

Scope of Nursing Practice

“Imagine a world without nurses. Think of a world without persons who know what nurses do; who have the effect that nurses have on the health of individuals, families, and the nation; who enjoy the trust that nurses enjoy from the American people. Imagine a world like that, a world without nurses.”
Margretta “Gretta” Madden Styles, EdD, RN, FAAN

DEFINITION OF NURSING

Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity.

This revised definition presents reordering the content from the 2015 version (ANA, 2015b), including the art and science of caring, replacing abilities with human functioning, and incorporating references to compassionate presence and recognition of the connection of all humanity. Such refinements reflect an evolution of thinking over the past five years and present enhancements intended to lead into the future.

Formatting the definition as a bullet list provides an opportunity to further appreciate the richness and diversity of the integrated concepts:

Nursing:

- Integrates the art and science of caring
- Protects, promotes, and optimizes health and human functioning
- Prevents illness and injury
- Facilitates healing
- Alleviates suffering through compassionate presence

Nursing is:

- the diagnosis and treatment of human responses and
- advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity.

OTHER DEFINITIONS

These definitions are provided to promote clarity and understanding for all readers:

Healthcare consumers are the patients, persons, clients, families, groups, communities, or populations who are the focus of nurses' attention. Healthcare consumers receive nursing services as sanctioned by the state regulatory bodies. The more global term "healthcare consumer" is intended to reflect a proactive focus on health and wellness care, rather than a reaction to disease and illness.

Registered nurses (RN) are individuals who are educationally prepared and then licensed by a state, commonwealth, territory, or government regulatory body to practice as a registered nurse. "Nurse" and "professional nurse" are synonyms for a registered nurse in this document. Numerous jurisdictions have identified "nurse" as a protected title.

Graduate-level prepared registered nurses are registered nurses prepared at the master's or doctoral educational level; have advanced knowledge, skills, abilities, and judgment; function in an advanced level as designated by elements of the nurse's role; and are not required to have additional regulatory oversight.

Advanced practice registered nurses (APRN) are a subset of graduate-level prepared registered nurses who have completed an accredited

graduate-level education program preparing the nurse for special licensure recognition and practice for one of the four recognized APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP). APRNs assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis, and management of healthcare consumer problems, which includes the use and prescription of pharmacologic and nonpharmacologic interventions (APRN Joint Dialogue Group, 2008). Some clinicians in this classification began APRN practice prior to the current educational preparation requirement and have been grandfathered to hold this designation.

DESCRIPTION OF THE SCOPE OF NURSING PRACTICE

The Scope of Nursing Practice describes the who, what, where, when, why, and how associated with nursing practice and roles. Each question must be answered to provide a complete picture of the dynamic and complex practice of nursing and its membership and evolving boundaries. The definition of nursing provides a succinct characterization of the “what” of nursing. All registered nurses, including those identified as graduate-level prepared nurses or advanced practice registered nurses, comprise the “who” constituency and have been educated, titled, and maintain active licensure to practice nursing. Nursing occurs “when” there is a need for nursing knowledge, wisdom, caring, leadership, practice, or education, anytime, anywhere.

Nursing occurs in any environment “where” there is a healthcare consumer in need of care, information, or advocacy. The “how” of nursing practice is defined as the ways, means, methods, and manners that nurses use to practice professionally. The “why” is characterized as nursing’s response to the changing needs of society to achieve positive healthcare consumer outcomes in keeping with nursing’s social contract and obligation to society. The depth and breadth in which registered nurses engage in the scope of nursing practice are dependent on their education, experience, role, and the population served. Formal periodic review and

revision of the scope of nursing practice statement ensure a contemporary description of nursing practice is in place.

DEVELOPMENT AND FUNCTION OF THE STANDARDS OF PROFESSIONAL NURSING PRACTICE

Standards of Professional Nursing Practice accompany the Scope of Nursing Practice statement. The standards are authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to competently perform. These published standards may serve as evidence of the standard of practice, with the understanding that application of the standards depends on context. The standards are subject to change with the dynamics of the nursing profession as evidence is discovered and new patterns of professional practice are developed and accepted by the nursing profession and the public. In addition, specific conditions and clinical circumstances may also affect the application of the standards at a given time, e.g., during a natural disaster, epidemic, or pandemic. As with the scope of practice statement, the standards are subject to formal, periodic review and revision.

The Standards of Professional Nursing Practice are divided into two components, Standards of Practice and Standards of Professional Performance. The Standards of Practice describe a competent level of nursing practice demonstrated by the critical-thinking model known as the nursing process. The nursing process encompasses significant actions completed by registered nurses and forms the foundation of the nurses' decision-making. The Standards of Professional Performance describe a competent level of behavior in the professional role. All registered nurses are expected to engage in professional role activities, including leadership, reflective of their education, experience, and position. The competencies accompanying each standard may be evidence of demonstrated compliance with the corresponding standard. The list of competencies is not exhaustive. Whether a particular standard or competency applies depends on the context, circumstances, or situation. Registered nurses are accountable for their

professional actions to themselves, healthcare consumers, peers, and ultimately to society.

THE ART AND SCIENCE OF NURSING

Nursing is a learned profession built on a core body of knowledge that reflects multiple ways of knowing, integrating both art and science. Nursing requires judgment and skill based on principles of the human biological, physical, behavioral, and social sciences. Nursing promotes the health, well-being, comfort, dignity, and humanity of all individuals, families, groups, communities, and populations. Nursing's focus on the healthcare consumer is enhanced by interprofessional collaboration, sharing knowledge, scientific discovery, integrative healthcare approaches, and social justice.

Registered nurses integrate objective data with knowledge gained from an assessment of the subjective experiences of healthcare consumers. They promote the delivery of whole person care to achieve optimal health outcomes throughout the life span and across the health–illness continuum. This is accomplished within an environmental context that encompasses resources, culture, ethics, law, politics, economics, and competing priorities.

Similarly, nurses promote community and population health by advocating for social and environmental justice, community engagement, and access to high-quality and equitable health care. The goals focus on maximizing health outcomes and eliminating health disparities. Nurses continually apply creativity, critical thinking, and clinical judgment to craft new methods for evaluating the quality, safety, and effectiveness of nursing practice.

