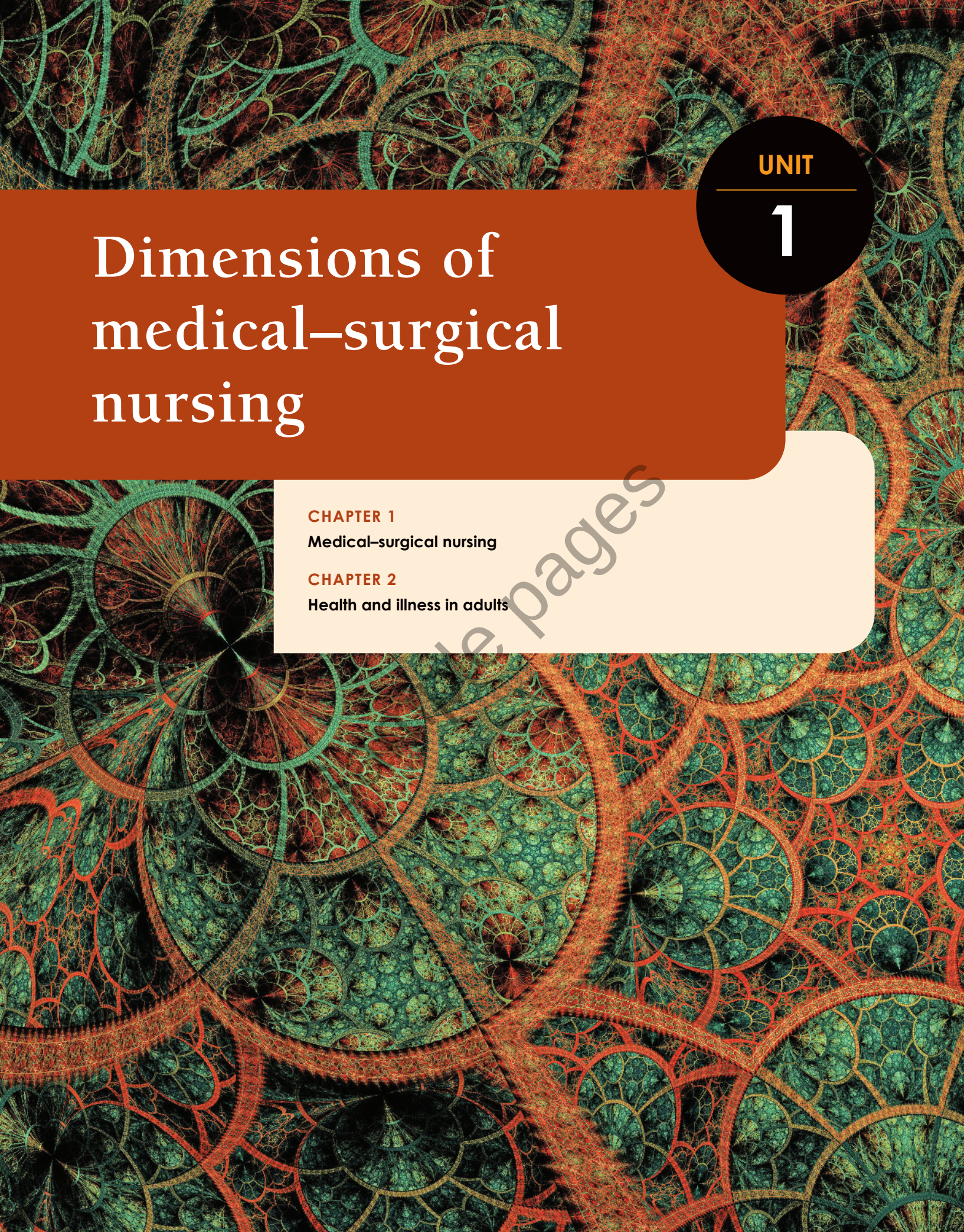

UNIT

1

Dimensions of medical–surgical nursing

CHAPTER 1

Medical–surgical nursing

Tracy Levett-Jones, Aimee Lamb

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Learning outcomes

- Define and discuss the importance of person-centred care.
- Describe the attitudes, attributes and skills necessary for critical thinking when providing nursing care.
- Outline the stages of the nursing process.
- Outline the stages of the Clinical Reasoning Cycle and how it was designed to positively impact on patient safety.
- Describe the importance of standards for practice, codes of ethics and codes of professional conduct as guidelines for accountable and professional nursing practice.
- Outline the concept of cultural competence as an integral component of nursing care.
- Discuss some of the legal and ethical dilemmas evident in medical–surgical nursing.
- Discuss the roles and functions of the nurse as caregiver, educator, advocate, leader/manager and researcher.

Clinical competencies

- Demonstrate critical thinking and clinical reasoning when providing evidence-based, professional, safe, person-centred and culturally competent nursing care.
- Provide clinical care within a framework that integrates, as appropriate, the medical–surgical nursing roles of caregiver, educator, advocate, leader/manager and researcher.

Medical–surgical nursing is one type of specialty nursing practice. However, within this area of practice there are also many sub-specialty areas; for example, acute care, day surgery, general practice, community nursing and renal dialysis. Medical–surgical nurses focus on the promotion of health, prevention of illness and the care of ill, disabled and dying people across the lifespan and in diverse practice contexts. Medical–surgical nurses are responsible for the provision of safe, empathic, person-centred, evidence-based care. They communicate and collaborate with patients, families and other healthcare professionals, and their care is informed by professional, ethical and legal frameworks. This chapter provides a broad overview of medical–surgical nursing, including the roles and functions of the medical–surgical nurse.

PERSON-CENTRED CARE

The terms '*person*' and '*patient*' denote the individual who is the recipient of care and are often used interchangeably, depending on the context of care. In this book, we generally use the term 'person' as this aligns with the concept of person-centred care.

Person-centred care means seeing the *person*, not just the patient or their disease process. That is, we speak of a *person* with a disease; for example, 'In bed 4 is Mr Johns who has had an appendectomy' rather than 'the appendectomy in bed 4', or 'Joanne requires assistance with her meals' rather than 'Joanne is a feed'.

Person-centred nurses are empathic, respectful, ethical, open-minded and self-aware. They have a profound sense of personal responsibility for actions (moral agency) and consider the person's needs and wishes as paramount (Australian College of Nursing, 2020). Integral to person-centred care is therapeutic communication and the nurse's commitment to understanding the person's beliefs and values, life history and cultural needs. There is a body of evidence indicating that person-centred care results in improved patient outcomes; for example, decreased mortality, fewer medication errors, decreased infection and readmission rates and improved quality of life for people with dementia (Rossiter, Levett-Jones & Pich, 2020).

PATIENT SAFETY COMPETENCY FRAMEWORK

1 Person-centred care

Person-centred care is central to safe and effective nursing care. The Patient Safety Competency Framework indicates that nursing students must demonstrate person-centred care by providing holistic care that takes into account the person's current situation, previous experiences and life history (Levett-Jones et al., 2017).

