The Value of Nursing Models in Practice

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Abstract

Our model or idea of nursing practice is our orientation to nursing and thus dictates what we choose to focus on. The essential value of formal nursing conceptual models (Neuman, Roy, etc.) is the provision of a shared view of the metaparadigm concepts (person, environment, health and nursing) and a focus on nursing's role: to *work with* patients to manage their health problems/life processes. However, nurses often cannot articulate what we do that makes us unique and we practice sometimes using a quasi-nursing/medical model. This paper defines nursing practice and briefly offer possible reasons why nursing and medical practice are confused. The benefits of using a formal nursing conceptual model in nursing practice are proposed. Also, a strategy for using one conceptual model (Neuman systems model) in nursing practice is offered along with a clinical example highlighting its benefits.

Key Words: Nursing Models, Neuman Systems Model, Practice, Methodology.

Hemşirelik Modellerinin Uygulamadaki Değeri

Özet

Hemşirelik modelimiz ya da hemşireliğe bakış açımız neye odaklanacağımızı bize söyler. Formal bir hemşirelik kavramsal modellerinin esas değeri (Neuman, Roy, vb.) metaparadigma kavramlarının (insan, çevre, sağlık ve hemşirelik) ortak tanımının yapılması ve hemşireliğin rolüne odaklanmalarıdır (sağlık problemleri/yaşam süreçleri konusunda hastalarla beraber çalışmak). Ancak, hemşireler genellikle bizi kendimize özgü yapan özellikleri bağdaştıramazlar. Biz uygulamamızda bazen yarı hemşirelik yarı tıbbi modeli kullanırız. Bu makale, hemşirelik uygulamasını tanımlamakta ve kısaca hemşirelik ve tıbbi modellerin birbiriyle karıştırılma nedenlerini açıklamaktadır. Formal hemşirelik kavramsal modellerinin hemşirelik uygulamasında kullanılmasının yararları savunulacaktır. Ek olarak, hemşirelik uygulamasında bir kavramsal modelin (Neuman sistemleri modeli) kullanılma stratejisi ve yararları vurgulanmaktadır.

Anahtar Kelimeler: Hemşirelik Modelleri, Neuman Sistemler Modeli, Uygulama, Yöntem.

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In the US, the question "do you use a nursing model"? is often met with a bewildered look by nurse researchers, nurse educators, and practicing nurses alike. This is because the question usually refers to use of a formal conceptual model of nursing such as the Neuman Systems Model (NSM) (Neuman, 2002). In actuality, we are asking a much broader and perhaps a more sensitive question: "Is your nursing practice congruent with the profession's definition of nursing?" For, whether we are aware of it or not, every nurse uses a conceptual model of nursing.

A conceptual model is one's idea about how things operate (Fawcett, 2000). For example, we have conceptual models (ideas) of what it means to be a spouse, parent, professor etc. that provide us with a reference point for our behavior. Every nurse then has an idea about her role in the nurse/patient relationship and what it is that she does to assist the patient toward health. Indeed, every nurse has her own personal conceptualization of health, be it absence of disease or self actualization (Pender, Murdaugh, & Parsons, 2006).

This model or idea of nursing provides our orientation to practice and dictates what it is we choose to focus on or what we feel is important. Thus the nurse who sees her role as *working with* patients to mutually set health goals (e.g., diabetes management) will ask the patient what they envision as an optimal outcome and how they think they can achieve this outcome. The emphasis will be on the patient coping with the health problem effectively. Conversely, the nurse who sees her role as *doing to or for* the patient will likely set health care goals for the patient and ask for little or no patient input. The emphasis here is on the nurse fixing the health problem.

These personally held ideas of the nurse-patient relationship, the nature of people, and what it means to be healthy developed from the culture's shared ideas of health and of nursing as well as media images and one's own life experiences. Once in formal nursing education, this personal idea of nursing was further shaped by one's professors' personal ideas of nursing as well as actual experience with patients in clinical settings. The nurse then begins practice with a clear idea of the metaparadigm of nursing (person, environment, health, and nursing) (Fawcett, 2000). Thus, when asked "do you use a nursing model?", each nurse can honestly answer "yes".

However, for reasons outlined below, these personal models of nursing practice are at times so inextricably linked with the medical model that we are practicing nursing using a quasi-nursing/medical model. Indeed, that is why formal nursing models such as the NSM were created; to distinguish nursing from medicine. For the essential value of each formal nursing model (Neuman, Roy, etc.) is the provision of a

shared view of the metaparadigm concepts and a focus on nursing's role: to *work with* patients to manage their health problems/life processes. Therefore, the purpose of this paper is twofold: first, to define nursing practice and briefly offer possible reasons why nursing and medical practice are confused; and secondly, to introduce a strategy for using the NSM in practice along with a clinical example highlighting its benefits.

