SHADES OF GREY: NOTES ON PRACTICE OWNERSHIP

Having been a developmental disability nurse for the last 30 years, and a founding member of PANDDA, it is high time I join in and stand here today. What better than to be able to discuss nursing practice ownership, central to the nursing narrative of any specialty; and ours is rich indeed.

What is in a title?

Shades of grey

I was the only RN doing a Bachelor of Nursing at the Australian Catholic University in 2008. I had to keep explaining my nursing background wherever I went. I was in many respects something of an enigma. When I signed on for the palliative care elective, I told the Lecturer that I hoped to keep up and do the work justice. He said that the other students (2nd year) still saw everything in black and white, whereas I could see the shades of grey. For me, this is the clarity, the wholeness of vision essential to approaching practice ownership.

Notes on practice ownership

The phenomenon of ownership, that of our specialty practice, necessarily invites analysis and discussion at more than one level. My intention here is to explore ownership at the individual (expert) practice level. I have looked to Nightingale's Notes on Nursing: what it is and what it is not (1860) as a guide. I wanted something that talks of passion and commitment to a lifetime's work; something that speaks of my clinical interest at the moment. Nightingale set the foundations for nursing practice which involved order, self-discipline, effective management and 'ceaseless care in the matters of detail'(Mathieson, c. 1918). Over the years, we as a body of nurses have set the foundations for our nursing specialty. We have had to respond and adapt to many challenges along the way (not least of which being the needs of our people), using past experiences and increased knowledge to improve service delivery. Nightingale formalised training for nurses. Those of us who received hospital training now have a place on the history of nursing timeline. The composition and education of the nursing workforce has changed significantly since then, creating a need to look carefully at how basic nursing care (and there really is nothing basic about it) is delivered – what is referred to as Nightingale's attention to detail; intolerance of less than excellence in care; fundamentals that must be provided for all in nursing, from the inexperienced to expert (Dunbar, 1969)). Nightingale was a great teacher who passed on what she had observed and learnt. There is much that we as expert nurses still can and must pass on to those whom we wish to continue excellence of care for our people.

Ownership up close

It is not always easy to organise one's thoughts or reflections on an entity into something resembling a coherent whole, let alone present them to peers and colleagues, but there is always risk in giving of the self in any [professional] situation. I liked the idea of 'notes' – it suggests preliminaries, something to work on.

I consider the nature of ownership as process, essentially subject to pressure from external changes and discourses. The impact leads to re-evaluations, from which research emerges and practice changes may occur. But how many of our individual, own efforts and achievements, with their meanings, are embedded in whatever it is that represents our collective ownership profile? Does it matter – and to whom? Has practice ownership been defined at a known point within nursing's past and present, or is it defined by the work that exists (has existed) from moment to moment?

Reporting in the literature with relevance to key words such as 'owning', 'practice', 'nursing' is concerned with advanced nursing practice; evidence-based practice; reflection; getting it right; expert nursing practice; presence; the influence of technology on practice (Duffy, 2007; Lewis-Hunstiger, 2011; Locsin & Purnell, 2007; Mackey, 2009; Mantzoukas, 2008; Morrison & Symes, 2011; & Taylor et al., 2008). This was not an exhaustive search; rather the beginning of exploration. Key words from ten RNs (Developmental Disability) included responsibility; competence; recognition or acknowledgement from outside the nursing specialty as integral to ownership; expert knowledge and excellence of practice at all times. Associated comments focused on frustration that nurses outside the specialty area had no idea what their expertise involved.

I would add promotion to this list, promotion of what makes us specialists, what we do, what we can offer. My experience as an acting CNC is an illustration of this, I think. Part of the role was to ensure continuity and quality of care during people's hospital admissions, and to co-ordinate discharge planning. Most of these admissions occurred in the same hospital, so some of the doctors and nurses got to know me quite well over a two year period. There were a lot of quite intense interactions, as quality of life, treatment options and outcomes were often the main points of discussion and negotiation. Many of the people and their family members I met for the first time in distressing circumstances. I gave what I judged was needed: strong advocacy for my people, based on their care needs at the time, backed by a wealth of knowledge and experience. The job was to deliver on the run mostly because of course time was ever in short supply.
Initially I was barely 'seen' as a nurse. I had to explain repeatedly who I was and what I could do to support their (the health teams) care of my people. Once they saw that I was not going to go away, that I was articulate and knew what I was talking about, things changed. I think that my presence – the way in which I positioned myself in those situations – and expertise made a

difference. Treating doctors would call me for advice; I had a few ‘thank God you’re here’ moments. The hospital CNCs would sometimes ask for advice for their patients who had a developmental disability. One doctor said how impressed he was by our pressure care. The doctors and nurses were great; they did their best for my people and of course it was rarely easy. I think that we all learnt from our shared experiences.
I will say that courage is another key word (Spence & Smythe, 2007). It takes courage to speak up sometimes in different professional settings. It takes courage sometimes to walk through that door when you know that you are going to have to give all that you have got.