CRITICAL THINKING

Critical thinking is a complex collection of cognitive skills and affective habits of the mind and has been described as the process of analysing and assessing thinking with a view to improving it. Critical thinking includes the ability to reflect on and think about one's own thinking; this is called metacognition.

To make sound clinical decisions, nurses require critical-thinking skills built on clinical reasoning (Christianson, 2020). Critical thinking requires practice so that it becomes integral to your clinical decision making. Thinking critically involves more than just cognitive (knowledge) skills. It is strongly influenced by one's attitudes and mental habits. These attitudes and mental habits include the following:

- Being able to think independently so that you make clinical decisions based on sound thinking and judgment. This means, for example, that you are not influenced by negative comments from other healthcare professionals about a person.
- Being willing to listen to and be fair in your evaluation of others' ideas and beliefs. This involves listening carefully to other people's ideas and views and making decisions based on what you have learned instead of how you feel.
- Having empathy and practising in a person-centred way by being able to put yourself in the place of another to better understand that person. For example, if you put yourself in the place of the person with severe pain, you are better able to understand why they are so upset when pain medications are late.
- Being fair minded, just and considerate of all viewpoints before making a decision. This means you consider the viewpoints of others that may be different from your own before reaching a conclusion. You also realise that you are constantly learning from others. You are not afraid to say, 'I don't know the answer to that question, but I will find out and let you know.'
- Being disciplined so that you do not stop at easy answers but continue to consider alternatives.
- Being creative and self-confident. Nurses often need to consider different ways of providing care and constantly look for improved and more cost-effective methods.

The major critical-thinking skills are divergent thinking, reasoning, clarifying and reflection. A description of each follows.

Divergent thinking is having the ability to weigh the importance of information. This means that when you collect data (information/cues) from a person, you can sort out the data that are relevant for the care of that person from the data that are not relevant and then explore alternatives before reaching a conclusion. Abnormal data are usually considered relevant; normal data are helpful but may not change the care you provide.

Reasoning is having the ability to discriminate between facts and guesses. By using known facts, problems are solved and decisions are made in a systematic, logical way. For example, when you take a pulse you must know the parameters

of the normal pulse rate for a person of this age, the types of medications the person is taking that may alter their pulse rate, and the emotional and physical state of the person. Based on these facts, you are able to decide if the pulse rate is normal or abnormal.

Clarifying involves noting similarities and differences and sifting out unnecessary information to help focus on the present situation. For example, when caring for a person with persistent (chronic) pain, you must know the definition of persistent pain and the similarities and differences between acute pain and persistent pain.

Reflection is a crucial professional activity and one that is intrinsic to learning. It is not simply introspection but is a deliberate, orderly and structured intellectual activity. It allows nurses to process their experiences and explore their understanding of what they are doing, why they are doing it and the impact it has on themselves and others. When this skill is developed and enhanced in relation to personal and professional practice, reflection becomes a purposeful activity that leads to improvement in practice and better patient outcomes.

THE NURSING PROCESS

The **nursing process** has been described as a tool that helps nurses to think critically in order to provide a competent level of care (Movlavi & Salehi, 2021). The activities within the nursing process differentiate nursing from other healthcare professions. The nursing process can be used in any healthcare setting and is aimed at promoting wellness, maintaining health, restoring health or facilitating coping with disability or death. The nursing process allows for the inclusion of holistic and person-centred care. The five steps or phases in the nursing process are assessment, diagnosis, planning, implementation and evaluation. These steps are interrelated and interdependent (see Figure 1.1).

This text assumes that students already have a basic understanding of the nursing process and are now ready to expand and apply that knowledge to people with medical–surgical health problems. Table 1.1 articulates the links between the steps of the nursing process and the corresponding critical-thinking applications.

Assessment

Assessment is usually listed as the first step of the nursing process, but it is a critical element in each of the steps. It begins with the person's first encounter with the healthcare system and continues as long as the person requires care. During assessment, data (cues or pieces of information) about the person's health status are collected, validated, organised, clustered into patterns and communicated either verbally or in written form. Assessment serves as the basis for developing an accurate nursing diagnosis, for planning and implementing both initial and ongoing care, and for evaluating the effectiveness of the care provided.

The data that the nurse collects must be holistic; that is, the nurse must carefully consider all dimensions of an individual (physical, mental, social, emotional and spiritual). The data

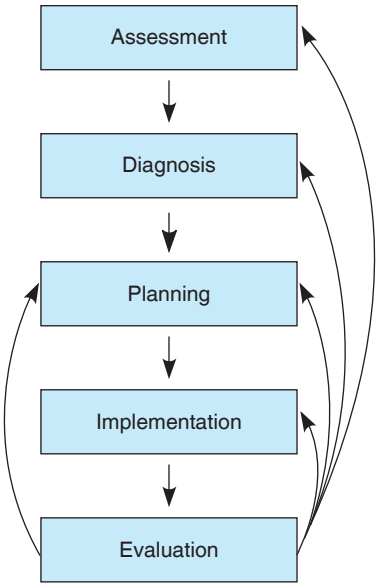

FIGURE 1.1 *The nursing process. Steps of the nursing process. Notice that the steps are interrelated and interdependent. For example, evaluation of the person might reveal the need for further assessment, additional nursing diagnoses and/or a revision of the plan of care*

collected are both objective and subjective. Information that the nurse perceives by the senses is *objective data*; it is seen, heard, touched or smelled, and can be verified by another person (e.g. blood pressure, temperature, pulse or the presence of infected drainage). Information that is perceived only by the person experiencing it (e.g. pain, dizziness or anxiety) is *subjective data*.

Nurses assess people in two ways: through an initial assessment and through focused assessments. The initial assessment of the person, conducted through a nursing history and physical assessment, is necessary to obtain comprehensive base-line data about health responses, to identify specific factors that contribute to these responses and to facilitate mutually established goals and outcomes of care.

Focused assessments (e.g. respiratory assessment) enable the nurse to evaluate nursing actions and make decisions about whether to continue or change interventions. They also provide structure for the documentation of nursing care. In addition, focused assessments enable the nurse to identify responses to a disease process or treatment modality not present during the initial assessment, or to monitor the status of an actual or potential problem previously identified.

To make accurate and holistic assessments, nurses must use a wide range of knowledge and skills. The ability to assess the physical, emotional and mental status of the person is essential, as is the ability to use effective communication techniques.

Nurses must be knowledgeable in pathophysiology and pharmacology, and be able to identify abnormal pathology and diagnostic test data. Finally, nurses must have a solid foundation of nursing knowledge and skills that will enable them to interpret assessment data and to use that interpretation as the basis for individualised care.

