



Royal College
of Nursing

Defining nursing





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Andrew Salmon became a member of the *Defining Nursing* Workgroup in April 2002 when he took on the role of research assistant in a voluntary capacity.

Tragically, after a short illness, Andrew Salmon died on 2 February 2003. Andrew's professionalism and friendship were greatly valued by the other members of the workgroup. Thanks to Andrew's skills, vision and determination, the values of today's nurses have been successfully integrated into our report. Andrew Salmon made an enormous contribution to our work. He will be fondly remembered and greatly missed by us all.

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This publication is due for review in December 2017. To provide feedback on its contents or on your experience of using the publication, please email publications.feedback@rcn.org.uk

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Defining nursing

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1

Introduction

The ability of nursing to respond to people's need for nursing within the rapidly changing environment of health care depends on:

- the way in which nursing work is organised in health care delivery systems
- the way in which nursing practice is regulated and the quality of care is assured
- the way in which practitioners are prepared.

And fundamentally, depends on:

- the way in which nursing itself is defined.

This publication was first published by the Royal College of Nursing in 2003, along with a supporting document *Defining nursing* that described why and how the definition was developed. The definition and supporting document were prepared by a group of nurse leaders; they incorporate the results of wide consultation and participation by RCN members and others. A review of published literature both from the UK and from other countries was undertaken, and a survey was carried out of all the members of the International Council of Nurses to identify definitions of nursing that had been developed in other countries, in particular the work of the then Queensland (Australia) Nursing Council.

In 2014, the RCN's Nursing Policy and Practice Committee (NPPC) confirmed that the definition remains current and fit for the following purposes:

- describing nursing to people who do not understand it
- clarifying the role of the nurse in the multidisciplinary health care team
- influencing policy agendas at local and national levels
- developing educational curricula
- identifying areas where research is needed to strengthen the knowledge base of nursing
- informing decisions about whether and how nursing work should be delegated to other personnel
- supporting negotiations at local and national level on issues such as nurse staffing, skill mix and nurses' pay.

The document defines what we believe to be the essence and six defining characteristics of nursing. Whilst other health care professions share some of these characteristics, they are uniquely combined as nursing.

The definition also reflects nursing's diversity which includes the care of people who are healthy and those who are sick, and of groups of people and individuals.

Throughout this diversity the essence of nursing is a constant and is reflected in the definition.

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A definition of nursing

The definition of nursing that is presented in this document is expressed in the form of a core explanation supported by six defining characteristics (see Glossary). It is important to recognise that nursing is the totality: while some parts of the definition are shared with other health care professions, the uniqueness of nursing lies in their

combination. The definition takes account of the great diversity of nursing, which includes the care of people who are healthy as well as those who are sick, and of groups of people as well as individuals. The definition expresses the common core of nursing which remains constant.

Nursing is...

The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

Its defining characteristics are:

1. A particular purpose: the purpose of nursing is to promote health, healing, growth and development, and to prevent disease, illness, injury, and disability. When people become ill or disabled, the purpose of nursing is, in addition, to minimise distress and suffering, and to enable people to understand and cope with their disease or disability, its treatment and its consequences. When death is inevitable, the purpose of nursing is to maintain the best possible quality of life until its end.
2. A particular mode of intervention: nursing interventions are concerned with empowering people, and helping them to achieve, maintain or recover independence. Nursing is an intellectual, physical, emotional and moral process which includes the identification of nursing needs; therapeutic interventions and personal care; information, education, advice and advocacy; and physical, emotional and spiritual support. In addition to direct patient care, nursing practice includes management, teaching, and policy and knowledge development.
3. A particular domain: the specific domain of nursing is people's unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves. People's responses may be physiological, psychological, social, cultural or spiritual, and are often a combination of all of these. The term people includes individuals of all ages, families and communities, throughout the entire life span.
4. A particular focus: the focus of nursing is the whole person and the human response rather than a particular aspect of the person or a particular pathological condition.
5. A particular value base: nursing is based on ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions. These values are expressed in written codes of ethics, and supported by a system of professional regulation.
6. A commitment to partnership: nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they will lead the team, prescribing, delegating and supervising the work of others; at other times they will participate under the leadership of others. At all times, however, they remain personally and professionally accountable for their own decisions and actions.

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The remainder of this document describes why and how this definition was developed, and explains its key concepts.

Why defining nursing has become an issue

The paradox of nursing

Nursing is experienced at some time by almost everybody. It is done by millions of nurses across the world, yet it is still difficult to describe and is poorly understood. In 1859 Florence Nightingale wrote:

“The elements of nursing are all but unknown.”¹

In the 21st century the statement is still true. Some people associate nursing with the physical tasks concerned with keeping a sick person safe, comfortable, nourished and clean. Some see nursing as assisting the doctor by carrying out tasks associated with medical treatment. While both of these elements are indeed part of nursing practice, the idea that nursing consists of these elements alone ignores the wider contribution of professional nursing to health care, and will result in a service which does not offer its full potential².

Nurses and patients know, and there is sound research evidence³ to demonstrate that skilled nursing makes a difference. However, it is difficult to put into words exactly what difference, to what, or how it was done. Part of the paradox is that the more skilful a nurse is in what they do, the less likely will be the observer, or even the patient, to recognise exactly what has been done⁴.

Distinguishing between professional nursing and the nursing undertaken by other people

Not all nursing is undertaken by qualified nurses, any more than all teaching is undertaken by qualified teachers. Other people who nurse include relatives, other informal carers, and a variety of care assistants and support workers. Their contribution to care is invaluable, but it is different from that of the professional nurse.

The distinction between professional nursing and the nursing undertaken by other people does not lie in the type of task performed, nor in the level of skill that is required to perform a particular task. As for all professional practice, the difference lies in:

- the clinical judgement inherent in the processes of assessment, diagnosis, prescription and evaluation
- the knowledge that is the basis of the assessment of need and the determination of action to meet the need
- the personal accountability for all decisions and actions, including the decision to delegate to others
- the structured relationship between the nurse and the patient which incorporates professional regulation and a code of ethics within a statutory framework.

This document focuses on professional nursing – the practice of those people who have undertaken the required educational preparation and hold a statutory qualification as a registered nurse. In the UK the use of the title of registered nurse is protected by law and the competencies required by the registered nurse are set out in statute.

Distinguishing between nursing and other health care disciplines

The complexity of people’s health care needs requires the collective knowledge, skills and actions of many disciplines and professions. Each discipline shares some knowledge and skills with other disciplines, but each also makes its own unique contribution to the collective pool. The unique contribution of each discipline lies in the particular and unique combination of its elements and its particular perspective and orientation. It is for this reason that the definition of nursing given in this document consists of a core plus its six defining characteristics.

Understanding the differences

Understanding these differences is important for several reasons. Firstly, because patients have a right to receive treatment and care from an appropriately qualified person. Secondly, because governments and health care managers have a responsibility to provide care in the most cost-effective and efficient way, making the best use of scarce resources. Thirdly, because, as the Scottish Home and Health Department has noted:

“Everyone involved has special skills to offer but at the margins of the field of competence and expertise of each professional group, there are areas where there is some overlap of function. Despite these small areas of overlap, the major responsibilities of each professional group are quite clear – with the exception of nursing, where there is a considerable variation in perception.”³

For this reason nursing is especially vulnerable to inappropriate use. As one economist has pointed out:

“Nursing care as a product is highly simplified by non-nurse buyers not possessing a clear idea of what professional nurses can/should do and how it differs from less skilled cheaper labour... These health care managers may accept unfounded assumptions and myths about nursing costs, care-giver mix and nursing productivity.”⁵

The responsibility for rectifying such a situation lies with nurses themselves. The purpose of this document is to help them to do so.

All nurses carry in their heads a personal concept of nursing – what it is, what it is for, and how we do it. The problem, at least in the UK, is that this concept is rarely put into words, and until it is, it cannot be communicated to other people. We do not know, therefore, whether all nurses share a common concept, let alone share it with patients and the public.

