Philosophy and Theory of Nursing

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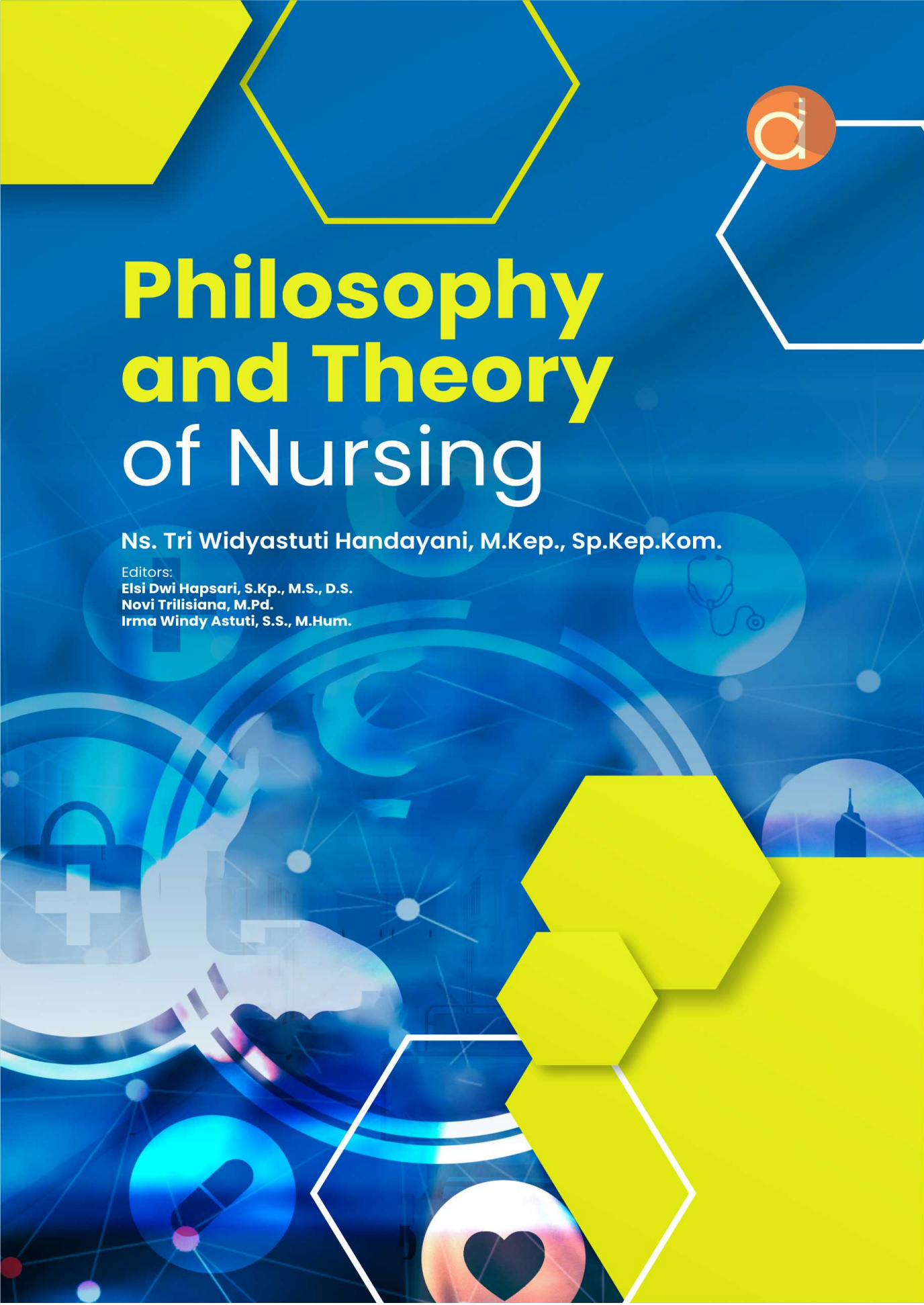

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FOREWORD

Our foremost and utmost gratitude to God The Almighty, for His abundant grace that allowed us, Deepublish Publisher to publish this book entitled ***Philosophy and Theory of Nursing***.

As a publisher that–above other missions–prioritizes its role to educate and glorify mankind, as well as to utilize science and technology to its best, we do not only attend to the work of established writers, but we provide the room and facility for people who wish to express their creativity and innovation in writing and conveying ideas and values.

Our warmest gratitude and appreciation to the author, Ns. Tri Widyastuti Handayani, M.Kep., Sp.Kep.Kom., who has given us trust and contribution to the perfection of this book. Hopefully, this book is useful, and educative, and contributes well in glorifying mankind and the utilization of science and technology in the country.

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CHAPTER 1

NURSING PHILOSOPHY AND NURSING PARADIGM

KEY TERMS

- Philosophy
- Nursing philosophy
- Nursing Paradigm

LEARNING OBJECTIVES

After completing learning this chapter:

1. Student can understand philosophy
2. Student can understand nursing philosophy
3. Student can understand nursing paradigm

INTRODUCTION

Every person needs a philosophy in himself. Because with a philosophy you can understand the value, beliefs and opinions about the world, to inform the ideas they have. The philosophy is present in a person based on the experience of life he has experienced. The way they evaluate an observation and experiment to solve the problems they face. Nursing is a discipline embedding science and art. As science, nursing has the body of knowledge that serves as rational for nursing practice; and as an art, nursing embodies effort to express the creativity in providing nursing care.

Nursing can be described as both an art and a science; a heart and a mind. At its heart, lies a fundamental respect for human dignity and an intuition for a patient's needs. This is supported by

the mind, in the form of rigorous core learning. Due to the vast range of specialisms and complex skills in the nursing profession, each nurse will have specific strengths, passions, and expertise. As current or aspiring nurse, you may have personal belief about what nursing means to you. Many healthcare professionals establish a set of values that guide their patient care decisions and motivate them in the workplace. As a nurse, you can develop your own nursing philosophy to outline the values, beliefs and goals that drive you to be an effective nurse.

Studying philosophy generally makes people wiser. Wisdom means understanding existing thoughts from the point of view from which they are deduced. Understanding and accepting something that exists from the side in which it exists. Plato felt that thinking and thinking about something was such an extraordinary favor that philosophy was given the title of the most precious desire.

HYSTORY OF PHILOSOPHY

Talking about the birth and development of philosophy at the beginning of its birth cannot be separated from the development (science) of knowledge that emerged during the Ancient civilization (Greek period). In 2000 BC, the Babylonians who lived in the valley of the Nile River (Egypt) and the Euphrates River had recognized a weight measuring device, a power number table, a multiplication table using ten fingers.

According to (Suaedi, 2015), the history of philosophy is divided into four periods:

1. Greek Period

The period of Greek philosophy is a very important period in the history of human civilization because at that time there was a change in human mindset from mythocentric to logo-centric. The mythocentric mindset is the mindset of people who are very familiar with myths to explain natural phenomena, such as earthquakes and rainbows. However, when philosophy was introduced, these natural phenomena were no longer considered as divine activities, but

natural activities that occur causally. The tracing of Greek philosophy is explained from the origin of the word philosophy. Around the 9th century BC or at least 700 BC, in Greece, *Softhia* was given the meaning of wisdom; *Sophia* also means skill. The word *philoshopos* was first proposed and used by Heraklitos (480-540 BC). While in the 500-580 BC century, these words were used by Pithagoras.

According to *Philosophos* (philosopher), to have extensive knowledge as an embodiment of his love for the truth and began to be really clearly used at the time of the sophists and Socrates who gave the meaning of *philosophein* as a systematic mastery of theoretical knowledge. *Philosopia* is the result of an action called *Philosophein*, while *philosophos* is the one who does philosophien. From the word *philosophia, the* words *philosophie* (Dutch, German, French), *philosophy* (English). In Indonesian, it is called falsafat (Suaedi, 2015).

2. Medieval Period

This period began with the birth of European philosophy. As with Greek philosophy which was influenced by beliefs, philosophy or thought in medieval times was also influenced by Christian beliefs. This means that medieval philosophical thought was dominated by religion. Solving all problems is always based on religion so that the style of philosophical thought is theocentric.

It wasn't until the sixth century, Matthew with the support of Karel the Great, that schools were established that taught grammar, dialectics, geometry, arithmetic, astronomy and music. This situation would encourage the development of philosophical thought in the 13th century, which was marked by the establishment of universities and orders. In these orders they devoted themselves to the advancement of science and religion, such as Anselmus (1033-1109), Abaelardus (1079-1143), and Thomas Aquinas (1225-1274). Among Islamic scholars (the Islamic Scholastic period of philosophy), al-Kindi, al-Farabi, Ibn Sina, al-Ghazali, Ibn Bajah, Ibn Tufail, and Ibn Rushd appeared. This Islamic scholastic period lasted from 850-1200. It

was during this period that the glory of Islam took place and science developed rapidly. However, after the fall of the Islamic Kingdom in Granada, Spain in 1492, western political power began to plunder the east. This was the greatest achievement in science, especially in philosophy. Here they were the link that transferred Greek philosophy, as Islamic scholars in the east did to Europe by adding their own Islamic thoughts. The Islamic philosophers themselves were partly assuming that Aristotle's philosophy was true, Plato's and the Qur'an's were true, they organized a fusion and syncretism between religion and philosophy.

Then these thoughts entered Europe which was the greatest contribution of Islam, which had a great influence on science and philosophical thought, especially in the fields of theology and natural science. The transition from medieval to modern times in the history of philosophy is referred to as the transition period, namely the emergence of the Renaissance and Humanism which took place in the 15th-16th centuries. The emergence of the Renaissance and Humanism is what started the modern age. From this modern era, the role of natural science is very prominent, so that as a result, philosophical thought is increasingly considered as a servant of theology, namely as a means of establishing truths about God that can be achieved by human reason.

3. The Modern Century

In this modern century, philosophical thought has succeeded in placing humans in a central place in the view of life so that the style of thought is anthropocentric, namely philosophical thought based on reason and experience. Earlier it was stated that the emergence of Renaissance and Humanism is the beginning of the modern era, where experts (philosophers) became the pioneers of the development of philosophy (in medieval times the pioneers of the development of philosophy were religious leaders). Philosophical thought during this modern era tried to lay the foundations for scientific logical methods. Philosophical thinking is sought to be more practical, meaning that

philosophical thinking is directed at human efforts to master the natural environment using various scientific discoveries.

Due to the rapid use of induction/experimental methods in scientific research, the development of philosophical thought began to lag behind the development of the *natural sciences*. Rene Descartes (1596-1650) as the father of modern philosophy who succeeded in giving birth to a concept from the combination of the methods of natural science and science into philosophical thought. This effort is intended so that the truth and reality of philosophy is also a clear and bright truth and reality.

In the 18th century, the development of philosophical thought led to the philosophy of science, where philosophical thought was filled with human endeavors, how to/what means are used to find the truth. and reality. George Berkeley (1685-1753), David Hume (1711-1776), and Rousseau (1722-1778) were prominent figures. In Germany, Christian Wolft (1679-1754) and Immanuel Kant (1724-1804) sought to make philosophy a definite and useful science, namely by forming clear notions and strong evidence (Amin, 1987).

In the 19th century, the development of philosophical thought was divided. Philosophical thought at that time was able to shape the personality of each nation in its own way. There was American philosophy, French philosophy, British philosophy, and German philosophy. The figures are Hegel (1770-1831), Karl Marx (1818-1883), August Comte (1798-1857), JS. Mill (1806-1873), John Dewey (1858-1952). Finally, with the emergence of these various philosophical thoughts, there is no longer a dominating philosophical thought. The next turn was the birth of contemporary philosophy or philosophy today.

4. This Century

Today's philosophy or 20th century philosophy is also called contemporary philosophy whose characteristic of philosophical thought is human decentralization because 20th century philosophical thought pays special attention to the fields of language and social

ethics. In the field of language there are key issues; the meaning of words and the meaning of statements. This problem arises because in today's reality many terms have emerged, where the way they are used is often not thought out in depth, causing different interpretations (double meaning). Therefore, analytical philosophy arises in which it discusses how to think about regulating the use of words/terms that cause confusion, as well as being able to show the dangers contained therein. Because language is the most important object in philosophical thought, scholars refer to it as logocentric. In the field of social ethics contains the main issues of what we want to do in today's society.

Then, in the first half of the 20th century, philosophical schools such as Neo-Thomism, Neo-Kantianism, Neo-Hegelianism, Science Criticism, Historicism, Irrationalism, Neo-Vitalism, Spiritualism, and Neo-Positivism emerged. Only a few of these schools still survive today. Meanwhile, in the early part of the 20th century, philosophical schools emerged that were more able to provide a style of thought, such as Analytic Philosophy, Philosophy of Existence, Structuralism, and Social Criticism.

DEFINITION OF SCIENCE AND KNOWLEDGE

1. Science

The word science comes from the Arabic "*alima*" and means knowledge. The use of this word in Indonesian is equivalent to the term "science". Science comes from the Latin: Scio, Scire which also means knowledge.

Science is knowledge. However, there are different kinds of knowledge. By "scientific knowledge" we mean knowledge that is certain, exact, and well-organized. So, knowledge that is based on reality and is well-organized.

Science contains three categories, namely hypotheses, theories, and legal propositions. Science must be systematic and based on methodology, it seeks to achieve generalization. In scientific studies, when little or no data has been collected, scientists

build hypotheses. A hypothesis is a conjecture based on some data. Hypotheses give direction to research in collecting data. Sufficient data as a result of research is confronted with hypotheses. If the data validates (valid)/accepts the hypothesis, the hypothesis becomes a thesis or hypothesis becomes a theory. If the theory reaches a general generalization, it becomes a postulate and if the theory confirms a completely permanent cause-and-effect relationship, it becomes a law.

Here are the different types of science (Suaedi, 2015):

a. Practical science; it does not just reach general laws or abstractions, it does not just stop at a theory, but also goes to the world of reality. It studies cause-and-effect relationships to be applied in the real world.
b. Practical science; it is normative, it provides criteria and norms.
c. Positive practical science provides more specific measures or norms than normative practical science. The norms studied are how to make something or what actions to take to achieve certain results.
d. Ideographic speculative science, whose aim is to study the truth of objects in reality in a particular time and space.
e. Nomothetic speculative science, aiming for general laws or substantive generalizations.
f. Theoretical speculative science, aimed at understanding causality. It aims to obtain the truth of a particular situation or event.

2. Knowledge

Etymologically, knowledge comes from the English word “knowledge”. The encyclopedia of philosophy explains that the definition of knowledge is true belief. While terminologically, several definitions of knowledge will be presented. According to Drs. Sidi Gazalba, knowledge is what is known or the result of knowing. The work of knowing is the result of knowing, being aware, realizing, understanding, and being clever. Knowledge is all property or

content of the mind. Thus, knowledge is the result of the process of human effort to know. The dictionary of philosophy explains that knowledge is the process of life that humans know directly from their own consciousness. Pragmatists, especially John Dewey, do not distinguish between knowledge and truth. So, knowledge must be true, otherwise it is a contradiction.

Type of knowledge (Suaedi, 2015):

a. Ordinary knowledge, which is knowledge that in philosophy is said to be common sense, is often interpreted as good sense because someone has something that he accepts well. Everyone calls something red because it is red, something is hot because it feels hot and so on.
b. Knowledge of science, namely science as a translation of science which in principle is an attempt to organize and systematize common sense, a knowledge derived from experience and observation in everyday life. Science can be an objective method of thinking (objective thinking), the aim is to describe and give meaning to the factual world. The knowledge gained by science is obtained through observation, experimentation, and classification. The analysis of science is objective and sets aside personal elements, logical thinking is prioritized, neutral in the sense that it is not influenced by something that is selfish because it starts with facts.
c. Philosophical knowledge, which is knowledge gained from contemplative and speculative thinking. Philosophical knowledge emphasizes the universality and depth of study of something. If science is only on one narrow field of knowledge, philosophy discusses broader and deeper things. Philosophy usually provides reflective and critical knowledge so that science that was rigid and tends to be closed becomes loose again.
d. Religious knowledge, which is knowledge that is only obtained from God through His messengers. Religious knowledge is absolute and must be believed by its adherents.

The conditions possessed by scientific knowledge are: (1) must have a specific object (formal and material object), (2) must be systemized, (3) has a specific method, and (4) must be general in nature. It can be concluded that knowledge is basically different from science. The difference can be seen from its systematic nature and the way it is obtained. In its development, knowledge and science are synonymous in meaning, while in a material sense they have differences.

3. Sources of Science

The main sources of science are as follows (Suaedi, 2015):

a. Rationalism

This notion of rationalism assumes that the source of human knowledge is the ratio. So, in the process of developing science owned by humans, it must start from the ratio. Without ratios, it is impossible for humans to gain knowledge. The ratio is thinking. Therefore, it is this thinking that then forms knowledge. It is humans who think that will gain knowledge. The more humans think, the more knowledge they will gain. Based on knowledge, humans act and determine their actions so that there will be differences in human behavior, actions, and actions according to the differences in knowledge gained earlier. The figures are Rene Descartes, Spinoza, Leibzniz, and Wolff; although in essence the roots of their thinking can be found in the thoughts of classical philosophers such as Plato, Aristotle, and others.

b. Empiricism

Epistemologically, the term empiricism comes from the Greek word *emperia* which means experience. Its figures are Thomas Hobbes, Jhon Locke, Berkeley, and most importantly David Hume. In contrast to rationalism, which gives position to the ratio as the source of knowledge, empiricism chooses experience as the main source of knowledge, both external and internal experience. Thomas Hobbes regarded sensory experience as the beginning of all knowledge. Intellectual

recognition is nothing but a kind of calculation (calculus), which is the combination of the same sensory data in different ways. The world and matter are the objects of cognition, which are material systems and are an ongoing process based on the laws of mechanism. On this view, Hobbes' teaching is the first materialistic system in the history of modern philosophy.

The principles and methods of empiricism were first applied by Jhon Locke. According to him, all knowledge comes from experience and nothing more than that and human reason is passive at the time of knowledge. The intellect cannot acquire knowledge of its own. The intellect is nothing but a blank white paper, it just receives everything that comes from experience. Locke does not distinguish between sensory knowledge and intellectual knowledge; the only objects of knowledge are ideas that arise because of external experience and because of inner experience. Outward experience relates to things that are outside us. While inner experience is related to things that exist within the human self/psychic itself.

Dr. Mulyadi Kartanegara defines the source of knowledge as a tool or something from which humans can obtain information about the object of knowledge that is different in nature. Because the source of knowledge is a tool, he mentions the senses, reason, and heart as sources of knowledge. Amsal Bakhtiar's opinion is not much different. According to him, the source of knowledge is a tool to obtain knowledge. With different terms, he mentions four kinds of sources of knowledge, namely *emperism, rationalism, intuition,* and *revelation*. Likewise, with Jujun Surya Sumantri, he mentions these four sources of knowledge.

Meanwhile, John Hospers in his book entitled *An Instruction to Philosophical Analysis*, mentions several tools for obtaining knowledge, including sensory experience, reason, authority, intuition, revelation, and belief (Suaedi, 2015):

1. Sensory experience, science obtained from human experience in real life related to the utilization of human sensory organs. Science based on human sensory facts.

2. Reasoning, science is obtained through the process of human reasoning using reason. Reasoning works by contrasting existing statements with new statements. The truth of the contradiction between the two is new knowledge.
3. *Authority*, science that is born from an authority of power recognized by members of the group. Science related to this truth does not need to be tested anymore
4. *Intuition,* science that is born from a human contemplation that has special abilities related to his soul. Science that comes from intuition cannot be proven immediately but through a long process and of course by utilizing human intuition.
5. *Revelation*, science that comes from divine revelation through prophets and messengers for the benefit of the people. The basis for accepting its truth is belief in the source of the revelation itself. From this belief comes what is called belief.
6. Belief or *faith*, science that comes from a strong belief. A deep-rooted belief in the truth of divine revelation and its messenger. This science does not need to be tested. Its adherents will immediately believe it as a necessity.

DEFINITION OF PHILOSOPHY

The definition of philosophy in the history of the development of philosophical thought between one philosopher and another is always different and almost as many as the philosophers themselves. Philosophy is a belief in values that are a guide to achieving a purpose and used as a view of life. Philosophy becomes the main characteristic of a community, whether large or small, one of them is the nursing profession. Butt & Rich (2011) philosophy stating science is about knowledge (originally from the Greek word *philosophia*) which means “love of wisdom”. Philosophy is the study of the fundamental nature of knowledge, reality, and existence, especially when considered as an academic discipline (Oxford Languages, 2023). A philosophy is a belief system, often an early effort to define nursing phenomena and serves as the basis for later theoretical formulation (Berman, Snyder,

& Frandsen, 2022). Philosophy provides a method of studying and existence and what is highly desirable, good, or useful

The definition of philosophy can be viewed from two aspects, namely etymology and terminology (Suaedi, 2015):

1. Philosophy in etymology

The word philosophy in Arabic is known as *Falsafah* and in English it is known as Philosophy and in Greek as *Philosophia*. The word *Philosophia* consists of the words *philein* which means love and *sophia* which means wisdom so that etymologically the term philosophy means love of wisdom in the deepest sense. Thus, a philosopher is a lover or seeker of wisdom. The word philosophy was first used by Phytagoras (582-486 BC). The meaning of philosophy at that time, then philosophy was clarified as it is widely used today and was also used by Socrates (470-390 BC) and other philosophers.