TABLE 1.1 Using critical thinking in the nursing process

NURSING PROCESS STEP	CRITICAL-THINKING SKILLS	QUESTIONS TO CHECK YOUR THINKING
Assessment	Selecting the correct assessment instrument Making reliable observations Distinguishing relevant from irrelevant data Distinguishing important from unimportant data Validating data Organising data Categorising data according to a framework Recognising assumptions	What assumptions am I making about the person? Are my data correct and accurate? How reliable are my sources? What data are important? What data are relevant? What biases do I have that might cause me to miss important information? Am I listening carefully to get the person's and family's perspective? Do I have all the facts? What other data might I need?
Diagnosis	Finding patterns and relationships among cues Identifying gaps in the data Making inferences Suspending judgment when lacking data Making interdisciplinary connections Stating the problem Examining assumptions Comparing patterns with norms Identifying factors contributing to the problem	Do I know what is within normal limits for the data? Do I have enough data to make a valid inference? What biases might I have that could affect how I see the person's problems? Do I have enough data to make a nursing diagnosis or should I make a 'possible' diagnosis? What other problems might this data suggest other than the one that seems most obvious to me?
Planning	Forming valid generalisations Transferring knowledge from one situation to another Developing evaluative criteria Hypothesising Making interprofessional connections Prioritising the person's problems Generalising principles from other sciences	Do I need help to plan interventions or am I qualified to do it? Did I remember to give high priority to the problems the person and family identified as important? What are the most important problems we need to address? What interventions worked in similar situations? Is this situation similar enough to merit using them with this person? Are there other plans that might be more agreeable to the person and therefore more likely to work? Why do I expect these interventions to be effective? Based on what knowledge?
Implementation	Applying knowledge to perform interventions Using interventions to test hypotheses	Has the person's condition changed since the plan was made? Have I overlooked any new developments? What is the person's initial response to the intervention? Are there any safety issues I have overlooked?
Evaluation	Deciding whether hypotheses are correct Making criterion-based evaluations	What are the person's responses after the interventions? Have I overlooked anything? Do the data indicate that goals were met? Does the person feel their goals were met? Does the person trust me enough to give honest answers? Am I sure the problem is really resolved? What might we have done that would have been more effective? What nursing care is still needed, if any?

Source: Wilkinson (2011). *Nursing process and critical thinking* (5th ed., pp. 325–327). Electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, NJ.

Diagnosis

The nurse examines each cluster of data (or pattern) derived from the assessment to develop appropriate nursing diagnoses. Nursing diagnoses are clinical judgments about a person's actual or potential health problems. Nursing diagnoses provide the basis for determining nursing interventions to achieve outcomes for which the nurse is accountable. Nurses then develop and implement a plan of care to address health concerns and prevent illness.

Writing a nursing diagnosis

A nursing diagnosis is generally written as a two- or three-part statement. The first part is the issue or problem that has been identified from the examination of the data collected during the patient assessment. The second part is the physical, psychosocial, cultural, spiritual and/or environmental factors (aetiologies) that cause or contribute to the occurrence of the problem. The final part is the cluster of cues (signs and/or symptoms) that provide evidence of the problem.

Examples of nursing diagnoses include:

- *Faecal incontinence* (part 1: problem) related to loss of sphincter control (part 2: cause), manifested by frequent and involuntary passage of stool (part 3: evidence).
- *Acute pain* related to inadequate education about patient-controlled analgesia (PCA) use, manifested by withdrawal, grimacing, restlessness and guarded positioning.
- *Fatigue* related to the side effects of chemotherapy, evidenced by exhaustion when undertaking activities of daily living.

A risk nursing diagnosis is a clinical judgment about a potential problem where the presence of risk factors indicates that a problem may develop unless nurses intervene appropriately.

A risk diagnosis is written in two parts and does not include signs and symptoms.

Examples of risk diagnoses include:

- risk of infection related to skin tear and type 2 diabetes
- risk of falls related to confusion.

Planning

During the planning step, the nurse identifies appropriate evidence-based nursing interventions (actions) and outcomes to improve health and/or to prevent or ameliorate ill health. These outcomes are usually developed collaboratively by the person, nurse and, at times, other healthcare professionals. They identify what the person will be able to do as a result of the care provided. For example, '30 minutes following administration of analgesic medication the person will report a reduction in pain from 8 to 3 on the numeric rating scale'.

Implementation

The implementation step is the action phase of the nursing process during which the nurse carries out planned interventions. Ongoing assessment of the person before, during and after the intervention is an essential component of implementation. Although the plan may be appropriate, many factors can influence how the person responds, making a revision to the plan necessary. For example, the nurse would not be able to encourage fluid intake if the person became nauseous. Additionally, the nurse should be aware of the interrelated nature of nursing interventions. For example, while giving a bed bath the nurse can assess the person's skin condition and at the same time use therapeutic communication to provide comfort.

Documentation is the final component of implementation and is a legal requirement. Many different methods are used to document care, including problem-oriented charting, charting by exception and electronic documentation. Additionally, systems assessments are becoming increasingly common for documentation of progress notes and the development of nursing care plans.

In Australia and internationally, documentation is increasingly being undertaken using **electronic medical records (EMRs)**. EMRs allow patient data to be stored in a structured, online form, supported by real-time active decision support. EMRs are seen as a way to increase efficiency and reduce duplication and healthcare errors (Patterson, Anders & Moffatt-Bruce, 2017).

Evaluation

The evaluation step allows the nurse to determine whether the actions taken were effective and whether to continue, revise or terminate the plan of care. The outcome criteria (goals) that were established during the planning step provide the basis for evaluation. Although evaluation is listed as the last part of the nursing process, it takes place continuously throughout each person's care. To evaluate a plan, the nurse collects data from the person and their clinical records. If the outcomes have not been accomplished, the nurse must modify the nursing diagnoses, outcomes or plan.

The nursing process in clinical practice

Experienced nurses may not consciously stop and consider each step of the nursing process. For example, when caring for a person who is haemorrhaging, the nurse would use all five steps simultaneously to meet critical, life-threatening needs. In contrast, when considering long-term needs for a person with a chronic illness or disability, the nurse undertakes in-depth assessments, mutually determines goals with the person, and provides a documented plan of care that can be developed over time and revised as necessary by all nurses providing care. As a nurse becomes an expert clinician, the nursing process becomes so much a part of their practice that they may not even consciously consider it while providing care.

CLINICAL REASONING

Clinical reasoning is often used interchangeably with the terms 'clinical judgment', 'problem solving', 'decision making' and 'critical thinking'. While in some ways the terms are similar, clinical reasoning is a cyclical process that often leads to a series of linked clinical encounters. **Clinical reasoning** can be defined as 'the process by which nurses (and other clinicians) collect cues, process the information, come to an understanding of a person's problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process' (Levett-Jones, 2023). Clinical reasoning can be influenced by the nurse's assumptions, perspectives, attitudes and preconceptions, and the capacity for self-awareness of one's cognitive biases is essential to patient safety.