It is part of the social mandate of a profession⁶ to make clear to the public the nature of the service it offers, and to ensure the quality of its service through mechanisms such as professional regulation. This is the basis of the relationship of trust between the profession and the public it serves and between the individual professional and the patient to whom the professional owes a duty of care. In specifying the service it offers, however, the profession must be sensitive and responsive to the needs of those it serves. Patients need and have a right to know what they can expect from a registered nurse, that would not be provided by other people, and also what they cannot expect. If the profession fails to provide this information, media-based stereotypes and managerial specifications will fill the vacuum.

Over and above this obligation, several developments during the past decade have increased the need, and the urgency, to develop a more explicit description of the service nurses can offer, and to differentiate the particular contribution of nursing within the framework of the multidisciplinary health care team. Nurses have expanded and extended their roles in many ways. But there have also been external drivers. For example, cost containment measures coupled with a shortage of registered nurses have led to skill-mix exercises in which work formerly undertaken by registered nurses has been transferred to various kinds of other staff. Research has shown that the proportion of registered nurses in the workforce affects patient outcomes such as speed of recovery, incidence of complications, and even mortality³ – but it does not yet explain why. At the same time, pressures on the availability of doctors have led to nurses taking on work that was previously undertaken by doctors. Research has shown (for example, research on the work of nurse practitioners⁷) that nurses can undertake a great deal of the work previously undertaken by doctors safely and competently and that patients appreciate it – but it is important to be able to recognise and value the particular contribution that nursing brings.

A particular issue has been the distinction between the nursing care and the social or personal care provided for frail older people. As a result of the 1990 NHS and Community Care Act (which gave local authority social services departments the lead responsibility for the provision of such services) much of the basic nursing care that used to be provided by nurses has been re-designated as social care and is provided by care assistants working under the supervision of social workers or lay managers. The 2001 Health and Social Care Act removed from local authorities the responsibility for providing care by a registered nurse. As a result of this newly defined division of responsibility between local authorities and the NHS, in England, Wales and Northern Ireland (Scotland has legislated differently) nursing care is funded by the NHS and is free of charge to the user at the point of delivery, but personal care is means tested. This policy required a definition of nursing that could be used in the legislation, and in the absence of any professional definition, the legislative definition of nursing care was formulated as:

“any services provided by a registered nurse and involving:

- a. the provision of care
- b. the planning, supervision or delegation of the provision of care other than any services which,

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having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.”⁸

Another example of how services have developed without the benefit of a clear understanding of the nature and potential of nursing can be seen in services for people with learning disabilities. The practice of registered nurses for people with learning disabilities (RNLDs) has long been based on a social rather than a medical model of health and health care. Since the Community Care Act 1990, services for people with learning disabilities have, like those for frail older people, been provided mainly through local authority social services departments. This does not mean that these nurses are no longer ‘doing nursing’, and they remain registered as nurses on the Nursing and Midwifery Council (NMC) register. However, many RNLDs who work in social services organisations have found that their nursing skills are unrecognised, that their practice is constrained by inappropriate policies, and that other nurses are brought in to provide designated nursing interventions which the RNLD is qualified and competent to provide⁹.

A third example can be seen in the debates about the role of nurses in prescribing drugs¹⁰ and in measures to reduce the hours of work of junior doctors¹¹.

In each case the potential of the contribution that nurses can make to people’s health and wellbeing may be compromised by poor understanding of what nursing is.

What others have said

The classic definitions

The task of defining nursing is not new. The first formal definition of nursing is probably that of Florence Nightingale:

“Nature alone cures... And what nursing has to do... is to put the patient in the best condition for nature to act upon him.”¹

Nightingale’s focus on the promotion of health and healing as distinct from the cure of illness, and the triad of the person, health and the environment, remain central to modern definitions of nursing.

The best known definition of nursing is probably that developed by Virginia Henderson. This definition was adopted by the International Council of Nurses in 1960 and is still the most widely and internationally used definition of nursing¹². The best known part of Henderson’s definition is her description of “the unique function of the nurse” as:

“to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible... This aspect of her work, this part of her function, she initiates and controls; of this she is master.”

However, this is only the first part of Henderson’s definition and only one part of nursing, and it is unfortunate that it is often used as if it were the full definition. Henderson continues:

“In addition she helps the patient to carry out the therapeutic plan as initiated by the physician,”

and

“She also, as a member of a team, helps others as they in turn help her, to plan and carry out the total program whether it be for the improvement of health, or recovery from illness, or support in death.”

Henderson thus describes both the independent and the interdependent aspects of nursing practice, and specifies the relationship between nursing and medicine (it is important to note that the nurse's purpose is to help the patient, not the doctor). This distinction between independent and interdependent practice is critical to understanding the complexity of nursing and its particular contribution within the multi-disciplinary health care team.

International definitions

In addition to adopting the Henderson definition, in 1987 the International Council of Nurses established an official definition of nursing for international use as follows:

“Nursing, as an integral part of the health care system, encompasses the promotion of health, the prevention of illness, and care of the physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual family and group responses to actual or potential health problems. These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population.”¹³

This definition incorporates the key concepts contained in many other definitions of nursing:

- a focus on health not merely on sickness
- a clientèle that includes people of all ages in all settings, as individuals, families and communities
- the identification of “human responses to actual or potential health problems” as nursing’s phenomena of concern.

Recently the ICN has promoted a shorter version:

“Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.”¹⁴

The ICN stresses that this is an edited version of the longer 1987 definition not a new definition, and that it maintains the concepts of the original definition. However, in omitting the key concept of nursing’s specific phenomena of concern, it loses the distinction between nursing and other health professions, several of which, it could be argued, would meet the definition now ascribed to nursing. This demonstrates the importance in defining any profession of identifying its unique knowledge base. It shows that a comprehensive definition must specify the domain as well as the purpose and the practice.

The same key concepts are also found in the definition of nursing developed by the World Health Organisation (WHO) in response to the strategy of Health for All by the year 2000:

“The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that relate to the promotion and maintenance of health as well as to the prevention of ill health. Nursing also includes the planning and implementation of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying. Nursing is the provision of care for individuals, families and groups throughout the entire lifespan – from conception to death. Nursing is both an art and a science that requires the understanding and application of the knowledge and skills specific to the discipline. It also draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences.”¹⁵

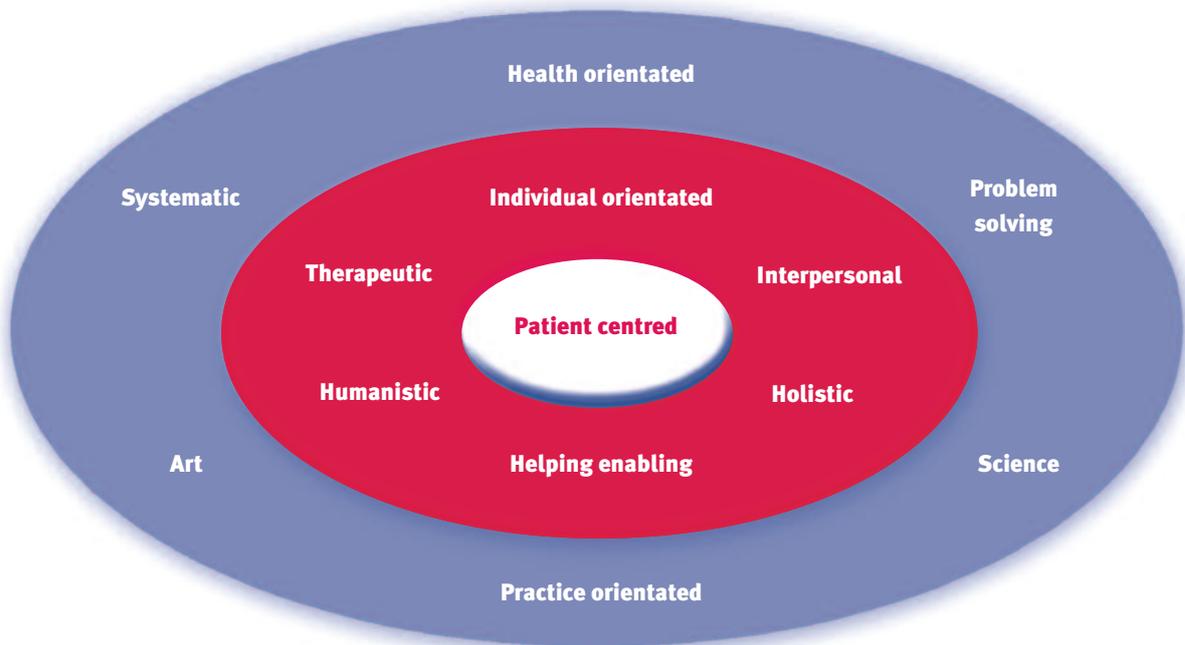


Figure 1. Key attributes of nursing derived from theoretical definitions/descriptions of nursing.²⁵