The Art of Nursing

The art of nursing is demonstrated by unconditionally accepting the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care. These actions support the belief that humans manifest a mind, body, and spirit unity; the human experience is contextual and culturally defined; and the presence of illness does not preclude health. Nurses provide safe, quality, and competent

care, practicing independently or collaboratively with interprofessional colleagues. The healthcare consumer is always at the center of care.

Rogers (1992) identified that the art of nursing is the creative use of the science of nursing for human betterment. Nurses protect, promote, and optimize health and quality of life in the context of chronic illness, disease, or disability; facilitate healing and alleviate suffering; and support the transition to a dignified and peaceful death. Nursing practice includes the diagnosis and treatment of human responses to actual or potential health problems or challenges. Identifying care needs involves a whole person approach and nurse partnership with the healthcare consumer. That partnership continues with the design of innovative, culturally sensitive, supportive, and restorative plans of care.

Care and Caring in Nursing Practice

“If nursing does not fulfill its societal mandate for sustaining human caring, preserving human dignity and humanness in self, systems, and society, it will not be carrying out its covenant to humankind and its reason for existence as a profession.” — Jean Watson

The act of caring is foundational to the practice of nursing. As suggested by Moffitt (2004, p. 30), “A great truth, the act of caring is the first step in the power to heal.” Watson (2012, p. 28) in her *Human Caring Science Theory*:

- Emphasizes the personal relationship between patient and nurse;
- Highlights the role of the nurse in defining the patient as a unique human being to be valued, respected, nurtured, understood, assisted; and
- Stresses the importance of the connections between the nurse and patient.

Human care and caring are upheld as the moral ideal of nursing. Human-to-human interactions attempt to protect, enhance, and preserve humanity and human dignity, integrity, and wholeness. These connections assist a person to find meaning in health, illness, suffering, pain, and existence.

Human caring helps self and others gain self-knowledge, self-control, self-caring, and self-healing, leading to restoration of a sense of inner harmony regardless of the external circumstances.

Caring is the compassionate application of professional knowledge, skills, and competencies. It is central to building relationships that lead to effective healing, cure, alleviation of illness, or actualization of human potential. Caring is grounded in ethics, beginning with respect for the autonomy of the care recipient. This attribute may be taught, modeled, learned, and mastered, and reflects the nurse's ability to establish a caring relationship with the care recipients in concert with the dynamics of each situation.

While recognized as a nursing science, caring is not unique to nurses. Caring is studied within caring science institutes and academies worldwide and can be analyzed and measured. Human caring involves presence, empathy, values, knowledge, caring actions, acceptance of consequences, a will, and a commitment to care. Caring in the healthcare environment is related to:

- Intersubjective human responses to health–illness–healing conditions,
- Knowledge of health-illness,
- Cultural humility,
- Environmental-personal relations,
- The nurse caring process,
- Co-designing creative solutions to individual and systems issues that arise; and
- Self-knowledge.

A human caring relationship in nursing involves an intentional partnership of the care recipient and the nurse. The nurse must possess competence, professional maturity, interpersonal sensitivity, a moral foundation that supports caring actions, and the ability to create an environment conducive to caring.

Everyone has an innate ability within to heal. Nurses promote that healing in whatever way the person is ready to receive support and care.

CARING ONE Set Aside for Special Work

Caring is weaving each thread of concern, by a chosen person with compassion, so tenderly
Intertwined with every human connection.

Each nurse and client is unique in what they bring to the relationship, so as to interact for the basic social purpose of connecting, growing, developing, leading, even healing and rest.

Caring is the bind that weaves throughout the fabric in every action of a caring nurse, be it:

A kind word of hope;

A soft touch of love;

A smile of understanding;

A bright glance of life;

A whispered prayer;

An embrace for a lost soul;

A song to share from one's heart;

A short minute to listen to the dream, the thoughts, even the sighs
when in sickness, sorrow, discomfort,
or sharing in the last breaths of life;

A bright mind of knowledge to share the “now”
by being present, to heed what was past,
and to sense what is coming.

Caring is being present in each precious moment to share one's tiny slice of life, in the World's fabric with another;

Such special moments leave a legacy—
a block in The Quilt of Life.

Such unique moments stay with the client forever,
whether remembered or not, to:

Give hope to the forlorn;

Share love with the lonely;

Believe in the power of healing.

For in the end, in life's fabric, the nurse is the:
Thread bearer of a greater purpose;
Instrument of healing;
Tool to deliver special care;
Voice for the voiceless, the forlorn, the broken, the abandoned, the
misdirected, even the lost.

Advocacy, the knitted threads in all the fabric,
is the gridline in the created quilt
Through each professional action of the nurturer.

This role, caregiver, is paramount to the ethos of one dedicated
to nursing—one set aside for this special work.

-Carla A. Lee, RN

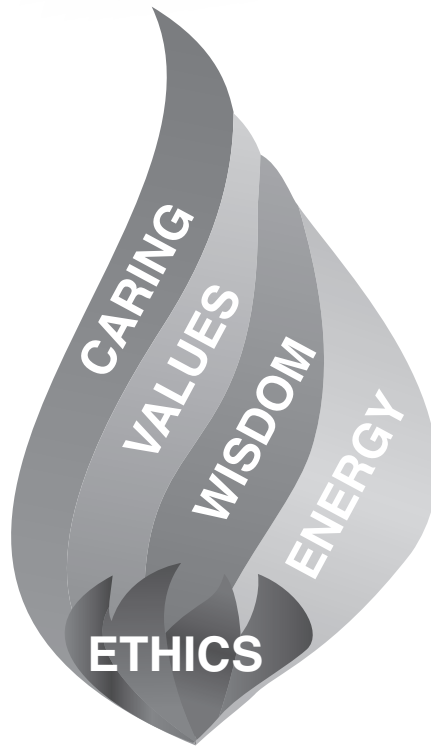
Development of a trusting, safe partnership will enable the person to learn, grow, adapt, and find meaning that in turn promotes well-being for both partners.

