as quiet as possible, and maximises the effects of naturally occurring healing elements such as light, fresh air and colour. Although contemporary nurses mainly delegate to appropriate assistants activities that ensure cleanliness, safety and order, they remain responsible to ensure that these activities are carried out to the highest possible standard.

Table 3 Practice competence and excellence concept and its eight dimensions

Practice competence and excellence	The eight dimensions of this concept encompass what is often viewed as clinical care and the nursing process. Its attitudes and actions are carried out at least with competence and always with the intent of developing excellence.
Great tenderness in all things	An attitude of sensitivity, loving kindness, compassion, gentleness and patience in attending to all experiences and needs of patients. It is linked to awareness of an infinite transcendent reality and mediated through the therapeutic milieu dimensions of caritas and contagious calmness. It is proposed to infuse all nurses' clinical attitudes and actions with the healing love of an infinite transcendent reality.
'Perfect' skill in fostering safety and comfort	Nurses' meticulous attention to detail in all aspects of patient care, ranging from the most elementary personal care to the most complex clinical interactions and techniques. It also includes precision in intellectual skills, such as theorising about processes of care, clinical decision-making and nursing diagnostic accuracy. The quotation marks around 'perfect' emphasise that although faultless detail can be essential, for example, in medication administration, perfection is also an ideal to be worked towards.
Watching and assessment	A composite of nurses' constant visual and perceptive attentiveness to patients and alertness to their bio-physical and psycho-spiritual condition and needs in order to be aware as immediately as possible of any changes in their conditions or levels of responsiveness to medical treatments, collaborative problems and nursing interventions. It provides the foundation for clinical reasoning and decision-making.
Clinical reasoning and decision-making	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.
Patient engagement in self-care	Patients' participation in decision-making about their nursing needs and care, as this is desired and possible on their part. It includes nurses' encouragement, education and on-going support so that patients may achieve independence or relative independence in caring for themselves.
Nursing diagnoses, outcomes and interventions	The widely recognised international, standardised languages of nursing diagnoses, nursing outcomes and nursing interventions selected in collaboration with patients. Nursing diagnoses are the specific clinical judgements nurses make about actual and potential patient responses to health problems and/or medical diagnoses that are within the scope of nursing. These are linked to desired nursing-related patient outcomes. Nursing interventions are implemented to achieve the outcomes and the entire process is continuously evaluated.
Patient family, friends, community supportive participation in care	The encouragement and support nurses' provide for patients' family members, friends and community services to participate in patients' care, according to patients' wishes and as this is possible and appropriate.
Health education	Providing patients, as well as supportive persons, with the knowledge they need to maximise patients' care and engagement in on-going healthy growth and development. This may be formal or informal, specific or general and includes attention to patients' broad knowledge of health and needs specific to particular vulnerabilities, illnesses or injuries.

Conclusion

Careful Nursing is fittingly developed as a philosophy and professional practice model rather than as a conceptual model developed according to theoretically predetermined criteria. The philosophy is important because it brings to the fore a nursing-sensitive understanding of the nature of the person and the innate dignity and worth of all persons. Although the model concepts and dimensions will be mostly familiar to nurses, it groups and emphasises them in particular ways. It balances the healing influence of attentive tenderness in nurse–patient relationships and the nursing milieu with knowledgeable nursing judgement and precision in clinical skills. Its history and emphasis on professional authority reminds nurses of their legacy as prime providers of healthcare for vulnerable and underserved populations

and as a transforming influence in the provision of hospital services.

Because the philosophy and model present enduring and widely recognised values, attitudes and actions distinctively inherent in skilled nursing practice, it is likely to be found relevant by practicing nurses. Its implementation could help to minimise incompetent and insensitive practice as well as sustain already exemplary practice. The message of Careful Nursing to contemporary nurses is that 'brilliant prestige in nursing' is theirs for the taking. But, at the same time, it is for nurses in practice to judge whether Careful Nursing matches their professional identity, their cultural DNA.

Careful Nursing is a philosophy and professional practice model that can contribute to closing the relevance gap between nursing practice and nursing science. It proposes a

Table 4 Management of practice and influence in health systems concept and its three dimensions

Management or practice and influence in health systems	The initiative nurses take in planning and managing patient care in health systems through support of nursing practice and through particular types of relationships with other healthcare personnel.
Support of nursing practice	Nurses' engagement in supporting and augmenting implementation of the therapeutic milieu and practice competence and excellence concepts at all organisational levels, and including their own professional development related to these concepts.
Trustworthy collaboration	Nurses' relationships with other health professionals and healthcare administrators wherein they often take the initiative in addressing patient needs and problems. They are respected and depended on to respond to needs with perceptiveness, prudent judgement and fortitude. Problems are addressed with patience, respectfulness and an eye to the enhancement of human relations. Questioning of situations or methods is done with 'exquisite tact' and always with determination to act in patients' best interest.
Participative–authoritative management	Nurses' relationships with nursing or care assistants and other assistive healthcare personnel wherein assistants work according to the directions of professional nurses who have authoritative responsibility for assistants' care of patients. Nurses participate with assistants to some extent in order to model how to carry out tasks with skill and attitudes which reflect caritas, contagious calmness and great tenderness in all things.