I want to talk a bit now about presence: the intentional use of self, in ontological terms, as this is central to my conception of practice ownership. Presence of course is a significant point of nursing research topics such as reflection, advanced practice, wellness and illness, technology and how it affects nursing practice (Lewis-Hunstiger, 2011; Mackey, 2009; McQueen & McQueen, 2010; & Taylor et al., 2008).I have not yet seen stated links with ‘ownership’ as such, but then I have not yet done extensive literature searches. What I find fascinating, as well as stressful, about writing, is that I never know what the end product will be. This is note taking indeed.

In talking about ownership at the expert level of practice, I am taking competence in terms of ‘nursing tasks’ and putting it to one side. Such competence is of course essential, but the challenge is to do these things whilst fully engaging with the moment; that is your relationship with your person at that time. Seeing your person as a full participant in his or her care, rather than merely a recipient of care. The object body and the subjective self (Mackey, 2009). I am no philosopher but I do seriously consider Heidegger’s and Sartre’s thoughts concerning what it means to ‘be’ (McQueen & McQueen, 2010).

How do people view themselves and their place in the world, and others in relation to themselves? How do we relate to differences in others?

When I was 14, at boarding school in England, we were sent to the nearby Epileptic Colony to sing Christmas carols. My memory is of us girls singing, while a man wearing a helmet (why?, I thought) poured himself a cup of coffee, moved away from the table, then suddenly dropped to the floor, the cup and coffee going in different directions. End of carols. I had nothing in my life experience at that point to enable me to make any meaning out of that in relation to his experience.

A few years ago, I was at Windsor with X (who uses a wheelchair). I saw a man staring at him, so I asked him what he had done.

How often have I heard ‘why is he still here? Wouldn’t it have been better if he had died ’? I reply: ‘you cannot know what his life is like, any more than he

can know what your life is. You cannot know what my life is, nor I yours. Of course you take in what you see and hear and draw conclusions, but they are not truth. The fact is that he exists in the world, here, now, and that has to be your point of reference. Also know this: I like him'! This form of existential wondering is valid as such, and supporting people (these were nursing students) through confronting situations and helping them to find workable meaning in the context of those situations, is part of the job. I suppose that such questions could have been put out there to see how I would react. I hope that they still learnt something useful.

I will talk further about being, and meaning, when I return to Nightingale's 'care in the matters of detail'(Mathieson,c.1918), in relation to the need to look carefully at how basic nursing care is delivered. I would like now to consider the dynamics of complex, highly emotional nursing situations as a way of describing the intentional use of self, and of highlighting the need for self care (Taylor et al., 2008). I choose to consider a person's dying at that critical point in the hospital environment where expert medical advice is given and hard decisions have to be made. These situations are not unique in themselves (in that they happen; otherwise of course they are unique), but my reactions, actions and the meaning that I attribute to them, are.

I have a certain amount of information before I become a presence in this situation: who the person is; that I do not know this person or the family members; how well I know the person and the family members; the health history leading the person to this critical lived moment; that this is sudden; that the family members are already present, or that they are on their way; that I am going to do what I judge to be right at the time, and trust myself. When I walk through the door, I will be fully committed to the moment, to the people in it, to my role as a nurse. I will embrace the unknown, with the potential of risk (getting it right) and of cost – to the self (Taylor et al., 2008).

Here, the dynamics are intense. There is a job to be done; the work towards best care outcomes, via decision making, for the person and the family members, for together they become an entity in the moment, by the dying of the one. We know how this management goes, in all its varieties. The focus here is on how I place my self in the moment, to guide and support the decision makers to that point of acceptance, of resolution? I need to judge what it is right for me to do and be in a given moment. I may be up close, I may step back, physically, but I remain present, fully attentive to the moment.

There is a real need for care of the self after immersion in complex, emotional nursing situations. Maintaining presence requires much energy. I do not know how long this will take; how events will unfold. I feel the pain and distress of others, as I maintain professional distance because that is required of me. I have to mentally put my own distress to one side because my self is engaged in the support of others. Afterwards, I can deal with my own emotions, and hope that I have got it right. I can reflect on the fact that it is a privilege to be present up close in the critical life moments of others; no more so than it is to be present up close in their 'everyday ways of being' (Mackey, 2009).

Attention to detail

‘[nursing] observation is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving lives and increasing health and comfort’ (Nightingale, 1860). Comfort is a word that holds meaning in all aspects of nursing care as we would analyse it today, but for time immemorial, comfort has been the focus of care for the other.

‘Ye shall also faithfully and charitably serve, and helpe the poore in al their grieves and diseases, as well by kepyng them swete and cleane, as in gevyng theim their meates and drinkes after the moste honest and comfortable maner’. Charge to Sisters, from ‘The Ordre of the Hospital of St Bartholomewes in Westsmythfielde’1552 (Yeo, 1995).