In a caring relationship, the nurse uses well-developed assessment skills to accurately identify nuances and help find meaning in the care recipient's situation. Interventions that reflect a caring consciousness may require innovation, creativity, and daring but also can be demonstrated in simple gestures of interpersonal connection. Such gestures may include attentive listening, making eye contact, touching, and verbal reassurances demonstrating sensitivity to and respect of the care recipients' cultural meanings associated with caring behaviors (Finfgeld-Connett, 2007). The caring embraced by nursing does not compete with nor is it diminished by technological advances, individual or group wealth or its absence, professional or socioeconomic status or prestige or its lack, or any other condition that attempts to categorize the place of the person in society.

Professional Nursing Model

The new ANA Professional Nursing Model (Figure 1) created by the ANA Workgroup represents the synergy of the nurse's caring, values, wisdom, and energy, all undergirded by ethical principles and situation ethics in

FIGURE 1 Professional Nursing Model (2021)



nursing practice. The flame is the inner light of the nurse and of nursing, always evolving, transforming, continuously lighting the way. The flame is intended to represent the seminal nursing attributes of courage, endurance, passion, and creativity. The Professional Nursing Model also provides a framework within the human sciences to reflect the work and evolution of nursing for all nurses in all settings. This model can be tested and used for future theory development.

Caring is integrated with the creative portion on the left of the model holding the values that arise from the shared beliefs grounding the profession. The logical side of the model is comprised of the wisdom and energy needed to practice as a nurse. The whole of the flame is supported by ethics.

Caring: This human approach promotes dignity, healing, and wholeness—the essence and heart of nursing and its practice. It occurs when there is a positive intention and action depending on context, directed toward the highest good, on behalf of the healthcare consumers. Caring is given freely and wholly to enhance the well-being and comfort of others, while also adding to the goodness and trustworthiness of the nursing profession. The caring component of the flame represents compassion, kindness, and calm.

Values: The values component of the flame represents respect, inspiration, and empathy. Nursing and its practice are based on values including, but not limited to, compassion, presence, trustworthiness, diversity, acceptance, and accountability. These values emerge from nursing practice beliefs: the importance of relationships, service, respect, willingness to bear witness, self-determination, and the pursuit of health.

Wisdom: Wisdom's component represents the movement from data to information to knowledge and eventually to wisdom in which nurses promote theory-guided, evidence-based practice, a culture of inquiry, critical thinking, and research to inform professional practice.

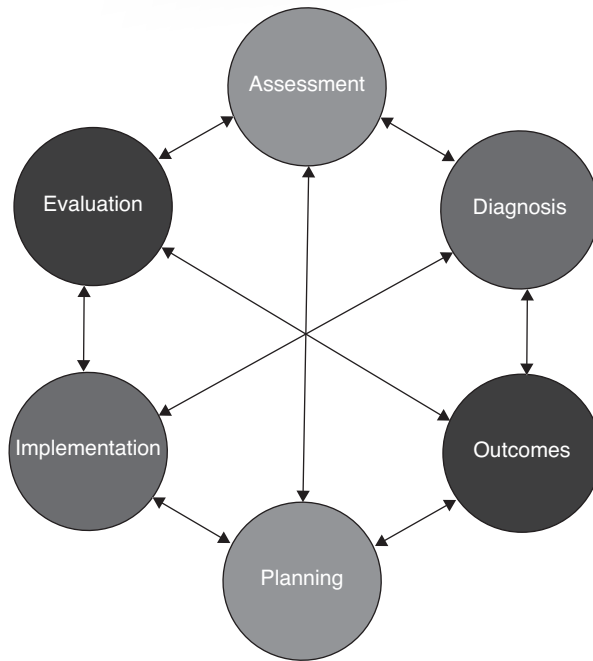
Energy: Energy's segment of the flame represents the energy and action sparked by nurses as evidenced by responsibility, communication, comfort, innovation, and transcendence.

Ethics: The ethics component represents trust, confidence, and loyalty, creating calmness and security. This foundation encompasses advocacy, integrity, justice, benevolence, and grace; and provides stability to the model. *The Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015a), the blueprint for ethical practice, outlines the expectations of each nurse's intentions and actions as well as those of the nursing profession.

Nursing Process

Regardless of the theoretical knowledge base upon which nursing and its practice are derived, that knowledge fits within the multidimensional nursing process, the analytical, critical-thinking framework guiding professional thinking and activities. The nursing process is conceptualized as a cyclic, iterative, and dynamic process, including assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The

FIGURE 2 Nursing Process



nursing process supports evidence-based practice and relies heavily on the bidirectional feedback loops between components (Figure 2). For example, questions regarding clinical practices for the purpose of improving the quality of care may involve assessment, diagnosis, planning, outcomes identification, implementation, evaluation, or a combination of these. Describing clinical problems using internal evidence relates to assessment data, diagnosis, and outcomes identification. Nurses engaged in nonclinical activities associated with administration, education, informatics, and research also use and rely on this iterative process.

Ethics for Nurses

Nurses encounter a range of ethical issues or dilemmas in their practice settings. Conflicts surrounding treatment goals, informed consent, equity, and access to care occur daily. Technological advances in genetics, genomics, and artificial intelligence may challenge nurses' ability to keep pace

with associated ethical concerns (Hoskins, Grady, and Ulrich, 2018; Savage, 2017; Stokes and Palmer, 2020; Robert, 2019; Tluczek et al., 2019). The ability to have a voice in these situations and others of increasing complexity (moral agency) is dependent upon several factors or skills including:

- Continuous appraisal of personal and professional values and how they may impact interpretation of an issue and decision-making,
- An awareness of ethical obligations as mandated in the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015a) (ethical awareness/sensitivity),
- Knowledge of ethical principles and their application in the decision-making process (ethical decision-making), and
- Having the motivation and skills to implement a chosen decision (ethical motivation and action).

Taken together, these skills are elements of ethical competence, identified initially in James Rest's Four Component Model (FCM) of moral development (1986). Ethical competence in nursing practice has been shown to promote moral agency, mitigate moral distress, and increase moral resilience (Kulju, K., et al., 2016; Koskenvuori et al 2019; Lechasseur et al., 2018; Milliken, A., 2018; Rushton, Caldwell, and Kurtz, 2016; American Nurses Association Professional Issues Panel on Moral Resilience, 2017).