2. Philosophy in terminology

Terminology is the meaning contained by the term philosophy. This is because the limitations of philosophy itself are many, so as an illustration, the following limitations are introduced.

a. Plato argues that philosophy is knowledge that tries to achieve knowledge of the original truth because truth is absolutely in the hands of God.
b. Aristotle argued that philosophy is the science (knowledge) that encompasses the truth in which the sciences of metaphysics, logic, rhetoric, ethics, and aesthetics are contained.
c. Prof. Dr. Fuad Hasan, philosophy is an effort to think radically, meaning starting from the radix of a symptom, from the root of a thing to be questioned.
d. Immanuel Kant, a western philosopher with the title of a giant of European thought, said that philosophy is the main science and the basis of all knowledge which includes four issues:
e. what can we know, answered by metaphysics?
f. what are we allowed to do, answered by ethics?
g. what is a human being, answered by anthropology? and

h. Where is our hope, answered by religion?
i. Rene Descartes said that philosophy is the science (knowledge) of the nature of how nature actually exists.

The characteristics of philosophy are comprehensive, fundamental, and speculative. The following are the characteristics of philosophizing.

1. **Comprehensive**, means broad thinking because it does not limit itself and is not only viewed from one particular point of view. Philosophical thinking wants to know the relationship between one science and other sciences, the relationship between science and morals, art, and the purpose of life.
2. **Fundamental**, means deep thinking to the fundamental or essential results of the object studied so it can be that Philosophy is the basis for all values and knowledge. Philosophy does not stop at the *periphery*, but penetrates to the depths.
3. **Speculative**, means that the results of the thinking obtained are used as a basis for further thinking. The results of philosophical thinking are always intended as a basis for exploring new areas of knowledge. However, this does not mean that the results of philosophical thinking are dubious because they are never complete.

The characteristics of philosophical thinking according to Ali Mudhofir are as follows.

1. Philosophical thinking is characterized as **radical**. Radical comes from the Greek, *Radix* meaning root. Radical thinking is thinking down to the roots, thinking down to the essence, essence, or substance of what is being thought about. Human beings who philosophize with their intellect try to capture ultimate knowledge, namely knowledge that underlies all sensory knowledge.
2. Philosophical thinking is characterized as **universal** (general). Thinking universally is thinking about things and processes that are general, in the sense of not thinking about partial things. Philosophy is concerned with the general experience of

mankind. By means of this radical search, philosophy tries to arrive at various conclusions that are universal (general).

3. Philosophical thinking is characterized as **conceptual**. The concept here is the result of generalization from experience about individual things and processes. With this conceptual characteristic, philosophical thinking goes beyond the limits of everyday life experience.
4. Philosophical thinking is characterized as **coherent** and consistent. Coherent means in accordance with the rules of thinking (logical). Consistent means that it does not contain contradictions.
5. Philosophical thinking is characterized as **systematic**. Systematic comes from the word system. The system here is the roundness of a number of elements that are interconnected according to an arrangement to achieve a purpose or fulfill a certain role. In expressing an answer to a problem. Opinions that constitute philosophical descriptions must be interconnected in an orderly manner and contain a certain purpose or goal.
6. Philosophical thinking is characterized by being **comprehensive**. Comprehensive is all-encompassing. Philosophical thinking. Philosophical thinking seeks to explain the universe as a whole.
7. Philosophical thinking is characterized as **free**. To a large extent, every philosophy can be said to be the result of free thought. Free from any social, historical, cultural, or religious prejudices.
8. Philosophical thinking is characterized by **responsible** thinking. A person who philosophizes is a person who thinks while being responsible. The first responsibility is to his own conscience. Here we see the connection between freedom of thought in philosophy and the ethics that underlie it. The next phase is how he formulates his thoughts so that they can be communicated to others

Philosophy involves a search for meaning; it represents a perspective, and it is a set of beliefs. Philosophy like a science, is both

a process and an outcome. The process of philosophy is the critical inquiry and examination of meaning and the method one undertakes when beliefs are examined, ideas are proposed, and assumptions are challenged. Philosophy encompasses more than rhetoric; it is the guide by which situation are approached, the view point used to see what is before one, and the method by which one searches for truth, as well as an understanding of what truth is. Philosophy is contextually grounded; it relies on the present but is embedded in the historical past. Philosophy is dynamic; it evolves and it is subtle while simultaneously being overt.

Three main content areas or type of inquiry in philosophy are: (1) ontology (metaphysics), (2) epistemology (study of knowledge), and (3) axiology (the study of value).

1. Ontology
   Ontology is the philosophical study of being, as well as related concept (existence, becoming, reality). Ontology is a branch of metaphysics that studies the nature of being and of reality (George, 2014).
2. Epistemology
   The term is derived from the Greek *episteme* (knowledge) and *logos* (reason). Epistemology (study of knowledge) is inquiry into the creation, dissemination, and categorization of knowledge.
3. Axiology
   Axiology term is derived from the Greek *axios* (worthy) and *logos* (science). Axiology is the study of value (Butts & Rich, 2011). Ethics is concerned with axiological inquiry.

Durant (1993) in Butts and Rich (2011), included five fields or studies and discourse within the discipline of philosophy: (1) logic (study of the nature and types of logic), (2) esthetics (study of beauty and taste), (3) ethics (study of what is right and wrong in human behavior), (4) politics (study of government, addressing question about the nature, scope, and legitimacy of public agents

and institutions), (5) metaphysics (study of the fundamental nature of reality).

DEFINITION OF NURSING PHILOSOPHY

Bruce et al. (2014) state nurses use philosophy that focuses on the conceptual framework, methods and view of life. A nursing philosophy is as statement that outlines a nurse's values, ethics, and beliefs. Nursing philosophy addresses a nurse's ethic as it relates to the practice of nursing. Nursing philosophy is a nurse's quality of nursing values that guides on nursing care, good to individuals, family, A group as well as a community. The confidence in the value of nursing must be the handle of every nurse, including you right now. As a nurse, it is mandatory for you to hold and instill the values of nursing in you when you're socializing or when you're giving patients a soft treatment. In the state of nursing, it's not something you should be aware of. It's a value attached to a nurse. In other words, Nursing philosophy is the soul of every nurse. Therefore, Nursing philosophy must be a guide for nurses in running their jobs. As a nurse certainly in the nursing profession you must always use nursing values in the service of patients.

Nurses can refer to and apply nursing philosophy to guide their practices. The nurse manifests a nursing philosophy as a view of life in every act of nursing practice that involves knowledge, ethical and otherwise. By making nursing philosophy a living view of nurses, one can develop theories, nursing practice and improve professionalism

For example, the three main content areas or type of inquiry in nursing philosophy are:

1. Ontology

   In nursing, ontology is what we believe to be "true" in terms of the central interest to the discipline; it answers the question, "What is it that we believe exists?" (Butts & Rich, 2011).
2. Epistemology

   In nursing, this area includes question such as "What can we know?" or "How do we know what we know about the

phenomena of interest?" (Butts & Rich, 2011). George (2014) describe epistemology as the study of the history of knowledge, including the origin, nature, methods, and limitations of knowledge development or framework for approach.

3. Axiology

   In nursing, axiology is used to try to pinpoint how to approach a patient's care by focusing on the intrinsic value of health and what they value as an individual, as well as the patient's rights.

DEFINITION OF NURSING PARADIGM

Paradigm is a global, general framework made up of assumptions about aspect of the discipline held by members to be essential in development of the discipline. Paradigms are particular perspectives on the metaparadigm or disciplinary domain (Smith & Parker, 2015). Fawcett (1995) in Alligood (2014) describe the nursing paradigm represents global ideas about individuals, groups, situations and phenomena interest to this discipline. Fawcett's (1984) explication of the nursing metaparadigm was another model for delineating the focus of nursing. According to Fawcett, the discipline of nursing is the study of the interrelationships among human beings, environment, health, and nursing. Although the metaparadigm is widely accepted, the inclusion of nursing as a major concept of the nursing discipline is tautological (Smith & Lierh, 2018). Nursing metaparadigm or nursing paradigm is "a set of concepts and propositions that sets forth the phenomena with which a discipline is concerned." In simple terms, it is all the features that go into a single framework–or everything that goes into being a nurse.

Nursing metaparadigm have four concepts (Berman, Snyder, & Frandsen, 2022).

1. Human Being

   Human beings are viewed as open energy fields with unique life experiences. As energy fields, they are greater than and different from the sum of their parts and cannot be predicted from knowledge of their parts. Humans, as holistic beings, are unique, dynamic, sentient,

and multidimensional, capable of abstract reasoning, creativity, aesthetic appreciation and self-responsibility. Language, empathy, caring, and other abstract patterns of communication are aspects of an individually high level of complexity and diversity and enable one to increase knowledge of self and environment. Humans are viewed as valued persons, to be respected, nurtured and understood with the right to make informed choices regarding their health.

For the purpose of study in nursing, biological, psychological, spiritual, intellectual and sociocultural dimensions of human beings and stages of human development are delineated as they affect behavior and health. These dimensions operate within and upon the human being in an open, interrelated, interdependent, and interactive way. The nursing client is an open system, continually changing in mutual process with the changing environment. Recipients of nursing actions may be well or ill and include individuals, families and communities.

2. Environment

Environment is the landscape and geography of human social experience, the setting or context of experience as everyday life and includes variations in space, time and quality. This geography includes personal, social, national, global, and beyond. Environment also includes societal beliefs, values, mores, customs, and expectations. The environment is an energy field in mutual process with the human energy field and is conceptualized as the arena in which the nursing client encounters aesthetic beauty, caring relationships, threats to wellness and the lived experiences of health. Dimensions that may affect health include physical, psychosocial, cultural, historical and developmental processes, as well as the political and economic aspects of the social world.

3. Health

Health, a dynamic process, is the synthesis of wellness and illness and is defined by the perception of the client across the life

span. This view focuses on the entire nature of the client in physical, social, aesthetic, and moral realms. Health is contextual and relational. Wellness, in this view, is the lived experience of congruence between one's possibilities and one's realities and is based on caring and feeling cared for. Illness is defined as the lived experience of loss or dysfunction that can be mediated by caring relationships. Inherent in this conceptualization is each client's approach to stress and coping. The degree or level of health is an expression of the mutual interactive process between human beings and their environment.

4. Nursing

Nursing is an academic discipline and a practice profession. It is the art and science of holistic health care guided by the values of human freedom, choice, and responsibility. Nursing science is a body of knowledge arrived through theory development, research, and logical analysis. Nursing and other supporting theories are essential to guide and advance nursing practice. The art of nursing practice, actualized through therapeutic nursing interventions, is the creative use of this knowledge in human care. Nurses use critical thinking and clinical judgment to provide evidence-based care to individuals, families, aggregates, and communities to achieve an optimal level of client wellness in diverse nursing settings/contexts. Clinical judgment skills are therefore essential for professional nursing practice.

SUMMARY

A philosophy is an individual's belief in certain values. A person's philosophy is a belief that comes from life's experience, observation and experiment. The definition of philosophy in the history of the development of philosophical thought between one philosopher and another is always different and almost as many as the philosophers themselves. The nurse must have a nursing philosophy in her as a confidence in her ability to perform treatment and apply nursing theories and give her space to understand her science. Three main content areas or type of inquiry in philosophy are: (1) ontology

(metaphysics), (2) epistemology (study of knowledge), and (3) axiology (the study of value). Nursing paradigm represents global ideas about individuals, groups, situations and phenomena interest to this discipline. Nursing paradigm have four concepts.

In essence, thinking philosophically can be interpreted as thinking very deeply to the essence, or thinking globally, thoroughly, or thinking seen from various perspectives of thought or scientific perspectives. This kind of thinking is an effort to be able to think precisely and correctly and can be accounted for. By understanding the concepts of philosophy, it is hoped that it can make it a view of life as a total and central human incarnation in accordance with human nature as a monodualist being (humans naturally consist of soul and body).

REVIEW QUESTIONS

1. “What kind of question is knowledge??” and “what is truth??” is a reliable branch of philosophy known as?
   A. Axiology
   B. Epistemology
   C. Ontology
   D. Philosophy
   E. Value
2. The branch of philosophy concerned with questions about existence is?
   A. Axiology
   B. Epistemology
   C. Ontology
   D. Philosophy
   E. Value
3. Human beings in the concept of nursing paradigms, viewed as an intact and complex individual, where humans are a bunch of organs that have an integrated function and a human trait seen as understandable?
   A. Biological

B. Psychology
C. Social
D. Spiritual
E. Culture

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CHAPTER 2.

CLASSIFICATION OF NURSING THEORIES

KEY TERMS

- Theory
- Nursing theory
- Nursing model

LEARNING OBJECTIVES

After completing learning this chapter:

1. Student can understand the definition of nursing theory
2. Student can understand the history of nursing theory
3. Student can understand the component of nursing theories
4. Student can understand the purpose of nursing theories
5. Student can understand the classification of nursing theories

INTRODUCTION

Nursing, as a profession, is committed to recognizing its own unparalleled body of knowledge vital to nursing practice and nursing science. To distinguish this foundation of knowledge, nurses need to identify, develop, and understand concepts and theories in line with nursing. As a science, nursing is based on the theory of what nursing is, what nurses do, and why. Nursing is a unique discipline and is separate from medicine. It has its own body of knowledge on which delivery of care is based. Understanding nursing theory is the prerequisite to choosing and using a theory to guide one's nursing practice.

Nursing theories have developed from the choices and assumptions about the nature of what a particular theorist believes about nursing, what the basis of nursing knowledge is, and what nurses do or how they practice in the real world. Each theory carries with it a reality and possibly shades or ignores aspects in other areas. Each theorist was influenced by her or his own values, the historical context or the discipline of nursing, and a knowledge base rooted in the world of nursing science.

DEFINITION OF NURSING THEORIES

Definitions of theory emphasize its various aspects. Nursing theories are organized bodies of knowledge to define what nursing is, what nurse do, and why they do. Nursing theory is a conceptualization of some aspect of reality (invented or discovered) that pertains to nursing. The conceptualization is articulated for the purpose of describing, explaining, predicting, or prescribing nursing care (Meleis, 2012). The following definitions of the theory are consistent with general ideas of theory in nursing practice, education, administration or research (Smith & Parker, 2015):

1. Theory is a set of concepts, definitions, and propositions that project a systematic view of phenomena by designating specific interrelations among concepts for purposes of describing, explaining, predicting, and/or controlling phenomena (Chinn & Jacob, 1987)
2. Theory is a creative and rigorous structuring of idea that projects a tentative, purposeful, and systematic view of phenomena (Chinn & Kramer, 2004)
3. Nursing theory is an inductively an/or deductively derived collage of coherent, creative, and focused nursing phenomena that frame, give meaning to, and help explain specific and selective aspects of nursing research and practice (Silva, 1997)
4. A theory is an imaginative grouping of knowledge, ideas, and experience that are represented symbolically and seek to illuminate a given phenomenon (Watson, 1985)

HISTORY OF NURSING THEORIES

Discipline can be classified as belonging to the science or humanities. In any science, there is a search for understanding about specified phenomena through creating some organizing frameworks (theories) about the nature of those phenomena. The evolution of nursing as a science has occurred within the past 70 years. The history of professional nursing began with Florence Nightingale. Nightingale envisioned nurse as a body of educated women at a time when women were neither educated nor employed in public service. Nightingale's (1859/1969) vision of nursing has been practiced for more than a century, and theory of development in nursing has evolved rapidly over the past 6 decades, leading to the recognition of nursing as an academic discipline with a specialized body of knowledge (Alligood, 2014).

Midway through the 1800s, Nightingale distinguished nursing knowledge from medical knowledge by recognizing the special purpose of nursing. She stated that a nurse's primary role is to prepare the patient so that nature can work its magic on them. She addressed the fact that medical professionals' knowledge base informs how they treat patients. Despite this early directive from Nightingale in the 1850s, the nursing community didn't start to seriously consider the necessity of building nursing knowledge separate from medical knowledge to guide nursing practice until 100 years later, in the 1950s. Due to this, nursing theory needed to be developed. Major advances in nursing theory occurred during the 1980s, which has been seen as a transitional time from the pre-paradigm to the paradigm era. The focus switched in the final decades of the twentieth century from studying the theorists to using their writings to develop research questions, direct practice, and set up curricula. These findings about the growth of nursing theory give rise to Kuhn's concept of normal science from 1970. His scientific philosophies help us better grasp how nursing theory has developed through paradigmatic science. The creation and use of the theory gave the nursing process significance, ushering in the period known as the nursing theory era. For the

purpose of knowledge growth, the theory-usage era has restored a balance between research and practice (Alligood, 2014).

Table 1. History of Nursing Theory
(Alligood, 2014)

Year	Figures Name	Discovery Theory
1860	Florence Nightingale	Environmental Theory: the act of utilizing the patient's environment to assist him in his recovery
1952	Hildegard Peplau	Theory of Interpersonal Relations: The nurse-client relationship as the foundation of nursing practice.
1955	Virginia Henderson	Nursing Need Theory: 14 fundamental needs
1960	Faye Abdellah	Typology of 21 Nursing Problems: the focus of nursing from a disease-centered approach to a patient-centered approach.
1962	Ida Jean Orlando	Emphasized the mutually beneficial interaction between the patient and the nurse and saw it as the professional responsibility of the nurse to determine the patient's immediate need for assistance and provide it.
1968	Dorothy Johnson	Behavioral System Model
1970	Martha Rogers	Considered nursing to be both a science and an art because it offers a perspective on the unitary human being who is a part of the cosmos.
1971	Dorothea Orem	According to her theory, a client needs nursing care if they are unable to meet their biological, psychological, developmental, or social needs.
1971	Imogene King's	Theory of Goal attainment
1972	Betty Neuman	The System Model of Nursing Practice

Year	Figures Name	Discovery Theory
1979	Callista Roy	The individual as a set of interrelated systems that maintain the balance between these various stimuli.
1979	Jean Watson	The Philosophy of Caring

COMPONENT OF NURSING THEORIES

Component of nursing theories (George, 2015):

1. Phenomenon
   A term given to describe an idea or response about an event, a situation, a process, a group of events, or a group of situations. Nursing theories focus on the phenomena of nursing.
2. Concepts
   An abstract notion; a vehicle of thought that involves images; words that describe objects, properties, or events
3. Definitions
   Definition is the general meaning of the concepts of the theory, it can be theoretical or operational.
4. Relational Statements
   Define the relationships between two or more concepts.
5. Assumptions
   Beliefs generated from past experiences that influence the nurse's view and understanding of the current situation.

PURPOSES OF NURSING THEORIES

The purposes of nursing theory:

1. Help nurses understand their purpose and role in the healthcare setting
2. Help recognize what should set the foundation of practice
3. Serve as a rationale or scientific reasons for nursing intervention
4. Serve as foundations of nursing practice
5. Define, predict, and demonstrate nursing phenomenon
6. Help guide research and informing evidence-based practice

7. Serve as the development of nursing education and training programs
8. Serve as a guide knowledge development and directs education, research, and practice

CLASSIFICATION OF NURSING THEORIES

Meleis (2012) describe theories by level of abstraction:

1. Grand theories
   Grand theories are systematic constructions of the nature of nursing, the missions of nursing, and the goals of nursing care. Grand theories are constructed form a synthesis of experiences, observations, insights, and research findings. Grand theories reflect the broadest scope and provide relationships between a large number of abstract concepts.
2. Middle range theories
   Theories that have more limited scope, less abstraction, address specific phenomena or concepts, and reflect practice (administration, clinical, or teaching) are considered middle range theories. Middle range theories lend themselves to empirical testing because the concepts are more specific and can be readily operationalized.
3. Situation specific theories
   Situation specific theories focus on specific nursing phenomena that reflect clinical practice and that are limited to specific populations or to a particular filed of practice. These theories are socially and historically contextualized; they are developed to incorporate, not transcend time, or social or politic structures.