Nursing Practice

The definition of nursing given by the North American Nursing Diagnosis Association (NANDA, 2007) is: Nurses diagnose and treat patients' responses to health problems/life processes. Based on this definition then, the nursing profession's focus is how patients cope with health problems (e.g., diabetes, hypertension, alcoholism, cancer) or life processes (e.g., aging, parenthood, disability, being a caregiver). Hence, nurses assist the patient to manage *coping with* the health problem/life process while physicians treat the disease (health problem) itself.

According to the NSM, nursing practice entails assessing both the patient's perception of the health problem as well as our own perceptions of the patient's health problem, judging congruency of these perceptions, and then working with the patient to mutually establish goals for an outcome that the patient deems optimal. This involves asking the patient and ourselves the NSM assessment questions in Table 1 (Neuman, 2002). Note that the focus is on assessment of stressors as well as the patient's resources for coping with these stressors. Specifically, the questions focus on the nurse's and patient's perception of the patient's difficulties (stressors) in dealing with the health problem, resulting lifestyle changes, coping resources, perception of how life will change due to the current problem, how they foresee managing this, and what they need in terms of assistance from others. The key here is that the nurse assesses what the patient sees as the major problem and works *with the patient* to help them solve their problem. This is in contrast to the nurse deciding what the problem is and then *doing for* the patient to solve the problem. In fact, not only is it impossible to solve someone else's problem but unless we ask we don't even know what the problem is.

Table 1. The NSM Assessment Questions

1. What do you consider to be your major stress area/problems/areas of concern?
2. How do present circumstances differ from your usual pattern of living?
3. Have you ever experienced a similar problem? (Past Coping Strategies)
4. What do anticipate for yourself in the future as a consequence of your present situation?
5. What are you doing and what can you do to help yourself?
6. What do you expect caregivers, family, friends, health care professionals and others to do for you? (needs)

Note: Adapted from "Assessment and Intervention Based on the Neuman Systems Model", by B. Neuman, in B. Neuman & J. Fawcett (Eds.), *The Neuman systems model* (p.351). Upper Saddle River, NJ: Prentice Hall.

Students in the author's Masters level theory course found that, prior to using the NSM assessment, they focused on physical problems and what *they (the nurse) should do* to manage the disease rather than on the patient's perception and coping resources. One student stated that she had worked with three hypertensive patients for four years and was telling them what to do instead of asking them what they were doing to help themselves. She said she learned more in 30 minutes, doing the NSM assessment, than she had in four years. Her focus changed when she conceptualized the patients as autonomous adults in control of their environments, health as optimal wellness while living with hypertension and not the absence of disease, and the role of nurse as partner in health care and not the health police. However, as outlined below, there are powerful forces working against even the best intentions to focus on nursing instead of medicine.

In the US, nurse educators present the metaparadigm of nursing in the first nursing course. However, the focus quickly shifts to the health problem not the patient's response to the health problem. This is understandable because students must have knowledge of the health problem (disease) and its attendant pathophysiology, and medical/surgical treatments if they are to be effective in helping the patient cope with it. Nevertheless, without continued emphasis on a nursing focus, the student often misses the point and the meaning of practicing nursing is distorted. They can recite the definition, but with no real comprehension.

This lack of orientation and focus on assisting patients to cope effectively with the health problem during nursing education is further compounded by demands of the health care setting. That is, nursing is naturally closely tied to medicine because patients present to the health care system when highly symptomatic and naturally, time is spent in dealing with the immediate problem. For example, if a patient presents with heart failure, the medical problem must be handled first. The nurse cannot explore coping with heart failure before dealing with the immediate problem. Unfortunately, there is often little time left to engage in discussing managing the health problem after treatment of the health problem is concluded. Patients are sent home quickly and new emergencies arise.

Conditions that foster the practice of nursing improve in community settings such as nursing home facilities, and home care settings, due to the longer patient contact. However, even in these settings, nursing care oftentimes focuses on medical treatment of the health problem. For example, blood sugar levels or blood pressure readings become the focus instead of how the patient is coping with being a diabetic or hypertensive. This may be the result of focus on the outcome (blood sugar levels, blood pressure readings) instead of the process of achieving this outcome. It also may be easier to admonish patients to follow the medical regimen than to

deal with why the patient is not following the medical regimen. For when one's idea of nursing is that the nurse fixes the problem for the patient, rather than assisting the patient to explore how they could fix the problem themselves, the nurse quickly recognizes how futile this is.