Theoretical definitions

From the early 1960s, advances in nursing education and a new emphasis on developing the knowledge base of nursing, especially in the USA, led to many new definitions as nurse teachers tried to find ways of explaining the nature of nursing to new entrants and to develop theories that would explain, predict, and guide nursing practice. Theorists such as Peplau¹⁶, Abdellah¹⁷, Orlando¹⁸, Johnson¹⁹, Orem²⁰, Roy²¹, Neuman²², King²³, and, in the UK, Roper, Tierney and Logan²⁴, emphasised different aspects of the patient and of nursing's purpose, but all identified and used the key concepts shown in Figure 1, above.

From the 1950s onward, the development of the nursing process, and the concept of nursing diagnosis, focused attention on the identification of the patient problems that nurses know about and treat. As nursing began to develop in the universities in countries such as the USA, Canada, Australia, and the Netherlands, the development of nursing science (the discipline-specific knowledge base of nursing) in these countries rapidly accelerated and came to be incorporated into definitions of nursing. The UK, however, has been slow to adopt these ideas and the concept of nursing science is poorly developed and nursing diagnosis is rarely used.

Other countries' definitions

Several other countries have developed formal definitions or descriptions of nursing for use in legislation or for framing nursing policy. As part of the *Defining nursing* project a survey of all the member countries of the International Council of Nurses was undertaken to identify countries that had a formal definition of nursing. A report of the survey is included in Appendix 1.

By far the most influential of these definitions has been that developed by the American Nurses Association, first published in 1980 in the document *Nursing: A social policy statement*:

“nursing is the diagnosis and treatment of human responses to actual or potential threats to health.”²⁶

This definition maintains the historical orientation towards health, but emphasises the process of clinical decision making (diagnosis and treatment) which is the core of all professional practice. It distinguishes nursing from medicine and other disciplines by identifying its expertise or knowledge domain as “human responses to actual or potential threats to health”.

By 1997, 42 of the 51 State Nursing Practice Acts were using the concept of the diagnosis of human responses in

their nursing legislation²⁷, and this definition is also used directly or forms the basis of the definitions used in several other countries identified in the survey of ICN members. It is also incorporated into the 1987 International Council of Nurses' definition quoted on page 7.

Codes of ethics

Definitions of nursing are also incorporated, sometimes implicitly, sometimes explicitly, in codes of ethics. For example, the Dutch Professional Code for Nursing begins with the question "What is nursing?" and gives the reply:

"The meaning of professional nursing is: to recognise, analyse, as well as give advice and assistance with regard to actual or threatening consequences of physical and/or mental courses of diseases, handicaps, disorders and their treatments for the benefit of the fundamental activities of daily living of an individual. Nursing also means influencing individuals in such a way that human potential is used for maintaining and promoting health."²⁸

The scope of nursing practice

Many of the definitions of nursing found in the literature and in documents supplied by other countries were embedded in the country's legislation or other specifications of nursing's scope of practice.

The Queensland Nursing Council²⁹ defines scope of nursing practice very simply as:

"That which nurses are educated, competent, and authorised to perform."

The International Council of Nurses' Position Paper *The Scope of Nursing Practice*³⁰ states:

"A scope of practice definition communicates to others the competencies and professional accountability of the nurse. Nursing is responsible for defining nurses' roles and scope of practice. However, while nurses, through professional, labour relations and regulatory bodies, bear primary responsibility for defining monitoring and periodically evaluating roles and scope of practice, views of others in society should be sought and considered in defining scope of practice... Nurses' spheres of responsibility include giving direct care, supervising others, leading, managing, teaching, undertaking research and developing health policy for health care systems."

The Canadian Nurses Association document *The scope of nursing practice: a review of issues and trends*³¹, published in 1993, summarises the nursing legislation of each of the nine provinces and two territories of Canada, and reviews trends across other countries. The review found that most Canadian provinces and many other countries specifically refer to the concept of the application of professional knowledge to the identification and treatment of nursing problems, and noted that jurisdictions were moving away from previously used lists of tasks towards definitions based on this approach.

In Australia, the Queensland Nursing Council (the regulatory body for nursing in Queensland) has undertaken a major project on the scope of nursing practice. The project included the development of a *Scope of nursing practice decision making framework*³². The documentation includes a list of definitions of the terms necessary to interpret the Framework, the first of which is a definition of nursing practice:

"Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick or disabled so that people with identified nursing needs may maintain or attain optimal wellbeing or achieve a peaceful death."²⁹

In many countries the nurse's scope of practice is specified in legislation, sometimes in specific nursing practice acts. In the UK, legislation is not used for this purpose as responsibility lies with the profession's regulatory body, formerly the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC), now the NMC.

The UKCC defined the scope of nursing practice as:

"The range of responsibilities which fall to individual nurses, midwives and health visitors... related to their personal experience and skill."³²

It noted, however, that:

"The practice of nursing, and education for that practice, will continue to be shaped by developments in care and treatment, and by other events which influence it."³²

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How the RCN definition of nursing was developed

Definitions of the scope of professional practice are also influenced by governments, employers, changing public expectations and changes in the practice of other health professionals.

In 1992, the UKCC published a document entitled *The scope of professional practice*³². This document changed the professional agenda by repudiating the idea that the scope of nursing practice could be defined by specifying tasks and introducing the principle that the limits of practice must be determined by the knowledge and skills required for safe and competent performance, and must be decided by the nurse. The document does not set out any list of tasks or functions that nurses can or cannot perform nor does it include any definition of nursing. Instead it bases its guidance on the principle that the limits of practice must be determined by the knowledge and skills required for safe and competent performance, and that the nurse is accountable for whatever he or she decides or does. This UKCC document was much debated and is still seen as a watershed in the development of nursing in the UK³³.

As the *Defining nursing* project developed, it became clear that definitions of nursing, specifications of the scope of nursing practice, codes of ethics, and professional regulation were closely related, and that more detailed work on these issues, outside the *Defining nursing* project, was needed. In particular, work is needed on defining the different types and levels of nursing practice. The preliminary work on this issue undertaken by the *Defining nursing* Steering Group is included in this document as Appendix 2, as a stimulus for the further work that needs to be undertaken.

Nursing may be defined as an activity, an occupation, a profession, or as a discipline. Professional practitioners (the doctor, the nurse, the lawyer) use their knowledge to identify and understand the problems presented by the client and to identify ways of solving them. The professional's knowledge base includes some knowledge that is shared with other people, but also includes discipline-specific knowledge about the particular conditions or problems which constitute the discipline's 'phenomena of concern' and the particular interventions that can be used to overcome them. This is the profession's particular domain – their particular expertise, or what they know about³⁴. Professional practitioners also have both shared and discipline-specific skills. The core skill, which defines and distinguishes professional practice in any field, is the judgement that matches the knowledge base to the individual client's need – the process that in health care is usually called clinical decision making or clinical judgement.

In the UK the most common approach to defining nursing has been by defining nursing as 'what nurses do', expressed in terms of roles, functions, or tasks. This approach is, however, inadequate because what people 'do' is determined by circumstances, and the boundaries change over time. Many tasks now undertaken routinely by nurses were once the exclusive prerogative of doctors, and sophisticated technical procedures which were once thought to require the skills of a registered nurse are nowadays taught to patients or their informal carers.

