

CAREFUL NURSING NEWS

CAREFUL NURSING PROFESSIONAL PRACTICE MODEL THEME FOR SEPTEMBER/OCTOBER 2015 ISSUE — GREAT TENDERNESS IN ALL THINGS

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 GREAT TENDERNESS IN ALL THINGS which is one of the eight dimensions of the Practice Competence and Excellence Concept. Meehan (2012) explains this theme of the newsletter as, "An attitude of sensitivity, loving kindness, compassion, gentleness and patience in attending to all experiences and needs of patients." (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 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

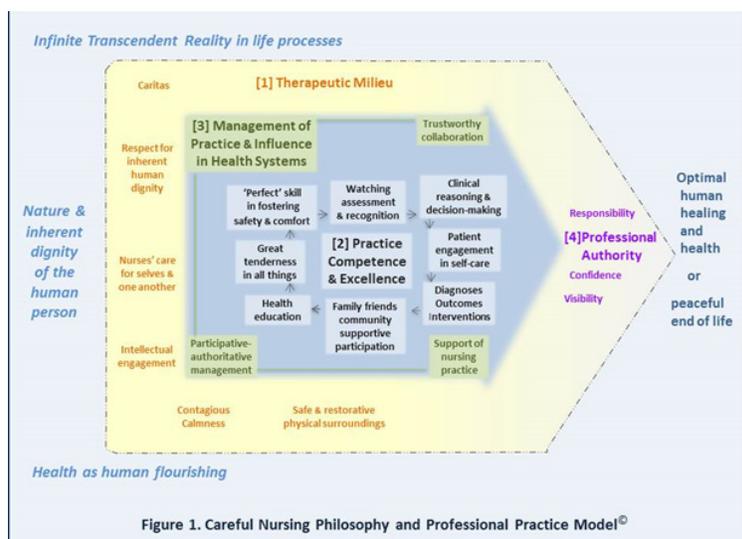
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CAREFUL NURSING PHILOSOPHY AND PROFESSIONAL PRACTICE MODEL®: PRACTICE COMPETENCE AND EXCELLENCE: GREAT TENDERNESS IN ALL THINGS

With this fall issue of *Careful Nursing News* we are moving from the therapeutic milieu dimension to the practice competence and excellence dimension of the Careful Nursing professional practice model. We will begin by reviewing practice competence and excellence and then will consider its concept of great tenderness in all things.

Practice competence and excellence

Let us take a few moments to look again at the illustration of the Careful Nursing in Figure 1. Recall that practice competence and excellence with its eight concepts is the blue section in the middle. It is surrounded and supported by the therapeutic milieu dimension with its six concepts, shown in the cream section, and both are infused by the three philosophical principles to their left, top and bottom. It is important to keep in mind that although the principles, dimensions and concepts are distinguishable, they exist in an ever-moving unity, a sort of **symphony of nursing practice**.



Recall also that our philosophy tells us that as human persons, we and our patients are unitary beings with two distinguishable realities, an outward bio-physical reality of body and senses and an inward psycho-spiritual reality of mind, spirit and communion with Infinite Transcendent Reality. As unitary beings these realities are always present to us, albeit at different levels of awareness. We experience them simultaneously although we tend to think of them separately.

As we considered the therapeutic milieu dimension concepts over the past several months, we were aware that they are mainly concerned with the inward, psycho-spiritual reality of our life and the life of patients.

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Very importantly, these concepts concerned the inner essence of our relationships with patients.

In turning to the practice competence and excellence dimension concepts, we will see that they are mainly focused on the outward life of body and senses, the bio-physical reality of our life and the life of patients. They are often viewed as what we do as nurses. This is understandable because the outward life is mainly objective, observable, and most of its characteristics can be measured.

Most of the practice competence and excellence concepts are vital to protecting patients from harm and in acute care settings some are frequently critical to patient survival. In this sense this dimension is the most important in Careful Nursing. If we do not practice the therapeutic milieu concepts very well vulnerable patients can feel lonely, disrespected and deeply hurt. If we do not practice most of the practice competence and excellence concepts very well, the very life of patients can be at serious risk.

Most practice competence and excellence concepts are immediately recognizable as steps of the nursing process. In Careful Nursing they are specified and emphasized in particular ways. We implement them at least with competence and always with an eye to achieving excellence.

Why the term practice competence and excellence was chosen

Analysis of the historical documents from which Careful Nursing was constructed revealed that most content described the nurses' direct care of sick and vulnerable people in hospitals and communities. The data strongly suggested competence as the best descriptor of their clinical practice because they assessed patients' needs and their personal, social and economic situations comprehensively; were organized, innovative, clear and confident about the care to be provided; were invariably calm, kind and patient in manner; were adroit at managing the community and organizational circumstances in which they were practicing; and were able to adjust quickly and appropriately to sudden changes and emergency situations. They were widely respected for their nursing practice ability, even by people who were very opposed to their cultural background and spiritual beliefs.