Over the past decade, research has identified the need for an explicit and sophisticated model both to explain how expert nurses think and as a foundation for nursing education

Links to National Patient Safety Standards

NSQHS: Communicating for Safety Standard

The use of EMRs to improve the quality of healthcare is recognised by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in the National Safety and Quality Health Service Standards. The Communicating for Safety Standard states that computerised healthcare records should be used across the organisation to enable electronic data entry and retrieval by clinicians, but high levels of security and access should be ensured.

Source: ACSQHC (2021). *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC. © Australian Commission on Safety and Quality in Health Care.

(Levett-Jones, 2023; Vierula et al., 2020). A model titled the Clinical Reasoning Cycle (CRC) was developed by Australian nurse researchers to clearly articulate how nurses use sophisticated thinking skills to inform their practice decisions and enhance patient safety (see Figure 1.2). The CRC builds upon the nursing process framework and represents the multi-faceted and increasingly complex nature of nursing care, and the necessity to respond appropriately to patients' needs, particularly in emergent, non-routine and unpredictable clinical situations. The CRC is integral to students' developing ability to 'think like a nurse' and its explicit meta-cognitive and reflective processes aim to identify and prevent cognitive errors that may lead to adverse patient outcomes. A body of evidence has identified that clinical reasoning skills have a positive impact on patient outcomes and that nurses with poor clinical reasoning skills often fail to detect and appropriately respond to patient deterioration (Liaw, Cooper & Levett-Jones, 2018). Clinical reasoning errors have also been implicated as a key factor in the majority of adverse patient outcomes (Institute of Medicine, 2016).

The Clinical Reasoning Cycle consists of eight main stages or steps: *consider the patient situation, collect cues, process information, identify problems and priorities, establish goals, take action, evaluate outcomes* and *reflect on process and new learning.*

ACCOUNTABLE AND RESPONSIBLE NURSING PRACTICE

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for accreditation of nursing and midwifery programs, while the Nursing and Midwifery Board of Australia (NMBA) has responsibility for professional registration, professional codes, standards and competency issues.

In Australia, there are three key documents that form the basic framework for accountable and responsible practice as a Registered Nurse. These are:

1. Nursing and Midwifery Board of Australia (NMBA), *Registered Nurse Standards for Practice* (2016).
2. The International Council of Nurses (ICN), *Code of Ethics for Nurses* (2012).
3. Nursing and Midwifery Board of Australia (NMBA), *Code of Conduct for Nurses* (2018).

Nursing and Midwifery Board of Australia (NMBA) *Registered Nurse Standards for Practice*

The *Registered Nurse Standards for Practice* (2016) were developed to promote a national approach to nursing in Australia. These standards are an integral component of the

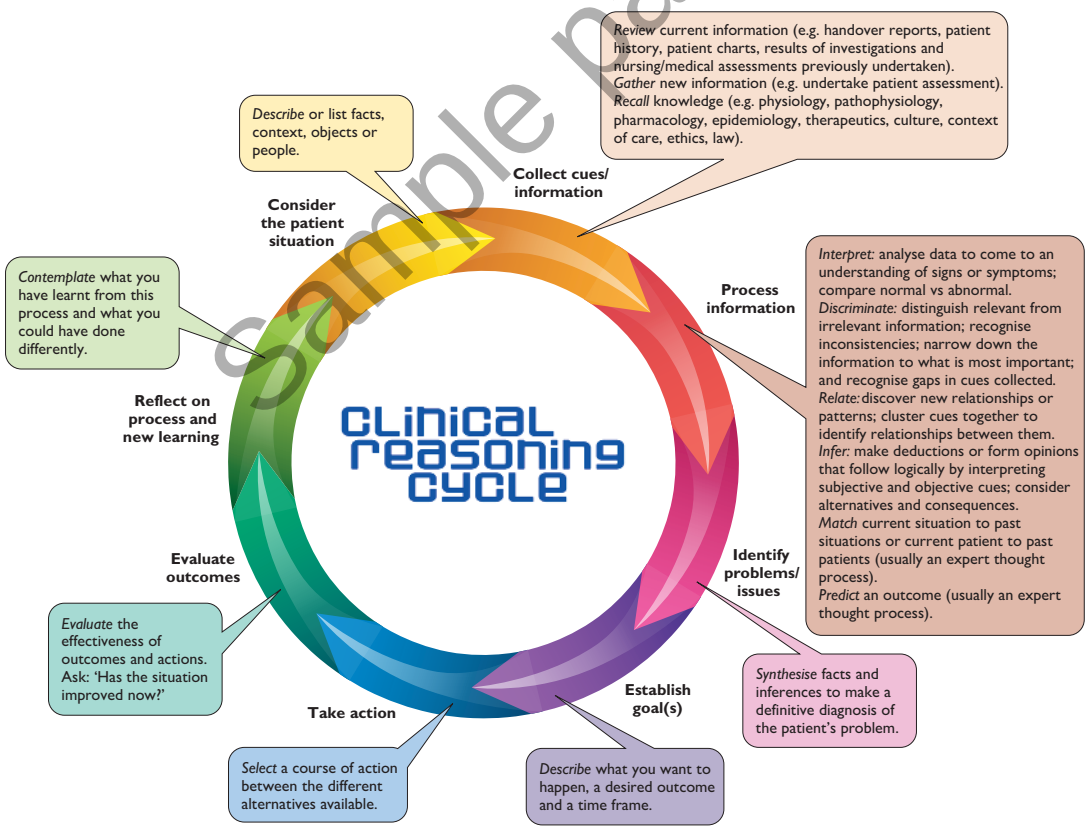

FIGURE 1.2 *The clinical reasoning process with descriptors*

Source: Levett-Jones (2023). *Clinical reasoning: Learning to think like a nurse*, p. 7; adapted from Levett-Jones et al. (2010). The 'five rights' of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients. *Nurse Education Today, 30*(6), 515–520.

nursing regulatory framework that assists nurses to deliver safe and competent care. They are the standards by which a nurse's performance is assessed to obtain and retain registration to practise as a nurse in Australia. As the ever-changing healthcare needs and expectations of Australians impact on quality and safety within the healthcare system, so must practice standards be regularly reviewed by the nursing profession. The NMBA standards for practice were reviewed and updated during 2015 and were published early in 2016. The standards are organised into domains, as illustrated in Box 1.1.

Code of Ethics for Nurses

In March 2018, the NMBA adopted the International Council of Nurses (ICN) *Code of Ethics for Nurses* (2012) as the guiding document for ethical decision making for nurses in Australia. The ICN Code of Ethics is a guide for action based on social values and needs, and is premised on the understanding that nurses have four fundamental responsibilities: (1) to promote health, (2) to prevent illness, (3) to restore health, and (4) to alleviate suffering. The Code includes respect for human rights, including cultural rights, the right to life and choice, and the right to dignity and to be treated with respect. It also emphasises that nursing care must be unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status (ICN, 2012).