The *Code of Ethics for Nurses with Interpretive Statements* (The Code) serves as a foundational document for the profession. The nine provisions of the Code describe “the ethical values, obligations, duties, and professional ideals of nurses individually and collectively” (ANA, 2015a, p. viii). The provisions address the nurse's fundamental values and commitments, accountability and duties to self and others, and aspects of obligations at the professional and societal levels. Each provision's accompanying interpretive statements offer specific guidance in the application of that provision in nursing practice. The Code also provides direction in addressing ethical issues that arise at the clinical, organizational, and societal levels (Epstein and Turner, 2015).

CODE OF ETHICS PROVISIONS

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and provide optimal care.

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence and continue personal and professional growth.

Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy. (ANA, 2015a)

The nurse needs an understanding of basic ethical nomenclature and principles to be able to discern ethical issues that arise within the course of nursing wherever and whenever nursing takes place. Key concepts include values, ethical competence, and ethical sensitivity. Awareness of personal

and professional values and understanding the values of others are vital to ethical competence and practice as nurses increasingly work with healthcare consumers and colleagues from different cultural backgrounds. Ethical competence includes the ability to recognize an ethical situation or issue (awareness or sensitivity) and the ability to determine a justifiable action (reflection or decision making). The nurse must also have the motivation, knowledge, and skills to implement the decision (comportment and action). Ethical sensitivity is the ability to recognize a moral problem when one exists and is a prerequisite to decision-making and action.

Ethical Decision-Making Models

Ethical decision-making is determining the right thing to do. This deliberative process should reflect knowledge of ethical principles, theories, and professional codes. Numerous ethical decision-making models have elements of reaching a judgment through organizing and identifying facts so that one can reflect on the issue. Although not based on a specific ethical theory, the steps of the nursing process (Table 1) or SBAR (situation, background, assessment, recommendation) are two templates that can be used to guide data collection and ethical analysis (Collingwood General and Marine Hospital, 2017; Fowler, 2015; Parker and McMillan, 2010).

CASE STUDY: USING THE NURSING PROCESS IN ETHICAL SITUATIONS

Assessment/Data collection and Analysis—Ethical Sensitivity

A bilingual cardiac care unit (CCU) nurse in a 400-bed community hospital easily communicated with a patient and the family whose first language was not English. The patient had been admitted to the CCU three times in the last six months for exacerbations of severe heart failure. Following two weeks of aggressive treatment during the current admission, a decision was made to wean the patient from the ventilator.

After numerous, unsuccessful attempts, the patient was diagnosed with ventilator dependency, and the treatment team recommended a tracheotomy. The nurse believed the patient and family did not fully understand the treatment options. Aware of the ethical obligation to advocate for the person and family but unsure of how to express those concerns, the nurse sought advice from the unit's clinical nurse specialist.

The CCU nurse shared the belief the patient would not want to be placed in a facility for ventilator dependent patients, a likely outcome that had not been discussed with the family. The patient had expressed the desire to not be a burden to the ill spouse and family, and the nurse stated personal difficulty imagining a life relying on a machine. The clinical nurse specialist encouraged the nurse to consider whether the nurse’s personal value of independence and autonomy may differ from that of the patient and family and suggested calling for discussion of such concerns with other members of the healthcare team. The surgeon and the intensivist confirmed that they believed the family was fully informed and planned to move ahead quickly with the tracheotomy so the patient could move out of the CCU.

TABLE 1 Using the Nursing Process in Ethical Situations

Assessment/Data

Collection

- What is the issue?
- Who is involved?
- What are the facts? (health status, pain, treatment)
- What are stakeholder values, concerns, preferences, disagreements? (individual/family; healthcare team; individual’s community)
- Identify ethics resources

Planning/Outcomes

- Using different approaches to ethics, identify a range of options or the best available when possibilities are limited.

Assessment/Analysis

- Analyze facts/values using aspects of ethics of care, virtue ethics, ethical principles, or another theory or approach.
- Access ethics resources, if needed, and document communication.

Implementation

- Ensure that the option chosen is right, suitable, and appropriate.
- Not all options are right or appropriate in all contexts.
- Implement the plan in collaboration with individual/family, stakeholders.

Diagnosis

- Determine the care context and issues, including areas of agreement and conflict.
- Consider the entire context including individual/family, healthcare team, institutional circumstances.

Evaluation

- Evaluate what has happened and what can be learned from the situation.

Diagnosis/Planning—Ethical Decision-Making

The nurse reflected on the conversation with the physicians and continued to believe that the patient and family required more information to make informed decisions. Discussion of the options with the clinical nurse specialist resulted in agreement that an ethics consultant may be able to recommend resolutions and discuss these alternatives with the patient and family.

Implementation/Evaluation—Ethical Motivation and Action

Not wanting to jeopardize a working relationship with the physicians, the nurse discussed the choice to request an ethics consultation. While they disagreed, all participated in the bedside conference with the patient, family, translator, and rehabilitation physician. The ethicist clarified all treatment options, care goals, and potential outcomes. These included performing the tracheotomy and placement in a rehabilitation unit, or terminal weaning. The patient and family were asked to think about what they value and consider quality of life in terms of the choices, given the diagnosis of severe heart failure. They decided to proceed with the tracheotomy and admission to the rehabilitation unit for one month after which they will consider the progress and other choices. After the ethics consultation, the nurse and clinical specialist reviewed and reflected on the process and outcome. The nurse expressed appreciation of the values and perspectives of all involved and agreed that being proactive regarding early ethics consultation may benefit individuals, family members, and caregivers. The outcome of this example: Nurses are encouraged and empowered to call ethics consults whenever they confront an ethical issue.

Other models integrate diverse theories and approaches as one alternative is not applicable in every situation. While some issues may not require consideration of all elements in a decision-making model, others may be more complex and necessitate careful evaluation. Table 2 contains examples of additional models of ethical analysis and available resources.

