elements are essential for your body and mind to work better and safer for the duration of your shift.

Try to incorporate some of these steps to prevent fatigue. I hope you will use you vacation days to recharge, decompress, re-focus and re-energize your body and mind. Take care of yourself.

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CAREFUL NURSING PROFESSIONAL PRACTICE MODEL THEME FOR JULY/AUGUST 2015 ISSUE – SAFE AND RESTORATIVE PHYSICAL ENVIRONMENT

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 SAFE and RESTORATIVE PHYSICAL ENVIRONMENT, which is one of the six dimensions of the therapeutic milieu concept. Meehan (2012) explains this theme of the newsletter as, "The results 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 maximizes the effects of naturally occurring healing elements such as light, fresh air and colour" (p. 2910).

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 and assessment
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

CHECK IT OUT

There is now a website with great information about Careful Nursing **www.carefulnursing.ie**

CAREFUL NURSING PHILOSOPHY AND PROFESSIONAL PRACTICE MODEL©:

CREATING A THERAPEUTIC MILIEU: A SAFE AND RESTORATIVE PHYSICAL ENVIRONMENT

Probably one of the earliest objective concerns of nurses, especially in hospitals, was the creation of a safe and restorative physical environment for vulnerable, sick or injured people. The principle elements of this concern were bought to our attention by Florence Nightingale in her landmark book, *Notes on Nursing* (1860/1969), in which she addressed nurses' responsibility for establishing and maintaining cleanliness, ventilation, fresh air, good light, minimal noise, well-ordered furniture, lack of clutter, and adequate personal space. She also noted the soothing effect a patient can experience from being able to look at a beautiful object, a particular color, or the natural world.

But we also know that nurses' concerns about patients' physical environment pre-date Nightingale. For example, from 1815-1819 John Cheyne (of Cheyne-Stokes breathing fame), was the attending physician at the Hardwick Fever Hospital in Dublin, Ireland, one of city's House of Industry (Workhouse) hospitals. He had the highest praise for the lay nurses employed there who, he found, allowed nothing to escape their observation. In collaboration, they drew up and he published nursing practice guidelines, in an article about fevers (Cheyne, 1817). While these focused in detail on essential physical care of patients, they also emphasized that nurses have primary responsibility for patients' safety, the cleanliness, ventilation and order of patients' surroundings, and the orderly conduct of visitors to the hospital.

Biley and Freshwater (1998) observe that many hospitals of earlier times were situated and designed to promote convalescence; a return to health; but that this aim has been replaced by promotion of instrumental and functional efficiency. Schweitzer *et al.*, (2004) also note that the healing and restorative effects of a patients' physical environment have been known for many centuries. They propose that with the rise of science, development of complex medical/surgical diagnostic techniques and treatments, and great emphasis on efficiency and cost-effectiveness, modern hospitals have become noisy and cluttered with little attention given to the healing potential of patients' physical surroundings, or to the potentially harmful effects of some physical surroundings.

These circumstances point to the great importance of the creation of a safe and restorative physical environment as part of the Careful Nursing therapeutic milieu dimension. In this issue of *Careful Nursing News (CNN)*, we will consider what this means for patients, ourselves, and our practice.

Careful Nursing definition

Taken the historical background of nurses' role in establishing and maintaining a safe and restorative physical environment for persons who are sick, injured or vulnerable, it is not surprising that this concept emerged from the historical data from which Careful Nursing was developed. It defined itself as "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 maximizes the effects of naturally

occurring healing elements such as light, fresh air and color" (Meehan, 2012, p. 2910). The data also indicated that although nurses may delegate to assistants activities that ensure cleanliness, safety and order, they remain responsible to ensure that these activities are carried out to the highest possible standard.

This concept fell naturally into the therapeutic milieu dimension of the practice model. It is easily recognized by contemporary nurses as an important nursing concept, based on their experience in practice and the many references to its importance and maintenance in the nursing literature.

A safe and restorative physical environment obviously concerns the bio-physical reality and outward life of a person, what is predominantly thought of as a person's environment. But, in Careful Nursing the environment, with its physical undertone, is differentiated within the therapeutic milieu. The therapeutic milieu encompasses the whole of persons and their unitary experience of their physical surroundings. The physical environment is a distinguishable physical reality within this milieu.

A safe and restorative physical environment is beneficial for us as well as patients. Well- designed space can make our care of patients easier to manage. Particular colors and wavelengths of lighting can have a healing influence on patients and ourselves. It is also important that we protect ourselves from physical injuries such as a fall due to wet floors or infection due to needle-stick injuries.