Code of Conduct for Nurses

The *Code of Conduct for Nurses* (NMBA, 2018) sets out the legal requirements, professional behaviours and conduct expectations for nurses in Australia, and underpins the delivery of safe, kind and compassionate nursing care. The principles of the Code apply to all types of nursing practice in all contexts. This includes any work where a nurse uses nursing skills and

BOX 1.1 Domains of the Nursing and Midwifery Board of Australia (NMBA) *Registered Nurse Standards for Practice*

1. Thinks critically and analyses nursing practice	**Nurses use a variety of thinking strategies, research and best available evidence in making decisions and providing safe, quality nursing practice within a person-centred framework.**
2. Engages in therapeutic and professional relationships	**Nursing practice is based on purposefully engaging in the formation and maintenance of effective therapeutic and professional relationships. This includes collegial generosity in the context of interdisciplinary and professional relationships.**
3. Maintains fitness for practice and participates in lifelong learning	**Registered Nurses, as regulated health professionals, are responsible and accountable for ensuring they are safe and have the capability for practice. This includes ongoing self-management and responding when there are concerns about other health professionals' fitness for practice. Registered Nurses are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.**
4. Comprehensively conducts assessments	**Registered Nurses accurately conduct comprehensive and systematic assessments, analyse information and data and communicate outcomes as the basis of practice.**
5. Develops a plan for nursing practice	**Registered Nurses are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the Registered Nurse's comprehensive assessment, use of evidence and judgment that is documented and communicated to all the relevant people.**
6. Provides safe, appropriate and responsive quality nursing practice	**Registered Nurses delegate and implement person-centred, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned outcomes.**
7. Evaluates outcomes to inform nursing practice	**Registered Nurses take responsibility for the evaluation of practice based on agreed outcomes to plan and revise practice accordingly.**

Source: Nursing and Midwifery Board of Australia (NMBA) (2016). *Registered Nurse Standards for Practice*. © Nursing and Midwifery Board of Australia, www.nursingmidwiferyboard.gov.au/.

BOX 1.2 NMBA *Code of Conduct for Nurses*

Domain: Practise legally

1. **Legal compliance**
   Nurses respect and adhere to their professional obligations under the National Law, and abide by relevant laws.

Domain: Practise safely, effectively and collaboratively

2. **Person-centred practice**
   Nurses provide safe, person-centred and evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision making and care delivery between the person, nominated partners, family, friends and health professionals.
3. **Cultural practice and respectful relationships**
   Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships, and adhere to their obligations about privacy and confidentiality.

Domain: Act with professional integrity

4. **Professional behaviour**
   Nurses embody integrity, honesty, respect and compassion.
5. **Teaching, supervising and assessing**
   Nurses commit to teaching, supervising and assessing students and other nurses in order to develop the nursing workforce across all contexts of practice.
6. **Research in health**
   Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision making of people who participate in research.

Domain: Promote health and wellbeing

7. **Health and wellbeing**
   Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves, and in a way that addresses health inequality.

Source: NMBA (2018). *Code of Conduct for Nurses.* © Nursing and Midwifery Board of Australia, www.nursingmidwiferyboard.gov.au/.

knowledge, whether paid or unpaid, clinical or non-clinical. The code of conduct includes seven principles of conduct, grouped into four domains (see Box 1.2).

CULTURALLY COMPETENT NURSING

The primary focus of nursing care is the person and how they respond to their environment and experiences or situations related to health or illness. These experiences are given shape and personal meaning by **culture**—the socially inherited characteristics of a human group. The healthcare system encompasses many people (staff and patients) who are culturally diverse. This diversity includes differences in country of origin, health beliefs, sexual orientation, race, socioeconomic level and age.

Culture influences us all in our work, home and social lives. We therefore need to understand what the term 'culture' means. Rosenjack-Burcham (2002) defines culture as 'a learned world viewpoint or paradigm shared by a population or group and transmitted socially. It influences values, beliefs, customs and behaviours, and is reflected in the language, dress, food, materials and social interactions of a group' (p. 7). In Leininger's seminal work (1991), culture is described as 'the learned and transmitted values, beliefs and practices … the blueprint for living, remaining healthy, or for dying' (p. 36). Culture is primarily learned in our family or community life and can be shared with others. Our own culture can be experienced by us in an unconscious way and can change over time. Culture is therefore different from ethnicity, which is determined at birth. Interacting across cultures requires us to be aware of our own culture and requires an understanding of and skill in interpersonal and group communication.

Increasing cultural and ethnic diversity in most regions of the world over the past 40 years has made provision of culturally competent care essential for nurses and other health professionals (Everson et al., 2015). However, studies indicate that people from non-English-speaking backgrounds experience significantly more adverse health events than English-speaking people do and that misunderstandings, miscommunication and culturally unsafe care by health professionals are frequently reported (Johnstone & Kanitsaki, 2008). Many factors account for culturally unsafe care, including lack of awareness, skills and empathy, as well as ethnocentrism (people's belief that their own cultural group's beliefs and values are the only acceptable ones) and prejudice.

People of every culture have the right to have their cultural values known, respected and addressed appropriately in nursing and other healthcare services (Leininger, 1991). To provide nursing care that is culturally competent, nurses must develop sensitivity to personal fundamental values about health and illness, must accept the existence of differing values and must be respectful of, interested in and empathetic towards people from different cultures without being judgmental. **Cultural competence** is essential to quality care. According to Betancourt et al. (2003), cultural competence 'entails understanding the importance of social and cultural influences on patients' health beliefs and behaviours, considering how these factors interact at multiple levels of the health care delivery system, and devising interventions that take these issues into account' (p. 294).

A related concept, **cultural safety**, was developed in a First Nations' context and is a philosophy of practice that takes into account people's unique needs. Cultural safety refers to how people are treated in society, and its focus is on systemic and structural issues that influence the social determinants of health. Unsafe cultural practice comprises any action that 'diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' (Nursing Council of New Zealand, 2012, pp. 32–33). Importantly, the 'presence or absence of cultural safety is determined by the recipient of care not by the caregiver' (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2014, p. 9).

Standard 2 of the NMBA *Registered Nurse Standards for Practice* (2016) refers to therapeutic relationships and indicates that Registered Nurses must 'establish, sustain and conclude therapeutic relationships in a way that is respectful and acknowledges the dignity, culture, values and beliefs and rights of a person'.