In fact, at a recent NSM Think Tank, trustees representing the US, Canada, and Holland, voiced similar experiences. Marlou de Kuiper (personal communication, June 6th 2008, NSM Trustee, Holland) noted that practicing nurses were reluctant to ask patients how they felt about their perception of conditions in a nursing home because they felt that there was nothing they (the nurse) could "do" about it. This further highlights the pervasiveness of the nursing model of *doing to* the patient, instead of assessing what the patient feels they could do.

Neuman Systems Model in Nursing Practice

However, though formal nursing models provide much guidance concerning how to view health and what our role is in helping patients achieve health, the language of formal nursing models such as the NSM are often quite cumbersome. This makes it difficult for nurses in a health care setting to adopt a nursing model without a great deal of effort and understandable resistance. Therefore, if nursing model advocates wish to foster the use of nursing models, we must make every effort to make it easy to use, for good ideas whose benefits can be immediately seen while obstacles to use are minimized really catch on (e.g., mobile phones!).

To do this we must lose the complex terminology and the NSM is ideal for such simplified use in nursing practice. Though scholars need to understand the intricacies of the lines of defense and resistance and the levels of prevention interventions, such knowledge is impractical for use of the NSM in practice. In fact, a chief complaint of practicing nurses is that using models takes too much time. They are correct in stating that, when practicing in real time, it is impossible to dissect the clinical situation into lines of defense and resistance and contemplate whether one is actually concerned with primary, secondary, or tertiary prevention. This author recommends that nursing scholars thoroughly understand the NSM and all its nuances and then introduce the NSM to practicing nurses in the following steps.

First, simply state the premise of the NSM and provide clinical examples, such as the one provided below. The premise, simply stated, is that nurses are concerned with assisting patients to manage stressors and to achieve optimal health. Stressors may result in a stress response and the patient uses his/her resources to cope with these stressors. Thus, the nurse assesses the patient's perception of the stressor and their coping resources. However, it is also important that the nurse first assess her own perceptions. Then after assessing the patient, the nurse compares her perception with the patient's perception and shares these with the patient. Finally, the nurse assists the patient to explore

how they might handle the stressor and mutually sets goals and decides on interventions that are likely to result in success.

Secondly, after providing several clinical examples, invite nurses to submit their own examples using the six NSM-assessment questions. Finally, incorporate these questions into nursing documentation. It is important to avoid overwhelming beginners with complex terms. As they progress, nurses can be introduced to the terms gradually. For example, in the clinical example below, nurses who have some experience with the NSM could then be asked to identify Mrs. W.'s lines of defense and resistance in terms of physiological, psychological, sociocultural, developmental, and spiritual variables. They could also identify primary, secondary, and tertiary prevention strategies. However, it is important not to get so engrossed in terminology that one loses sight of the essence of NSM model-guided practice.

Clinical Example:

Mrs. W. is an 89 year old widow who, due to childhood tuberculosis and asbestos exposure in a defense plant during World War II, has Chronic Obstructive Pulmonary Disease (COPD). Due to low oxygen saturation levels, her physician recently ordered oxygen therapy. When the nurse visited Mrs. W.'s home to evaluate her environment before arranging oxygen delivery, Mrs. W. listened attentively and recited back to the nurse the precautions she needed to take when using oxygen. However, one week later, the nurse found that Mrs. W. had lost weight, and the oxygen tank was still quite full indicating that it was not used regularly. The nurse's initial perception was that Mrs. W. did not understand how to use the oxygen and that the weight loss was due to depression about her declining health. She knew that Mrs. W. did not go out often and so had not perceived that there would be a real change in Mrs. W.'s usual pattern of living. However, she recognized that her perception may be different from Mrs. W's and she asked the six NSM assessment questions (see table 1). Mrs. W.'s responses are provided below:

1. What do you consider to be your major stress area/problems/areas of concern?

Mrs. W. answered "losing my independence". Using a stationary oxygen tank with long tubing to allow movement in her home made her feel like being chained to a machine. Although the oxygen made her feel comfortable, her daughter had also insisted that she use a walker now because she was in danger of tripping on the long oxygen tubing. She hated using the walker so she avoided using the oxygen if she did not feel too badly. She noted though that when she did not use the oxygen she felt "foggy" and was afraid she was showing signs of Alzheimer's disease and she dreaded "losing my mind". However, when she used the oxygen, she had to use the walker because she agreed that she could easily trip and break her hip and then she would have to go to a nursing home and she dreaded that too.