Properties	Grand Theories	Middle-Range Theories	Situation-Specific Theories
Level of Abstraction	High	Medium	Low
Scope	The nature, mission, and goals of nursing	Specific phenomena or concepts transcending and crossing different nursing fields	Specific nursing phenomena limited to specific populations or to a particular field
Level of Context	Low	Medium	High
Connection to nursing research and practice	Too broad to connect	Limited	Relationship readily apparent (may prescribe for clinical practice)
Diversities, generalizations, and/or universalization	Ensuring universalization and generalization, but negating diversities	Crossing different nursing fields and reflecting a wide variety of nursing care situations, but rarely respecting diversities in them	Respecting diversities in nursing phenomena, but negating universalization and limiting generalization
Examples	Theories by Peplau, Henderson, Hall, Johnson, Abdellah, King, Wiedenbach, and Rogers	Theories by Hagerty, et al. and Mishel	Theories by Braden, Im and Meleis, and Hall, et al.

Box 1: Properties and examples of grand, middle-range, and situation-specific theories
(Meleis, 2012).

Meleis (2012) describe theories by level of abstraction:

4. Descriptive theories

   Descriptive theories are those that describe a phenomenon, an event, a situation, or a relationship; they identify its properties and its components; and they identify some of the circumstances under which it occurs. Descriptive theories are complete theories and have the potential to guide research.

   There are two types of descriptive theories. The first type is the factor-isolating, category-formulating, pr labeling theory. This theory describes the properties and dimensions of phenomena. The second type is the explanatory theory, which describes and explains the nature of relationships of certain phenomena to other phenomena. Descriptive nursing theories are those that help describe, explain, and predict nursing phenomena and relationships between nursing phenomena. Descriptive

theories are not action oriented and do not attempt to produce or change a situation.

5. Prescriptive theories
   Prescriptive theories are those that address nursing therapeutics and the outcome of interventions. A Prescriptive theory include propositions that call for change and predict the consequences of a certain strategy for a nursing intervention.

Alligood (2014) describe four categorized nursing theories (See box 2):

1. Nursing Philosophy
   Philosophy is the most abstract type and sets forth the meaning of nursing phenomena through analysis, reasoning, and logical presentation. Early works that predate the nursing theory era, contributed to knowledge development by providing direction or a basis for subsequent development. Later works reflect contemporary human science and its methods.
2. Nursing Conceptual Models
   Nursing conceptual models comprises nursing works by theorist referred to by some a pioneer in nursing. The nursing models are comprehensive, and each addresses the metaparadigm concepts of person, environment, health, and nursing. The nursing conceptual models have explicit theories derived from them by the theorist or other nurse scholars and implicit theories within them yet to be developed.
3. Nursing Theory
   Nursing theory comprises works that derived from nursing philosophies, conceptual models, abstract nursing theories, or works in other classified as a nursing theory. It is developed from some conceptual framework and is generally not as specific as a middle range theory. Although some use the terms model and theory interchangeably, theories differ from models as they propose a testable action

4. Middle Range Theory

   Middle range theories have the most specific focus and is concrete in its level of abstraction. Middle range theories are precise and answer specifics of nursing situations within the perspective of the model or theory which derived from patient, the family situation, the patient's health condition, the location of the patient and most importantly the action of the nurse.

Nursing Philosophies:	**Nursing Theories:**
Nightingale	Boykin and Schoenhofer
Watson	Meleis
Ray	Pender
Benner	Leininger
Martinsen	Newman
Eriksson	Parse
	Erickson, Tomlin, And Swain
	Husted and Husted
Nursing Conceptual Models:	**Middle-Range Nursing Theories:**
Levine	Mercer
Rogers	Mishel
Orem	Reed
King	Wiener and Dodd
Neuman	Eakes, Burke, and Hainsworth
Roy	Barker
Johnson	Kolcaba
	Swanson
	Ruland and Moore

Box 2: Type of Nursing Theoretical Woks
(Alligood, 2014)

SUMMARY

The theory of nursing is a notion or idea that explains about experiences, observations, captures of relationship and results. The nursing theory is extremely important for the nursing for being a discipline professional nurse. The theory of nursing is a design created for monitoring the development of the science, and explained

the phenomenon happened in nursing into more specific level. The theory used to support nursing practice help nurses in making decisions about what they know and what is needed. Nursing also has a treatment theory reference that can be used in the practice and the development of nursing science. The theory of nursing itself has some levels of function which is four levels or kind of metatheory, grand theory, middle range theory, and practice theory.

REVIEW QUESTION

1. An idea that explains the experience, results of observation, description of the relationship and the result is a sense of?
   A. Theory
   B. Philosophy
   C. Metaparadigm
   D. Nursing Paradigm
   E. Nursing Philosophy
2. The theory that contains a theory that serves to identify the phenomenon formed through the concept of an abstract theory called?
   A. Meta Theory
   B. Grand Theory
   C. Middle Range Theory
   D. Practice Theory
   E. Nursing Theory
3. The theory used to practice nursing and explain the phenomena that occur in the practice of nurses and population more specifically is called?
   A. Meta Theory
   B. Grand Theory
   C. Middle Range Theory
   D. Practice Theory
   E. Nursing Theory

4. The theory that is used to explore and orient an action that manifest focus on clinical practice in a given population and situations is?
   A. Meta Theory
   B. Grand Theory
   C. Middle Range Theory
   D. Practice Theory
   E. Nursing Theory

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CHAPTER 3.

MIDDLE RANGE NURSING THEORIES

KEY TERMS

- Nursing Theory
- Nursing Model
- Middle Range Theory
- Maternal Role Attainment/Becoming a Mother Theory
- Uncertainty in Illness Theory

LEARNING OBJECTIVES

After completing learning this chapter:

1. Student can understand the definition of middle range nursing theories
2. Student can understand the scope of middle range theories

INTRODUCTION

Middle-range nursing theories frequently have a narrower scope and provide more tangible links between grand nursing theories and nursing practice. Less complex and more easily testable are typically the concepts of middle-range theories. These theories frequently make an effort to define, explain, or anticipate certain clinical practice phenomena. Instead of beginning with a wide abstract concept like the social system, middle-range theory starts with an actual phenomenon and abstracts from it to produce broader claims that can be supported by data.

DEFINITION OF MIDDLE RANGE THEORY

Middle range theories are defined as the coherent articulation of a set of concepts that describe and explain relationships that are related to a particular phenomenon. Middle-Range nursing theories frequently have a narrower scope and provide more tangible links between Grand Nursing Theories and Nursing Practice. Less complex and more easily testable are typically the concepts of middle-range theories. These theories frequently make an effort to define, explain, or anticipate certain clinical practice phenomena. Middle range theory is less abstract than grand theory, are more accessible to researchers and clinicians, but reside at a higher level of abstraction than do empirical findings, and they contain proportions that reflect generalizations that go beyond specific clinical case studies (Meleis, 2012).

Merton (1968) in George (2015) describes middle range theories as those that lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research and the all-inclusive systematic efforts to develop unified theory that will explain all the observed uniformities of social behavior, social organization and social change. George (2015) has described middle range theories as follows:

1. Narrowed in scope than grand theories
2. Composed of a limit number of concepts and propositions that are written at a level that is concrete and specific
3. Concerned with less abstract, more specific phenomena
4. More applicable to practice

Middle range theories have direct linkages to research and practice. They may be developed inductively through qualitative research and practice observations, or deductively through logical analysis and synthesis. They may evolve through retroductive processes of rhythmic induction–deduction. As scholarly work extends middle range theories, research and practice traditions continue to develop. Nurses in practice can take middle range theories and develop practice guidelines based on them. The use of this protocol

in practice will feed back to the middle range theory, extending the evidence for practice and contributing to ongoing theory development. The use of middle range theories to structure research and practice builds the substance, organization, and integration of the discipline.
The process of developing a middle range theory (Meleis, 2012):

1. Clinical observation of different groups to whom nurses were providing care, and facilitation of developing new roles for patients and significant others
2. Identifying similarities and differences in groups and in nursing care provided
3. Developing a conceptually based nursing intervention
4. Testing the intervention clinically and through a series of research studies
5. Integrating the research findings, and finding commonalities and themes
6. Asking the next set of questions to reveal any lack of knowledge about the concept
7. A thorough review of research and clinical publications in nursing about the concepts
8. An analysis of commonalities and difference in the literature, and an identification of concept depicting the nature of questions about theory
9. Communicating and reporting theory at different stages

SCOPE OF MIDDLE RANGE THEORY

Smith and Liehr (1999) in George (2015) propose five approaches for middle range theory generation in the 21st century:

1. Introduction through research and practice
2. Deductive from research and practice applications of grand nursing theories
3. Combination of existing nursing and non-nursing middle range theories
4. Derivation form theories of other disciplines that relate to nursing's disciplinary perspective

5. Derivation from practice guidelines and standards rooted in research

The following is an example of middle range theory:

1. Maternal Role Attainment – Becoming a Mother Theory (Ramona T. Mercer)

Ramona T. Mercer received her diploma in nursing in 1950 from Saint Margaret's School of Nursing, Montgomery, Alabama; bachelor of science in nursing from the University of New Mexico (UNM), Albuquerque, in 1962; master of science in maternal child nursing from Emory University, Atlanta, Georgia; and Ph.D. in maternal nursing from the University of Pittsburgh, Pennsylvania. She is Professor Emeritus, Department of Family Health Care Nursing, at the University of California, San Francisco (UCSF). Her career has focused on maternal–child nursing. Her research on high-risk situations and transition to the maternal role has spanned over 30 years. She currently lectures, consults, and writes. Dr. Mercer was the 1984 recipient of the UCSF School of Nursing Helen Nahm Lecture Award, the 1988 recipient of the Western Society for Research in Nursing Distinguished Research Lectureship Award, and the 1990 recipient of the American Nursing Foundation's Distinguished Contribution to Nursing Science Award and, in 2004, was the first recipient of the UNM College of Nursing Distinguished Alumni Award. She is a fellow in the American Academy of Nursing (AAN) and was named an AAN Living Legend in 2003. She is the author of Nursing Care for Parents at Risk (1977), Perspectives on Adolescent Health Care (1979), First-Time Motherhood: Experiences from Teens to Forties (1986a), Parents at Risk (1990), and becoming a mother: Research on Maternal.

Based on Mercer examination of the literature and the findings of researchers from other fields, Mercer chose both maternal and newborn characteristics for her studies. The intricacy of her investigations was increased when she discovered that a wide range of circumstances may have an impact on maternal function, either directly or indirectly. Age at first birth, birth experience, separation from the infant too soon,

social stress, social support, personality traits, self-concept, views on raising children, and health were all considered maternal factors in Mercer's research. She took into account the infant's temperament, looks, responsiveness, and health status.

Maternal role attainment states the following assumptions:

a. A relatively stable core self, acquired through life long socialization, determines how a mother defines and perceives events; her perceptions of her infant's and others' responses to her mothering, with her life situation, are the real world to which she responds
b. In addition to the mother's socialization, her developmental level and innate personality characteristics also influence her behavioral responses
c. The mother's role partner, her infant, will reflect the mother's competence in the mothering role through growth and development
d. The infant is considered an active partner in the maternal role-taking process, affecting and being affected by the role enactment
e. The father's or mother's intimate partner contributes to role attainment in a way that cannot be duplicated by any other supportive person
f. Maternal identity develops concurrently with maternal attachment, and each depends on the other.

Maternal role attainment nursing metaparadigm (Alligood, 2014; George, 2015, Smith & Liehr, 2018):

a. Nursing

   According to Mercer (1995), nurses are the health professionals having the most sustained and intense interaction with women in the maternity cycle. She said that nurses are pioneers in developing and disseminating evaluation strategies for these patients and are in charge of promoting the health of families and children. Mercer does not mention specific nursing care, however she emphasizes that the kind of help or care a woman

receives during pregnancy and the first year following birth can have long-term effects for her and her child. Nurses in maternal-child settings play a sizable role in providing both care and information during this period.

b. Person

Mercer refers to the self or core self rather than a specific definition of a person. According to her, one is distinct from the other in the roles they play. A woman may reclaim her own personality through maternal individuation as she extrapolates herself from the mother-infant dyad. The core self dictates how events are defined, shaped, and developed within a cultural framework. The ideals of self-worth and self-confidence are crucial for fulfilling the maternal role. The mother interacts with her child, the father, or her significant other as a separate individual. She has an effect on them both and is affected by them both.

c. Health

Health status is described by Mercer as the parents' perceptions of their past and present health, as well as their outlook on their future health. It also includes their resistance to illness, sensitivity to illness, level of stress about their health, attitude toward sickness, and denial of the sick role. The extent of any diseases present and the infant's health state as determined by the parents' assessment of their general health Antepartum stress has a severe impact on a family's overall health. In families with children, health status has a significant indirect impact on relationship satisfaction. The child's health is seen as another desirable result. Both maternal and baby factors have an impact on it.

d. Environment

Mercer based his conception of the environment on the ecological environment. This model demonstrates the ecologically interconnected habitats where the attainment of mother roles develops. According to Mercer, a role's

or person's development cannot be separated from their environment because both the developing person and the evolving characteristics of their immediate surroundings, as well as the connections between those surroundings and the larger contexts in which those surroundings are embedded, must be accommodated. The environment's stresses and social support have an impact on how well parents perform their roles as well as how a child develops.

Mercer's theory of Maternal Role Attainment (MRA)/Becoming a Mother (BAM) is based on her extensive education, experience, and research in maternity nursing. MRA is an interactional and developmental process occurring over time in which the mother becomes attached to her infant, acquires competence in the caretaking tasks involved in the role, and expresses pleasure and gratification in the role. Mercer's model of Maternal Role Attainment was placed within Bronfenbrenner's (1979) nested circles of the microsystem, mesosystem, and macrosystem (see Figure 1).

a. The microsystem is the immediate environment in which maternal attainment occurs. It includes factors such as the father's role, family function and relationships, family support systems, economic status, values, and stressors. All of the microsystem elements affect the transition to motherhood and are the most influential on MRA. In order to influence the transition to motherhood, one or more of the other variables must interact with the variables present in this immediate setting. The family unit encompasses the infant as an individual. The family is perceived as a semi-closed organization that maintains boundaries and exerts control over interactions with other social systems.
b. The mesosystem is comprised of the social systems that surround the microsystem. Interactions between the microsystem and the larger mesosystem influence the developing maternal role and the child. The mesosystem includes school, church, day care, and other social systems within the immediate community.

c. The macrosystem refers to the larger culture surrounding the family. It includes the social, political, and cultural influences on the other two systems. It also includes the health care system and health policies that may affect MRA.

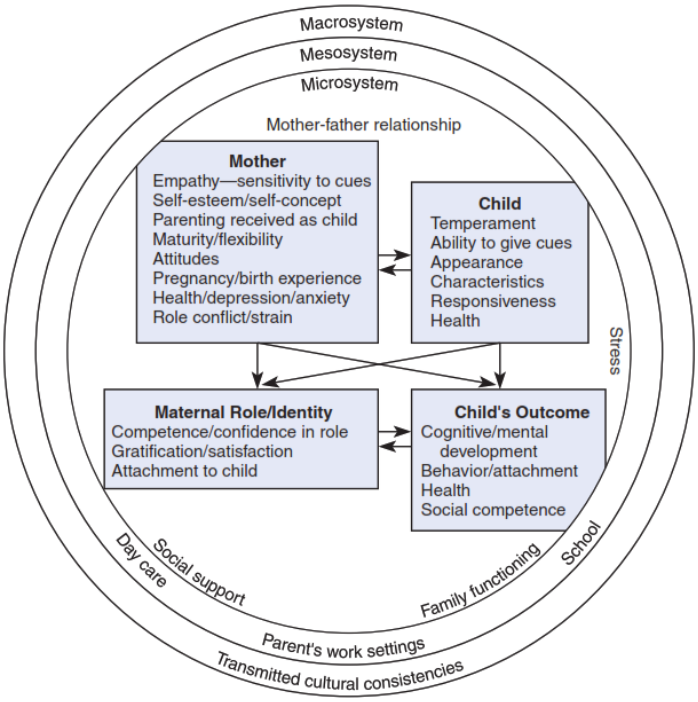

Figure 1: Model of Maternal Role Attainment
(Alligood, 2014)

Maternal role attainment is a process that follows four stages of role acquisition. The following stages are indicated in Figure 2 as the layers a through d (Alligood, 2014):

a. Anticipatory: The anticipatory stage begins during pregnancy and includes the initial social and psychological adjustments to pregnancy. The mother learns the expectations of the role, fantasizes about the role, relates to the fetus in utero, and begins to role-play.

b. Formal: The formal stage begins with the birth of the infant and includes learning and taking on the role of mother. Role behaviors are guided by formal, consensual expectations of others in the mother's social system.
c. Informal: The informal stage begins as the mother develops unique ways of dealing with the role not conveyed by the social system. The woman makes her new role fit within her existing lifestyle based on past experiences and future goals.
d. Personal: The personal or role-identity stage occurs as the woman internalizes her role. The mother experiences a sense of harmony, confidence, and competence in the way she performs the role, and the maternal role is achieved.

As the infant grows and develops, the stages of role achievement change and overlap. It can take a month or many months to develop a mother-role identity. Social support, stress, the functioning of the family, and the relationship between the mother and father or other significant other all have an impact on the stages.

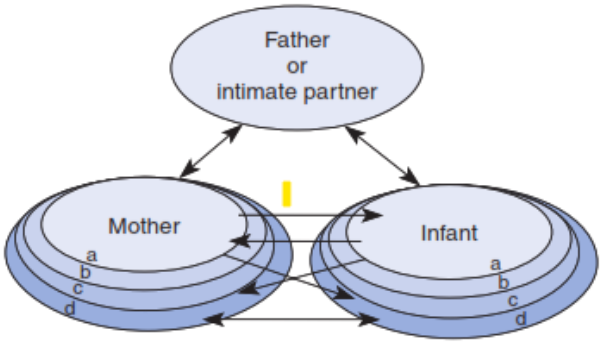

Figure 2: A microsystem within the evolving model of maternal role attainment.
(Alligood, 2014)

Becoming a mother: A Revised Model

Mercer has persisted in using both her own study and other researchers' research as the foundation for her argument. She

started reevaluating the Theory of Maternal Role Attainment in 2003 and suggested that, in light of recent studies, the term “becoming a mother” more appropriately describes the process. The idea of interdependent, nested ecological environments that Bronfenbrenner developed has been carried forward by Mercer. She gave them new names nonetheless to better reflect their surroundings of residence: family and friends, the local community, and society as a whole (Figure 3). According to this approach, the relationships between the mother, child, and father are at the heart of social contexts.

Physical and social support, family values, cultural parenting norms, knowledge and parenting abilities, family functioning, and motherhood affirmation are all factors within the context of family and friends. Daycare centers, houses of worship, schools, workplaces, health care facilities, entertainment centers, and support groups are all part of the communal environment. Laws impacting women and children, developing reproductive and neonatal science, national health care systems, numerous social initiatives, and funding for research supporting motherhood all have an impact on society as a whole.

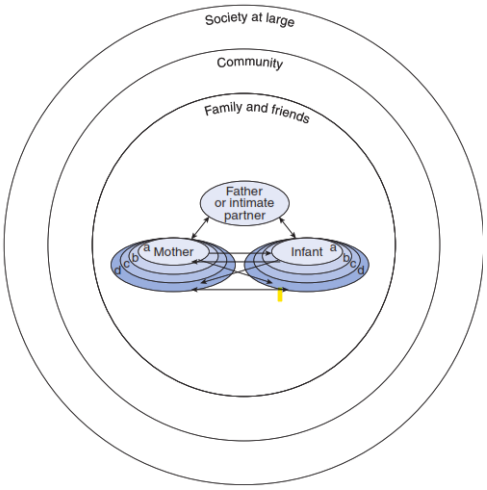

Figure 3: Becoming a mother: A revised model
(Alligood, 2014)

The most recent model (Figure 4) illustrates how several environments interact to influence the process of becoming a mother. Based on an analysis of nursing research on the efficacy of treatments designed to support the process of becoming a mother, the model was created in 2006. This model represents the intricate problems that could either help or hinder the process of becoming a mother. According to Mercer and Walker (2006), the model provides environmental variables and implications for nursing practice as well as for further research.