While developing a growing appreciation of the various cultural groups you come into contact with in your many nursing roles is essential, developing an appreciation and understanding of the history and culture of Aboriginal and Torres Strait Islander peoples (Australia's First Peoples) is fundamental to the development of professional nurses and to nursing practice which is experienced as culturally safe. In order to be effective in delivering appropriate care to Aboriginal and Torres Strait Islander people, nurses need:

- awareness of important Aboriginal and Torres Strait Islander issues, such as cultural differences, and specific aspects of Indigenous history and their impact on Indigenous peoples in contemporary Australian society
- the skills to interact and communicate sensitively and effectively with Indigenous peoples
- the motivation to interact successfully with Indigenous peoples in order to improve access, service delivery and patient outcomes (Farrelly & Lumby, 2009).

Undertaking this journey into the history and culture of Indigenous Australians is likely to challenge your understanding of your own culture and how your cultural values impact on the way you provide nursing care to all people.

In the chapters that follow, the cultural implications of the various clinical situations are discussed and expanded upon, and you will be presented with opportunities to apply and contextualise your learning about cultural safety.

LEGAL AND ETHICAL DILEMMAS IN NURSING

A **dilemma** is a choice between two unpleasant, ethically troubling alternatives. Nurses face dilemmas almost daily—so many, in fact, that a complete discussion of them is impossible here. However, many commonly experienced dilemmas involve confidentiality, human rights and issues of dying and death. The nurse must use ethical and legal guidelines to make decisions about moral actions when providing care in these and many other situations.

The rights of each individual can result in dilemmas for nurses in the clinical setting. For example, the right to refuse treatment (including surgery, medication, nutrition and hydration) is an example of a person's rights that can conflict with a nurse's personal and professional values and may cause ethical dilemmas. The situation, the alternatives and the potential consequences of refusal must be carefully explored with the person.

The issues surrounding dying and death have become increasingly topical as advances in technology extend the lives of people with chronic debilitating illness and major trauma. These changes have altered concepts of living and dying, resulting in ethical dilemmas regarding quality of life and death with dignity versus technological preservation of life. Additionally, difficulties in establishing a person's competence to make informed decisions about withholding and withdrawing treatment, and use of opioids at the end of life are some of the issues that nurses will encounter in their practice.

ROLES OF THE NURSE IN MEDICAL–SURGICAL NURSING PRACTICE

Healthcare today is a vast and complex system. It reflects changes in society, changes in the populations requiring nursing care and a philosophical shift towards health promotion rather than illness care. The roles of the medical–surgical nurse have broadened and expanded in response to these changes. Medical–surgical nurses are not only caregivers, but also educators, advocates, leaders, managers, and researchers. The nurse assumes these various roles to promote and maintain health, to prevent illness and to facilitate coping with disability or death for people in a range of healthcare settings.

The nurse as caregiver

Nurses have always been caregivers. However, the activities carried out within the caregiver role have changed tremendously in the 21st century. From 1900 to the 1960s, the nurse was almost always female and was regarded primarily as the person who gave personal care and carried out doctors' orders. This dependent role has changed as a result of the increased education of nurses, research into and the development of nursing knowledge, a strong evidence base and the recognition that nurses are autonomous and well-informed professionals.

The caregiver role for the nurse today is both independent and collaborative. Nurses independently make assessments and plan and implement patient care based on nursing knowledge and skills. Nurses also collaborate with other members of the interprofessional healthcare team to implement and evaluate care (see Figure 1.3).

In providing comprehensive and person-centred care, the nurse uses critical-thinking skills to analyse and synthesise knowledge from the arts, the sciences, and nursing research and theory. The science (knowledge base) of nursing is translated into the art of nursing through caring. Caring is the means by which the nurse is connected with and concerned for the person who is the recipient of care. Thus, the nurse as caregiver is knowledgeable, skilled and empathic. Nursing care must address not only the physical needs but also the psychosocial, cultural, spiritual and environmental needs of each person and their family. Considering all aspects of a person's being ensures a holistic approach to nursing. Subsumed within the concept of 'holistic healthcare' is the concept of caring for the mind, body and spirit.

The nurse as educator

The nurse's role as educator is becoming increasingly important for several reasons. There is much greater emphasis on health promotion and illness prevention, hospital stays are becoming shorter and the number of people with chronic illnesses in our society is increasing. Early discharge of people from the hospital

FIGURE 1.3 *The healthcare team discusses the individualised plan of care and outcomes*

Source: Arno Massee/Science Photo Library/Alamy.

FIGURE 1.4 *The nurse's role as educator is an essential component of care. As part of the discharge planning process, the nurse is responsible for teaching for self-care at home*

Source: © Monkey Business Images/Shutterstock.com.

setting to the home means that family caregivers must learn how to perform complex skills. All these factors make the educator role essential to maintaining people's health and wellbeing.

The framework for the role of educator is the teaching–learning process. Within this framework the nurse assesses learning needs, plans and implements teaching methods to meet those needs, and evaluates the effectiveness of the teaching. To be effective educators, nurses need effective interpersonal skills and familiarity with adult learning principles (see Figure 1.4).

A major component of the educator role today is discharge planning. Discharge planning, which begins on admission to a healthcare setting, is a systematic method of preparing the person and their family for departure from the healthcare facility and for maintaining continuity of care after they leave the setting. Discharge planning also involves making referrals, identifying community and personal resources, and arranging necessary equipment and supplies for home care.

The nurse as advocate

The person entering the healthcare system may not always be prepared to make independent decisions. However, nurses need to be aware that today's healthcare consumer is better educated about options for care and may have very definite opinions. The nurse as patient advocate actively promotes the patient's right to autonomy and free choice. The nurse as advocate speaks for the person if needed, mediates between the person and other people, and/or protects the person's right to self-determination. The goals of the nurse as advocate are to:

- assess the need for advocacy
- communicate with other healthcare team members
- assist and support decision making
- serve as a change agent in the healthcare system
- participate in health policy formulation.

The nurse must practise advocacy while maintaining the belief that people have the right to choose treatment options, based on information about the results of accepting or rejecting the treatment, without coercion. The nurse must also accept and respect the decisions of the person, even though they may differ from the decisions the nurse would make.

The nurse as leader and manager

All nurses are leaders and managers. They practise leadership and they manage time, people, resources and the environment in which they provide care. Nurses carry out these roles by directing, delegating and coordinating nursing activities. Nurses must be knowledgeable about how and when to delegate, as well as the legal requirements of delegation. As leaders and managers, nurses also evaluate the quality of care provided.

Models of care delivery

Nurses are leaders and managers of patient care within a variety of models of care delivery. Models of care may include:

- task-oriented nursing
- team nursing
- patient allocation or total patient care
- primary nursing
- case management.

Task-oriented nursing refers to a model in which nurses undertake specific tasks related to nursing care across a group of people. Some examples of task allocation may be when a nurse showers all the people in a ward while another nurse administers medications for the same group of people. In this model of care delivery, nursing care relates to discrete sets of activities that are performed by nurses.