Table 5 Professional authority concept and its two dimensions

Professional authority	Encompasses the power, relative autonomy, intellectual and political influence as well as the respect that professional nurses are accorded within healthcare systems and society at-large because they provide their distinctive service very well. This recognition helps nurses to grow in professional self-confidence and visibility and, in turn, enhances further their development of professional knowledge and skill.
Professional self-confidence	Nurses' strong, yet gracious and unassuming, sense of professional affirmation that arises from providing a skilled and valuable public service. It is reinforced by their deep commitment to their professional values and skills and conviction that there is very little in the domain of nursing service that they cannot accomplish.
Professional visibility	Recognition of the nursing profession at all levels of society for its distinct and effective contribution to healing and health. In contemporary society it includes nurses' willingness to contribute to the professional literature and lay press and engage in media and other public debates on health issues.

view of the domain and nature of nursing responsibility, its concepts can be developed and relationships amongst them examined and theories developed. But, only if Careful Nursing becomes a 'must have' model for professional practice and increases public satisfaction with nursing practice, would its full development, both philosophically and theoretically, become worthwhile.

Relevance to clinical practice

The Careful Nursing philosophy and professional practice model provides a structure, processes and values for nursing practice, supports nurses' control over their practice and can be used in all types of practice areas and settings. It is consistent with the principles of nursing shared governance (Dunbar *et al.* 2007) and could strengthen the implementation of shared governance, especially through the dimension of trustworthy collaboration. Nurses report that implementation of the practice competence and excellence dimensions enables them to re-establish and document clearly their discipline-specific responsibilities for patient care in multi-

disciplinary contexts and that this, in turn, strengthens their professional self-confidence (Murphy 2011). The use of nursing standardised languages can dramatically change nurses from an almost exclusive focus on medical diagnoses and procedures to a focus that gives prominence to their professional nursing responsibilities (Jones *et al.* 2010, Murphy 2010). Such experiences support nurses in the important process of establishing more clearly their professional practice boundaries in multidisciplinary healthcare settings (McNamara *et al.* 2011).

The relationship between the Careful Nursing concepts of the therapeutic milieu and practice competence and excellence balances two long-standing themes in nursing practice; 'tenderness and technique' (Meyer 1960, p. 1); that is, between the personal disposition of nurses and their knowledge and technical skill. Further, in contemporary healthcare settings, increasingly dominated by critically important but often alienating machines and cost-cutting measures that can be dehumanising, Careful Nursing provides an essential corrective by supporting nurses' enduring role in fostering and modelling respect for the innate dignity and worth of all

persons. It calls nurses' attention to what this role means for them in terms of their care for themselves and one another as professional nurses as well as for how they engage in relationships with patients.

Careful Nursing offers a perspective on the much-discussed nature of the spiritual in nursing practice. It does not guide nurses to focus on spiritual assessments, diagnoses and interventions, although these could emerge naturally in practice. Rather, through the dimensions of caritas, contagious calmness and great tenderness in all things, it proposes that the spiritual aspect of human life permeates nurse–patient relationships and is at the heart of how nurses practice. This perspective is consistent with the view that nurses can provide spiritual care by being aware of their own spiritual nature and that of their patients (Ellis & Narayanasamy 2009) and with research indicating that spiritual care occurs naturally in attentive nurse–patient relationships (Carr 2008). Whilst the model presupposes the existence of an infinite transcendent reality, it also allows for the fact that nurses' personal understanding of the spiritual ranges along a psycho-spiritual continuum, which can extend from a humanist or atheistic understanding where the spiritual is understood as purely psychological (Costello 2009), to a deeply religious understanding where an infinite transcendent reality is profoundly acknowledged.

Hospital nursing departments in the US (Weldon 2009, Clayton 2010, Ellerbe 2011) and Ireland (McMullin *et al.* 2009) are finding the philosophical assumptions and model concepts relevant to practice. They are also being used to inspire a particular nursing practice model in a large healthcare system (Goedken 2011). The idea of creating a therapeutic milieu for patients is attractive because of its potential for counteracting stress and promoting safety. Contagious calmness is invariably the most popular dimen-

sion of the therapeutic milieu because nurses find that just remembering the idea helps them to feel and act calmly. The effectiveness of contagious calmness in managing stressful acute care settings, originally described by Proudfoot (1983), has been more recently confirmed by Borgatti (2003). Nurses' care for themselves and one another has been identified as an important prerequisite in implementing Careful Nursing (Goedken & Rocklage 2010). Together with caritas and contagious calmness, it can strengthen nurses' ability to recognise their own innate dignity and worth and enhance their disposition to look upon themselves and one another with compassion and kindness. This could help to counter the international problem of bullying amongst nurses (Johnson 2009). Cleary *et al.* (2010) also emphasise the importance of 'cultivating an environment in which nurses treat each other with dignity and respect' (p. 335).

Finally, the potential of Careful Nursing for nurse-led transformation of healthcare settings depends on nurses taking the initiative to engage all healthcare personnel in understanding its philosophy and concepts. Nurses' trustworthy collaboration with other professionals and participative–authoritative relationships with healthcare assistants and supportive personnel can enhance the work satisfaction of all and contribute further to patients' overall satisfaction with the care they receive.

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Conflict of interest

No conflict of interest is declared by the author.

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