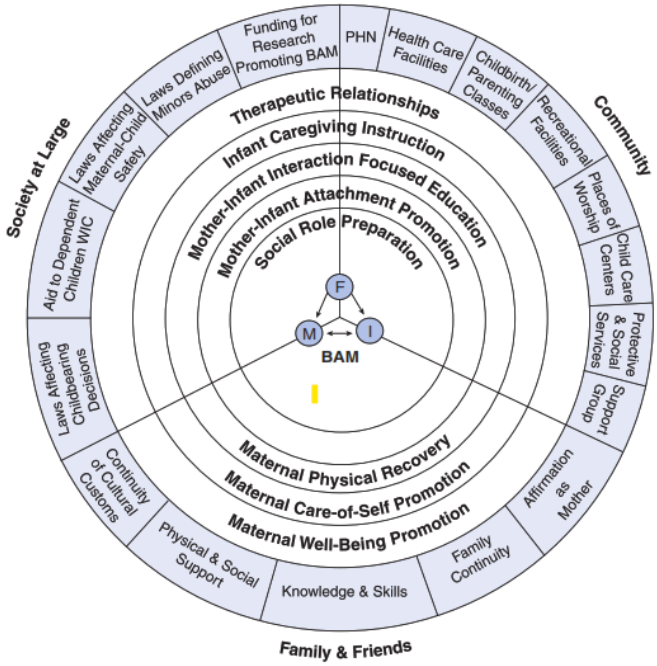

Figure 4: Interacting environment that effect the process of becoming a mother
(Alligood, 2014)

2. Uncertainty in Illness Theory (Merle H. Mishel)

Merle H. Mishel earned a bachelor's degree from Boston University and an M.A. in 1961; a master's degree in psychiatric nursing from the University of California, Los Angeles (UCLA), in 1966;

and a master's degree (1976) and Ph.D. (1980) in social psychology from the Claremont Graduate University, Claremont, California. She has had faculty appointments at UCLA; California State University, Los Angeles, and University of Arizona, Tucson, and has been at the University of North Carolina, Chapel Hill, since 1991, where she is the Kenan Professor of Nursing and director of the Doctoral and Post-Doctoral Programs. Dr. Mishel's honors and awards include the Friends of the National Institute of Nursing Research's Research Merit Award (1997); Kenan Professorship (1994); fellow, American Academy of Nursing (1990); the Mary Wolanin Research Award (1986); and first alternate, Fulbright Award, Sigma Theta Tau Nurse Research Predoctoral Fellowship, 1977–1979.

When Mishel started her investigation into uncertainty, the idea had not been used in relation to health and illness. Her original Uncertainty in Illness Theory drew on information-processing models already in use and psychological research on perceptual states to define uncertainty as a cognitive state brought on by a lack of cues with which to construct a cognitive schema or internal representation of a situation or event. According to Mishel, the experiment provided the basis for the original theory's stress-appraisal-coping-adaptation framework. This approach was unusual in that it addressed ambiguity as a stressor in the context of disease, which was a particularly valuable suggestion for nursing. With the theory's reinterpretation, it became clear that the Western scientific method supported a mechanical viewpoint with a focus on control and predictability. She identified bias in the original theory's orientation toward certainty and adaptation using critical social theory. For a more accurate illustration of how chronic sickness causes disequilibrium and how humans absorb ongoing uncertainty to discover new meaning in illness, Mishel incorporated principles from chaos theory and open systems.

Major assumptions the original uncertainty in illness theory (Alligood, 2014):

1. Uncertainty is a cognitive state, representing the inadequacy of an existing cognitive schema to support the interpretation of illness related events.
2. Uncertainty is an inherently neutral experience, neither desirable nor aversive until it is appraised as such
3. Adaptation represents the continuity of an individual's usual biopsychosocial behavior and is the desired outcome of coping efforts to either reduce uncertainty appraised as danger or maintain uncertainty appraised as opportunity.
4. The relationships among illness events, uncertainty, appraisal, coping, and adaptation are linier and unidirectional, moving from situations promoting uncertainty toward adaptation

Uncertainty in Illness Theory (UIT)

Mishel's original uncertainty in illness theory (UIT) was published in 1988 (see figure 5). UIT is middle range and focused on persons. It was developed to address uncertainty during the diagnostic and treatment phases of an illness or an illness with a determined downward trajectory. It proposes that uncertainty exists in illness situations that are ambiguous, complex, unpredictable, and when information is inconsistent or not available. The major concepts of the UIT are uncertainty and cognitive schema. Uncertainty is the inability to determine the meaning of illness-related events, occurring when the decision maker is unable to assign definite value to objects or events, or is unable to predict outcomes accurately (Mishel, 1988 in Alligood, 2014). It is a cognitive state that occurs, when an individual cannot adequately structure or categorize an illness event because of insufficient cues. Cognitive schema is a person's subjective interpretation of illness, treatment, and hospitalization. The UIT is applicable in both acute and chronic illnesses, prior to diagnosis as well as during diagnosis and treatment. The focus of the UIT is on the ill individual and the family of that individual. The three major themes of the theory are the antecedents of uncertainty, the appraisal of uncertainty, and coping with uncertainty.

According to Mishel and Clayton (2003), the stimulus frame, cognitive capacity, and structural suppliers are the antecedents of uncertainty. The symptom pattern, event familiarity, and event congruence are the components of the stimulus frame. Symptoms become patterns when they appear frequently enough to be recognized as such. The person will feel less uncertain and especially have less ambiguity regarding the condition when symptoms start to take on a pattern (Mishel & Braden, 1988). Uncertainty is caused by inconsistent symptoms since they make it impossible to determine the illness's severity with accuracy. Event familiarity refers to the degree to which cues in the medical environment are recognized, such as if a situation is repeated from a previous experience or even exhibits the qualities of being familiar. Keep in mind that event familiarity pertains to past encounters in the healthcare setting, and symptom pattern relates to the arrangement of bodily feelings. Event familiarity involves repeated exposure to the healthcare environment, and its growth will be reduced by exposure to unfamiliar or novel environments as well as by increasingly complex events (Mishel, 1988). The degree to which anticipated illness-related events and actual events line up is known as event congruence. When an experience falls short of expectations, the person may begin to doubt the accuracy of future predictions as well as the consistency of future experiences (Mishel, 1988).

Providers of cognitive ability and structure have an impact on each of the three components of the stimulus frame. The ability to digest information is referred to as cognitive capacity. Cognitive skills, especially those that demand attention, are negatively impacted by physiological abnormalities. When attention demands arise, the processing of the stimulus frame is interfered with, leading to uncertainty. Drugs, pain, inadequate nutrition, and sleep deprivation all have an adverse effect on one's capacity for attention (Mishel, 1988).

Each of the three elements of the stimulus frame is impacted by the cognitive capacity and structure of the providers. Cognitive capacity

is the term used to describe the capability to process information. Physiological anomalies have a detrimental effect on cognitive abilities, especially those that need concentration. Uncertainty results from interference with the processing of the stimulus frame caused by attention demands. Drugs, physical discomfort, poor diet, and sleep deprivation all negatively impact one's ability to pay attention. In order to reduce ambiguity in a variety of life crises, social support functions by providing feedback on the significance of occurrences. This gives structure. Structure is also provided by credible authority, or the level of faith and assurance that patients and their families place in medical professionals. A reliable source reinforces the stimulus frame by offering pertinent details about the illness's events.

The second theme is the appraisal of uncertainty, which is described as "the process of placing a value on an uncertain event or situation" (Mishel & Clayton, 2003). This method is based on deception and inference. When prior experiences and relevant knowledge are utilized to assess current occurrences, inference happens; when beliefs are generated from an unclear scenario and they connect to a positive viewpoint, illusion develops. Choosing whether an unknown is a risk or an opportunity is the result of the evaluation process.

The ideas of risk, opportunity, coping, and adaptability are all parts of the third topic, dealing with uncertainty. Both danger and opportunity refer to the perception of the potential outcomes, with opportunity being connected with a positive outcome and danger with a negative outcome. With either appraisal, coping takes place. With an assessment of the risk, coping will work to lessen uncertainty and control the feelings brought on by the risk. When opportunities are evaluated, coping is likely to aim to keep things unknown. All of a person's biological, psychological, and social behaviors that take place within the bounds of that person's typical range of behavior are included in adaptation.

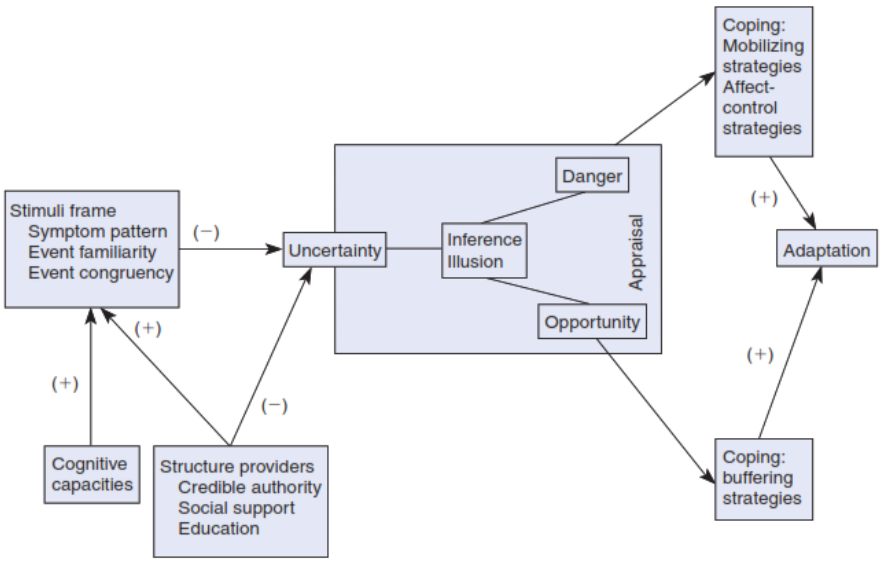

Figure 5: Model of Perceived Uncertainty in Illness
(Alligood, 2014)

SUMMARY

Middle range theory describes how people use objects and structures, and the human behaviors associated with this use. Middle range theory is the theory used to link the gap between limited hypothesis of study of empiricism and large theories. Some say that middle range theory is an untrustworthy theory, but it was necessary for the development of hypothesis in research until it took systematic effort to develop a combined theory that would explain all the uniform research. This theory is used as development of a testable hypothesis, not as a study control device. It usually produces a research model. Middle-range theory is agreed upon as a relatively vast field compared to a phenomenon, but instead of discussing the entire phenomenon, and was very concerned about the discipline in building it. The following is an example of middle range theory are Maternal Role Attainment – Becoming a Mother Theory (MRA/BAM Theory) and Uncertainty in Illness Theory (UIT).

REVIEW QUESTION

5. Which of the following characterizes the middle range theory?
   A. Abstract
   B. Less complex
   C. Difficult to explain theory
   D. Easy to read
   E. Not applicable
6. The family nurse is providing nursing care to a new couple expecting their first child. What is the most appropriate nursing theory to be applied by the nurse?
   A. Maternal Role Attainment Theory
   B. Uncertainty in Illness Theory
   C. Adaptation Theory
   D. Culture Care Theory
   E. Human Basic Needs Theory
7. In the uncertainty in Illness Theory, what is meant by the degree of trust and confidence a person has in his or her health care providers?
   A. Uncertainty
   B. Social support
   C. Credible Authority
   D. Cognitive Capacity
   E. Structure Provider

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CHAPTER 4.

NURSING THEORIES AND THEORIST

KEY TERMS

- Nursing theories
- Florence Nightingale
- Henderson
- Orem
- Calista Roy
- Peplau
- Leininger
- Betty Neuman

LEARNING OBJECTIVES

After completing this chapter:

1. Student can understand Florence Nightingale theory
2. Student can understand Henderson theory
3. Student can understand Orem theory
4. Student can understand Calista Roy theory
5. Student can understand Peplau theory
6. Student can understand Leininger theory
7. Student can understand Betty Neuman Model

INTRODUCTION

Nursing theory is the basis for the practice of nursing today. In many cases nursing theory guides and directs knowledge, education, Research and practice of nursing. Nursing theory is an organized collection of knowledge to define what nursing is, what a nurse

does and why a nurse does it. Nursing theory defines nursing as a separate profession of other disciplines (e.g., medicine). Nursing as a profession, It has its own science stem which is important for the practice of nursing. Historical reviews show that nursing has compiled the developing nursing knowledge. Nursing concepts and theories have evolved since the nightingale era. Who has established the nursing, speaking with confidence about nursing as a profession that requires knowledge that makes it different from the knowledge of medicine. For that, the nurse needs to identify, expand, and understand the concepts and theories that are compatible with nursing.

FLORENCE NIGHTINGALE THEORY

On May 12, 1820, Florence Nightingale was born in Florence, Italy, during one of her parents' frequent travels. Her father gave her a fairly diverse education as she grew up, which was uncommon for Victorian ladies. Nightingale is regarded as the originator of contemporary nursing. To help her in the creation of modern nursing, she combined information from many of her life experiences. Her position in history has already been determined. Reviewing Nightingale's beginnings is useful in order to comprehend how she came to build her conception of nursing. She was well educated for a woman of the Victorian era, as was mentioned. She struggled to use her knowledge because of prevalent social conventions. The expectations of women in upper-class British society in the nineteenth century conflicted with her wish to hold a job that was beneficial to society. Germany was sowing the seeds of contemporary nursing as Nightingale struggled with life decisions.

Nightingale developed an approach to nursing as well as to the administration and design of hospitals using her vast base of knowledge, her comprehension of the frequency and prevalence of disease, and her acute abilities of observation. Controlling the atmosphere for people and families, both well and ill, was Nightingale's main concern. She spoke about the importance of healthy nutrition,

sewage disposal, and ventilation and lighting in sick rooms. The American Nurses Association's original Social Policy Statement, which states that nursing is the diagnosis and treatment of human responses to present or potential health problems (American Nurses Association, 1980), reflects Nightingale's belief that disease is a reparative process. The "environment" is defined by Webster's (1991) as the external factors that affect or alter a course of development. Miller (1978) asserts that the system needs to communicate with and adapt to its surroundings.

Nursing care, in Nightingale's opinion, includes significant physical environment management. She listed several key aspects of the environment that the nurse might influence, including the health of homes, ventilation and warmth, light, noise, variety, beds and bedding, cleanliness of rooms and walls, personal cleanliness, and nutrition ("taking food" and "what food"). The client must exert extra energy to combat environmental stress when one or more environmental factors are out of balance. These pressures deplete the client's energy, which is necessary for healing. The individual's social and psychological environment has an impact on these physical environment characteristics as well. These environmental factors were covered by Nightingale in the chapters "Chattering Hopes and Advices," "Petty Management," "Variety," and "Observation of the Sick." If you want to learn in detail about Florence Nightingale, you can read the book *Florence Nightingale: Founder of the Nightingale School of Nursing*.

Table 1: History of Florence Nightingale

YEAR	HISTORY
1820	Florence Nightingale was born on May 12, 1820, in Florence, Italy.
1837	Nightingale believed she heard a call from God on February 7. The voice told her she had a special mission in life.
1849	Nightingale takes a trip with friends to Egypt and Europe.

YEAR	HISTORY
1851	Nightingale studies nursing at the hospital in Kaiserswerth, Germany.
1853	The Crimean War begins. Nightingale takes an unpaid job running a London hospital.
1854	The British and French enter the Crimean War in March. Nightingale arrives at the British army hospital in Turkey on November 3.
1856	The Crimean War ended, and Nightingale returned home as a national heroine.
1859	Notes on Hospitals was published.
1860	Notes on Nursing was published, and the Nightingale Training School for Nurses opened
1870	Nightingale helps start the National Society for Aid to the Sick and Wounded, the precursor to the British Red Cross.
1907	The British Order of Merit is awarded to Nightingale, the first woman in history to ever receive this high honor from the British monarchy.
1910	Nightingale dies on August 13.

Nightingale Nursing Paradigm (George, 2015; Alligood, 2014)

1. Nursing

   In the sense that nursing involves being in charge of someone else's health, Nightingale thought that every woman would work as a nurse at some point in her life. However, trained nurses were expected to learn more scientific ideas to apply in their work and to become more adept at monitoring and reporting patients' health status as they received care and recovered.

2. Environment

   Nightingale emphasizes the actual surroundings in her work. She concentrated on cleanliness, noise, light, warmth, ventilation, and noise. The writings of Nightingale illustrate a community health paradigm where everything around them is taken into account in connection to their level of health. She

combined her firsthand understanding of sickness with the hygienic environmental conditions that were in place.

3. Health

   According to Nightingale, being healthy means making the most of all of one's abilities (or resources) while living. She also believed that when a person neglected their health, nature-imposed disease and illness as a form of retribution. Nightingale envisioned the preservation of health as the result of disease prevention via social responsibility and environmental control. In response to what she reported, public health nursing and

4. Human Beings

   Nightingale typically referred to the subject as a patient in her writings. To aid in the patient's rehabilitation, nurses performed tasks for and with the patient as well as managed the environment. In this interaction, Nightingale primarily spoke of a passive patient. However, there are specific mentions of the patient participating in self-care activities when possible and, in particular, being involved in the timing and content of meals. It is clear that Nightingale thought of each patient as an individual because she instructed the nurse to inquire about the patient's preferences. Nightingale (1969), on the other hand, emphasized that the nurse was in charge of and accountable for the patient's surrounding environment. Nightingale respected people from all walks of life and did not hold social status in high regard.

Environment Models Florence Nightingale

The "environment" is defined by Webster's (1991) as the external factors that affect or alter a course of development. Miller (1978) asserts that the system needs to communicate with and adapt to its surroundings. Nightingale believed that controlling the physical environment was a crucial part of providing nursing care. She listed several key aspects of the environment that the nurse might influence, including the health of homes, ventilation and warmth, light, noise,

variety, beds and bedding, cleanliness of rooms and walls, personal cleanliness, and nutrition (“taking food” and “what food”). The client must exert extra energy to combat environmental stress when one or more environmental factors are out of balance. These pressures deplete the client’s energy, which is necessary for healing. The individual’s social and psychological environment has an impact on these physical environment characteristics as well (George, 2015)

1. Health of Houses
   In Notes on Nursing Nightingale discussed the importance of the health of houses as being closely related to the presence of pure air, pure water, efficient drainage, cleanliness, and light. Nightingale also noted that the cleanliness outside the house affected the inside. Just as Nightingale noted that dung heaps affected the health of houses in her time, so too can modern families be affected by toxic waste, contaminated water, and polluted air.
2. Ventilation and Warming
   Nightingale stated it was essential to keep the air s/he breathes as pure as the external air, without chilling him/her. Nightingale believed that the person who repeatedly breathed his or her own air would become sick or remain sick. The temperature could be controlled by appropriate balance between burning fires and ventilation from windows.
3. Light
   Nightingale believed that second to fresh air that the sick needed was light. She noted that people do not consider the difference between light needed in a bedroom (where individuals sleep at night) and light needed in a sick-room. To a healthy sleeper it does not matter where the light is because he or she is usually in this room only during hours of darkness. The lack of appropriate environmental stimuli can lead to intensive care psychosis or confusion related to the lack of the accustomed cycling of day and night.

4. Noise

   Noise was also of concern to Nightingale, particularly those noises that could jar the patient. She stated that patients should never be wakened intentionally or accidentally. Nightingale was very critical of noises that annoyed the patient, such as a window shade blowing against the window frame. She viewed it as the nurse's responsibility to assess and stop this kind of noise

5. Variety

   Nightingale believed that variety in the environment was a critical aspect affecting the patient's recovery. She discussed the need for changes in color and form, including bringing the patient brightly colored flowers or plants.

6. Bed and Bedding

   The Nightingale considered the surroundings to be vital, even the bedding. She stated that an adult in good health exhales roughly three quarts of moisture through the skin and lungs in a 24-hour period, despite the fact that her opinion has not been supported by facts. He thought the patient should be able to see out of a window, and the bed should be positioned in the area of the room that receives the most natural light. Mattress covers in contemporary hospitals are typically made of plastic or another material that can be cleaned to remove drainage, excreta, or other debris. The patient frequently perspires as a result of these mattresses, leaving their bedclothes moist. Sheets also do not fit tightly on these mattresses, leading to wrinkles that can result in pressure points on the skin of the patient lying in bed. Modern technology may also interfere with providing a comfortable bed environment for the patient.

7. Cleanliness of Rooms and Walls

   According to Nightingale, "the majority of nursing consists of maintaining cleanliness. She makes the argument that a room that is not initially clean cannot be made fresher by the finest airflow. She recommends removing dust rather than moving it.

In other words, use a moist cloth rather than a feather duster. Instead of having carpets that trap dust, floors should be simple to clean. It should be simple to clean furniture and walls, and they shouldn't be harmed by dampness. Many of Nightingale's prohibitions on carpet, textiles, and wallpaper may now be overcome because of modern cleaning tools like vacuum cleaners. The idea that a clean room is a healthy environment, however, is still valid.

8. Personal Cleanliness
   Nightingale viewed the function of the skin as important, believing that many diseases "disordered," or caused breaks in the skin. She thought this was particularly true of children and that the excretion that comes from the skin must be washed away. She also believed that personal cleanliness extended to the nurse and that every nurse ought to wash her hands very frequently during the day.
9. Nutrition and Taking Food
   Nightingale addressed the food presented to the patient and discussed the importance of variety in the food presented. She found that attention provided to the patient affected how the patient ate. She noted that individuals desire different foods at different times of the day and that frequent small servings may be more beneficial to the patient than a large breakfast or dinner.
10. Chattering Hopes and Advices
    Nightingale did not speak to the social and psychological environment of the patient to the same degree that she addressed the physical environment. However, she included the chapter "Chattering Hopes and Advices," which discussed what is said to the patient. Nightingale encouraged the nurse to heed what is being said by visitors, believing that sick persons should hear good news that would assist them in becoming healthier.