The four-quadrant approach to analysis developed by Jonsen et al. (2015), Schuman & Alfandre, (2008), and University of Washington (2018)

TABLE 2 Collection of Ethical Analysis Models/Resources

Model	Components	Links
Four Quadrant Approach	Considers medical (healthcare) indications, individual preferences, quality of life, and context according to ethical principles	https://depts.washington.edu/bhdept/ethics-medicine/bioethics-tools
MORAL Model	Five-step analysis process: M = Massage the dilemma O = Outline options R = Review criteria A = Affirm and act L = Look back	https://www.nursingcenter.com/wkhlrp/Handlrs/articleContent.pdf?key=pdf_01376517-200812000-00006
DECIDE Model	Six-step process for healthcare managers: D = Define problem E = Establish criteria C = Consider alternatives I = Identify best alternative D = Develop/implement a plan of action E = Evaluate and monitor	https://dspace.lib.hawaii.edu/bitstream/10790/2991/1/guo.k-2008-0014.pdf
Framework for Ethical Decision-Making: Markkula Center for Applied Ethics (2020)	Five component analysis process: Recognize an ethical issue Get the facts Identify alternative actions Make a decision and test it Act and reflect on the outcome	https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/a-framework-for-ethical-decision-making/ https://www.youtube.com/watch?v=53fw6jOG7RI https://www.scu.edu/ethics-app/
Making Ethical Decisions-7 Step Path	Seven-step path integrating core values: trustworthiness, respect, responsibility, fairness, caring, citizenship.	https://blink.ucsd.edu/finance/accountability/ethics/path.html
Ethics consultation	When to call: What to expect	https://www.youtube.com/watch?v=n5QeaW6pyT0&feature=youtu.be

integrates ethical principles in conjunction with healthcare indications (beneficence and nonmaleficence), individual and family preferences (respect for autonomy), quality of life (beneficence, nonmaleficence, autonomy), and contextual features (justice). The sample questions displayed in Table 3, Four Quadrant Approach to Interprofessional Ethical Analysis, are presented as examples and are not an exhaustive list.

Although nurses may recognize an ethical issue or dilemma and identify a justifiable course of action, they may encounter personal (internal) or situational (organizational) barriers that impede their motivation to act. Competing personal values or conflicts of interest, such as protecting one's position or conflict avoidance, or a deficient ethical environment that lacks ethics resources, team collaboration, or supervisory support, or all of these may obstruct action (Hamric and Epstein, 2017; Pavlish, C., Brown-Saltzman, K., Fine, A., and Iorillo 2015; Pavlish, C., Brown-Saltzman, K., Fine, A., and Jakel, P., 2015; Robichaux, 2017). Moral courage is a virtue that must be developed to determine when action is required (Lachman, 2010; Lachman et al., 2012). Nurse leaders and organizations can support the development of moral courage and resilience by creating environments where nurses feel safe and are supported to speak up (Solomon, 2017). Additional approaches to strengthen communication and enhance nurse moral agency include elements of TeamSTEPPS® (Strategies & Tools to Enhance Performance and Patient Safety), cognitive rehearsal strategies, and crucial conversations, among others (Clark, 2019; Haynes & Strickler, 2014; Sunago, 2020; Agency for Healthcare Research and Quality [AHRQ], 2020). See ANA's dedicated ethics site for many more resources: nursingworld.org/ethics.

Respect, Equity, Inclusion, and Social Justice

Nursing's social contract explains the relationship between nursing and society as a whole, including reciprocal expectations that authorize nurses to meet the healthcare needs of society and articulate nursing's expectations of society. Through this agreement, nurses must provide compassionate care that addresses the individual's needs for protection, advocacy, empowerment, optimization of health, prevention of illness and injury, alleviation of suffering, and comfort and well-being. This social

TABLE 3 Four Quadrant Approach to Interprofessional Ethical Analysis

Healthcare Indications

Beneficence and Nonmaleficence

What is the diagnosis/prognosis?
 What are the goals of treatment/care?
 What is the likelihood of success of treatment?
 Will the proposed treatment benefit the person and avoid harm?

Quality of Life

Beneficence, Nonmaleficence, and Respect for Patient Autonomy

What is the probability of a return to a normal life with or without treatment?
 Would the person experience any physical, mental, or social deficits even if the treatment succeeds?
 Do providers have any biases that might prejudice their evaluation of the individual's quality of life?
 Has forgoing treatment been discussed?
 Are there plans for comfort/palliative care?

Individual/Family Preferences

Respect for Autonomy

Does the person understand their condition?
 Has the individual been informed of and do they understand risks/benefits of proposed treatment?
 What are the individual's preferences?
 Is the person competent and capacitated to make decisions?
 If not, is there a surrogate decision-maker who understands the patient's preferences?

Contextual Features

Justice and Fairness

Are there family or provider issues, such as implicit bias, that might influence treatment decisions?
 Are there religious, financial, social, racial, or legal issues/factors that might affect treatment decisions?
 Are there issues related to allocation of resources that might affect treatment?

Adapted from Jonsen, Siegler, and Winslade (2015) and the University of Washington (2018).

contract also supports the need for nurses to lead the effort to address social determinants of health (SDOH) with strategies to also continue to improve diversity within the profession of nursing. This necessarily should include unrelenting, unwavering, and encompassing efforts for equity, diversity, inclusion, and social justice.

Issues of inequity, bias, exclusion, racism, and injustice have long been part of the fabric of society. A review of past social, political, and legal initiatives and policies describes the deepening cultural divides present in America related to systemic social, economic, health, and legal structures and opportunities for success. For example, the U.S. Census Bureau reported the official poverty rate in 2019 was 10.5 percent, which equates to 34.0 million people in poverty ([census.gov/library/publications/2020/demo/p60-270.html](https://www.census.gov/library/publications/2020/demo/p60-270.html)). Additionally, many do not have access to equal opportunities because of the structural and systemic divides related to lack of access to basic provisions of clean water, food, housing, education, transportation, technology, and health care. All nurses must be open to examining the impact of history on today's laws and regulations to understand and acknowledge that the nursing profession itself has a historical and existing connection to policy and politics.

Facing inequity allows for the bandage that covers the wound of inhumanity to start to peel away, bearing witness to what has always been there, but for so long effectively “dressed and covered.” Nurses must recognize the complexities rooted in the integration of these unveiled realities and their impact on health and well-being. Each exists and must be addressed, at the individual level, within the profession, and then at institutional and societal/global levels.

The cornerstone of equity, diversity, inclusion, and social justice begins with the essential element of respect for oneself and others. No matter the practice setting or environment, the philosopher, Kant, suggests that people have a moral duty to respect other human beings even if others are not yet met or known (Kant, 1949). Milton (2005) defines respect as a *way of mattering* so that other persons matter in the same way as one matters to themselves.