Team nursing is a model that 'teams' experienced nurses with less experienced or casual staff to achieve nursing goals using a group-based approach. A team may consist of a Registered Nurse, an Enrolled Nurse and an Assistant in Nursing. The Registered Nurse is the team leader. The team leader is responsible for delegating care activities and has overall responsibility for patient care by team members.

All team members work together, each performing the activities for which they are best prepared.

Patient allocation models were developed because nurses recognised the need for total patient care. The implementation of these types of models results in nurses getting to know the whole person, rather than people being cared for as a series of tasks. A nurse will be allocated to their patients (the number is dependent on factors such as patient need, staff mix and ward policies) and undertake all nursing care for the allocated person/people.

Primary nursing allows the nurse to provide individualised direct care to a small number of people during their entire inpatient stay. This model was developed to reduce the fragmentation of care experienced by patients and to facilitate continuity of care. In primary nursing, the nurse provides care; communicates with the person, families and other healthcare providers; and carries out discharge planning.

Case management focuses on management of a caseload (group) of patients. The purpose of case management is to maximise positive outcomes and contain costs. The nurse who is case manager is usually a clinical specialist, and the caseload consists of people with similar healthcare needs. As case manager, the nurse makes appropriate referrals to other healthcare providers and manages the quality of care provided, including accuracy, timeliness and cost. The case manager is also in contact with patients after discharge, ensuring continuity of care and health maintenance.

The model of care delivery implemented on a ward will depend on a range of factors, including the degree of innovation and commitment by the people involved. Some models work better when there are sufficient numbers of experienced Registered Nurses to deliver care; others may focus on supporting less experienced staff using a team approach.

Delegation

Delegation is carried out when the nurse assigns appropriate work activities to other members of the healthcare team. When the nurse delegates nursing care activities to another person, that person is authorised to act in the place of the nurse, although the nurse retains the accountability for the activities performed. Delegation depends on knowing one's own scope of practice and that of the person to whom one plans to delegate.

Nurses' **scope of practice** refers to the roles, functions, responsibilities, activities and decision-making capacity that they are educated, competent and authorised to perform. One's scope of practice is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population. Registered Nurses have a key role in the coordination and supervision of others who assist them in the provision of care to people.

Evaluating outcomes of nursing care

CLINICAL PATHWAYS A **clinical pathway** is a plan designed to provide healthcare, often within a multidisciplinary team. Such pathways are generally developed for specific diagnoses—usually high-volume, high-risk and high-cost case types—with the collaboration of members of the healthcare team. This patient care management tool describes how resources will be used to achieve predetermined outcomes. It also establishes the sequence of multidisciplinary interventions, including education, discharge planning, consultations, medication administration, diagnostics, therapeutics and treatments.

The goals of clinical pathways are to:

- achieve realistic, expected person and family outcomes
- promote professional and collaborative practice and care
- ensure continuity of care
- guarantee appropriate use of resources
- reduce costs and length of stay
- provide the framework for continuous improvement.

Clinical pathways are often used in conjunction with case management models and/or quality improvement efforts. The overall goal is to design pathways that facilitate a reproducible standard of care for specific patient populations and improve the quality and proficiency of that care.

The healthcare facility determines the process for developing a clinical pathway. Information imperative to the development of any clinical pathway includes literature reviews, chart reviews and expert opinion. A typical approach is to first identify high-cost, high-volume and high-risk case types for the agency. Next, a multidisciplinary team develops a consensus around the management of the case type and a clinical pathway. The pathway is then piloted with a designated group of people and revised based on the number and types of variances. The goal is to develop a pathway that best meets the needs of people in the particular practice setting.

When people do not achieve expected outcomes, variances (deviations from the established plan) from the clinical pathways are recorded and studied by the multidisciplinary team. In many facilities, clinical pathways are designed so that interventions and variances can be easily documented. Most documentation systems require a check-off when interventions are performed or variances occur.

In many facilities, clinical pathways are replacing traditional nursing care plans. The advantages of clinical pathways are that they are outcome driven and provide a timeline to achieve specified goals. Additionally, clinical pathways provide opportunities for healthcare workers to collaborate and establish dynamic plans of care that consider all of the people's needs. Although initially developed for acute hospitalisations, clinical pathways are now being developed to manage people in the home, outpatients and those in long-term settings.

Clinical governance

Clinical governance is defined as a systematic and integrated approach that improves quality and safety and results in optimal patient outcomes. Clinical governance places the responsibility for the quality of care jointly on organisations and on individuals within organisations. As a leader and manager within a

Links to National Patient Safety Standards

NSQHS: Clinical Governance Standard

The Clinical Governance Standard of the National Safety and Quality Health Service Standards specifies that there is the set of relationships and responsibilities established by a health service organisation to ensure that systems are in place to deliver safe and high-quality healthcare and to continuously improve services.

Source: ACSQHC (2021). *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC. © Australian Commission on Safety and Quality in Health Care.

healthcare organisation, the nurse has an important role in promoting continuous quality improvement through governance structures such as:

- clinical risk management
- clinical quality and safety frameworks
- consumer participation
- clinical effectiveness
- clinical audit
- evidence-based practice
- credentialling/professional development
- research and development.

The medical–surgical nurse is well placed to contribute to the evaluation of the quality of clinical practice through peer review, clinical audit and external accreditation processes.

The nurse as researcher

The science of nursing is established through clinical research and then published so that the findings can be used by all nurses to provide evidence-based, person-centred care. This means that all nurses must consider the researcher role as integral to nursing practice and are expected to use the best clinical evidence available to inform their patient care decisions. Nursing care that is based on high-quality research evidence is more likely to be cost effective and result in positive patient outcomes (Chien, 2019).

This text is informed by and based on nursing research, with summaries of relevant studies included throughout many chapters. These include discussions about each study and a critical-thinking section that encourages students to apply the findings to their clinical practice.

CHAPTER HIGHLIGHTS

- Safe and effective nursing care focuses on the provision of person-centred care, working in interprofessional teams, using evidence-based practice and working within legal and ethical frameworks.
- The nursing process is an approach used by nurses to provide care to promote wellness, maintain health, restore health or facilitate coping with disability or death. The five steps of the nursing process are assessment, diagnosis, planning, implementation and evaluation.
- Clinical reasoning is a dynamic process in which nurses collect cues, process this information, come to an understanding of the situation (or patient's problem), plan and implement care, evaluate outcomes, and reflect on and learn from the process. The questioning of assumptions and the avoidance of clinical reasoning errors are integral to this process.
- The clinical practice of nurses is guided by codes of conduct, codes of ethics and standards for practice.
- Nurses function as caregivers, educators, advocates, leaders and managers, and researchers to promote and maintain health, prevent illness and facilitate coping with disability or death for the adult person.