In the absence of an agreed definition, nursing in the UK has, in the past, been defined by:

- specific tasks and procedures
- which agency provides the service (NHS or local authority social services departments)
- its location (for example, care provided in hospital is defined as nursing, but not when it is provided in a care home)

- how it is funded (for example, NHS-funded continuing care)
- by the person who does it (for example, only if undertaken by a registered nurse).

None of these approaches is adequate.

In the multi-disciplinary activity of health care, where the purpose, values, and some of the knowledge and skills are shared by several professions, and where the allocation of tasks varies with circumstances, capturing the uniqueness of any one profession in a definition is not easy. Similar difficulties have been reported by other health care professions³⁵. It was suggested earlier in this document that the uniqueness of nursing (as of other health care professions) is in the particular combination of its elements and the way in which they are used. Analysis of the definitions identified in this project suggested that in order to be comprehensive and to distinguish it from other related professions, any definition of nursing must include its purpose, the means by which the purpose is achieved, and the particular domain that is identified by its discipline-specific knowledge base.

These factors were also identified in the Values Clarification Exercise³⁶ that was used in this project as a means of identifying and articulating the values and beliefs about nursing held by practising nurses. The Values Clarification Exercise consists of a series of statements of belief which the participant is invited to complete. It begins with a statement to help identify the main purpose of the topic for study, for example, *I believe the purpose of x is...* This statement is followed by a second statement which identifies how the purpose can be achieved, for example, *I believe this purpose can be achieved by...* A number of other statements are usually added depending on the purpose of the exercise and the concepts that are thought to be significant for developing and realising the shared vision. The statements are completed either by individual participants or by participants working in small groups, and the responses are then used as the basis for group discussion. Following the group discussion the responses are redefined and re-discussed, so that gradually a consensus statement is achieved. As many stakeholders as possible should be involved in the process.³⁶

This method was used at a meeting at RCN Congress 2002 which was attended by approximately 100 members. After Congress the statements (in the form of a questionnaire) were placed on the RCN website and

RCN members were invited to complete them either online or by printing and returning the completed form by post. The form was also used opportunistically with a variety of other groups of nurses. This was not a scientific exercise, and because of this opportunistic approach, the samples cannot be assumed to be representative of all nurses in the UK, but the exercise was important because it enabled every RCN member who wished to participate in the development of the statement to do so, and the data provides a rich picture of nurses' values, beliefs, and views about many aspects of their work.

The purpose of nursing

Respondents had no difficulty in articulating the purpose of nursing, and there was a clear consensus among them. Six key purposes emerged.

1. To promote and maintain health.
2. To care for people when their health is compromised.
3. To assist recovery.
4. To facilitate independence.
5. To meet needs.
6. To improve/maintain wellbeing/quality of life.

These responses reflect the formal definitions found in the literature, several of which (for example, Nightingale¹, Henderson¹², ICN¹³) define nursing explicitly by its purpose. They also reflect WHO's definition of nursing's mission¹⁵. The emphasis on promoting independence supports Henderson's widely used definition of the "unique function of the nurse"¹².

The practice of nursing

The second statement which respondents were required to complete tried to identify the means by which nursing achieves these purposes (the activities which constitute the practice of nursing). Many responses described the characteristics of the nurse (including personal qualities such as compassion, integrity, non-judgemental attitudes). Knowledge and education were clearly identified as important. Although some respondents identified concepts related to the provision of nursing services (for example, managing systems, setting standards) most responses described nursing skills used in direct patient care. The most common responses were:

- using knowledge/education/experience
- enabling/empowering/working with patients/advocacy

- communication skills (listening/ translating/counselling)
- teaching/giving information
- teamwork
- personal qualities of the nurse (for example, compassion, respect, integrity, non-judgemental approach).

The practice of nursing is not limited to direct patient care. The WHO definition of the functions of the nurse²¹ includes:

- providing and managing direct practical nursing
- teaching patients, clients and health care personnel
- acting as an effective member of a health care team
- developing nursing practice based on critical thinking and research.¹⁷

The activities and tasks in which the nurse fulfils these functions, “are a product of the knowledge and skills of the practitioners in the discipline”.¹⁷

Nursing knowledge

The third statement attempted to identify the discipline-specific knowledge base of nursing. The statement was initially expressed as: “I believe that nursing knowledge is...” When this was found to provide only adjectival responses such as “lifelong”, the statement was modified to “I believe that nursing knowledge is about...” Even so, and although nurses had identified using knowledge as one of the main ways in which the purpose of nursing is achieved, respondents had great difficulty in completing this statement. The difficulty may be because nurses are not used to describing their knowledge in this way, or because of the lack of a language to describe it, or because they are unaware of the knowledge they have. Some equated knowledge with experience, or with intuition, or with common sense. Since one of the defining characteristics of a profession is that it has an organised body of knowledge, this view of nursing knowledge denies the professionalism of nursing, and also the importance of evidence-based practice³⁷ which in earlier statements respondents had stressed. This may not be what respondents intended, but it clearly reflects the traditional UK view of nursing as ‘doing’.

Identifying the knowledge base of nursing is important because the possession and use of a knowledge base is seen as one of the most important defining

characteristics of a profession (for example, it is what distinguishes the work of the registered nurse from the nursing undertaken by support workers and informal carers). It is the discipline-specific knowledge base that distinguishes one profession from another, for example, nursing from medicine. It is clear, both from the nursing research literature and from observations of expert nursing practice, that nurses do have and do use a knowledge base, although it is not always well articulated, formulated, or tested. Benner has described nursing knowledge as “embedded in practice”.³⁸

In order for it to be communicated and tested, however, knowledge has to be expressed, normally through the use of language. At present nursing has no universally agreed terminology for describing its phenomena of concern. The ordinary words we use are not standardised, so their meanings vary according to the personal understanding of the people using them, and they are therefore inadequate for purposes such as documentation or research³⁹. The American Nurses Association (ANA) has taken a strong lead in developing nursing language since the 1970s, and in 1991 the ICN began a project to develop an International Classification for Nursing Practice (ICNP) in which many countries are participating^{40,41}, but in the UK interest has so far been limited to a few enthusiasts. However, the development of computerised clinical information systems and a standardised language for health care⁴² as part of the Government’s modernisation agenda is demonstrating the importance of this task. As in the case of defining nursing, it is important that nursing takes responsibility for its own terminology.

A full discussion of the nature of nursing knowledge is outside the scope of this document, but a critical issue is the difference between the two kinds of knowledge that are often referred to as know-how and know-that⁴³. Know-how knowledge is associated with personal experience, is usually unarticulated or communicated by word of mouth, and is used directly in nursing practice. Know-that knowledge is derived from theory and research, is usually communicated through the written word and formal education programmes, and is used for describing, predicting and prescribing nursing practice. Know-how knowledge is sometimes related to the art of nursing, know-that to the science⁴⁴. The two kinds of knowledge are sometimes perceived as competing alternatives, and the difference between them is sometimes described as the theory-practice gap. In reality, nursing, like all professional practice, requires both – while compassionate care is important, compassionate but ill-informed care may be harmful.

The British nursing literature, confirmed by the results of the Values Clarification Exercise³⁶, suggests that in the UK perhaps more than in other countries, know-how is much more highly valued than know-that. For example, the phrase nursing science, which is commonly used in other countries, is rarely used by nurses in the UK.

Where content was specified, a wide range of fields was identified. They included knowledge about health and illness, physical sciences such as physiology, and social sciences such as psychology (often expressed as understanding people). These responses reflect the WHO statement that nursing draws on the knowledge and techniques derived from the humanities, and the physical, social, medical and biological sciences in addition to knowledge and skills specific to the discipline¹⁴.

They do not, however, make explicit the discipline-specific knowledge base that constitutes nursing's particular domain.

The conditions that give rise to a need for nursing most commonly relate to the following:

- A self-care deficit: the person's inability to manage unaided those physiological, psychological, or social processes which are necessary to recover, maintain, or improve health.
- A knowledge or motivational deficit: the person's lack of knowledge, understanding or will to behave in ways that are necessary to recover maintain or improve health.
- Physiological or psychological instability.
- Pain or discomfort (physical, psychological or spiritual).
- An identified risk of any of the above⁴⁵.