As systems of care, institutions, and policies have evolved, persons and entities in power positions set the specifics of care and the tone of care delivery. Such systems, whether purposefully or inadvertently, have created situations that respect some persons and disregard others (Milton, 2005). Rosemary Parse, a nursing theorist, named this concept as *potential disregard*, which occurs when nurses dismiss, label, or judge others regarding

characteristics that differ from the nurse or nursing group (1998). McGee suggests that others are dehumanized when nurses and nursing fail to demonstrate respect, whether consciously or not, during care delivery (1994). Many have adopted the concept that *respect must be earned*, but current thinking has evolved that respect is a basic human right that all deserve and need without conditionality.

Lack of respect can lead to harm and suffering. Dempsey (2018) builds on this concept by introducing and differentiating the concepts of *inherent suffering* and *avoidable suffering*. Inherent suffering is the suffering that occurs due to the illness, injury, or disability experienced by the healthcare consumer, family, and community. *Avoidable suffering* occurs due to lack of respect for others manifested by dysfunctional processes and inherent biases embedded within the systems of care. Besides causing suffering of others, avoidable suffering also contributes to caregiver suffering (Dempsey, 2018).

Fifty years ago, Judith Goldsborough wrote a seminal piece in the *American Journal of Nursing* discussing the importance of nurses providing *nonjudgmental care*. One can only wonder what progress nursing and nurses have made since that time. It is essential that nursing education programs ensure student nurses examine differing values and stereotypes, and the profession reminds seasoned nurses of the meaning and value of nonjudgmental care. Goldsborough (1970) describes nonjudgmental nursing care as “learning to relate to each other by using our common bonds, we could then mean and feel the word ‘brother’” (p.2342).

Nonjudgmental care cannot be an acting role in which nurses split themselves in half: their private half suppressing their personal biases but then delivering forced care in their professional role. The risk of bifurcating these feelings is the unconscious emergence of substandard care manifested in many ways: under medicating pain, re-prioritizing nursing care activities, not advocating as strenuously, delivering less comfort via lack of listening or being more aloof, all because someone else has different values and beliefs. An affront toward humanity occurs when judgmental care is rendered.

The nursing profession, rooted in caring relationships, demands that nurses know themselves, and work on the evolution of nonjudgmental attitudes by focusing on the common bonds that bind all of us together. Bauer, Southard, and Kummerow (2017) stipulate that nurses must reflect “unconditional positive regard” for every patient (p. 234). “Patient advocacy, selflessness and a willingness to suspend judgment are hallmarks of compassionate nursing care” which is required when stigmas, stereotypes, and biases enter our practice ethos (Bauer, Southard, and Kummerow, 2017, p. 234). The trust that patients place in nurses is unique, incomparable, sacred, and must not be broken by biases that seep into care delivery and decision-making.

Today’s healthcare environment and global connectivity confirm the need to embrace continued learning about another’s culture, a process that starts with examination of one’s own beliefs and cultural identities (Tervalon and Murray-Garcia, 1998). Gillon (1985) provides this frame of reference: “It is not putting yourself into another’s shoes that is morally relevant, it is understanding what it is like for that other person to be in his or her own shoes that is morally important.” Cultivating an attitude of authentic respect illuminates a path to cultural humility that, according to Ackerman-Barger (2020), provides a framework for promoting health equity.

“Cultural humility is a humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process” (Gonzales and Levitas, 2020). First described by Tervalon and Murray-García (1998) for use in medical education, this beautiful approach is relevant in nursing and all human sciences. Cultural humility departs from the traditional approach of attaining cultural competence and congruence. It requires a commitment of lifelong learning and exposure starting from providing dignity, respect, and grace to people regardless of origin, race, sexual preference, background, or socioeconomic status. Self-awareness, self-evaluation, and self-critique are also necessary to redress the power imbalances in relationships to advance relationships that are

mutually beneficial and non-paternalistic (Tervalon and Murray-Garcia, 1998).

Cultural humility is built on four guiding tenets:

- Nurturing a life-long commitment to self-reflection, self-evaluation, and self-critique
- Redressing power imbalances in the person-clinician, educator-student, colleague-colleague, and academic center-community dynamic
- Developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities
- Stewarding an organizational-level development process that is also ongoing and parallels the first three tenets of cultural humility (Tervalon & Murray-Garcia, 2021)

While each of these tenets can serve as action points on the path toward health equity, the first step begins with self.

Nurses must first respect themselves before being capable of respecting others. They must become clear on how equity, diversity, inclusion, and social justice inform them as people. One desirable outcome for this clarity and call to action is to improve diversity within the nursing profession. This can be a difficult, painful exploration when meeting one's own beliefs and biases. It is essential that nurses invest in learning about others and associated environments, stressors, and influencers. A deep understanding that informs acceptance of others is not easily achieved using a reductionist method of reading a few paragraphs about those who differ in their background and experiences. Rather, nurses must seek out new information and commit to lifelong learning to inform their own worldview. The nurse can operationalize respect by being truly interested in another's welfare and care and acting in a way that shows recognition and appreciation for another's humanity (McGee, 1994). This awareness is foundational in cultivating respectful, equitable practice.

Cultural humility releases nurses from mastering the task of competent care and allows, instead, a less restrictive approach "that focuses on

identities including intersectional identities and relationships.” Intersectionality, a term coined in 1985 by legal scholar Kimberlé Crenshaw, refers to the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies, and the outcomes of these interactions in terms of power (Davis, 2008, p.68.) Steinmetz (2020) reported Crenshaw identifies that intersectionality provides a lens to view how various forms of inequality operate together and intensify each other. People are complex, whole beings who experience multiple identities. Viewed through this lens, nurses can better understand how certain aspects of a person will increase their access to good things or their openness to bad things in life. Thus intersectionality as a concept “disrupts the idea of social identities as operating in isolation” (Fisher-Borne, Cain, and Martin, 2015).