11. Social Consideration

    Nightingale was an excellent manager. She believed that the house and the hospital needed to be well managed that is, organized, clean, and with appropriate supplies. Nightingale supported the importance of looking beyond the individual to the social environment in which he or she lived.

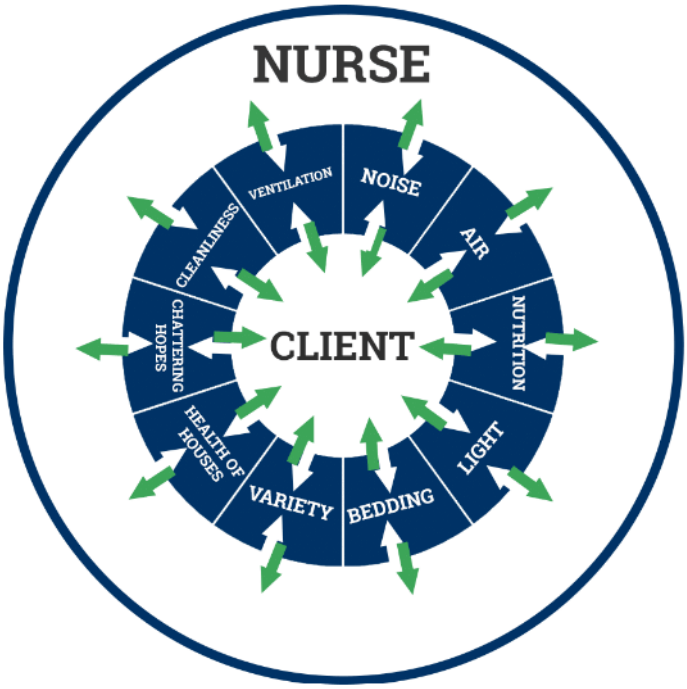

Figure 1: Conceptual Framework of Florence Nightingale's Environmental Theory
(George, 2015; www.nurseslabs.com)

Nightingale and The Nursing Process

In the assessment of clients, Nightingale advocated two essential behaviors by the nurse. The first is to ask the client what is needed or wanted. If the patient is in pain, ask where the pain is located. If the patient is not eating, ask when he or she would like to eat and what food is desired. Find out what the patient believes

is wrong. Nightingale warned against asking leading questions and advocated asking precise questions. Nightingale also warned that the individual asking the questions needed to be concerned about the shyness of the patient in answering questions.

The second area of assessment that Nightingale advocated was the use of observation. She used precise observations concerning all aspects of the client's physical health and environment. Nurses must make the observations because clients may be too weak or shy to make them. Observations revolve around Nightingale's environmental model, that is, the impact of the environment on the individual. For example, how do light, noise, smells, and bedding affect the client?

An assessment guide can be structured from Nightingale's environmental model. The major environmental concepts guide the structure of the assessment tool, leading to examining the impact of the environment on clients and integrating the expanding body of scientific knowledge concerning the effects of a balanced or unbalanced environment. Nursing diagnoses are based on an analysis of the conclusions gained from the information in the assessment. Nightingale believed data should be used as the basis for forming any conclusion. It is important that the diagnosis be the clients' response to their environment and not the environmental problem. Nursing diagnoses reflect the importance of the environment to the health and well-being of the client.

Planning includes identifying the nursing actions needed to keep clients comfortable, dry, and in the best state for nature to work on. Planning is focused on modifying the environment to enhance the client's ability to respond to the disease process.

Implementation takes place in the environment that affects the client and involves taking action to modify that environment. All factors of the environment should be considered, including noise, air, odors, bedding, cleanliness, light, and variety—all the factors that place clients in the best position for nature to work upon them.

Evaluation is based on the effect of the changes in the environment on the clients' ability to regain their health at the least

expense of energy. Observation is the primary method of data collection used to evaluate the client's response to the intervention. Some have proposed using Nightingale to guide their practice (e.g., Gillette, 1996); however, these reviews are not data based, nor has any testing of the efficacy of using Nightingale's framework been done.

HENDERSON THEORY

Virginia Henderson was born on March 19, 1897, in Kansas City, Missouri and passed away on November 30, 1996. She was the fifth child in a family of eight, and she spent the majority of her formative years there while her father was a practicing lawyer in Washington. Henderson was dedicated to the process of state licensure that regulates the nursing profession. She believed that in order to do this, nursing needed to be clearly defined in nurse practice acts that would set out the legal requirements for nurses' duties in providing care for patients and protect the public from inexperienced and unqualified practitioners.

Henderson Nursing Metaparadigm (George, 2015; Alligood, 2014):

1. Nursing
   When seen in the context of time, Henderson's nursing notion is intriguing. She was a pioneer in the idea that nurses require a liberal education that encompasses knowledge of the sciences, social sciences, and humanities. In addition to applying the 14 elements of basic nursing care and the concept of nursing, the nurse is expected to implement the doctor's treatment plan. Nursing innovation in care planning leads to individualized care.
2. Environment
   She considered people in the context of their families, but she rarely talked about how the community affected the person and family. She supported the duties of private and public entities in maintaining people's health. According to Henderson, society wants and requires nurses to provide care for those who are

unable to care for themselves. She expected society to support nursing education in return.

3. Health

   Henderson's views on health were founded on a person's capacity for self-sufficiency, as described in the 14th component. She emphasized that it is tricky for the nurse to assist the patient in achieving excellent health because it is a difficult objective for individuals to achieve. Age, cultural background, physical and intellectual prowess, and emotional stability are all elements that affect one's health. These circumstances are persistent and have an impact on necessities.

4. Human Being

   Henderson took into account the biological, psychological, sociological, and spiritual aspects of the concept of the person or individual. Her 14 nursing function components fall into the following categories: The first eight components are physiological, the ninth is protective, the 10th and 14th are psychological aspects of communicating and learning, the 11th is spiritual and moral, and the 12th and 13th are sociologically oriented to occupation and recreation. The first eight components are physiological. Humans, according to her, have fundamental requirements that are covered by the 14 components.

Virginia Henderson saw the patient as a person who needs assistance in order to become independent and full, or entire, in both mind and body. She made it clear that nursing practice is separate from medical practice and stated that her understanding of the nurse's duty is a synthesis of numerous influences. Henderson's first definition of nursing in 1955, Nursing is largely about helping the patient whether they are sick or healthy perform the tasks that are necessary for their recovery, health, or even their peaceful death if they had the strength, will, or knowledge to do so on their own. The special contribution of nursing is to assist the patient in becoming as independent as feasible with such assistance. Henderson's focus on

assisting individuals with duties required to maintain health, recover from disease, or pass away peacefully demonstrates her focus on delivering personalized care. Henderson emphasized the art of nursing and proposed 14 basic human needs on which nursing care is based. In her definition, she listed 14 components of basic nursing care:

1. Breathe normally
2. Eat and drink adequately
3. Eliminate body wastes
4. Move and maintain desirable postures
5. Sleep and rest
6. Select suitable clothes dress and undress
7. Maintain body temperature within normal range by adjusting clothing and modifying the environment
8. Keep the body clean and well-groomed and protect the integument
9. Avoid dangers in the environment and avoid injuring others
10. Communicate with others in expressing emotions, needs, fears, or opinions
11. Worship according to one's faith
12. Work in such a way that there is a sense of accomplishment
13. Play or participate in various forms of recreation
14. Learn, discover, or satisfy the curiosity that leads to normal development and health and use the available health facilities

Henderson and The Nursing Process

Henderson thought of the nursing process as "really the application of the logical approach to the problem solution." The steps follow the rules of science. Each client can receive tailored care using this strategy. Similar to this, personalized care is the outcome of the nursing process. Perhaps the issue with the nursing procedure is semantics. The true worth of the nursing process depends on how it is comprehended, interpreted, integrated, and used. Now, using Henderson's concept of nursing, the nursing process is analyzed.

The nurse must analyze the data to complete the evaluation part of the nursing process. Henderson claims that the nurse needs to be knowledgeable about what is typical in both health and disease. The nurse then contrasts the evaluation results with what was previously known about the location using this knowledge base. For instance, if a 50-year-old adult was observed to be breathing 40 times per minute, the nurse would draw the conclusion that this person's respiratory rate is higher than usual. Or, if a lab result revealed that the urine was extremely concentrated, the nurse would understand that this means that the patient's fluid intake is inadequate, unless he is losing body fluids by other routes. With a scientific knowledge base, the nurse can draw conclusions from the assessment data. Henderson (1997) stated that the nursing needed by the individual is affected by age, cultural background, emotional balance and the patient's physical and intellectual capacities. All of these should be considered in the nurse's evaluation of the patient's needs for help.

The nurse determines the nursing diagnosis after analyzing the data in light of these considerations. Henderson avoided addressing nursing diagnosis in particular. She thought that either both the doctor and the nurse could reach the same conclusion and there was no need for a separate nursing diagnostic, or that the doctor makes the diagnosis and the nurse acts on that conclusion. Henderson's definition, on the other hand, focuses on determining a person's capacity to meet human needs either with or without aid, while also taking into account that person's fortitude, determination, and knowledge. The evaluation data and its analysis allow the nurse to pinpoint actual issues like irregular respirations.

Once a nursing diagnosis has been made, the nurse must determine the targeted goals and create a strong care plan. Henderson thought that every effective nursing intervention was preplanned. She also stated that a written plan encourages those who create it to think about the needs of the individual unless the person's regimen is tailored to match the institution's schedule. She argued that information from family and friends should be incorporated into

our understanding of the patient. The Nature of Nursing provides an example that identifies treatment and nursing care needs before making recommendations on how to provide care, demonstrating Henderson's belief in the significance of a plan of care. She offers an hourly schedule of care for a person from the time they wake up in the morning until they go to bed. Unless the patient is restless or requests something, she also counsels the nurse to let the patient sleep through the night.

Nursing care implementation comes after planning. Henderson (1966, 1991) focused nursing implementation on assisting the patient in fulfilling the 14 components. For instance, before administering medication, the nurse tries well-known techniques for assisting the patient with sleep and rest. The doctor's recommended course of treatment is part of the overall care plan. The interaction between the nurse and patient is another crucial component of implementation. In order to better understand the patient's needs and implement strategies to address those needs, the nurse goes inside the patient's skin.

Henderson bases his assessment of each person on how quickly or to what extent he completes autonomously the tasks that, for him, constitute a typical day. Her explanation of nursing and of the particular role of the nurse outlines this idea. Changes in a person's level of functioning must be noticed and noted for evaluation reasons. Pre- and post-nursing care data on the patient's functional skills are compared. All alterations are noted for assessment.

OREM THEORY

One of the most prominent nursing thinkers in America, Dorothea Elizabeth Orem, was born in Baltimore, Maryland, in 1914. In the early 1930s, she graduated from Providence Hospital School of Nursing in Washington, DC, where she started her nursing career. Orem graduated with a BS in Nursing Education from Catholic University of America (CUA) in 1939, and the same institution also awarded her an MS in Nursing Education in 1946. The idea that

nursing involved the delivery of self-care was first published by Orem in 1959. Orem persisted in refining her theories about nursing and the self-care deficit. She released Nursing: Concepts of Practice in 1971. Orem's experiences as a nurse served as the main inspiration for her theories about nursing. According to Orem. "Nursing belongs to the family of health services that are organized to provide direct care to persons who have legitimate needs for different types of direct care because of their health states or the nature of their health care requirements".

Orem's Nursing Metaparadigm

1. Nursing

   Orem defines the art of nursing as an intellectual quality of the individual nurse; this quality is related to creativity as well as analysis and synthesis of information (in her terms, the variables and conditioning factors in the situation), all of which contribute to development of nursing systems to assist individuals or multi person units (p. 293). These decisions require a theoretical base in the discipline of nursing and in the sciences, arts, and humanities. This base directs decisions when designing nursing systems within the nursing process. Nursing prudence leads the nurse to seek the help of others when needed (as in a new or very challenging situation), to come to appropriate conclusions, to make decisions about what actions to take, and to take those actions

2. Environment

   In addition, the theory emphasizes the fact that the environment can promote better results of the outlined actions by influencing patients in a beneficial way and contributing to the spark of their interest in care. In such a way, the creation of an appropriate environment is a top priority for all specialists involved in the work of the healthcare sector.

3. Health

   Orem (2001) supports the World Health Organization's definition of health as "a state of physical, mental, and social

well-being and not merely the absence of disease or infirmity" as well as speaking to the relationship between health, well-being, and being whole or sound. However, she acknowledges that a person's definition of health will change as the person's physical and mental characteristics change. Orem recognizes that the various aspects of health (physical, psychological, interpersonal, and social) cannot be separated within the individual. Orem also presents health based on the concept of preventive health care. This health care includes the promotion and maintenance of health (primary prevention), the treatment of disease or injury (secondary prevention), and the prevention of complications (tertiary prevention). Orem also discusses the mental health of individuals. She indicates that over the course of a lifetime, an individual will continue to seek to gain and maintain positive mental or psychic health as part of the process of maturing.

4. Human Being

   Human beings are different from other living things in that they have the ability to think about themselves and their interactions with their environment, to create symbols relating to their experiences, and to use symbols such as words and concepts to think, communicate, and act in efforts to be useful to themselves and to others. Integrated human functioning includes physical, psychological, interpersonal, and social aspects. Orem believes that individuals have the potential for learning and developing. The way an individual meets self-care needs is not instinctual but is a learned behavior. Factors that affect learning include age, mental capacity, culture, society, and the emotional state of the individual. If the individual cannot learn self-care measures, others must learn the care and provide it.

Orem General Theory of Nursing

Orem states her general theory as follows: Nursing has as its special concern that man's need for self-care action and the provision and maintenance of it on a continuous basis in order to sustain life and health, recover from disease and injury, and cope with their effects. The overall theory that Orem created, the Self-Care Deficiency Nursing Theory, is made up of three interconnected theories: the theory of self-care, the theory of self-care deficiency, and the theory of nursing systems. Six central notions and one peripheral concept are included in these three theories. The connections between these ideas and the three interconnected theories are shown in Table 3.

Table 3. Relationship of Orem's Concepts to The Three Theories
Source: George (2015)

Theory of Self-care	Theory if Self-care Deficiency	Theory Nursing Systems
Self-care Self-care agency Self-care requisites Universal Developmental Health deviation Therapeutic self-care demand	When therapeutic self-care demand exceeds self-care agency, a self-care deficit exists and nursing is needed	Nursing agency Nursing systems Wholly compensatory Partly compensatory Supportive–educative

The Theory of Self-care

To understand the theory of self-care one must first understand the concepts of self-care, self-care agency, basic conditioning factors, and therapeutic self-care demand. Self-care is the performance or practice of activities that individuals initiate and perform on their own behalf to maintain life, health, and well-being. When self-care is effectively performed, it helps to maintain structural integrity and human functioning and contributes to human development. Self-care is learned through interpersonal relations and communications.

Self-care agency is the human's acquired powers and capabilities to engage in self-care. The ability to engage in self-care is affected by basic conditioning factors. These basic conditioning factors are age, gender, developmental state, health state, sociocultural orientations, health care system factors (i.e., diagnostic and treatment modalities), family system factors, patterns of living (e.g., activities one regularly engages in), environmental factors, and resource adequacy and availability.

Orem presents three categories of self-care requisites, or requirements: (1) universal, (2) developmental, and (3) health deviation. Universal self-care requisites are found in every human being, across all stages of life, and are involved with the maintenance of both structure and function as well as with general well-being. In contrast with universal self-care requisites, developmental self-care requisites are more specific to the processes of growth and development and are influenced by what is happening during the life cycle stages; such influence may be positive or negative. In contrast with universal self-care requisites, developmental self-care requisites are more specific to the processes of growth and development and are influenced by what is happening during the life cycle stages; such influence may be positive or negative. In the theory of self-care, Orem explains what is meant by self-care and lists the various factors that affect its provision. In the self-care deficit theory, she specifies when nursing is needed to assist individuals in the provision of self-care.

The Theory of Self-care Deficit

The theory of self-care deficit is the basic element of Orem's (2001) general theory of nursing because it delineates when nursing is needed. Nursing may be provided if the capacity to provide care is less than what is needed for an identified self-care demand or when the ability to provide care is currently adequate but a deficit is predicted for the future due to predictable decreases in the ability to provide care, increases in the care demands, or both. Nursing may be necessary when individuals need to carry out new and complex

measures of self-care, particularly when these new measures require specialized knowledge or skill that must be obtained through instruction and practice, or when an individual needs help in dealing with an illness or injury, either to recover from or to cope with changes that result from the illness or injury. It is important to note that the first category includes universal, developmental, and health-deviation self-care needs, whereas the other categories focus on health-deviation self-care.

The nurse may help the individual by using any or all of these methods to provide assistance with self-care. From this model it can be seen that at any given time an individual has specific self-care abilities (self-care agency) as well as therapeutic self-care demands. If there are more demands than abilities, nursing is needed. The activities in which nurses engage when they provide nursing care can be used to describe the domain of nursing. Orem identifies the following five methods of helping that nurses may use:

1. Acting for or doing for other
2. Guiding and directing
3. Providing physical or psychological support
4. Providing and maintaining an environment that supports personal development
5. Teaching

Self-care has been defined and the need for nursing explained in the first and second theories (self-care and self-care deficit theories). In Orem's third theory of nursing systems, she outlines how the patient's self-care needs will be met by the nurse, the patient, or both.

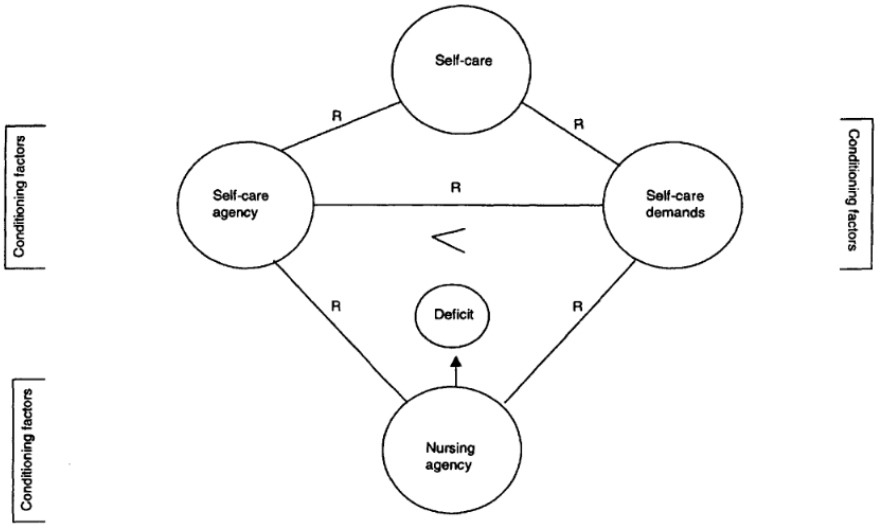

Figure 2: Orem Conceptual Model
(Orem, 2003)

The Theory of Nursing Systems

The nursing system, designed by the nurse, is based on the assessment of an individual's self-care needs and on the assessment of the abilities of the patient to perform self-care activities. If there is a self-care deficit—that is, if there is a difference between what the individual can do (self-care agency) and what needs to be done to maintain optimum functioning (therapeutic self-care demand)—nursing is required.

Nursing agency is a complex property or attribute of mature or maturing people educated and trained as nurses that enables them to act, to know, and to help others meet their therapeutic self-care demands. Nursing agency is similar to self-care agency in that both symbolize characteristics and abilities for specific types of deliberate action. They differ in that nursing agency is carried out for the benefit and well-being of others, and self-care agency is employed for one's own benefit. Nursing agency is power that the nurse has to engage in effective nursing practice. It has been developed by the nurse and

enables the nurse to compose and manage a system of nursing. Self-care agency, self-care demand, and nursing agency may be affected by conditioning factors. These conditioning factors are human or environmental factors that affect self-care agency, self-care demand, and nursing agency at points in time. Orem has identified three classifications of nursing systems to meet the self-care requisites of the patient. These systems are the wholly compensatory system, the partly compensatory system, and the supportive–educative system.

1. The wholly compensatory nursing system is represented by a situation in which the individual is unable to carry out needed self-care actions (including ambulation and other movement), either through inability to be self-directed or due to a medical prescription. Those who have such limitations are dependent upon others for their well-being and even their very existence. Subtypes of the wholly compensatory system are nursing systems for those who are not able to perform any kind of deliberate action, for those who are aware and can make decisions but either cannot or should not be physically active, and for those who can be physically active but who must have supervision due to their inability to make rational decisions.
2. The partly compensatory nursing system is represented by a situation in which the patient and nurse are both physically active in meeting the patient's self-care needs and either may perform the majority of the needed actions.
3. The third nursing system is the supportive–educative system. In this system, the person is fully capable of performing self-care activities or needs to learn how to meet therapeutic self-care needs; in either case, the person needs some manner of assistance. This is also known as a supportive–developmental system. In this system the patient is doing all of the self-care and requires help only in the areas of making decisions, controlling behavior, and gaining knowledge and skills. The nurse's role, then, is to promote the patient as a self-care agent.