In the definitions of nursing developed by the ANA²⁶, ICN¹⁷, and several other countries these conditions are described as human responses to actual or potential threats to health, and in most countries these responses are termed nursing diagnoses.

In the UK the concept of nursing diagnosis is rarely used. However, two related ideas emerged from the Values Clarification Exercise³⁶. These were:

1. the focus on the patient's experience
2. nursing knowledge as an amalgam.

The concept of the patient's experience which was identified by several respondents is quite similar to the

concept of human responses to actual and potential threats to health. The identification of the human responses with which nursing is concerned needs further research, but would include physiological responses such as skin breakdown, psychological and emotional responses (for example, anxiety), and social responses such as social isolation. The patient's experience is more difficult to define, but constitutes an amalgam of these responses.

The concept of nursing knowledge as a 'mixture' or an 'amalgam' is also well established. Many analysts have described nursing as "the glue that holds everything together". 'Amalgam' is an interesting term in that as well as meaning 'mixture' it is also (for example in dentistry) a complex substance in its own right. The complexity of nursing has been likened to the complexity of the body's connective tissue:

"The connective tissue matrix supports, sustains and co-ordinates the work of the specialised cells which carry out the function of the tissue. In older histology textbooks the matrix is depicted as white space with no discernible structure, but modern texts show that it is far from an amorphous substance – it is highly structured and organised."⁴⁶

A framework for a definition

Using the results of the Values Clarification Exercise³⁶, a definition of nursing was built up by combining the responses to Statement 1 (purpose) with Statement 2 (the practice) and Statement 3 (the knowledge base). The draft definition was used as a basis for consultation, which in turn identified additional concepts.

A single definitional statement that would incorporate all of the concepts identified would be long and complex. To retain brevity and simplicity, therefore, the definition presented is expressed as a core supported by six specific defining characteristics as outlined in Figure 2, see page 14. The full definition incorporates both parts.

Nursing is...

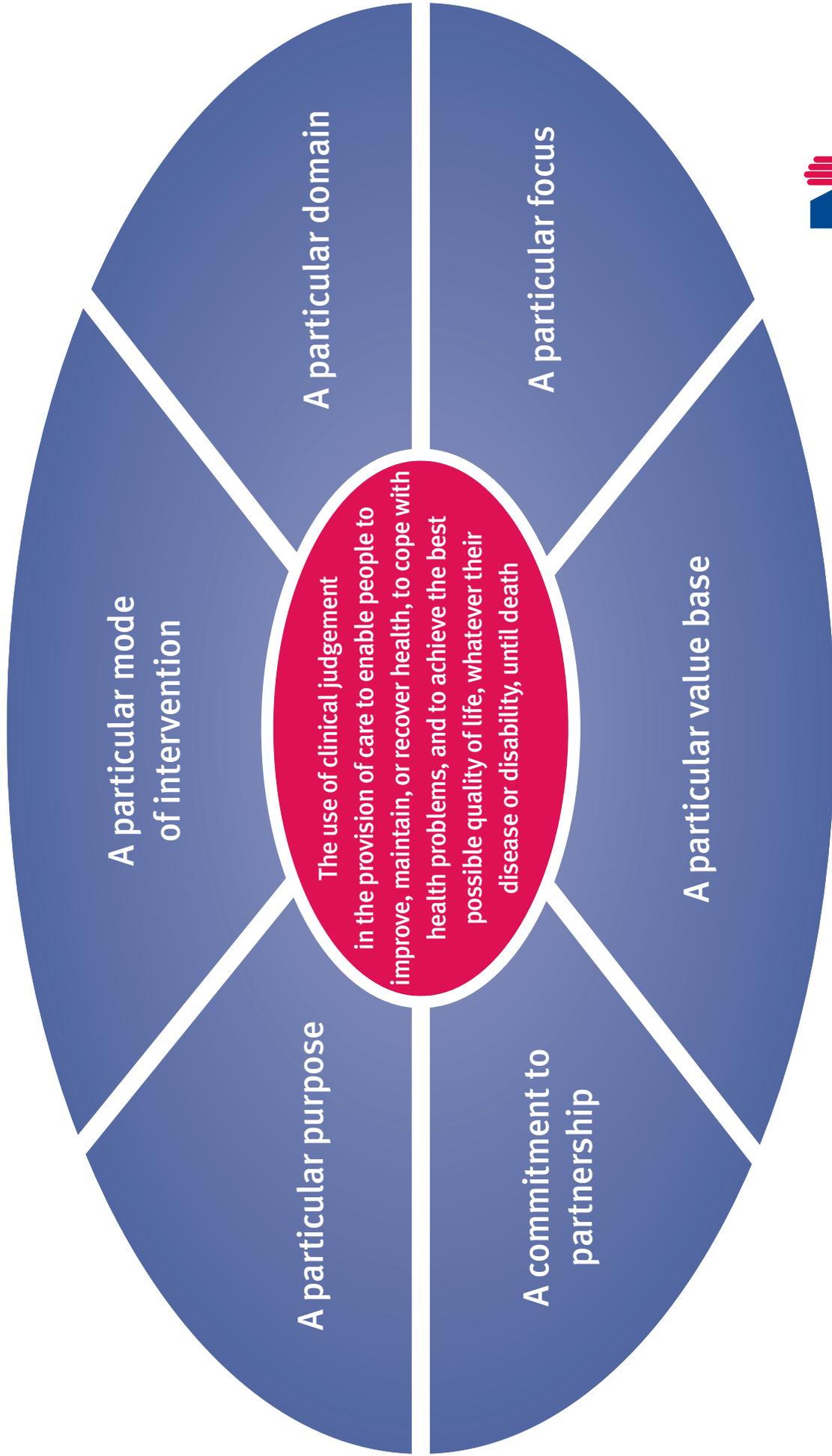


Figure 2: Core definition supported by six specific defining characteristics

6

Conclusion

The ability of nursing to respond to people's need for nursing within the rapidly changing environment of health care depends on the way in which:

1. nursing work is organised in health care delivery systems
 2. practice is regulated and the quality of care is assured
 3. practitioners are prepared,
- and, fundamentally, on
4. the way in which nursing itself is defined⁴.

Defining nursing is not easy: the concept is as complex as many of its activities. But that is not a reason for not doing it or for believing that it cannot be done. As stated earlier in this document, the International Council of Nurses makes clear that:

“Nursing is responsible for defining nurses’ roles and scope of nursing practice... ICN is responsible for articulating and disseminating a clear definition of nursing and the roles nurses engage in. National nursing organisations bear the responsibility for defining nursing and nurses’ roles that are consistent with accepted international definitions and relevant to their nation’s health care needs.”³⁰

This document represents the RCN's recognition and acceptance of this responsibility and its response to the challenge.

7

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8

Glossary

Sources of definitions:

AM: Meleis A (1997) (3rd ed) *Theoretical nursing*. Philadelphia: Lippincott.

ANA: American Nurses Association (1984) *Issues in professional nursing: 2 Specialisation in nursing practice*. Kansas City: ANA.

COD: Concise Oxford Dictionary (1999) (10th ed) Oxford: OUP.

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ICN: International Council of Nurses: Position statements. Geneva: ICN.

ICNP: International Council of Nurses (2001) ICNP Beta2. Geneva: ICN.

ISO: International Standards Organisation. International Standard ISO 1087: Terminology Vocabulary. Geneva: ISO.

JMM: Johnson M, Maas M, Moorhead S (2000) (2nd ed) *Nursing outcomes classification*. St. Louis: Mosby.

NANDA: North American Nursing Diagnosis Association (2001) *Nursing diagnosis: definitions and classifications 2001-2002*. Philadelphia: NANDA.

Nessling: Nessling R (1990) *Skill mix: A practical approach for health professionals*. London: Department of Health.

QNC: Queensland Nursing Council (1998) *Scope of nursing practice*. Brisbane: QNC.

RC: Report of the Royal Commission on Long Term Care (1999) *With respect to old age*. London: The Stationery Office.

RT: Roget's Thesaurus (2002) (150th Anniversary ed) London: Penguin Books.