Justice, a principle and moral obligation to act on the basis of equality and equity, is a standard linked to fairness for all in society. Justice for all is protection of human rights for all persons by the law. This obligation guarantees not only basic rights (respect, human dignity, autonomy, security, and safety) but also fairness of evidence in all operations of societal structures. This includes being delivered with fairness, rightness, correctness, unbiasedness, and inclusiveness while being based on well-founded reason and evidence.

Social justice is a critical component related to respect, equity, and inclusion. Social justice is a form of justice that engages in social criticism and social change. Its focus is the analysis, critique, and change of social structures, policies, laws, customs, power, and privilege that disadvantage or harm vulnerable social groups through marginalization, exclusion, exploitation, and voicelessness. Among social justice’s ends are a more equitable distribution of social and economic benefits and burdens; greater personal, social, and political dignity; and a deeper moral vision for society. Social justice may refer to a theory, process, or end (ANA, 2015a, p. 46).

Nurses need to model the profession’s commitment to social justice and health through actions and advocacy to address the social determinants of health and promote well-being in all settings within society. Nurses must address unjust systems and structures and use their voices to

advocate for transformative action-oriented policies and initiatives that mitigate inequality and promote social justice. Professional nursing organizations must actively engage in the political process, especially those that address the public's health and the profession of nursing. Nurses must promote open and honest communication that enables nurses to advance a nursing agenda for public health and safety.

Thurman and Pfitzinger-Lippe (2017) argued that education needs to be redesigned to allow nurses to return to the profession's social justice roots. Although social justice is a recurring theme in the literature, nursing education must be redesigned to incorporate social justice concepts and tools throughout the entire curriculum. By educating the current and future nursing workforce, the profession can begin to upend the roots of social justice to address structural inequalities and social injustices that manifest as health inequities and disparities in the United States. As nursing and society evolve together, it is essential that nurses recall their social contract to serve society with the highest respect for those they serve.

THE SCIENCE OF NURSING

“What you want are facts, not opinions. . . . The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate improvement—what the reverse—which are of importance—which are of none—which are the evidence of neglect—and of what kind of neglect.” (Nightingale, 1860, p.105)

Nurses and nursing have been ubiquitous through history and their manner of education and working agreements have changed over time. Ancient historical records mention Phoebe in about 100 BC who cared for others in a selfless and charitable manner. She brought travelers into her humble residence and cared for them. Throughout the Middle Ages, nurses served as apprentices, coming from all walks of life, including Crusaders, prisoners, religious women, prostitutes, and alcoholics. During the Renaissance, monasteries began to close as appreciation for the arts and literature began to grow. Nursing was not viewed as an intellectual pursuit during this time, making the status of nursing low.

The emergence of hospitals and training programs came with the Industrial Revolution in 19th-century Europe and America. This is where contemporary nursing had its roots. Florence Nightingale's work in the Crimea is considered an exemplar of what would become foundational nursing science: focus on basic hygiene, collect and correlate data, and educate nurses. She is credited with providing a foundation for nursing and the basis for autonomous nursing practice as distinct from medicine. During that same time, Black-Scottish Jamaican-born Mary Jane Seacole, a businesswoman and notable historic nurse, traveled independently to the Crimea to create her British Hotel to care for wounded and sick soldiers.

Nursing Knowledge and Scholarly Inquiry

Nursing, as an art and a science, reflects all the ways of knowing (e.g., empirical, ethical, personal, and aesthetic as identified by Carper [1978]), gleaned from scientific investigations, accumulated and graded evidence, qualitative analysis, narratives, appreciative inquiry, case studies, interpersonal and cultural sensitivity, insight, sociopolitical awareness, intuition, experience, reflection, introspection, creative thinking, philosophical analysis, and spirituality. This provides the basis for scholarly inquiry and scholarship.

The science of nursing is a combination of theoretical and investigative activities that address the phenomenon of health, the concept of caring, and the interactions of persons with the environment and vice versa. The aims of nursing science are the pursuit of knowledge and the attainment of truth through the methods of description, explanation, correlation, prediction, and experimentation. Nurses as scientists rely on qualitative and quantitative research methods to secure evidence to guide professional practice; inform development of policies, procedures, and guidelines; and identify health outcomes and the effectiveness of healthcare delivery systems.

Nursing research is defined as: “systematic inquiry designed to develop knowledge about issues of importance to the nursing professions” (Polit and Beck, 2017, p. 737). Nursing research was able to flourish only as nurses received advanced educational preparation. In the early 1900s,

nurses received advanced degrees in nursing education, and nursing research was limited to studies of nurses and nursing education. Case studies on nursing interventions were conducted in the 1920s and 1930s and the results published in the *American Journal of Nursing*.

In the 1950s, interest in nursing care studies began to rise. In 1952, the first issue of *Nursing Research* was published. In the 1960s, nursing studies began to explore theoretical and conceptual frameworks as a basis for practice. By the 1970s, more doctorally prepared nurses were conducting research, especially studies related to practice and the improvement of patient care. By the 1980s, there were greater numbers of qualified nurse researchers than ever before, and more computers available for collection and analysis of data. In 1985, the National Center for Nursing Research (now known as the National Institute of Nursing Research [NINR]) was established within the National Institutes of Health, putting nursing research into the mainstream of health research (Cantelon, 2010).

In the last half of the 20th century, nurse researchers (1950s) and nurse theorists (1960s and 1970s) greatly contributed to the expanding body of nursing knowledge with their studies of nursing practice and the development of nursing models and theories. Theories are patterns that guide the thinking about, being, and doing of nursing. Theories provide structure and substance to organize knowledge, guide practice, enhance the care of healthcare consumers, and guide inquiry to advance the science and practice of the profession. Theory is defined as “an abstract generalization that presents a systematic explanation about the relationships among phenomena” (Polit and Beck, 2017. p. 746). Further development and expanded use of nursing theories and models continue today and are essential to the ongoing evolution of nursing. Appendix B includes a list of selected nurse theorists and their work.

Knowledge encompasses the facts discovered by research or known by traditional inquiry and reflection within an established discipline. Knowledge encompasses thinking; understanding of science and humanities, and professional standards of practice; and insights gained from context, practical experiences, personal capabilities, and leadership competence

(ANA, 2014). Scholarly inquiry is the logical, organized process of searching for answers to questions via research, assessment of findings from literature searches, and examination of other knowledge sources.