2. How do present circumstances differ from your usual pattern of living?

When asked about her lifestyle changes she sighed and said she was so frightened that she might trip and break her hip that she limited her steps to the kitchen and also found it impossible to carry her heated food to the table when using the walker. She was not a big eater but liked cake and found that eating a piece of cake filled her up and she did not need to bother with the hot food (hence the weight loss). Furthermore, she did not want her neighbors to see her using the walker when they came to visit so she was refusing their company that she had really enjoyed. Without the oxygen she could not talk for long and with it she felt stigmatized by the walker.

3. Have you ever experienced a similar problem? (Past Coping Strategies)

Mrs. W. replied that she had little experience with being dependent. She had always been independent and helped her neighbors out and now she needed help and she did not like that.

4. What do anticipate for yourself in the future as a consequence of your present situation?

Mrs. W. stated again that though she hated the walker she was afraid that if she tripped and broke her hip she would wind up in a nursing home and she really feared that. In fact, she had taken many precautions in the past including installing a chair in her shower and removing throw rugs. When asked what Mrs. W. saw as the optimal outcome, Mrs. W. said “I know I need this oxygen though I don’t like it but I would like to get some of my independence back”.

5. What are you doing and what can you do to help yourself?

Mrs. W. said she understood her medical problems and her prognosis. She mentioned that she had taught herself to use the computer and prided herself on her use of the internet as well as being able to program her TV to record shows. She had no other medical problems and though she did not like the oxygen she felt so much better and “clear-headed” when using it that she felt that she should resign herself to its use.

6. What do you expect caregivers, family, friends, health care professionals and others to do for you? (needs)

Mrs. W. said she had a modest income and owned her own home; she had two daughters who lived nearby and came each week to shop as well as bringing home cooked meals that they had frozen. She again stated that she hated most of all being dependent. She had refused the local meal delivery service as well as her neighbors offers to shop for her. She again said that she used to ask them if they needed anything and now hated the role reversal. She said her daughters wanted her to get an aide to help her manage her shower and meals but Mrs. W. refused. Also she said she wanted to live independently and not go to either of her daughter’s houses, as they had requested, or to assisted living.

Sharing Perceptions. The nurse shared her perceptions with Mrs. W. noting that Mrs. W. seemed to be an independent and cautious woman who understood the benefits of using the oxygen but hated the limitations it posed. Mrs. W. agreed that this was the major problem.

Setting Goals. The nurse asked Mrs. W. what she thought would be an optimal outcome and Mrs. W. stated that she wanted "to stay as independent as possible for as long as possible". She stated that she saw that her options were limited and the major priority was living on her own and that meant "not falling and being able to think straight". The oxygen helped her "think straight" and the walker helped her use the oxygen. Mrs. W. agreed that though she may not like the walker perhaps she should use it and use the oxygen regularly.

Planning Interventions. Though normally the nurse would not advise portable oxygen as a waist pack for an 89 year old woman because of the difficulty with reading the meters and filling the canister daily, she recognized that Mrs. W.'s great strengths were her technical ability and independence. Therefore she suggested portable oxygen and Mrs. W. liked the idea. She agreed to use the walker when using the stationary oxygen and when using the bathroom at night.

Summary. By assessing Mrs. W.'s stressors and resources, the nurse could accurately assess Mrs. W.'s response to the health problem (COPD) and life process (aging and loss of independence). She was then able to explore some options with Mrs. W. as well as opening the lines of communication. Mrs. W. still hated losing her independence but was able to set her own goal of continuing to live independently and she takes pride in managing the portable oxygen herself.

Conclusions and Recommendations

Nursing and medicine are closely related, though each has its own distinct focus. Without guidance, each nurse is left to form her own idea about nursing's focus. This can be distorted by overemphasis on the health problem and under-emphasis on the patient's response to the health problem/life process. Formal conceptual models of nursing, such as the NSM, provide a shared orientation to nursing practice and help us focus on the essential elements of that practice: working *with* the patient to assist them towards optimal health.

However, the complex terminology of these models hinders their widespread use in the practice setting. The author proposed a strategy for implementation of the NSM in nursing practice. This strategy focuses on simply stating the main idea of the model, providing clinical examples, and incorporating the six NSM assessment questions into nursing documentation. The above clinical example showed that, without use of complex terminology, the nurse saw Mrs. W. as an autonomous individual who needed assistance in dealing with this current health problem. She also recognized her resources and viewed her as a

partner in health care. Finally, and perhaps most importantly, she accurately recognized that her own perceptions of the problem may be far different from the patient's perception. Without use of the NSM, this nurse may have recommended dietary supplements, advised Mrs. W. that it was really necessary to use the oxygen all the time, and documented her as being noncompliant with advised medical care. None of these interventions would have improved the situation for Mrs. W. and may actually have contributed to her hastened loss of independence.

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