Further, although a safe and restorative physical healthcare environment concerns everyone who enters it, it is our professional responsibility to take the lead in creating and maintaining it. Historically, this has been a nursing responsibility. Also, because we are continually present in the environment we are best placed to take the lead in this area. When we delegate activities that maintain this environment to care assistants or contract it to companies, for example cleaning, it is still our responsibility to ensure that the activities are carried out effectively.

How we know about our physical environment

While there are a range of theoretical views on how we know about objects in our physical environment and how they influence us, we will draw again on our philosopher Thomas Aquinas and his theory of how we come to know about ourselves and the world in which we live. As we discussed previously in relation to the concept of intellectual engagement (*CNN*, 2015, 7(2), p.11), Aquinas places great emphasis on the physical body, our bio-physical reality and its five outer senses; sight, hearing, smell, taste, and touch; because they put us in direct contact with the external, physical world in which we are embedded. It is through these bodily senses that we sense the concrete qualities of our physical surroundings. Our five outer senses also allow us to take the first step in the process of acquiring all knowledge (Aquinas, 1265-1274/1948, Pt. I, Q.78, Art. 3-4).

As we also discussed in relation to intellectual engagement, our five outer senses are in continuous simultaneous interaction with our four inner senses through which we perceive and understand the messages from our outer senses and everything related to them. Our outer senses may send messages to our inner senses together or alone. For example, smell and sight may send messages about the nature of a puddle of fluid on a floor; or smell, touch and sight may send messages about the state of a surgical wound we are assessing. Sight is our only sense that sends messages alone; messages relating to color and sometimes beauty. Our sense of sight is also said to have a direct link to spiritual experience.

Because we are unitary human persons (see *CNN*, 2013, 4 (4) pp. 2-7), coming to know physical objects is a unitary process, much too complex for us to consider here. But the point here is that for Aquinas the body and senses are an exceedingly important distinguishable bio-physical reality. Likewise, the body and senses are an exceedingly important distinguishable bio-physical reality in our nursing practice, here particularly in relation to the physical environment.

A safe physical environment

Protection of patients, ourselves and others from harm caused by physical objects, especially in busy and sometimes over-crowded hospital environments, is of the highest priority. From experience in practice we can categorize physical objects into macroscopic, such as furniture, equipment, or electric leads trailing across a floor, and microscopic, such as bacteria. Protection from macroscopic objects most often concerns removal of clutter from hallways and patient rooms, particularly equipment that is waiting to be cleaned or charged. Protection from microscopic objects invariably means meticulous, on-going cleaning, and when necessary wearing protective equipment and garments. Protection from infection is one of the greatest safety concerns in healthcare.

The design of a hospital or healthcare building itself may contribute to or detract from the safety of its physical environment. For example, its floors may provide for more secure or less secure walking stability. The width and position of its doors may influence their safe use. The size and shape of its rooms may be more or less likely to facilitate care of patients as well as cleaning and elimination of bacteria. As nurses, we are in a perfect position to serve as consultants to architects in relation to the design of safe healthcare buildings.

A restorative physical environment

A safe physical environment is a necessary foundation for a restorative physical environment. A restorative environment is a source of sense messages that facilitate relaxation, calmness, and healing. Schweitzer et al., (2004) review in detail research-based healing effects of certain environmental colors and aromas, fresh air and good ventilation, ambient temperature, calming sound, full-spectrum lighting, artwork, certain types of music, and a view of the natural world. While these restorative influences may not be possible in all hospitals, they can be in many and can be adapted for different settings. Some of these influences may cost more, but whether cost-containment should always come before healing influence is worth considering. For example, full-spectrum lighting, which is similar to natural sunlight, costs more than fluorescent lighting. However, research findings demonstrate its significant healing effects in many types of healthcare settings (Schweitzer *et al.*, 2004). Further, research has shown that full spectrum lighting can be effective in reducing infection (Wiltshire *et al.*, 2015). Full-spectrum lighting could be more cost effective in the long run. Some physical environmental influences may be easier to establish in some types of settings. For example, many can be successfully implemented in long-term care facilities (Komarek, 2004). But some can also be implemented in hospital intensive care units (Bazuin & Cardon, 2011).