Knowledge and scholarly inquiry occur on a continuum from scholarship to evidence-based practice to research. Scholarship is the ability to delineate the premise on which one's questions and decisions are based; the ability to critically assess the objective and subjective components in their inquiry; and scholarly efforts are concentrated on sharpening and refining our knowledge of the theory-making process identified as central to the discipline and on using the frameworks that define a nursing perspective (Meleis, 2017). The practice of nursing is rooted in evidence-based knowledge.

Evidence-based practice (EBP) is a lifelong problem-solving approach that integrates:

- The best evidence from well-designed research studies and evidence-based theories;
- Clinical expertise and evidence from assessment of the healthcare consumer's history and condition, as well as healthcare resources; and
- Person, family, group, community, and population preferences and values.

The best made clinical decisions yield positive healthcare consumer outcomes when evidence-based practice is delivered in a context of caring and a culture, as well as an ecosystem or environment that supports it (Melnyk and Fineout-Overholt, 2019). The EBP process itself provides a framework for clinicians, educators, and nurse researchers to ponder and then expertly construct the most relevant, person-centered, and testable questions. The EBP process promotes the asking of the question and then uses the scientific framework of peer-reviewed literature searches, critical appraisal, and the foundation of nursing knowledge to reach an endpoint that can be reproduced, translated, and built into new knowledge. This process yields important practice guidelines for optimizing healthcare consumer outcomes.

Evidence-informed practice is another term often used synonymously for evidence-based practice. However, there are differences. Evidence-informed practice is practice delivered in an inclusive, nonhierarchical manner that uses tacit knowledge (all ways of knowing), information-gathering and interpretation, practice wisdom and lived experience, clinical narratives and case studies, research findings along with client's wishes, values, and knowledge (Webber and Carr, 2015).

Roy (2018) noted that as a practice-oriented discipline, the goals of nursing logically relate to the outcome of using nursing knowledge in contributing to health. The structure of knowledge, including the domain-derived basic science of nursing and the practice-shaped basic science knowledge, leads to nursing's role in translational research and a strong position for nursing in the transdisciplinary revision of practice environments. By moving knowledge from "bench to bedside," desired outcomes, for example, high-quality person-, family-, and community-centered care, equity, and a culture of safety, can be achieved. This effort continues to be one of the most daunting challenges to registered nurses but provides exciting opportunities for change.

Nursing theory guided practice (NTGP) is defined as "human health service to society based on the discipline-specific knowledge articulated in the nursing frameworks and theory" (Younas and Quennell, 2019, pp. 540-541). NTGP describes, predicts, and explains nursing phenomena (person, health, environment, and nursing) and allows nurses to recognize the nature of nursing practice. It serves as a tool for personal knowing, reflection, reasoning, critical thinking, and effective decision-making.

While EBP translates knowledge, research generates knowledge. Research studies are designed to explore and examine a broad range of research questions. Methodological approaches commonly used include quantitative, qualitative, and mixed-methods approaches. Reliability, validity, statistical significance, trustworthiness, and clinical significance are common research terms. Research competencies are an expectation for the graduate-level prepared registered nurse, as well as those completing Doctor of Nursing Practice (DNP) and the Doctor of Philosophy (PhD) degrees.

Doctoral programs in nursing fall into two principal types: research-focused and practice-focused. Research-focused programs are designed to prepare nurse scientists and scholars, focusing heavily on scientific content and research methodology, and requiring a dissertation. Practice-focused programs are focused on developing practice that is innovative and evidence-based, reflecting the application of credible research findings. Although differing in goals and competencies of their graduates, the programs represent complementary, alternative approaches to the highest level of educational preparation in nursing (American Association of Colleges of Nursing [AACN], 2020).

Research-focused nurses engage in the science of nursing and spirit of inquiry by designing, implementing, and evaluating research studies directed to the generation of new knowledge to improve and reform nursing practice and the systems in which nursing practice occurs. They conduct research directed to specific and salient nursing practice phenomena and serve as a leader in integrating research findings into the practice of nursing.

Practice-focused nurses translate research into practice, which is a science unto itself, known as translational research. Translational research has two sequential definitions: (1) from bench to bedside—translating basic science into research about new healthcare options for healthcare consumers, followed by (2) research that explores how evidence-based interventions can be best translated to real-world clinical change (Melnyk & Fineout-Overholt, 2019, p. 762). Nurses are at the forefront of this work as they implement evidence-based practices into clinical care, lead research teams to investigate facilitators and barriers of knowledge translation, and advocate at all policy levels for the adoption of these practices throughout the healthcare system. The surge in the scholarly evaluation of evidence-based practice by the expanding ranks of nurses prepared at the doctoral level has contributed to enhanced utilization of evidence-based practice or translation of research into practice.

Aligning translational research with evidence-based practice initiatives can result in research knowledge being more effectively and efficiently incorporated into the practice setting. By aligning EBP projects

with rigorous translational research, organizations will place themselves at the leading edge of practice-based knowledge development. This is accomplished through validation of best practices in real-world settings and discovery of the implementation processes that promote the achievement of best practice outcomes (Weiss et al., 2018).

Nursing also relies on epidemiologic models of practice and the environment or its variations. When such models are used, cases are tracked; individuals, families, and communities are treated; and prevention strategies are employed. More recently, nurses within public health are conscious of and employ strategies that consider the entire ecological system to optimize health and prevent or treat illness.

THE HOW OF NURSING

The “how” of nursing practice is defined as the ways, processes, means, methods, and manner the registered nurse practices.

Ways

The ways in which registered nurses practice reflect integration of the five core practice competencies of all healthcare professionals: healthcare consumer-centered practice, evidence-based practice, interprofessional collaboration, use of informatics, and continuous quality improvement (Institute of Medicine, 2003).

Processes

Registered nurses recognize that using a whole-person approach aligns with the art and science of caring and prevents omission of relevant data when implementing the nursing process. When incorporating a *healthcare consumer-centered approach*, the registered nurse cares for, collaborates with, and treats all healthcare consumers with the utmost dignity and respect. The registered nurse demonstrates cultural humility, always advocating that healthcare consumers have sufficient information and all their questions answered, enabling them to exercise their autonomy to make the final decisions regarding their preferred care.