The data also suggested that the nurses' ultimate practice aspiration was excellence. While they viewed excellence, in part, as using their knowledge and ingenuity to create the very best overall circumstances possible to promote patient safety and healing, ultimately excellence included fostering and recognizing moments of transcendent love, peace and joy that could emerge for patients in the flow of human healing relationships.

A brief review of the literature on competence and excellence will help set these concepts in the contemporary context.

Competence

Although competence has been analyzed extensively in philosophical and professional literature over recent decades and although it appears everywhere in the nursing literature, its meaning remains ambiguous. It continues to lack consistent definition, including among health profes-

sions (Fernandez *et al.*, 2012). Searching for the meaning of competence in nursing has been likened to entering a "bottomless pit" (Watson *et al.*, 2002, p. 428).

Definitions of competence in dictionaries indicate that it signifies being capable of doing what one is expected or licensed to do. For example, our registration as professional nurses attests to our practice competence and signifies to the public that we know what we are doing. At the same time, and less reassuring, being competent can imply being only adequate or passable in meeting performance responsibilities.

Historically, competence was thought of in intellectual terms, for example knowing a body of knowledge well and having the ability to think critically. But this view became almost completely displaced by behaviorist theories of competence concerned with performance of functional skills, often called competencies, and theories of cognitive competence. Such theories, applied particularly to clinical competence, came to be contrasted with intellectual competence and preferred in practice settings.

Behavioral and cognitive competencies are obviously very important, the bedrock of clinical competence in nursing. But sole emphasis on them has been widely criticized because they exclude social and other contextual influences on competence and marginalize the principles and values fundamental to the practice of public service professions (Hyland, 1997). Thus, efforts have been made to broaden the meaning of competence. It is now increasingly being considered a holistic concept, for example, as it is summarized by Le Deist and Winterton (2005) to include the following aspects:

- functional: skills specific to a profession which can be demonstrated
- cognitive: knowledge which includes informal, tacit knowing derived from experience
- personal: characteristics known to be desirable in the practice of a professional group
- ethical: appropriate personal and professional values upon which to make sound judgements in varying practice situations
- meta-competence: being able to cope with uncertainty and engage in learning and reflection

A holistic understanding of competence is evident in most nursing codes of professional practice and scope of practice documents. In fact, nursing's adoption of a holistic definition of competence is in keeping with the word's original Latin meaning: *com*, meaning to come together jointly or simultaneously and *petere* meaning to seek or desire. Competence originally signified bringing different factors or persons together in seeking what was required or desired (Partridge, 1958). Interestingly, through its Latin source competence is closely related to the idea of competition, which implies that it can also suggest striving for excellence.

Excellence

Excellence immediately signifies going beyond competence. In the well-known work of Benner (2000), excellence is being an expert practitioner.

For Benner, what is necessary for excellence is the ability to build on

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theoretical knowledge by moving beyond it to understand and act on its meaning in different relational and contextual situations, always with attentiveness, kindness and compassion.

In reaching toward excellence we can take some cues from our philosophers, Aquinas and Aristotle. In previous articles on health as human flourishing (*CNN* 5(2), 2014, pp. 6-8) and (*CNN* 5(3), 2014, pp.5-9) we discussed the virtue theories of Aquinas and Aristotle. Both philosophers define virtues as habits of thinking and acting in excellent ways that help us to live a flourishing life. They can help us flourish in our professional life; to practice with excellence.

Recall that Aquinas's and Aristotle's ideas about virtues relate to two central aspects of our practice, thinking (intelligence and insight, scientific knowledge, prudence, and wisdom, etc.) and doing (courage, generosity, good temper, truthfulness, and justice, etc.). A third aspect of our practice, the spiritual in nursing, is addressed by Aquinas in his three additional virtues of faith, hope and love. Earlier this year (*CNN* 6 (1), 2015, pp. 9-15), we considered how the virtues of friendliness, courage, gentleness and wittiness can foster care for ourselves and one another, which we can think of as excellence in professional relationships.

In reaching for excellence we can also draw on the values evident in our professional codes. Values are similar to virtues in some ways and can be thought of as virtues. For example, we can think of respect and personal integrity as habits of thinking and acting that help us attain excellence. Overall, we might particularly keep in mind the virtue of prudence or practical wisdom, which enables us to act according to Aristotle's right rule. That is, to choose to act at the right time, with the right motive, with the right people, in the right way.

A competence-excellence continuum

Overall, the literature suggests that competence and excellence form a kaleidoscopic continuum intended to move from competence as satisfactory performance of functional skills, to expanded views of competence, to competence as a holistic concept, to reaching for excellence, to attaining excellence. While it is a developmental continuum, it is also ever-changing and its movement can go either way. Many personal and situational factors influence how well we are able to practice at any given time. We know from experience that we have times when we are close to or attain excellence and times when we are closer to different levels of competence. While we are required to be competent, our intention is always to aim for excellence.