Relationship to other therapeutic milieu concepts

Although in Careful Nursing terms this concept mainly concerns the outward life of patients and ourselves, it is closely interrelated with the other therapeutic milieu concepts which are more concerned with the inward life. A restorative healing environment supports our practice of caritas, contagious calmness, and our care of ourselves and one another. Intellectual engagement is important in thinking creatively about ways to enhance physical safety and physical elements of a restorative environment. Very importantly, a safe and restorative healing environment respects the inherent dignity of every person. All the concepts are linked together and permeated by the Careful Nursing philosophical principles.

Suggestions for practice

Our creation and maintenance of a safe and restorative physical environment depends on our being ever watchful and not taking our familiar physical surroundings for granted. Weiss-Krupa *et al.* (2011) make the point that "the smallest missed detail can have the biggest impact" on safety (p. e55). As critical care

nurses they were aware of the always-possible need to move patients quickly from critical care units during an emergency. But they realized that the usually cluttered units and surrounding hallways, sometimes crowded with equipment and transfer beds, would make this very difficult.

They adapted a system from the Navy called "Walk the Deck." This involved developing a comprehensive check list of all physical threats to safety in and around their units. Then, twice a day a senior nurse's aide would "walk the units" (p e55) doing a thorough inspection according to the checklist and then meet with the charge nurse to resolve any safety threats. Over three months, compliance with safety standards increased from 5-10% and units and hallways were consistently clearer. This is an innovative approach which could be adapted to many settings.

Another innovative research approach to improving safety, this time in a hospital outpatient hemodialysis unit, is reported by Marck *et al.* (2014). Using nurses' focus group stories about the physical safety and quality of the unit and photos taken on a nurse-led photo walk-around of the unit, they identified several common threats to unit safety including clutter, poor air quality, sources of infection, and tripping hazards from hoses. Conducting the study deepened their awareness of the complexity of maintaining a safe environment. It also stimulated a rich dialogue among nurses about identifying safety threats and enhancing safety. This approach could also be followed or adapted for use in many settings.

Words of caution

Many of us will have had the experience of caring for older persons who find themselves unexpectedly admitted to a hospital. They are sometimes deeply shocked by the sudden change from their home environment and to that of a hospital and can easily sink into a state of disorientation. Experience suggests we can help them avoid this state by encouraging them to keep small meaningful personal objects close to them. These may include a pillow, a blanket, a piece of clothing, photos or other small objects. Surely, it would be unwise to mistake such personally grounding objects for bedside clutter.

Also, consider the story of a community health nurse who once a week visited an elderly gentleman in his tiny, council-owned flat. He had friends but no living family members. He was well-oriented to present time and very quick and witty in conversation. But, like himself, everything in his comforting little home was very old and not as clean as we might think necessary. Due to a decline in his health, he was admitted briefly to a community hospital for assessment. While he was there, well-meaning persons took the opportunity to spring clean his little place. Everything was washed, walls were painted, and curtains, some furniture and kitchen items were replaced. When the nurse next visited him she found him sitting at a new table on a new chair trying to come to terms with his new relentlessly clean and ordered physical environment. With soft, sad eyes he met her gaze despondently and said "I feel like I'm in a sepulcher" (a stone tomb in which a body is buried). He got along alright for a while but never really recovered.

Summary

As professional nurses, our responsibility and leadership in relation to the creation and maintenance of a safe and restorative physical environment for persons who are sick, injured or vulnerable is long-standing. Threats to patients' safety and the restorative quality of their environment change over time in response to advances in science and healthcare, and to changes in economic conditions. Currently, threats to creation of a restorative environment may be overlooked in the interests of technical needs and functional efficiency. Judgements about threats to patient safety are always to

be considered humanely in relation to patients' personal needs.

With this sixth concept of the therapeutic milieu dimension of the professional practice model, we complete our consideration of the therapeutic milieu as the distinctive nursing surrounding and atmosphere that we are responsible to create for recipients of our care and for ourselves. In the next issue of *Careful Nursing News*, we will move on to examining the practice competence and excellence dimension of the model.

In the meantime, do take some time to reflect on all six concepts of the therapeutic milieu, how they are interrelated, and the nature of the dimension as a whole. Reflect also on how the philosophical principles permeate this dimension of our practice. I hope you will send your thoughts about the therapeutic milieu and its concepts to Sue Weaver, the editor of *Careful Nursing News*, or to the Careful Nursing webpage (**http://www.carefulnursing.ie/go/about/contact_us)**. For example, how do you find thinking about the therapeutic milieu and its concepts as a practical guide to your practice? Are there aspects of it that you think are particularly useful? Are their aspects of it that you think need to be clarified or modified? We are looking forward to hearing from you.

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