CONCEPT CHECK

1 The Nursing and Midwifery Board of Australia (NMBA) has developed a set of standards for practice. What is the primary purpose of these standards?
1 to make all nurses equal
2 to promote safe and effective nursing care
3 to reduce the number of legal actions
4 to provide a set of ethical guidelines

2 What does the nurse use in the clinical setting to make clinical judgments and decisions?
1 nursing process
2 standards of care
3 clinical reasoning skills
4 all of the above

3 Which of the following statements is true of outcomes developed during the planning phase of the nursing process?
1 Outcomes are mutually established by the person and the nurse.
2 Outcomes are mutually established by the nurse and the doctor.
3 Outcomes are mandated by institutional policies and standards.
4 Outcomes are written by the person receiving care and their family members.

4 The steps of the nursing process are used when providing care. From the list below, select the order in which the steps are most often used.
1 diagnosis
2 assessment
3 evaluation
4 implementation
5 planning

5 When nurses discuss the 'science of nursing', what does this phrase mean?
1 clinical competency
2 holistic care
3 evidence-based practice
4 practice component

6 What role does the nurse demonstrate when appraising health information?
1 advocate
2 caregiver
3 researcher
4 educator

7 What goal is a component of the nurse's role as advocate?
1 assisting and supporting the person in their decision making
2 conducting research about the effects of exercise
3 delegating responsibilities for care to others
4 performing range-of-motion exercises

8 A nurse assigns appropriate work activities to other members of her team. What role is being illustrated?
1 advocate
2 leader/manager
3 researcher
4 caregiver

9 A method of establishing a standard of care and evaluating outcomes of that standard involves:
1 writing a dress-code policy for a healthcare agency
2 creating a clinical pathway for a specific type of person
3 establishing clinical governance approaches
4 implementing a new procedure to change dressings

10 A Registered Nurse delegates vital signs assessment to an Assistant in Nursing. Who is accountable for the assessment findings?
1 the Assistant in Nursing
2 the person receiving care
3 the nurse
4 the doctor

BIBLIOGRAPHY

Australian College of Nursing (2020). *Person-centred care position statement*. Reviewed May 2020. Retrieved from https://www.acn.edu.au

Australian Commission on Safety and Quality in Health Care (2021). *National Safety and Quality Health Service Standards* (2nd ed.). Sydney: ACSQHC.

Betancourt, J. R., Green, A. R., Carrillo, J. E. & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*, 293–302.

Chien L. Y. (2019). Evidence-based practice and nursing research. *The Journal of Nursing Research*, *27*(4), e29. https://doi.org/10.1097/jnr.0000000000000346

Christianson, K. L. (2020). Emotional intelligence and critical thinking in nursing students: Integrative review of literature. *Nurse Educator*, *45*, E62–E65. https://doi.org/10.1097/NNE.0000000000000801

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (2014). *Towards a shared understanding of terms and concepts: Strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples*. Canberra. Retrieved from http://catsinam.org.au/

Everson, N., Levett-Jones, T., Lapkin, S., Pitt, V., van der Riet, P., Rossiter, R., Courtney-Pratt, H., Gilligan, C. & Jones, D. (2015). Measuring the impact of a 3D simulation experience on nursing students' cultural empathy using a modified version of the Kiersma-Chen Empathy Scale. *Journal of Clinical Nursing, 24*(19–20), 2849–2858.

Farrelly, T. & Lumby, B. (2009). A best practice approach to cultural competence training. *Aboriginal and Islander Health Worker Journal*, *33*(5), 14–22.

Institute of Medicine (2016). *The future of nursing: Focus on education*. Retrieved from http://www.nursingworld.org

International Council of Nurses (ICN) (2012). *The ICN Code of Ethics for Nurses*. Geneva. Retrieved from http://www.icn.ch/

Johnstone, M. J. & Kanitsaki, O. (2008). Cultural racism, language prejudice and discrimination in hospital contexts: An Australian study. *Diversity in Health and Social Care*, *5*, 19–30. Retrieved from www.ingentaconnect.com/

Leininger, M. (1991). Transcultural care principles, human rights, and ethical considerations. *Journal of Transcultural Nursing*, *3*(1), 21–23.

Levett-Jones, T. (2023). Clinical reasoning: What it is and why it matters. In T. Levett-Jones (ed.), *Clinical reasoning: Learning how to think like a nurse* (3rd ed.). Frenchs Forest: Pearson.

Levett-Jones, T., Dwyer, T., Reid-Searl, K., Heaton, L., Flenady, T., Applegarth, J., Guinea, S. & Andersen, P. (2017). *Patient Safety Competency Framework (PSCF) for Nursing Students*. Sydney. Retrieved from http://psframework.wpengine.com/

Levett-Jones, T., Hoffman, K., Dempsey, Y., Jeong, S., Noble, D., Norton, C., Roche, J. & Hickey, N. (2010). The 'five rights' of clinical reasoning: An educational modelto enhance nursing students' ability to identify and manage clinically 'at risk' patients. *Nurse Education Today*, *30*(6), 515–520.

Liaw, S., Cooper, S. & Levett-Jones, T. (2018). Development and psychometric testing of a Clinical Reasoning Evaluation Simulation Tool (CREST) for assessing ability to recognize and respond to clinical deterioration. *Nurse Education Today*, *62*, 74–79. https://doi.org/10.1016/j.nedt.2017.12.009

Movlavi, S. & Salehi, S. (2021). Examining the effect of implementation of the nursing process on students' health behaviors. *International Journal of Adolescent Medicine and Health*, *33*(5). https://doi.org/10.1515/ijamh-2018-0244

Nursing and Midwifery Board of Australia (NMBA) (2016). *Registered Nurse Standards for Practice*. Retrieved from https://www.nursingmidwiferyboard.gov.au/

Nursing and Midwifery Board of Australia (NMBA) (2018). *Code of Conduct for Nurses*. Retrieved from https://www.nursingmidwiferyboard.gov.au/

Nursing Council of New Zealand (2012). *Competencies for registered nurses*. Retrieved from https://www.nursingcouncil.org.nz/

Patterson, E., Anders, S. & Moffatt-Bruce, S. (2017). Clustering and prioritizing patient safety issues during EHR implementation and upgrades in hospital settings. *Proceedings of the International Symposium on Human Factors and Ergonomics in Health Care*, *6*(1), 125–131.

Rosenjack-Burcham, J. L. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum*, *37*(4), 5–16.

Rossiter, C., Levett-Jones, T. & Pich, J. (2020). The impact of person-centred care on patient safety: An umbrella review of systematic reviews. *International Journal of Nursing Studies*, *109*, 103658.

Vierula, J., Hupli, M., Talman, K. & Haavisto, E. (2020). Identifying reasoning skills for the selection of undergraduate nursing students: A focus group study. *Contemporary Nurse*, *56*(2), 120–131.

Wilkinson, J. M. (2011). *Nursing process and critical thinking* (5th ed.). Upper Saddle River, NJ: Pearson Education, Inc.