Stevenson & Woods: Stevenson J and Woods N (1985) cited in: McKenna H (1997) *Nursing theories and models*. London: Routledge.

Styles: Styles MM (1985) ICN Regulation Project.

TCMD: Tabers Cyclopedic Medical Dictionary (2001) Philadelphia: FA Davis.

Advanced practice: Advanced practice is characterised by greater and increasing complexity and exists beyond beginning practice on the continuum of nursing practice. Education, experience and competence development mark advancing practice. As practice becomes more advanced nurses demonstrate more effective integration of theory, practice, and experiences along with increasing degrees of autonomy in judgements and interventions, Advanced practitioners may take leadership roles in relation to nursing and other health care activities. (QNC)

Advocacy: The act of speaking or acting on behalf of another.

Autonomy: Self determination (RT); the right and the ability to decide for oneself.

Clinical judgement: The exercise of the clinician's experience and knowledge in diagnosing and treating illness and disease (TCMD)

Characteristic: A feature or quality typical of a person, place or thing. (COD)

Defining characteristic: A characteristic which is indispensable to understanding a concept and used for delimiting the concept from other concepts. (ISO adapted)

Definition: A formal statement of the exact meaning of a word; an exact description of the nature, scope, or meaning of something. (COD)

Diagnosis:

1. The identification of the nature of an illness or other problem by examination of the symptoms. (COD)
2. The name given to the problem identified. (COD)

Discipline: A branch or domain of knowledge, instruction or learning. Nursing, medicine, physical therapy, and social work are examples of professional disciplines. History, sociology, psychology, chemistry, and physics are examples of academic disciplines. (TCMD)

A discipline is characterised by a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its enquiry. Nursing as a discipline is broader than nursing as a science. Its uniqueness stems from its perspective rather than the focus of enquiry or methods of enquiry. (Donaldson and Crowley)

Discipline-specific knowledge base: The knowledge base that is unique to a particular discipline.

Domain: A sphere of activity or knowledge. (COD)

The domain is the perspective and the territory of the discipline. It contains the subject matter of a

discipline, the main agreed-on values and beliefs, the central concepts, the phenomena of interest, and the methods used to provide answers in the discipline. (AM)

Generalist: A person competent in several different fields or activities. (COD)

Generalist nursing practice: Generalist practice encompasses a comprehensive spectrum of activities. It is directed towards a diversity of people with different health needs, it takes place in a wide range of healthcare settings, and it is reflective of a broad range of knowledge and skills. Generalist practice may occur at any point on the continuum from beginning to advanced practice. (QNC)

Generic: Relating to a class or group; not specific; having no brand name. (COD)

Higher level practice: The term used by the UKCC in preference to the term 'advanced practice'. The UKCC does not define the term, but states that practitioners working at this level have the capacity to bring about change and development within their own and others' practice and within the services in which they work.

Holism: The treating of the whole person rather than just the symptoms of a disease. (COD)

Nurse: Most countries define a nurse as 'a person qualified and authorised to practise nursing'. In the UK there is no such legal definition, and the term nurse is also used by veterinary and dental assistants and by nursery nurses, but only those whose names appear on the Register maintained by the Nursing and Midwifery Council are legally entitled to be called "registered nurse".

Nursing diagnosis

1. A clinical judgement about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable. (NANDA, 2001)

2. Label given by a nurse to the decision about a phenomenon which is the focus of nursing interventions. (ICNP)

3. The conditions that nurses treat that are analogous to the conditions (medical diagnoses) that doctors treat.

Nursing intervention: Action taken in response to a nursing diagnosis in order to produce a nursing outcome. (ICNP)

Nursing outcome: The measure or status of a nursing diagnosis at points of time after a nursing intervention. (ICNP)

Nursing sensitive patient outcome: A measurable patient or family state, behaviour or perception that is influenced by and sensitive to nursing interventions. (JMM)

Nursing science: A domain of knowledge concerned with the adaptation of individuals and groups to actual and potential health problems, the environments that influence health in humans, and the therapeutic interventions that promote health and affect the consequences of illness. (Stevenson and Woods)

Outcome: Those changes, either favourable or adverse in actual or potential health status of persons, groups, or communities that can be attributed to prior or concurrent care. (Don)

Pathological: Diseased, due to a disease. (TCMD)

Patient: A person receiving medical [or nursing] treatment. (COD)

Personal care: Care that directly involves touching a person's body (and therefore incorporates issues of intimacy, personal dignity and confidentiality), and is distinct both from treatment/therapy (see below) and from indirect care such as home help or the provision of meals... It falls within the internationally recognised definition of nursing, but may be delivered by many people who are not nurses. (RC)

Prescribe: To advise and authorise the use of. (COD)

Professional regulation: The forms and processes whereby order, consistency, and control are brought to an occupation and its practice (ICN).

How the profession is governed, the standards set for nursing education and practice, the process for developing those standards, and the mechanisms for putting those standards into effect. (Styles)

Professional self-regulation: A contract between the public and the professions which allows them to regulate their own members in order to protect the public from harm that could be caused by poor or unsafe professional practice. (UKCC)

Science: A unified body of knowledge about phenomena that is supported by agreed-upon evidence. (AM)

Scope of practice:

1. That which nurses are educated, competent, and authorised to perform. (QNC)

2. The range of responsibilities which fall to individual nurses, midwives and health visitors... related to their personal experience and skill. (UKCC, 1992)

Skill-mix: The balance between trained and untrained, qualified and unqualified, and supervisory and operative staff within a service area as well as between staff groups. (Nessling)

Specialisation:

1. The limitation of one's practice to a particular branch of medicine, surgery, dentistry or nursing. This is customarily done after having received postgraduate training in the area of specialisation. (TCMD)
2. A narrow focus on part of the whole field of nursing. It entails the application of a broad range of theories to selected phenomena within the domain of nursing, in order to secure depth of understanding as a basis for advances in nursing. (ANA)

Specialist nursing practice:

1. Specialist practice focuses on a specific area of nursing. It is directed towards a defined population or a defined area of activity and is reflective of depth of knowledge and relevant skills. Specialist practice may occur at any point on the continuum from beginning to advanced practice. (QNC)
2. The exercising of higher levels of judgement, discretion, and decision making in clinical care. (UKCC)

Specialist practitioner: A nurse who, having undertaken an educational programme that meets the specified NMC standards, holds the specialist practitioner qualification.

Therapeutic intervention: An intervention intended to have a good effect on the body or the mind. (COD)

Treatment: Any specific procedure used for the cure or amelioration of a disease or pathological condition. (TCMD)

A procedure deliberately intended to cure, or ameliorate a pathological condition. (Royal Commission on Long Term Care, 1999).

9

Appendix 1: Survey of members of the International Council of Nurses

In order to identify definitions of nursing that had been developed in other countries, a short questionnaire, with a covering letter explaining the *Defining nursing* project, was sent to the presidents of the 123 members (excluding the UK) of the International Council of Nurses. The questionnaire asked whether the country in question had an official definition of nursing, and whether the National Nurses Association (NNA) had developed a definition of nursing, and where either the answer to either question was affirmative, to send any relevant documentation. With the help of ICN staff, the letter and questionnaire were translated into French and Spanish so that each country was able to receive it and to respond in their most familiar ICN language. Wherever possible the letter and questionnaire were distributed by email as well as in hard copy form.

Thirty-four replies were received, a response rate of just under 30 per cent. While this response rate was disappointingly low, it is typical and understandable for this kind of survey.

Thirty countries were identified as having either an official country definition of nursing, or a definition developed by the NNA, or both. In some cases the NNA definition had been adopted as the official country definition.

Of these thirty countries, eleven used the ICN definition of nursing, and two used the Henderson definition, and key concepts used in these definitions could be seen in several of the 'independent' NNA definitions.