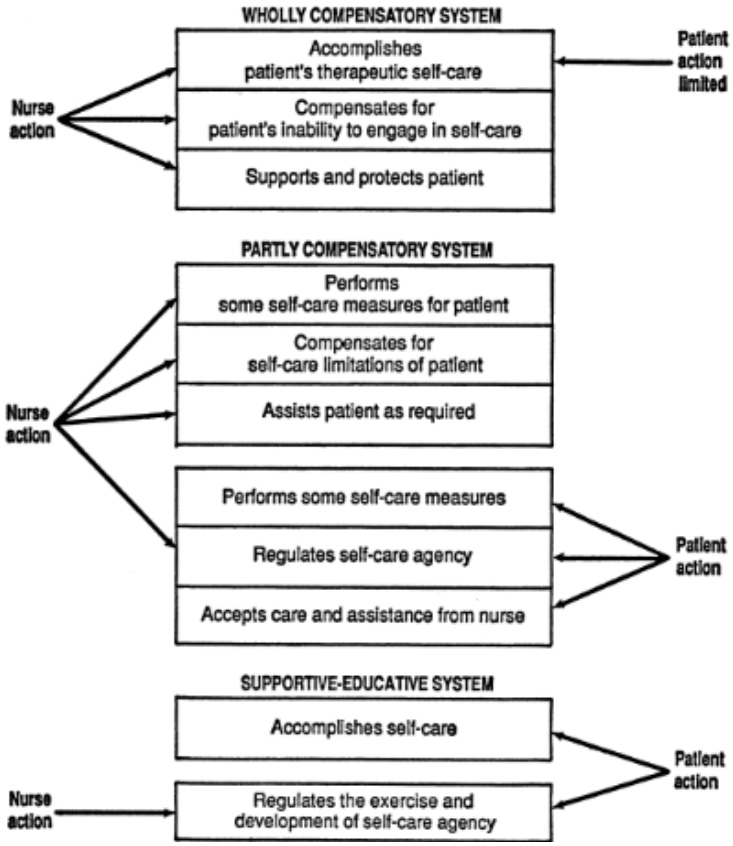

Figure 2: Basic Nursing System
(Orem, 2003)

Orem's Theory and The Nursing Process

Orem (2001) describes nursing process as the phrase used by nurses to describe what she terms the "professional-technologic" aspects of the practice of nursing. Other activities associated with nursing process are planning and evaluation. A process is a continuous and regular sequence of goal-achieving, deliberately performed actions taking place or carried out in a definite manner.

Table 4. Comparison of Orem's Nursing Process and the Nursing Process

Source: George (2015)

Nursing Process	Orem's Nursing Process
Assessment Nursing Diagnosis Outcomes	Step 1: Diagnosis and prescription; determine why nursing is needed. Analyze and interpret make judgments regarding care.
Plans with scientific rationale Implementation	Step 2: Design of a nursing system and plan for delivery of care.
Evaluation	Step 3: Production and management of nursing systems.

CALISTA ROY THEORY

Sister Callista Roy, a member of the Sisters of Saint Joseph of Carondelet, was born in Los Angeles, California, on October 14, 1939. She graduated with a nursing bachelor's degree from Mount Saint Mary's College in Los Angeles in 1963 and a nursing master's degree from the University of California, Los Angeles, in 1966. Roy started her sociology studies after getting her nursing degrees, gaining both a master's and a doctorate in sociology from the University of California in 1973 and 1977, respectively. Professor and nurse theorist at Boston College's William F. Connell School of Nursing is Sister Callista Roy, RN, PhD. Roy's work with the Roy Adaptation Model (RAM) has earned her international recognition. She engaged in scholarly writing, research, and thinking about the advancement of nursing practice and knowledge in addition to teaching. Her conceptual work includes a philosophical understanding of knowledge's nature as a Universal Cosmic Imperative and how this worldview influences the advancement of nursing knowledge

and practice (Roy & Jones, 2007). She founded the Boston-Based Adaptation Research in Nursing Society, currently known as the Roy Adaptation Association, alongside colleagues.

She founded the Boston-Based Adaptation Research in Nursing Society, currently known as the Roy Adaptation Association, alongside colleagues. Before being hired by the Connell School of Nursing, Roy held a number of leadership positions, including chair of the nursing department at Mount Saint Mary's College in Los Angeles, California; adjunct professor in the graduate program at the school of nursing at the University of Portland, Oregon; and acting director and nurse consultant at Saint Mary's Hospital. Roy also served as a postdoctoral fellow and Robert Wood Johnson Clinical Nurse Scholar at the University of California, San Francisco.

Sister Roy received her B.S. in nursing from Mount Saint Mary's College in Los Angeles in 1963, her M.S. in nursing from the University of California, Los Angeles in 1966, and her Ph.D. in sociology from the same institution in 1977. She belongs to the American Academy of Nursing as a fellow. Several of her works have been published as the author, co-author, or contributing author, including Introduction to Nursing: An Adaptation Model (Roy, 1976, 1984), Essentials of the Roy Adaptation Model (Andrews & Roy, 1986), Theory Construction in Nursing: An Adaptation Model (Roy & Roberts, 1981), The Roy Adaptation Model: The Definitive Statement (Roy & Andrews, 1991), and The Roy Adaptation Model (Roy & Jone, 2007).

The Roy Adaptation Model (RAM) has evoked much interest and respect since its 1964 inception by Sister Roy as part of her graduate work under the guidance of Dorothy E. Johnson at the University of California, Los Angeles. In 1970, the faculty of Mount Saint Mary's College in Los Angeles adopted the RAM as the conceptual framework of the undergraduate nursing curriculum. That same year Roy first published her ideas about adaptation (Roy, 1970). A text, written by Roy and fellow faculty, described the RAM and presented nursing assessment and intervention reflective of the distinctive focus of the model (Roy, 1976). In 1991 Roy and Andrews presented The

Roy Adaptation Model: The Definitive Statement, which included the collective experiences of several contributing authors who taught and practiced using the Roy model for over two decades. Based on four earlier books, this text included the diagrammatic conceptualizations of the model developed at the Royal Alexandra Hospital's School of Nursing, Edmonton, Alberta, Canada. In 1999, Roy redefined elements in the RAM in preparation for nursing in the 21st century (Roy & Andrews, 1999).

Roy Nursing Metaparadigm (Alligood, 2014):

1. Nursing

According to Roy, nursing is a broad definition of a medical specialty that concentrates on human life processes and patterns and places a strong emphasis on promoting health for people, families, groups, and society at large. According to Roy's paradigm, nursing is specifically defined as the science and profession that fosters the transformation of both the individual and the environment. She describes the assessment of behavior and the inputs that influence adaption as nursing tasks. Based on this evaluation, nursing decisions are made, and actions are developed to manage the stimuli. Roy distinguishes between nursing as a practical discipline and nursing as a science. Nursing science is a growing body of knowledge about people that studies, categorizes, and connects the processes by which people improve their state of health. The scientific body of knowledge employed in nursing practice is used to promote people's ability to positively influence their health, which is a crucial service to be provided to them. Nursing practices aim to improve how well a person interacts with their surroundings and encourage adaptation.

2. Person

Roy claims that people are complex, adaptable systems. The human system is characterized as an adaptive system as a whole, made up of pieces that work together cohesively to provide a certain function. Individuals and groups of people make up human systems, which also include families, organizations, communities, and society

at large. Despite their enormous differences, all people share a similar destiny. Human systems have thinking and feeling abilities that are anchored in awareness and meaning and that allow them to respond efficiently to environmental changes and have an impact on the environment. People and the earth share shared-patterns, reciprocal relationships, and meaningful relationships. According to Roy, a person is a living, complex, adaptive system with internal processes (cognator and regulator) acting to maintain adaptation in the four adaptive modes (physiological, self-concept, role function, and interdependence). This person is the primary focus of nursing and the recipient of nursing care.

3. Health

A state of being and a process of developing into an integrated and entire individual is health. It is a reflection of adaptability, or the way a person and their environment interact. This definition was derived by Roy (1984) from the idea that adaptation is a process of fostering psychological, social, and physiological integrity, and that integrity denotes an unimpaired situation leading to completeness or oneness. According to Brower and Baker (1976), Roy's earlier writings, when discussing health, saw it as a continuum that ranged from death and extremely poor health to high levels and peak wellness. Roy began to write more on health as a process in which both health and illness might coexist in the late 1990s. Health, according to Roy, is the capacity to deal with life's inevitable challenges death, illness, sorrow, and stress in a skillful manner. When humans continuously adapt, health results. People are free to react to new stimuli as they become accustomed to the current ones. The release of energy from futile attempts at coping can aid in healing and improving health.

4. Environment

According to Roy, environment is all the conditions, circumstances, and influences surrounding and affecting the development and behavior of persons or groups, with particular

consideration of the mutuality of persons and earth resources that includes focal, contextual, and residual stimuli. The stimulus for making adaptive reactions comes from the changing environment. The environment serves as the person's input as an adaptive system that takes into account both internal and external influences. These elements could be small or significant, harmful or beneficial. Any environmental change, though, necessitates greater energy expenditure for adaptation. Focal, contextual, and residual stimuli are the three types of environmental factors that have an impact on a person.

Assumptions of the Roy Adaptation Model for 21st Century (Smith & Parker, 2015; Alligood, 2014; George, 2015):

Philosophic Assumption:

1. Persons have mutual relationships with the world and the God figure
2. Human meaning is rooted in an omega point convergence of the universe
3. God is intimately revealed in the diversity of creation and is the common destiny of creation
4. Persons are accountable for entering the process of deriving, sustaining, and transforming the universe
5. Persons use human creative abilities of awareness, enlightenment, and faith

Scientific Assumption:

1. Systems of matter and energy progress to higher levels of complex self-organization
2. Consciousness and meaning are constitutive of person and environment integration
3. Awareness of self and environment is rooted in thinking and feeling.
4. Humans, by their decisions, are accountable for the integration of creative processes
5. Thinking and feeling mediate human action
6. System relationships include acceptance, protection, and fostering of interdependence
7. Persons and the earth have common patterns and integral relationships
8. Persons and environmental transformations are created in human consciousness
9. Integration of human and environmental meanings results in adaptation

Cultural Assumption:

1. Experiences within a specific culture will influence how each element of the Roy adaptation model is expressed
2. Within a culture, there may be a concept that is central to the culture and will influence some or all of the elements of the Roy Adaptation model to a greater or lesser extent
3. Cultural expressions of the elements of the Roy adaptation model may lead to changes in practice activities such as nursing assessment
4. As Roy adaptation model elements evolve within a cultural perspective, implications for education and research may differ from experience in the original culture.

The Roy Adaptation Model

Roy credits the works of von Bertalanffy's (1968) general system theory and Helson's (1964) adaptation theory as forming the original basis of the scientific assumptions underlying the RAM. The general system theory by von Bertalanffy from 1968 and the adaptation theory by Helson from 1964, according to Roy, served as the first inspiration for the scientific presumptions underlying the RAM. According to Helson's theory of adaptation, the adaptive level and the incoming stimulus influence the adaptive reactions. A stimulus is anything that causes a reaction. The internal or external environment might provide stimuli. The combined effects of the following three categories of stimuli make up the adaption level:

1. Focal stimuli refers to those which are immediate in their impact and which require the individual to respond rapidly. A focal stimulus therefore confronts the individual with a requirement for immediate response in order to adjust to the changing environment.
2. Contextual stimuli are those which contribute to the overall response by the individual. These occur alongside the focal stimuli and may influence adaptive responses from the individual.

3. Residual stimuli are those others which are not validated by immediate experience of the individual but owe their contribution to the post experience, beliefs or attitude.

The Adaptation Model uses an approach which focuses on the individuals who may be experiencing difficulties in coping with changes in their lives. The cornerstone of its contribution to the theoretical framework for nursing is its use of a problem-solving approach designed to assist and support people in achieving adaptive states consequent upon changes in their environments. An important aspect of any theory is that assumptions have to be made in setting basic parameters for an understanding of its underlying concepts, principles and their later application to practical problems. Roy's Adaptation Model makes an important contribution to the development of theoretical ideas and their uses as a framework for nursing practice. Roy's model is concerned with the problem of human adaptation.

PEPLAU THEORY

Because of the way that her theoretical and clinical work influenced the growth of the distinct specialty field of mental nursing, Hildegard E. Peplau has been referred to as the "mother of psychiatric nursing." Her achievements as a psychiatric nursing expert, educator, author, nursing leader, and theorist are just a few of the ways she has influenced nursing (Alligood, 2014). Nursing is therapeutic since it is a healing art that aids someone who is ill or in need of medical attention, claims Peplau. Considering that nursing requires interactions between two or more people working toward a common objective, it can be seen as an interpersonal process. In nursing, this shared objective serves as the impetus for the therapeutic process in which the nurse and patient appreciate one another as unique people with a shared objective. As their friendship develops, the nurse and patient start to comprehend one another's duties and the circumstances around the issue. From this point on, the patient and the nurse work together toward a same goal until it is

fixed. As the nurse and the patient work together, they become more knowledgeable and mature throughout the process.

Peplau Nursing Metaparadigm

1. Nursing
   As stated on page 16, nursing is a significant therapeutic and interpersonal process. According to her definition, it is a human relationship between a person who is ill or in need of health services and a nurse who is specially trained to recognize and address the need for assistance. This interpersonal process is helped by the nurse's concern for the patient. The nurse, patient, therapeutic interaction, goals, human needs, tension, and dissatisfaction are key themes in this process.
2. Environment
   Peplau does encourage the nurse to consider the patient's culture and mores when the patient adjusts to hospital routine
3. Health
   A word symbol that implies the forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal, and community living according to the definition of health
4. Human Being
   Human as an organism that strives in its own way to reduce tension generated by needs.

Interpersonal Theory Peplau

In the beginning, Peplau classified interpersonal connections into four consecutive phases: (1) orientation; (2) identification; (3) exploitation' (4) resolution (George, 2015; Alligood, 2014). As the process progresses toward a solution, each of these phases overlaps, interacts, and has a different length of time. Peplau combined her two initial phases identification and exploitation into the working phase when she wrote in 1997 that the nurse-patient interaction is made up of three phases: the orientation phase, the working phase, and the

termination phase. During each step, a different nursing role is taken on. Teachers, resources, counselors, leaders, technical experts, and surrogates are a few broad categories that apply to these jobs.

Peplau Phase in Nursing

1. Orientation Phase
   At this stage, the process of collecting data, and the process of building a trustworthy relationship between the nurse and the client. The process of gathering information and establishing a reliable rapport between the nurse and the client is ongoing at this time. The nurse's response to the patient is influenced by both the patient's and the nurse's culture, religion, race, educational background, experiences, and preconceived notions and expectations. The same variables also affect the patient's response to the nurse. Nursing is an interpersonal activity, and the therapeutic relationship between the nurse and the patient is equally significant. The nurse and the patient first meet at the beginning of the orientation phase. At the conclusion of the orientation phase, they are simultaneously attempting to pinpoint the issue and warming up to one another. The patient also feels more at ease in supportive surroundings. Now that the nursing phase is complete, the patient and nurse are prepared to move on to the working phase.
2. Working Phase
   The activities referred to as the identification and exploitation phases in Peplau's early writings are included in the working phase. The patient responds selectively to people who are able to meet his demands as this working phase, which was formerly the identification phase, gets started. In this phase, each patient reacts differently. For instance, the patient might actively look for the nurse or patiently await her arrival. There are three ways to respond to the nurse: (1) participate with and depend on the nurse; (2) be independent and self-sufficient with the nursing; or (3) be submissive and reliant on the nurse.

The patient and the nurse must communicate their perceptions and expectations to one another during the working phase. Even more difficult than in the orientation phase are the patient's and the nurse's perceptions and expectations during the working phase. Now, the patient is only sometimes reacting to the assistant. A more intense therapeutic interaction is necessary for this. The patient then utilizes the services provided in accordance with his needs and interests. The patient and nurse collaborate to overcome obstacles and progress toward optimum health throughout this phase. As a result, during the working phase, the nurse helps the patient use services to assist in problem-solving. The termination phase, the last stage, is approaching.

3. Termination Phase

Termination is the last stage of Peplau's interpersonal process. The joint efforts between the patient and nurse have already addressed the patient's needs. It is now necessary for the patient and nurse to end their therapeutic alliance and cut all ties. The patient wanders away from connecting with the nurse, who is aiding them, during a successful termination. After that, as the nurse gains independence from the patient, the patient also gains independence from the nurse. Both the patient and the nurse grow stronger and more mature as a result of this process. Once the patient's demands are addressed, additional goals might be pursued. Only when the earlier steps are successfully completed does termination occur. Table 1 indicates the focus of each phase (George, 2015).

Table 1. Phase of the Nurse-Patient Relationship
(Source: George, 2015)

Phase	Focus
Orientation	Problem definition
Working	Selection of appropriate professional assistance and use of professional assistance for problem solving alternatives
Termination	Termination of the professional relationship

Similarities between the nursing process and Peplau's continuum, comprising the three phases of orientation, working, and termination, are evident. The nursing process and Peplau's phases are both sequential and emphasize therapeutic contact. Both emphasize the necessity for the nurse and patient to work together to solve problems in order to best serve the patient's requirements. Peplau's phase and the nursing process are related (see Table 2).

Table 2. Comparison of Nursing Process and Peplau's Process
(Source: George, 2015)

Nursing Process	Peplau's International Process
Assessment Data collection and analysis Need not necessarily be a "felt need"; may be nurse initiated	Orientation Nurse and patient come together as strangers meeting initiated by patient who expresses a "felt need"; work together to recognize, clarify, and define facts related to need. (Note: Data collection is continuous.)
Nursing Diagnosis Summary statement based on nurse analysis, with possible patient involvement Outcomes and Planning Mutually set outcomes and goals	Patient clarifies "felt need" Working Interdependent goal setting. Patient has feeling of belonging and selectively responds to those who can meet his needs. Patient initiated.
Implementation Plans initiated that move toward achievement of mutually set goals May be accomplished by patient, health care professional, or patient's family	Patient actively seeking and drawing on knowledge and expertise of those who can help. Patient initiated.

Nursing Process	Peplau's International Process
Evaluation Based on mutually established expected behaviors May lead to termination of relationship or initiation of new plans	Termination Occurs after other phases are successfully completed. Lead to termination of the relationship

THEORY OF CULTURE CARE DIVERSITY AND UNIVERSALITY

Madeleine M. Leininger was born July 13, 1925, in Sutton, Nebraska, and received her basic nursing education at St. Anthony's School of Nursing, Denver, Colorado, graduating in 1948. In 1950 she earned a bachelor of science degree in biological science from Mount St. Scholastica College (now known as Benedictine College), Atchison, Kansas; in 1954 a master of science in psychiatric-mental health nursing from The Catholic University of America, Washington, D.C.; and in 1965 a Ph.D. in cultural and social anthropology from the University of Washington, Seattle. She isa fellow in the American Academy of Nursing and holds honorary doctorates from Benedictine College; the University of Indianapolis, Indiana; and the University of Kuopio, Kuopio, Finland. In 1998 she was named a Living Legend by the American Academy of Nursing.

In the 1940s Leininger (1991) recognized the importance of caring to nursing. Statements of appreciation for nursing care made by patients alerted her to caring values and led to her long-standing focus on care as the dominant ethos of nursing. During the mid-1950s, she experienced what she describes as cultural shock while she was working in a child guidance home in the midwestern United States. While working as a clinical nurse specialist with disturbed children and their parents, she observed recurrent behavioral differences among the children and finally concluded that these differences had a cultural base. She identified a lack of knowledge of the children's cultures as the missing link in nursing to understand the variations needed in the care of clients. This experience led her to become the

first professional nurse in the world to earn a doctorate in anthropology and led to the development of the field of transcultural nursing.

Leininger first used the terms transcultural nursing, ethnonursing, and cross-cultural nursing in the 1960s. In 1966, at the University of Colorado, she offered the first transcultural nursing course with field experiences and has been instrumental in the development of similar courses at a number of other institutions. In 2006, Leininger affirmed her definition of transcultural nursing as a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health care practices that are culturally based. Transcultural nursing as a discipline with a body of knowledge and practices to attain and maintain the goal of culturally congruent care for health and wellbeing.