Great tenderness in all things

The concept of tenderness in nursing probably dates back to the first century when early Christian nurses such as Phoebe and Fabiola would have drawn on the idea of expressing the tenderness of God's love in their nursing care. It is likely that this understanding of tenderness was central in nursing practice in the Western world for many centuries. Nightingale refers to the tenderness of God in her spiritual journey (McDonald, 2001), although she appears not to have written about tenderness in nursing practice.

But for the early to mid-19th century Irish nurses, the forerunners of *Careful Nursing*, the expression of tenderness was central to their practice. Catherine McAuley in particular emphasized in her guidelines for the care of the sick the importance of "great tenderness in all things" (Sullivan, 2012, p. 169).

Definition

In *Careful Nursing* great tenderness in all things is define as:

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 (Meehan, 2012, p. 2911).

In dictionaries, tenderness refers to the state or quality of being tender. Its Latin root, *tendere*, means to stretch towards (Partridge, 1958). Various associations with its Latin root suggest that it is associated with a quality of being exquisite, that is, of including great sensitivity, delicate beauty and intense feeling. Thus, human tenderness has the meaning of reaching towards another person showing love and concern for their welfare by being infinitely considerate, gentle, caring, and compassionate. The general use of tenderness in this meaning was relatively common in 1800, and in the 1820s of Catherine McAuley's work in nursing, but it is much less commonly used today (Tenderness, 2015).

The probability that tenderness entered nursing through its association with Christianity indicates that it is a spiritual concept. Its association with love, as *caritas*, and compassion supports this view. The *Careful Nursing* historical data suggested that although it was related to the therapeutic milieu dimensions of calmness and *caritas*, it included a different quality. This quality seemed to be a physical, clinical action quality which had a subtly gentle but enduring powerfulness. Hence its location in the practice competence and excellence dimension where it seems to act a mirror image of its related therapeutic milieu concepts. Its clinical action quality is supported by one of the few articles about tenderness that come up in a search of nursing literature, "A little tenderness goes a long way" (Galland, 2008) which we discussed in *CNN* 7(2), 2015, pp.10-19.

Literature on tenderness

No studies exploring tenderness appear in the nursing literature. In the psychology literature tenderness is viewed as an emotional component of empathy, understood as concern for the welfare of someone in need. Kalwski (2010) proposes that tenderness is experienced as an emotional surge that corresponds to the love of care-giving. His research indicated that it is a basic emotion in the same way that fear and joy are basic emotions. Luscher *et al.*, (2011) propose that tenderness arises from a parental or parent-like concern to nurture and protect another from harm. Along with Niezink *et al.*, (2012), they found that tenderness is distinct from sympathy and is elicited by perceiving in another, long term vulnerability and need for protection.

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The absence of research on tenderness in nursing suggests that it is not recognized or valued by contemporary nurses as a nursing concept. Surely its history in nursing suggests that it warrants at least a concept analysis. The psychology studies were all conducted in laboratory settings and would serve as a basis for exploring tenderness in nursing practice settings.

Tenderness as a nursing value

In the 1960s tenderness was proposed as an important nursing value. In *Tenderness and Technique: Nursing Values in Transition*, Meyer (1960) uses the term tenderness to represent personal attentiveness and tender loving care in nurse-patient relationships. She contrasts it with technique, represented by knowledge and technical skill. She presents these as two important aspects of nursing which must be kept in balance, for example, she remarks that “technical competence necessarily involves tenderness” (p.7).

Meyer’s (1960) research suggested that as nurses become concerned with professionalism, they turn to technique, advanced knowledge and skills, at the expense of a concern for tenderness. She argues that tenderness must be reintegrated into nursing so that nurses practice with a synthesis of knowledge and feeling. She believes this will happen because “nursing the whole patient has given new dignity and meaning to the concept of tenderness” (p.11). Generally, this has happened, but it seems that we just do not call it tenderness any more.

Should tenderness be retained as a Careful Nursing concept?

The concept of tenderness has a long history of being embedded in nursing practice. Emphasis on it permeates the 19th-century Irish nurses’ work. As recently as 1960 the word tenderness was chosen to represent the healing, loving aspect of nursing practice. In 2008 Galland chose tenderness as the name of her profoundly healing encounter with a dying patient.

But for the most part tenderness has been lost from the mind of the nursing profession and words such as caring and empathy seem to have taken its place. Do we need tenderness anymore? In as much as the language of Careful Nursing must be relevant to the language 21st century nurses, do we need tenderness in Careful Nursing? My answer is yes, definitely, at least until the concept has been thoroughly examined. On the other hand, the words of some nursing students ring in my ears. Shifting uneasily in their lecture hall seats they say, “that’s over the top, get rid of it”.

So, what do you think at Saint Clare’s Health System? Maybe you would take a poll: yes? or no? Should we keep the concept of tenderness in Careful Nursing? And, Sue Weaver, suweaver@saintclares.org would be very keen to hear any additional thoughts you might have on tenderness as a nursing concept.

Now that the new academic year has started some will soon be looking for a term paper or thesis topic. Is there an intrepid nurse at Saint Clare’s who would be willing to take the plunge and examine the concept of tenderness in nursing?

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