The eighteen independent definitions that were submitted showed several common features. Several contained phrases that are also contained in the ICN definition. Almost all contained wording which defined the purposes of nursing to include the promotion of health, often utilising the phraseology of "promotion, prevention, maintenance, and recovery" as used in the ICN and other definitions. Most specified the nurses' clientele, and where clientele was specified, it always included families and communities (or groups) as well as individuals, and included healthy people as well as sick people. Only two countries (Japan and Thailand) appeared to focus on the care of the sick. Several

included an expression of values, including terms such as caring, holism, and dignity. Denmark claimed to have no official definition but to use instead a detailed statement of values. Twelve definitions specifically referred to the use of knowledge and skills, or the use of the nursing process, or described nursing as a scientific discipline. Four specifically identified the domain of nursing as human responses, or outcomes, or consequences as opposed to pathology.

The findings suggest that the definition of nursing contains a large core which is geographically global and specifies a common purpose, common values, common activities, and incorporates as its clientele people of all ages as individuals, families and group.

10

Appendix 2: Thinking ahead: key issues for the definition of nursing in the UK

As the *Defining nursing* project developed, it became clear that definitions of nursing, specifications of the scope of nursing practice, codes of ethics, and professional regulation were closely related, and that more detailed work on these issues, outside the *Defining nursing* project, was needed. The consultation process indicated several areas where there is a particular need for further work. One such area is the definition of the different types and levels of nursing practice. The preliminary work on this issue undertaken by the *Defining nursing* steering group is included here as a stimulus for the further work that needs to be undertaken.

Types and levels of nursing practice

Different types and levels of practice in nursing have long been recognised, but the definition and the scope of the different types and levels are still much debated. The Queensland Nursing Council describes nursing as a “continuum”:

“The scope of nursing practice encompasses clinical, educational, administrative and scholarly dimensions of nursing practice on a continuum from beginning to advanced. It also incorporates generalist and specialist practice of the registered nurse.”¹

This definition incorporates the different fields of nursing practice (clinical practice, education, management and research), the range (generalist and specialist), and the different levels (beginning to advanced). It is important that these three concepts (field of practice, range, and level) are not conflated or confused.

From novice to expert

Benner² has described the development of nursing practice through a series of five stages: novice practice, advanced beginner practice, competent practice, proficient practice, and expert practice. This model was originally developed by Dreyfus and Dreyfus³ who studied skill acquisition among chess players and airplane pilots. The practitioner progresses from decision making guided by reliance on rules and

guidelines (novice practice) to decision making that is characterised by an intuitive grasp of the most salient aspect of each situation with the minimum number of cues (expert practice). Benner shows the importance of experience in the development of nursing expertise, and also the centrality of clinical decision making and clinical judgement, as opposed to technical skills, in nursing practice. Benner’s work has been very influential in the development of nursing practice, but it is sometimes misunderstood. For example, the five stages have been used to describe the progress of nursing students, whereas Benner’s work concerned only registered nurses, and Benner would define the level of practice of the newly registered nurse as novice. Benner also argued that each time a nurse moves from one field of practice to another, she becomes a novice again, however expert she was in her previous field.

Expert practice

Benner’s work has stimulated further study of the concept of expert practice. For example, Conway⁴ has described four different kinds of expert nurses based on the nurse’s world view and using titles which she suggests encapsulate their characteristics.

- The technologist: demonstrates anticipatory, diagnostic, know-how, and monitoring knowledge.
- The traditionalist: focuses on survival and sees nursing as papering over the cracks, is pre-occupied with getting the work done, concentrates on the management of care, attaches value to doing rather than reflection, sees education as an optional extra and not essential to expert practice.
- The specialist: focuses on prescribing treatment regimes, including medication.
- The human existentialist: passionate about nursing, holistic in perspective, a risk taker, educationally well developed, self aware and aware of her influence on others.

Conway shows the effects of socialisation and organisational culture on the use and development of nursing knowledge in expert practice.

The RCN's *Expertise in practice* project⁵ aimed to develop a deeper understanding of expertise in British nursing practice and to develop a recognition process for expertise. The project was able to demonstrate the interconnectedness of contextual factors and other professional skills with actual patient care. The project identified the following attributes of expertise in nursing, which the participants demonstrated in everything they did, regardless of the type of intervention:

- knowing the patient (which enables personalised care to be delivered)
- holistic knowledge and practice (this was seen in the integration of different types of knowledge from different sources)
- saliency (which enables the expert to identify and give priority to a patient's most significant issue)
- moral agency (practice guided by respect for the person's autonomy and dignity and the belief that nursing should be done in a warm and caring way)
- skilled know-how (demonstrated in dextrous and skilled integrated performance of both technical and non-technical skills).

Specialisation in nursing

Specialisation is a feature of the development of most professions. Specialisation in nursing has been defined as:

“a narrow focus on part of the whole field of nursing. It entails the application of a broad range of theories to selected phenomena within the domain of nursing, in order to secure depth of understanding as a basis for advances in nursing.”⁶

Specialisation in nursing has been discussed since the beginning of the last century, but became a particular issue for debate during the 1980s^{6,7,8,9,10,11}. The drivers of specialisation have been identified as:

- new knowledge
- technological advances
- public needs and demands.

The controversy arises from the tension between these factors and concerns that specialisation may lead to fragmented care and the loss of holism. Concern has also been expressed that development of specialisation in nursing tends to follow medical specialties rather than using its own conceptual frameworks. The

International Council of Nurses was alarmed by the rapid and disorderly escalation of new specialties and new nursing roles, and in 1992 it issued guidance⁹ stressing the importance of adopting a consistent approach to the identification and designation of nursing specialties (the range of nursing practice), and the need to set standards (the regulation of nursing specialists). It proposed ten criteria that national nurses' associations should consider in developing a systematic means for reviewing and designating specialties¹⁰.

Specialist and generalist

The tension between specialist and generalist is currently a contested issue in all the health care professions.^{11,12} In the UK, which is now the only country in the world that does not prepare a generalist nurse at the level of initial registration, the debate is currently centred on the UKCC's proposals¹³ for review of the branch structure in pre-registration preparation.

There is considerable confusion between the terms generalist and generic, and there have been proposals¹⁴ for a generic health care worker. The Concise Oxford Dictionary defines the term 'generic' as:

characteristic of a genus or class; applied to any individual of a large group or class; general, not specific or special.¹⁵

and the term generalist as:

a person competent in several different fields.

The Queensland Nursing Council (Australia) defines generalist nursing practice as follows:

“Generalist practice encompasses a comprehensive spectrum of activities. It is directed towards a diversity of people with different health needs, it takes place in a wide range of health care settings, and it is reflective of a broad range of knowledge and skills. Generalist practice may occur at any point on a continuum from beginning to advanced.”¹

The European Union Advisory Committee on Training in Nursing defines the scope of practice of “the nurse responsible for general care” as follows:

“The professional practice of a nurse responsible for general care covers the care of children, youths, adults and elderly persons who are treated in the context of in-patient or out-patient care for acute or chronic health complaints of a somatic or psychiatric nature.”¹⁶

Care has been taken to ensure that UK pre-registration programmes in care of the adult meet the requirements of the EU Directives, but the other branch programmes do not, and the registration of nurses in these branches may therefore not be recognised for the purpose of the free movement of labour across the EU.

While few nurses support the notion of a generic nurse, RCN enquiries suggest¹⁷ that an increasing number support the development of the generalist nurse at the point of initial registration, to be followed by specialisation at the post basic level.

Specialist practice

The Queensland Nursing Council (Australia) defined specialist practice as follows:

“Specialist practice focuses on a specific area of nursing. It is directed towards a defined population or a defined area of activity and is reflective of depth of knowledge and relevant skills. Specialist practice may occur at any point on a continuum from beginning to advanced.”¹

This definition explicitly distinguishes between range and level and states that specialist practice may occur at any level of practice. However, by stressing the need for post-registration preparation for specialist practice, other organisations, including the UKCC, identify specialist practice as a higher level of practice. The ICN⁹ recommended that specialist status should be reserved for nurses who had obtained a post-basic educational qualification, possibly at masters level, in their particular specialty. However, this position assumes that initial registration, and therefore initial practice as a registered nurse, is generalist.