Leininger Nursing Metaparadigm

1. Person

Leininger is adamant that the concept of person is not culturally appropriate in many cultures; person often is not a central or dominant concept in a culture. Human beings are best represented in her work. Humans are believed to be caring and to be capable of being concerned about the needs, well-being, and survival of others. Human care is universal, that is, seen in all cultures. Humans have survived within cultures and through place and time because they have been able to care for infants, children, and the elderly in a variety of ways and in many different environments. Thus, humans are universally caring beings who survive in a diversity of cultures through their ability to provide the universality of care in a variety of ways according to differing cultures, needs, and settings. Leininger (1991) also indicates that nursing as a caring science should focus beyond traditional “nurse–patient interactions and dyads [to include] families, groups, communities, total cultures, and institutions” as well as world-wide health institutions and ways to develop international nursing care policies and practices. She points out that in many non-

Western cultures, family and institutions dominate. In these cultures, person is not an important concept. Indeed, there may be no term in the language for "person." Thus, in the theory of Culture Care Diversity and Universality the focus is on human beings and not necessarily on the individual. A focus on the individual should occur only if it is appropriate to the culture in which care is being given.

2. Health

Health is "a state of well-being that is culturally defined and constituted; a state of being to maintain and the ability to help individuals or groups to perform their daily role activities in culturally expressed beneficial care and patterned lifeways". Leininger indicates that all cultures have generic or folk health care practices, that professional practices usually vary across cultures, and that in any culture there will be cultural similarities and differences between the care receivers (generic) and the professional caregivers. Leininger speaks of health systems, health care practices, changing health patterns, health promotion and health maintenance. Health is an important concept in transcultural nursing. Because the emphasis is on the need for nurses to have knowledge that is specific to the culture in which nursing is being practiced, it is presumed that health is viewed as being universal across cultures but defined within each culture in a manner that reflects the beliefs, values, and practices of that particular culture. Thus, health is both universal and diverse.

3. Environment

Leininger speaks to social structure and worldview rather than society. She defines environment as "the totality of geophysical situations or the lived in geographic and ecological settings of cultures". However, society and environment, if viewed as being represented in culture, are a major theme of Leininger's theory. Leininger's (1991) definition of culture focuses on a particular group (society) and the patterning of actions, thoughts, and decisions that occurs as the result of "learned, shared, and transmitted values,

beliefs, norms, and lifeways". This learning, sharing, transmitting, and patterning occur within a group of people who function in an identifiable setting or environment.

4. Nursing

Leininger also defines nursing as "a learned, humanistic, and scientific profession and discipline focused on human care phenomena and caring activities in order to assist, support, and facilitate or enable individuals or groups to maintain or regain their health or well-being in culturally meaningful and beneficial ways, or to help individuals face handicaps or death" (Leininger & McFarland, 2002). Professional nursing care (caring) is defined as "formal and cognitively learned professional care knowledge and practice skills, obtained through educational institutions, that are expected to provide assistive, supportive, enabling or facilitative acts to or for another individual or group in order to improve a human health condition (or well-being), disability, lifeway, or to work with dying clients". She also discusses that nursing, as a profession, has a societal mandate to serve people and, as a discipline, is expected to discover, develop, and use knowledge distinctive to nursing's focus on human care and caring. She expresses concern that nurses do not have adequate preparation for a transcultural perspective and that they neither value nor practice from such a perspective to the fullest extent possible. She presents three types of nursing actions that are culturally based and thus congruent with the needs and values of the clients. These are culture care preservation/maintenance, culture care accommodation/ negotiation, and culture care repatterning/restructuring. These three modes of action can lead to the delivery of nursing care that best fits with the client's culture and thus decreases cultural stress and potential for conflict between client and caregiver.

Assumptive premises of the Leininger theory, are the following (Leininger & Mc. Farland, 2002):

1. Care is the essence of nursing and a distinct, dominant, central, and unifying focus.

2. Culturally based care (caring) is essential for well-being, health, growth, and survival and to face handicaps or death.
3. Culturally based care is the most comprehensive and holistic means to know, explain, interpret, and predict nursing care phenomena and to guide nursing decisions and actions.
4. Transcultural nursing is a humanistic and scientific care discipline and profession with the central purpose to serve individuals, groups, communities, societies, and institutions.
5. Culturally based caring is essential to curing and healing, for there can be no curing without caring, but caring can exist without curing.
6. Culture-care concepts, meanings, expressions, patterns, processes, and structural forms of care vary transculturally with diversities (differences) and some universalities (commonalities).
7. Every human culture has generic (lay, folk, or indigenous) care knowledge and practices and usually professional care knowledge and practices, which vary transculturally and individually.
8. Culture-care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental context of cultures.
9. Beneficial, healthy, and satisfying culturally based care influences the health and well-being of individuals, families, groups, and communities within their environmental context.
10. Culturally congruent and beneficial nursing care can only occur when care values, expressions, or patterns are known and used explicitly for appropriate, safe, and meaningful care.
11. Culture-care differences and similarities exist between professional and client-generic care in human cultures worldwide.

12. Cultural conflicts, cultural imposition practices, cultural stresses, and cultural pain reflect the lack of culture-care knowledge to provide culturally congruent, responsible, safe, and sensitive care.
13. The ethnonursing qualitative research method provides an important means to accurately discover and interpret emic and etic embedded, complex, and diverse culture-care data.

Theory Culture Care Diversity and Universality

Leininger named her theory Culture Care Diversity and Universality and depicts it in what she now terms the Sunrise Enabler (formerly known as the Sunrise Model) (see Figure 1). This enabler may be viewed as a cognitive map that moves from the most abstract to the least abstract. The top of the enabler is the worldview and cultural and social structure levels, which direct the study of perceptions of the world outside of the culture the supra system in general system terms. Leininger states that the world-view leads to the study of the nature, meaning, and attributes of care from three perspectives. Values and social structure could be a part of each of three perspectives. The micro perspective studies individuals within a culture; these studies typically would be on a small scale. The middle perspective focuses on more complex factors in one specific culture; these studies are on a larger scale than microstudies. The macro studies investigate phenomena across several cultures and are large in scale.

The culture care worldview flows into the cultural and social structure dimensions and the multiple factors that make up these dimensions. Aspects of these factors include their environmental context, language, and ethnohistory. The factors influence how care patterns and practices are expressed to provide holistic care in health, illness, and death. Next is knowledge about individuals, families, groups, communities, and institutions in diverse health care contexts. This knowledge provides culturally specific meanings and expressions in relation to care and health. The next focus is on the

generic or folk care, professional care-cure practices, and nursing care practices. Information about these includes the characteristics and the specific care features of each. This information allows for the identification of similarities and differences or culture care universality and culture care diversity.

Next are transcultural care decisions and actions that involve culture care preservation/maintenance, culture care accommodation/ negotiation, and culture care repatterning/restructuring. It is here that nursing care is delivered. Within the Sunrise Enabler, culture congruent care is developed. This care is both congruent with and valued by the members of the culture.

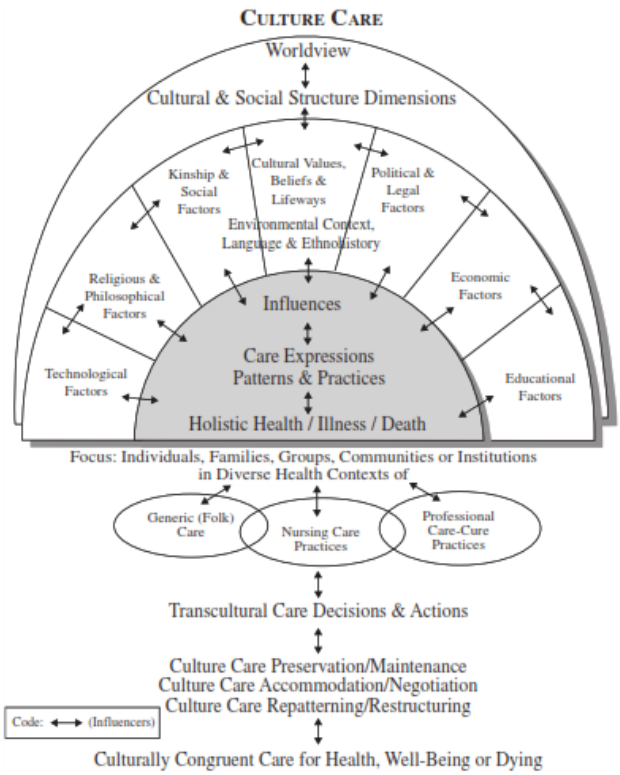

Figure 1: Leininger's Sunrise Model to depict the Theory of Cultural Care Diversity and Universality
(Source: Leininger &Mc. Farland, 2002)

In using the theory of Culture Care, nurses benefit from a broad, liberal arts university preparation to identify and understand holistic dimensions such as social structure factors, ethnohistory, genetics, religion, spiritually, ethics, language uses, environment, politics, family structures, arts, and other ideas reflected in the Sunrise Model, all as influencers or potential influencers of human care. With the Sunrise Model, a truly holistic and comprehensive picture can be discovered to reflect the totality of knowing people in their lifeworld or culture. The following definitions are used with the Culture Care theory as a guide to discover culture care phenomena (Leininger & Mc. Farland, 2022):

1. Human Care/Caring
   Refers to the abstract and manifest phenomena with expressions of assistive, supportive, enabling, and facilitating ways to help self or others with evident or anticipated needs to improve health, a human condition, or a lifeway or to face disabilities or dying.
2. Culture
   Refers to patterned lifeways, values, beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared, and usually transmitted intergenerationally over time.
3. Culture Care
   Refers to the synthesized and culturally constituted assistive, supportive, and facilitative caring acts toward self or others focused on evident or anticipated needs for the client's health or well-being or to face disabilities, death, or other human conditions.
4. Culture Care Diversity
   Refers to cultural variabilities or differences in care beliefs, meanings, patterns, values, symbols, and lifeways within and between cultures and human beings.

5. Culture Care Universality
   Refers to commonalties or similar culturally based care meanings (“truths”), patterns, values, symbols, and lifeways reflecting care as a universal humanity.
6. Worldview
   Refers to the way an individual or group looks out on and understands their world about them as a value, stance, picture, or perspective about life or the world.
7. Cultural and Social Structure Dimensions
   Refers to the dynamic, holistic, and interrelated patterns of structured features of a culture (or subculture), including religion (or spirituality), kinship (social), political (legal), economic, education, technology, cultural values, philosophy, history, and language.
8. Environmental Context
   Refers to the totality of an environment (physical, geographic, and sociocultural), situation, or event with related experiences that give interpretative meanings to guide human expressions and decisions with reference to a particular environment or situation.
9. Ethnohistory
   Refers to the sequence of facts, events, or developments over time as known, witnessed, or documented about a designated people of a culture.
10. Emic
    Refers to the local, indigenous, or insider’s views and values about a phenomenon.
11. Etic
    Refers to the outsider’s or more universal views and values about a phenomenon.
12. Health
    Refers to a state of well-being or restorative state that is culturally constituted, defined, valued, and practiced by individuals or groups that enables them to function in their daily lives.

13. Transcultural Nursing
    Refers to a formal area of humanistic and scientific knowledge and practices focused on holistic culture care (caring) phenomena and competencies to assist individuals or groups to maintain or regain their health (or well-being) and to deal with disabilities, dying, or other human conditions in culturally congruent and beneficial ways.
14. Culture Care Preservation and/or Maintenance
    Refers to those assistive, supportive, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or maintain meaningful care values and lifeways for their well-being, to recover from illness, or to deal with handicaps or dying.
15. Culture Care Accommodation and/or Negotiation
    Refers to those assistive, supportive, facilitative, or enabling creative professional actions and decisions that help people of a designated culture (or subculture) to adapt to or to negotiate with others for meaningful, beneficial, and congruent health outcomes.
16. Culture Care Repatterning and/or Restructuring
    Refers to the assistive, supportive, facilitative, or enabling professional actions and decisions that help clients reorder, change, or modify their lifeways for new, different, and beneficial health care outcomes.
17. Culturally Competent Nursing Care
    Refers to the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death.

BETTY NEUMAN MODEL

Betty Neuman was born in 1924 on a 100-acre farm in Ohio. The middle of three children and the only daughter, she was 11

when her father died after six years of intermittent hospitalizations for treatment of chronic kidney disease. His praise of his nurses influenced Neuman's view of nursing and her commitment to becoming an excellent bedside nurse. Her mother's work as a rural midwife was also a significant influence. In 1947 Neuman graduated from the diploma program of Peoples Hospital (now Akron General Medical Center), Akron, Ohio. She received a B.S. in public health nursing (1957) and an M.S. as a public health–mental health nurse consultant (1966) from the University of California, Los Angeles. She has received honorary doctorates from Grand Valley State University, Allendale, Michigan, and Neumann College, Aston, Pennsylvania. In 1993 she became a fellow in the American Academy of Nursing. She has practiced bedside nursing as a staff, head, and private-duty nurse in a wide variety of hospital settings. Her work in community settings has included school and industrial nursing, office nurse in her husband Kree's private practice, and counseling and crisis intervention in community mental health settings. In 1967, six months after completion of her M.S. degree, she became the faculty chair of the program from which she graduated and began her contributions as teacher, author, lecturer, and consultant in nursing and interdisciplinary health care.

In 1973 she and her family returned to Ohio. Since then, she has worked as a state mental health consultant, provided continuing education programs, and continued the development of her model. She was one of the first nurses licensed in California as a marriage and family counselor (now marriage and family Therapist) and clinical fellow of the American Association of Marriage and Family Therapists and has maintained a limited private counseling practice. She is also a licensed real estate agent and obtained a private pilot's license in California. In addition to her professional activities, she has exercised her interest in personal property management and other investments as well as health maintenance and promotion activities.

The Neuman System Model Nursing Metaparadigm

1. Person

   The human being is viewed as an open system that interacts with both internal and external environmental forces and stressors. The human is in constant change, moving toward a dynamic state of system stability or toward illness of varying degrees. This open system is comprised of the five variables with a central core and protective lines of defense

2. Environment

   The environment is a vital arena that is germane to the system and its function; it includes internal, external, and created environment. The environment may be viewed as all factors that affect and are affected by the system.

3. Nursing

   The primary concern of nursing is to define the appropriate action in situations that are stress related or in relation to possible reactions of the client or client system to stressors. Nursing interventions are aimed at helping the system adapt or adjust and to retain, restore, or maintain some degree of stability between and among the client system variables and environmental stressors, with a focus on conserving energy.

4. Health

   Health is defined as the condition or degree of system stability and is viewed as a continuum from wellness to illness (see Figure 3). Stability occurs when all the system's parts and subparts are in balance or harmony so that the whole system is in balance. When system needs are met, optimal wellness exists. When needs are not satisfied, illness exists. When the energy needed to support life is not available, death occurs.

The Neuman System Model

The Neuman Systems Model is a unique, open systems–based perspective that provides a unifying focus for approaching a wide range of nursing concerns. A system acts as a boundary for a single

client, a group, and even a number of groups; it can also be defined for a social issue. The client system in interaction with the environment delineates the domain of nursing concerns. The Neuman Systems Model is dynamic because it is based on the client's continuous relationship to environmental stress factors, which have potential for causing a reaction, or obvious symptomatic reaction to stress, or could affect reconstitution following treatment of a stress reaction. In particular, the model takes into account all variables affecting a client's possible or actual response to stressors and explains how system stability is achieved in relation to environmental stressors imposed on the client. The main nursing goal is to facilitate optimal wellness for the client through retention, attainment, or maintenance of client system stability. Optimal wellness represents the greatest possible degree of system stability at a given point in time. Thus, wellness is a matter of degree, a point on a continuum running from the greatest degree of wellness to severe illness or death. Nursing action or intervention is based on a synthesis of comprehensive client data and relevant theory that is appropriate to the client's perception of need and is related to functional competence or possibility within the client's environmental context.

The Neuman Systems Model (NSM) was originally developed in 1970 in response to the request of graduate students at the University of California, Los Angeles, for an introductory course that would provide an overview of the physiological, psychological, sociocultural, and developmental aspects of human beings. The model was developed as a teaching aid to provide structure for the integration of this material in a wholistic manner. After a two-year evaluation, the model was first published in Nursing Research. Since then, it has become one of the most widely used nursing models in the world. Neuman has published four editions of The Neuman Systems Model (Neuman & Fawcett, 2011).

Neuman says that her personal philosophy of helping each other live was supportive in developing the wholistic systems perspective of the NSM. She drew upon her clinical experiences from a variety of

health care and community settings and the theoretical perspectives of stress and systems. Caplan's (1964) levels of prevention were also incorporated into the model. The original title of the model, "A Model for Teaching Total Person Approach to Patient Problems," reflected its origin as a teaching aid (Neuman & Young, 1972). As the model began to be recognized and utilized in clinical practice and research, as well as education, the title changed to "The Betty Neuman Health Care Systems Model: A Total Person Approach to Patient Problems" (Neuman, 1974, 1980). In 1982, while the book was titled *The Neuman Systems Model*, her chapter about the model was titled "The Neuman Health-Care Systems Model: A Total Approach to Client Care" (Neuman, 1982a, 1982b). In 1985, she used "The Neuman Systems Model" and has consistently used this title since then (Neuman & Fawcett, 2011).

In the NSM, nursing is considered a system because nursing practice contains elements in interaction with one another, and there is increasing diversity of nursing roles and functions. Advantages of an open-system perspective in nursing include the use of systems as a unifying force across various scientific fields, as well as the increasing complexity of nursing, which calls for an organizational system that can respond to change. A systems perspective supports recognition of the complex whole while valuing the importance of the parts. The relationships between the parts and the interactions of the parts or the whole with the environment provide a mechanism for viewing the system–environment exchanges, which support the dynamic and constantly changing nature of the system. Neuman (2002c) views wholism as both a philosophical and a biological concept. Wholism includes relationships that arise from wholeness, dynamic freedom, and creativity as the system responds to stressors from the internal and external environments. Each component must be considered not as alone but as part of the whole and will influence one's perception of the whole.

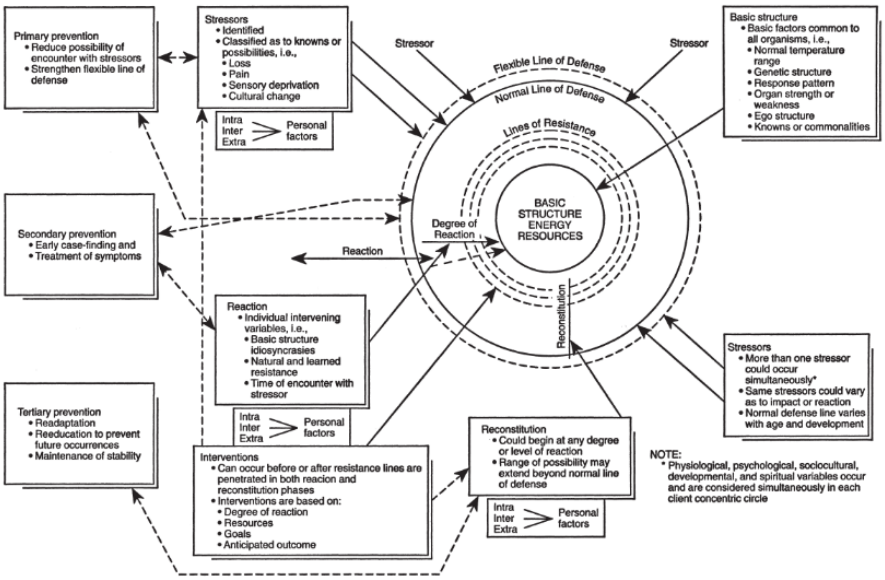

Figure 1: The Neuman System Model

(Source: Neuman & Fawcett, 2011)

The NSM diagram (see Figure 1) presents the major aspects of the model: the basic structure and energy resources; physiological, psychological, sociocultural, developmental, and spiritual variables; lines of resistance; normal line of defense; flexible line of defense; stressors; reaction; primary, secondary, and tertiary prevention; intra-, inter-, and extra personal factors; and reconstitution. The environment, health, and nursing are inherent parts of the model, although they are not labeled within the model. The client system is represented in the diagram by a basic structure surrounded by a series of concentric circles and is a living, open system.

1. Basic Structure and Energy Resources

The basic structure, or central core, is made up of those basic survival factors common to the species (Neuman, 2002c). These factors include the system variables (physiological, psychological, sociocultural, developmental, and spiritual), genetic features, and

strengths and weaknesses of the components of the system. If the client system is a human being, the basic structure contains such features as the ability to maintain body temperature within a normal range, genetic characteristics such as hair color and response to stimuli, and the functioning of various body systems and their interrelationships. There are also the baseline characteristics associated with each of the five variables, such as physical strength, cognitive ability, cultural perspectives, developmental stage, and value systems. Neuman identifies system stability as occurring when the energy exchanges with the environment occur without disrupting the characteristics of the system. Since the system is an open system, stability is dynamic. As output becomes feedback and input, the system seeks to regulate itself. A change in one direction is countered by a compensating movement in the opposite direction. When the system is disturbed from its normal, or stable, state, there is a rapid surge in the amount of energy needed to deal with the disorganization that results from the disturbance. In stability, the system is able to cope with stressors to attain, retain, or maintain optimal health and integrity.