A young V.A.D wrote impressions on active service in northern France in 1917 (Graham, 1917): ‘…The patients are washed and all their beds freshly made for the night…Night duty!...long quiet, watchful hours…memories of the past…one sees the boys lying in the mud in the trenches, the sailors’ weary watch at sea, and the dear people at home, quietly sleeping. A patient coughs or calls out and, armed with a lantern, one creeps silently down the ward, peering into shadow faces to see if they are asleep…another poor sleepless one whispers “Sister, I can’t sleep, my head’s bad”’. The orderlies ‘vied with each other as to which of them could make his Sister most comfortable… Imagine me on a June night, sitting in an arm-chair banked with pillows and covered with a blanket nursing a hot-water bag. Many a time I surreptitiously smuggled it into a patient’s bed’.

I have recently returned to the direct care of people with developmental disabilities who have high support needs. Engaging in their ‘everyday ways of being’(Mackey, 2009), I see anew the physical effects of the ageing process (in terms of the body’s life progress). I feel a strong need to reflect on comfort in the context of the everyday in our nursing.
So far I have talked of my own views of practice ownership at the expert level. In making such a self-analysis, I have to say that presence, from an intentional use of self (Taylor et al., 2008), does not become a permanent, exalted state. That would be idealistic in the extreme. Rather it is a work in progress, achieved in the moment.

Dunbar (1969), in her preface to Nightingale’s Notes on Nursing (1860), talks of ‘becoming with [Nightingale] intolerant of any mediocrity in the care the nurse gives her patient, including what is called here the “momentous minutiae”’. Momentous minutiae – what are they? To me, they are all the details of daily activities, the things that we do so often, support others to complete, that we may barely consider them from one day to the next. They are momentous, because the routine, commonplace nature of them, does not rob them of their complexity.

I said earlier that the composition and education of the nursing workforce have changed significantly in recent years. Morrison & Symes (2011) in a review of expert nursing practice, identify a need to reduce the widening gap between expert nursing practice and that which is less so, via the transfer of knowledge. It is in this context that I propose a need to re-assess our (nurses at all levels of practice within our specialty) approach to the 'momentous minutiae' as I have described them. What is the nature of their complexity? Consider physically assisting a person to have a bath. I said that it is a privilege to be present up close in a person's 'everyday ways of being' (Mackey, 2009). There is an intimacy here that needs to be acknowledged by me in this shared experience. The fact that the person is bathed every day does not mean that he or she will experience the process in the same way today as yesterday. Each moment or shared experience is unique, with its own meaning. This, I think, is how the person becomes a full participant in his or her own care; it is not dependent upon physical or communicative ability alone. The person is empowered in that I have to acknowledge the intimacy; by the fact that I have to plan my position in the moment.
Comfort has everything to do with this, and of course much more. I only have time for note taking here, but I will consider research options because nothing less than excellence in the nursing care of my people will do.

Catharine Hulst BA(Hons) RN BN

References

Duffy, A. (2007). A concept analysis of reflective practice: Determining its value to nurses [Electronic version]. *British Journal of Nursing*, 16(22), 40-47.

Dunbar, V.M. (1969). Forward: *Notes on nursing: What it is and what it is not by Florence Nightingale*. New York: Dover Publications Inc.

Graham, E.P. (1917). *Impressions of a V.A.D. on active service somewhere in France, 1917*. Unpublished.

Lewis-Hunstiger, M. (2011). The making and meaning of presence: A conversation with Jayne Felgen, MPA, RN [Electronic version]. *Creative Nursing*, 17(1), 5-11.

Locsin, R.C., & Purnell, M. (2007). Rapture and suffering with technology in nursing [Electronic version]. *International Journal for Human Caring*, 11(1), 38-42.

Mackey, S. (2009).Towards an ontological theory of wellness: A discussion of conceptual foundations and implications for nursing [Electronic version]. *Nursing Philosophy*, 10, 103-112.

Mantzoukas, S. (2008). A review of evidence-based practice, nursing research and reflection: Levelling the hierarchy [Electronic version]. *Journal of Clinical Nursing*, 17, 214-223.

Mathieson, A. (c. 1918). *Florence Nightingale: A biography*. London: Nelson & Sons.

McQueen, P., & McQueen, H. (2010). *Key concepts in philosophy*. Basingstoke, Hampshire: Palgrave Macmillan.

Morrison, S.M., & Symes, L. (2011). An integrative review of expert nursing practice [Electronic version]. *Journal of Nursing Scholarship*, 43(2), 163-170.

Nightingale, F. (1860). *Notes on nursing: What it is and what it is not*. New York: Dover Publications Inc.

Spence, D., & Smythe, L. (2007). Courage as integral to advancing nursing practice [Electronic version]. *Nursing Praxis in New Zealand*, 23(2), 43-54.

Taylor, B., Bewley, J., Bulmer, B., Fayers, L., Hickey, A., Hill, L., Luxford, C., McFarlane, J., & Stirling, K. (2008). Getting it right under pressure: Action research and reflection in palliative nursing [Electronic version]. *International Journal of Palliative Nursing*, 14(7), 326-331.

Yeo, G. (1995). *Nursing at Bart's: A history of nursing service and nurse education at St Bartholomew's Hospital, London*. United Kingdom: Alan Sutton Publishing Ltd.