In line with the ICN’s approach, the UKCC drew a clear distinction between “practising with a specialty” and “being a nursing specialist” and explicitly defined and set standards for specialist practice¹⁸. In 1994, as part of its Post-registration Education and Practice (PREP) project, the Council published educational standards for eight specialised areas of nursing within the field of public health/community nursing, along with systems for recording the qualification and using the title of specialist practitioner. (It also identified a further level of advanced practice, but decided at that time not to set standards for advanced practice.) This development has caused some confusion, because as well as being regarded as a level of practice, the qualification is also the recognised preparation to work in any area of

community practice, and for health visiting it is the initial (and registerable) qualification which is mandatory for practice as a health visitor.

The latest (2001) guidance from the UKCC¹⁹ specifies standards for specialist practice and systems for recording the qualification and for using the title of specialist practitioner. It explicitly defines specialist practice as a level of practice:

“Specialist practice is the exercising of higher levels of judgement, discretion and decision making in clinical care. Such practice will demonstrate higher levels of clinical decision making and so enable the monitoring and improving of standards of care through – supervision of practice; clinical audit; development of practice through research; teaching and the support of professional colleagues and the profession of skilled professional leadership... Specialist practice will require the exercising of higher levels of judgement, discretion and decision making, focusing on four broad areas:

- clinical practice
- care and programme management
- clinical practice development and
- clinical practice leadership.

This higher level of practice can be exercised in any area of healthcare delivery”.

In retrospect, it can be seen that the use of the term higher level of practice in statements about specialist level practice was extremely confusing, particularly as in January 2002 the UKCC went on to suggest standards for a distinctive ‘higher level of practice’ – see below.

The RCN is currently taking its own initiative in developing an integrated framework for post-registration education and practice in nursing specialties. The newly formed Faculty of Emergency Nursing has developed and piloted a core competency framework, covering differing levels of practice. The findings of this pilot will inform the final stages of establishing the faculty and rolling out the programme to other specialisms across the UK.²⁰

Basic and higher levels of practice

The term used to describe the level of practice that follows initial registration varies from country to country. In most countries it is called basic nursing practice. In 1994 the UKCC Post registration Education and Practice Project used the term primary practice, but this became confused with the term primary nursing (which is a method of organising nursing work), and primary care (which is a specific field of practice) and was subsequently dropped. The Queensland Nursing Council uses the term 'beginning practice' which it defines as:

“the initial practice for which they [ie registered nurses] are educationally prepared and in which they have demonstrated the achievement of beginning level competencies.”¹

In most countries the scope of this level of practice is expressed in the specification of the competencies required for initial registration as a nurse. In the UK these are set out in statutory rules developed by the regulatory body and elaborated in the requirements and other guidance documents developed by the various organisations responsible for assuring the quality of nursing education. In most countries this level of practice implies generalist nursing, but as explained above, in the UK, practice following registration is currently based on specialisation in one of four branches of nursing – care of the adult, child, people with mental health problems, and people with learning disabilities.

Advanced and Higher Level Practice

The term advanced nursing practice and nurses who were called advanced practice nurses began to emerge in the USA during the early 1980s. In the UK, debate initially centred around the distinction between the extended and the expanded role of the nurse²¹. The term extended referred to the performance by nurses of tasks formerly undertaken by doctors and was subject to the decision of the doctor to delegate and the decision of the employer to authorise. The Department of Health issued guidance on lists of tasks and processes to protect against litigation²², and employers provided certificates of competence which were not transferable to other employers. The term expanded referred to the enhancement of existing nursing roles through greater autonomy based on increasing depth of nursing knowledge. The UKCC's document, *The scope of professional practice*²³, changed the professional

agenda by repudiating the idea that the scope of nursing practice could be defined by specifying tasks and introducing the principle that the limits of practice must be determined by the knowledge and skills required for safe and competent performance, and must be decided by the nurse.

The Queensland Nursing Council (Australia) offers the following definition and description of advanced practice:

“Advanced practice is characterised by greater and increasing complexity and exists beyond beginning practice on the continuum of nursing practice. Education, experience and competence development mark advancing practice. As practice becomes more advanced nurses demonstrate more effective integration of theory practice and experiences along with increasing degrees of autonomy in judgements and interventions. Advanced practitioners may take leadership roles in relation to nursing and other health care activities.”¹

The ICN has recently defined the scope of practice of advanced practice nurses and nurse practitioners.²⁴ The definition includes the following characteristics associated with the nature of practice.

- Integrates research, education and practice.
- High degree of professional autonomy and independent practice.
- Case management/own caseload.
- Advanced health assessment skills, decision making skills and diagnostic reasoning skills.
- Recognised advanced clinical competencies.
- Provision of consultant services to health providers.
- Plans, implements and evaluates programs.
- Recognised first point of contact for clients.

It is clear from these definitions that the concept of advanced practice implies a qualitatively different kind of decision making of the kind that is described by Benner as expert practice, although it implies more than the possession of expertise. It is not directly related to a series of tasks performed or occupational competencies. It is quite different from the concept implied by the UKCC in their statement that:

“all practitioners have the opportunity of advancing their practice,”

and it is not intrinsically related to the performance of specific roles such as ‘consultant’ or ‘researcher’, although it is likely that nurses who are undertaking advanced practice will be able and will be expected to undertake such roles. However, much of the literature on advanced practice deals with the roles of the Advanced Practice Nurses (a term not used in the UK) and the characteristics of the nurses who are to fulfil such roles, rather than defining the characteristics of the practice itself²⁵.

In January 2002, the UKCC published the outcome of its higher level of practice Pilot and Project²⁶. The Post-registration Education and Practice (PREP) project had originally identified two levels of practice beyond the point of registration: specialist and advanced, but became clear that many members of the profession wanted the UKCC to complete its work on a post-registration framework by setting a recordable standard for a higher level of practice (a term which was considered preferable to that of advanced practice). The Council developed a draft descriptor, standard and assessment system and piloted it across the UK. The final standard has seven competencies against which individual nurses would be assessed: providing effective health care; leading and developing practice; improving quality and health outcomes; innovation and changing practice; evaluation and research; developing self and others; and working across professional and organisational boundaries.

The position of the UKCC and its successor body the NMC remains unclear.

Further work

The future role, function, and scope of practice of nurses depend heavily on policies which are currently being developed at local, regional, and international level. These policies include workforce development, systems for nursing education, and the future role of nurses in health and social care. It is vitally important that these policies are based on a clear understanding of the nature of nursing and its potential contribution to the health of people, and that nurses themselves, who understand best the nature and purpose of their work, are fully involved in their development. *Defining nursing* forms a foundation upon which the RCN, through its members, influences and shapes these policies at all these levels.

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Appendix 3: The RCN Principles of nursing practice

In 2010, the RCN developed and published *The RCN Principles of nursing practice*. The principles are a set of statements describing what constitutes safe and effective nursing care. They apply to all nursing staff, in any setting – for example, ward managers in hospitals, team leaders in community, specialist nurses, community and mental health nurses, health visitors, health care assistants and nursing students. Developed through the working jointly with patients, the public, health care colleagues and nurses and encompassing current literature, the principles are endorsed by the NMC and patient groups. Importantly, *The RCN Principles of nursing practice* cover aspects of behaviour, attitude and approach which underpin good nursing care and are often the focus of care quality reviews:

- dignity
- responsibility
- risk management
- patient-centred care
- communication
- knowledge and skills
- team working
- leadership.

Therefore they can be used by nurses to help them reflect on practice; to generate discussion on aspects of behaviour, attitude and approach which underpin good nursing care and to challenge situations where expectations are not being met. Students can use the principles to help them understand good practice; to think about nursing values; and to develop as a professional. Patients can use the principles as a sort of checklist to evaluate the care they ultimately receive.

www.rcn.org.uk/principles

The Principles of Nursing Practice

The Principles of Nursing Practice tell us what patients, colleagues, families and carers can expect from nursing.

The Principles

A

Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

B

Nurses and nursing staff take responsibility for the care they provide and answer for their own judgements and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

C

Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

D

Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

E

Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

F

Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

G

Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

H

Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

Nursing is provided by nursing staff, including ward managers (in hospitals) or team members (in the community), specialist nurses, community nurses, health visitors, healthcare assistants or student nurses.

www.rcn.org.uk/nursingprinciples



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