2. Client Variables

The client system is a composite of five interacting variable areas, which are in varying degrees of development and have a wide range of interactive styles and potential. The five client system variables are defined broadly and generally; the first until four, physiological, psychological, sociocultural, developmental are commonly understood by nurses and members of other health professions. The fifth, spirituality is rarely made explicit within a conceptual model. The five client system variables are:

a. Physiological
   Refers to bodily structure and internal function.
b. Psychological
   Refers to mental processes and interactive environmental effects, both internally and externally.

c. Sociocultural
   Refers to combined effects of social cultural conditions, and influences.
d. Developmental
   Refers to age-related development processes and activities.
e. Spiritual
   Refers to spiritual beliefs and influences. The spiritual variable was added in 1989.

In the ideal situation, these variables function in harmony and stability in relation to internal and external environmental stressors. Each of the variables should be considered when assessing system reaction to stressors for each of the concentric circles in the model diagram. It is vital to avoid fragmentation if optimum stability of the client system is to be promoted through nursing care.

1. Line of Resistance

The lines of resistance protect the basic structure and become activated when the normal line of defense is invaded by environmental stressors. An example of a response involving lines of resistance is the activation of the immune system mechanisms. If the lines of resistance are effective in their response, the system can reconstitute; if the lines of resistance are not effective, the resulting energy depletion may lead to death.

2. Normal Line of Defense

In terms of system stability, the normal line of defense represents stability over time. It is considered to be the usual level of stability for the system or the normal wellness state and is used as the baseline for determining deviation from wellness for the client system. For the system, the normal line of defense changes over time as a result of coping with a variety of stressors. The stability represented by the normal line of defense is actually a range of responses to the environment. Any stressor may invade the normal line of defense when the flexible line of defense offers inadequate protection. When the normal line of defense is invaded or penetrated, the client system

reacts. The reaction will be apparent in symptoms of instability or illness and may reduce the system's ability to withstand additional stressors.

3. Flexible Line of Defense

The flexible line of defense is represented in the model diagram as the outer boundary and initial response, or protection, of the system to stressors. The flexible line of defense serves as a cushion and is described as accordion-like as it expands away from or contracts closer to the normal line of defense. It protects the normal line of defense and acts as a buffer for the client system's usual stable state. Ideally, the flexible line of defense prevents stressors from invading the system. As the distance between the flexible and normal lines of defense increases, so does the degree of protection available to the system. The flexible line of defense is dynamic rather than stable and can be altered over a relatively short period by factors such as inadequate nutrition, lack of sleep, or danger. Either single or multiple stressors may invade the flexible line of defense.

4. Environment

Neuman defines environment as all the internal and external factors or influences that surround the client or client system. The influence of the client on the environment and the environment on the client may be positive or negative at any time. Variations in both the client system and the environment can affect the direction of the reaction. For example, individuals who experience sleep deprivation are more susceptible to viruses of the common cold from the environment than those who are well rested.

The internal environment exists within the client system and is intrapersonal. All forces and interactive influences that are exclusively within the boundaries of the client system make up this environment.

The external environment exists outside the client system and is inter and extra personal. Those forces and interactive influences that are outside the system boundaries are identified as external.

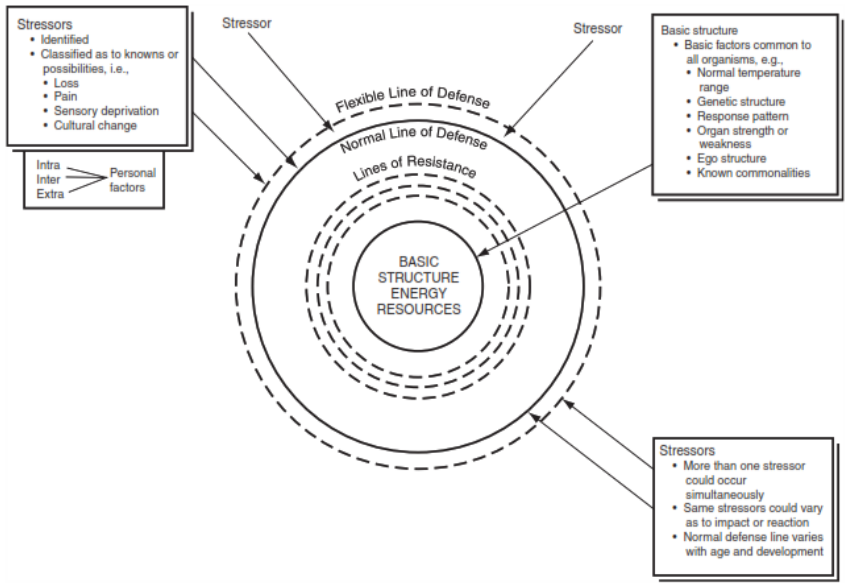

Figure 2: Environment
(Source: Neuman & Fawcett, 2011)

5. Stressor

Neuman defines stressors as stimuli that produce tensions and have the potential for causing system instability. She views stressors, within themselves, as neutral; it is the client/client system's perception that determines the impact as positive or negative. The system may need to deal with one or more stressors at any given time. It is important to identify the type, nature, and intensity of the stressor; the time of the system's encounter with the stressor; and the nature of the system's reaction or potential reaction to that encounter, including the amount of energy needed. The reaction may occur in one or more subparts, or subsystems, of the system. A reaction in one subsystem may, in turn, affect the original stressor. Outcomes may be positive with the potential for beneficial system changes that may be temporary or permanent. Stressors are present both within or outside of the system. Neuman classifies stressors as intra-, inter-, or extra personal in nature. Intrapersonal stressors are

those that occur within the client system boundary and correlate with the internal environment. An example for the individual client system is the autoimmune response. Interpersonal stressors occur outside the client system boundary, are proximal to the system, and have an impact on the system. An example is role expectations. Extra personal stressors also occur outside the system boundaries but are at a greater distance from the system than are interpersonal stressors. An example is social policy. Interpersonal and extra personal stressors correlate with the external environment. The created environment includes intra, inter, and extra personal stressors.

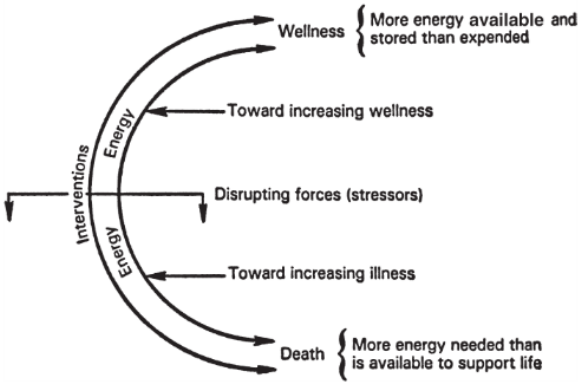

Figure 3: Neuman Systems Model Wellness-Illness Continuum
(Source: Neuman & Fawcett, 2011)

6. Health

Neuman identifies health as optimal system stability, harmony among the five variables, or the optimal state of wellness at a given time. Health is seen as a continuum from wellness to illness (see Figure 3). Health is also described as dynamic, with changing levels occurring within a normal range for the client system over time. The levels vary because of basic structure factors and the client system's response and adjustment to environmental stressors. Wellness may be determined by identifying the actual or potential effects of invading stressors on the system's available energy levels. The client

system moves toward illness and death (entropy) when more energy is needed than is available and toward wellness (negentropy) when more energy is available, or can be generated, than is needed.

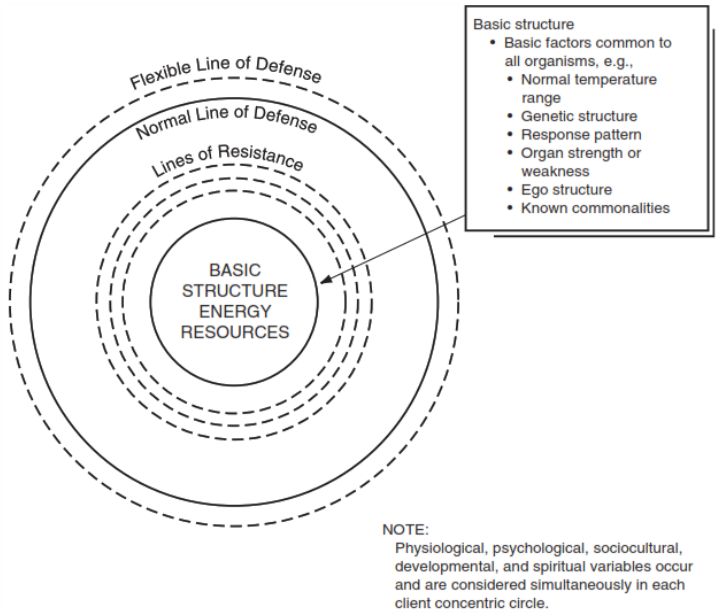

Figure 4: Health
(Source: Neuman & Fawcett, 2011)

7. Reaction

Although reaction is identified within Figure 1, Neuman does not discuss it separately. She does point out that reactions and outcomes may be positive or negative, and she discusses system movement toward negentropy or entropy.

8. Prevention as Intervention

Primary, secondary, and tertiary prevention-as-interventions are used to retain, attain, and maintain system balance. More than one prevention as intervention mode may be used simultaneously.

Primary prevention-as-intervention occurs before the system reacts to a stressor; it includes health promotion and maintenance of

wellness. Primary prevention focuses on strengthening the flexible line of defense through preventing stress and reducing risk factors. This intervention occurs when the risk or hazard is identified but before a reaction occurs. Strategies that might be used include immunization, health education, exercise, and lifestyle changes. Neuman indicates that health promotion is an area of major concern to client and caregiver and that, in the ideal situation, health promotion, as a component of primary prevention-as-intervention, should work with both secondary and tertiary prevention-as-intervention to promote optimal wellness.

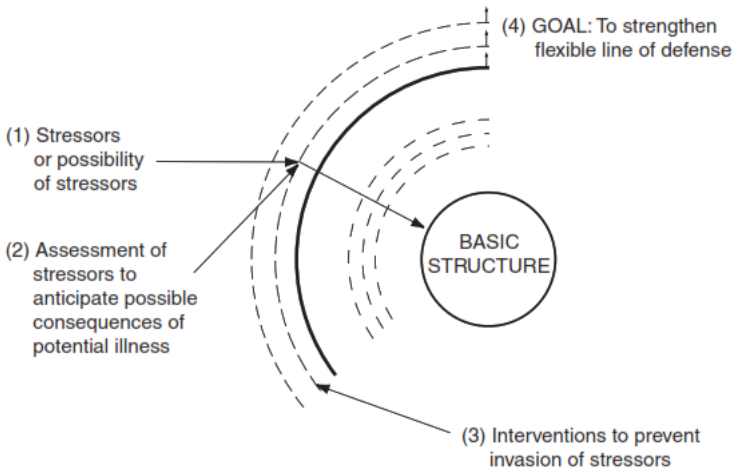

Figure 5: Format of Primary Prevention as Intervention Mode
(Source: Neuman & Fawcett, 2011)

Secondary prevention-as-intervention occurs after the system reacts to a stressor and is provided in terms of existing symptoms. Secondary prevention focuses on strengthening the internal lines of resistance and thus protects the basic structure through appropriate treatment of symptoms. The intent is to regain optimal system stability and to conserve energy in doing so. If secondary prevention is unsuccessful and reconstitution does not occur, the basic structure will be unable to support the system and its interventions, and death

will occur. Examples of secondary prevention include the use of analgesics or of positioning to decrease pain.

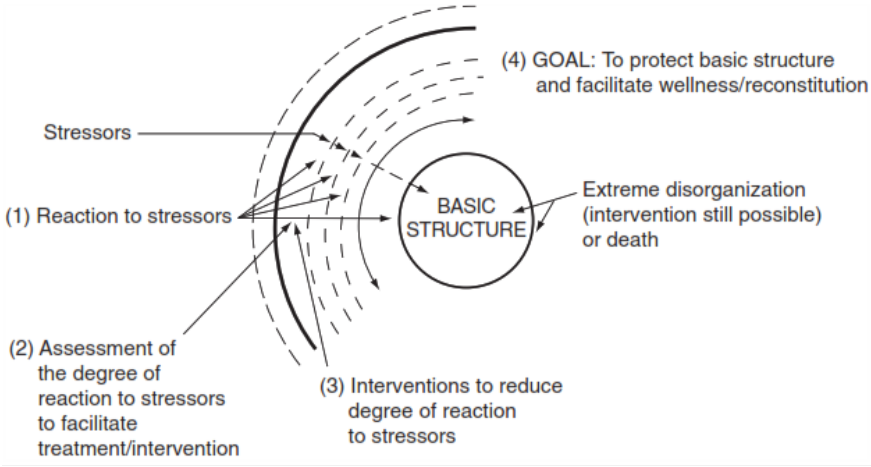

Figure 6: Format of Secondary Prevention as Intervention Mode
(Source: Neuman & Fawcett, 2011)

Tertiary prevention-as-intervention occurs after the system has been treated through secondary prevention strategies. Its purpose is to maintain wellness or protect the client system reconstitution through supporting existing strengths and continuing to conserve energy. Tertiary prevention may begin at any point after system stability has begun to be reestablished (reconstitution has begun). Tertiary prevention tends to lead back to primary prevention. An example of tertiary prevention is participation in a cardiac rehabilitation program.

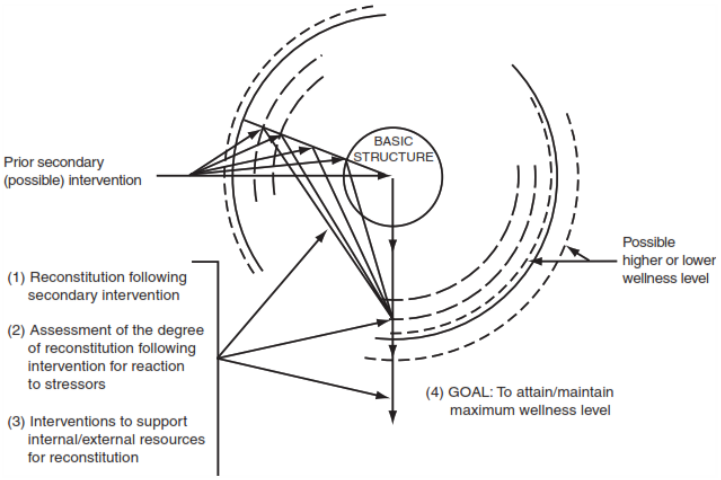

Figure 7: Format of Tertiary Prevention as Intervention Mode
(Source: Neuman & Fawcett, 2011)

9. Reconstitution

Reconstitution begins at any point following initiation of treatment for invasion of stressors. Neuman defines reconstitution as the return to and maintenance of system stability. Reconstitution may expand the normal line of defense beyond its previous level to a higher level of wellness, stabilize the system at a lower level of wellness, or return it to the level that existed before the illness. It depends on successful mobilization of client resources to prevent further reaction to the stressor and represents a dynamic state of adjustment.

10. Nursing

Neuman also discusses nursing as part of the model. The major concern of nursing is to help the client system attain, maintain, or retain system stability. The goal of optimal wellness is achieved when the system has the greatest possible degree of stability at any given time. This may be accomplished through accurate assessment of both the actual and the potential effects of stressor invasion and

assisting the client system to make those adjustments necessary for optimal wellness through primary, secondary, and tertiary prevention-as-intervention. In supporting system stability, the nurse provides the linkage between the client system, the environment, health, and nursing.

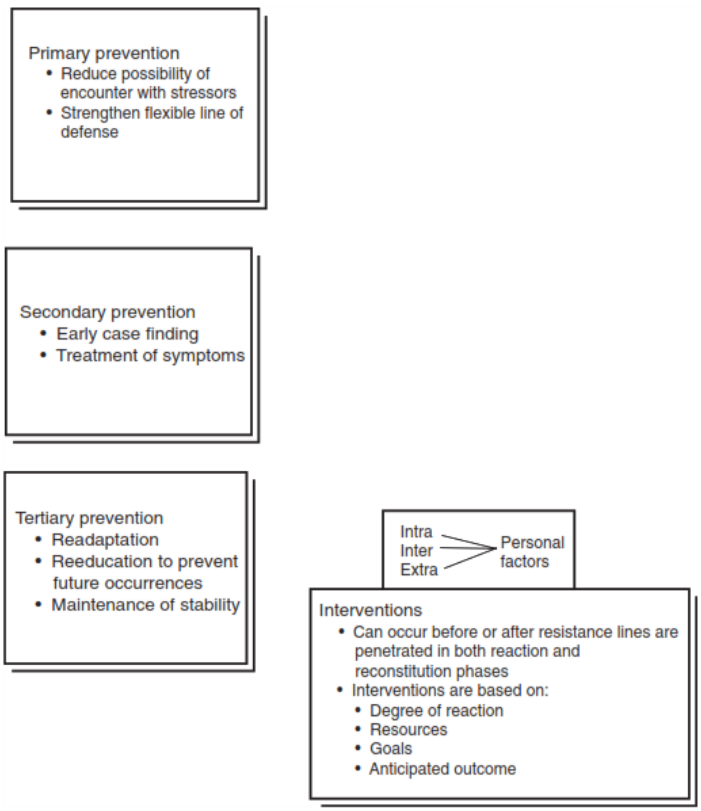

Figure 8: Nursing
(Source: Neuman & Fawcett, 2011)

Neuman and Fawcett (2011), have provided guidelines for clinical practice based in the NSM:

1. The purpose of clinical practice is to assist clients to retain, attain, or maintain optimal system stability.

2. Clinical problems encompass actual or potential reactions to intrapersonal, interpersonal, and extra personal stressors.
3. Clinical practice occurs in virtually any health care or community-based setting, such as clinics, hospitals, hospices, homes, and the streets and sidewalks of the community.
4. Legitimate participants in clinical practice are those individuals, families, groups, and communities who are faced with actual or potential intrapersonal, interpersonal, and extra personal stressors.
5. The process of clinical practice is the Neuman Systems Model Process Format, which encompasses three components diagnosis, goals, and outcomes.
6. The Neuman Systems Model Process Format engages the client system and the caregiver in a mutual partnership to determine diagnosis, goals, and outcomes.
7. Diagnoses may be classified into a Neuman Systems Model diagnostic taxonomy that is organized according to client system (individual, family, group, community), level of response (primary, secondary, tertiary), client subsystem responding to the stressor (physiological, psychological, sociocultural, developmental, spiritual), source of the stressor (intra system, intersystem, extra system), and type of stressor (physiological, psychological, socio-cultural, developmental, spiritual).
8. Clinical interventions occur as primary, secondary, and tertiary prevention interventions, in accord with the degree to which stressors have penetrated the client system's lines of defense and resistance.
9. General outcomes are derived from the content of the Neuman Systems Model. Client-system-specific outcomes involve application of the general outcomes to particular clinical situations.
10. Neuman Systems Model based clinical practice contributes to client system well-being by facilitating the highest possible level of stability achievable at a given point in time.

11. Clinical practice is linked to research through the use of research findings to direct practice. In turn, problems encountered in clinical practice give rise to new research questions.

SUMMARY

A creative and rigorous organization of concepts that presents a tentative, deliberate, and systematic interpretation of phenomena is what is referred to as nursing theory. Nurses are able to acquire knowledge relevant to enhancing patient care through methodical inquiry, whether in nursing research or practice. Over time, the nursing field has undergone significant change. Nursing has its own theoretical practice, nursing models, and unique nursing interventions as it transitions from dependence on total medical direction to deliver basic care as an independent practice modality. A cohesive collection of broad claims that serve as explanational guiding principles is referred to as a theory. Nursing theories provide a framework for reflection that allows one to consider the direction in which the plan should go. This framework offers a framework for management, research, and decision-making as new situations are encountered. Nursing theories can provide a framework for interacting with other nurses as well as with other team members and representatives. Nursing theories aid in the formulation of nursing's ideas, values, and objectives. They aid in defining the various unique contributions that nursing makes to the treatment of patients. Research and practice are guided by nursing theory.

REVIEW QUESTIONS

1. Nurses treat and treat patients holistically. This is due to the assumption that disease occurs due to physical disharmony and mind and spirit. Who is the nursing figure who made this statement?
   A. Orem
   B. Martha Roger
   C. Newman

D. Watson
E. Roy

2. The nurse is visiting the home of a patient who has suffered a stroke. The patient currently has right hemiparesis. The nurse comes to visit to practice ROM. According to Orem's theory, what type of role does the nurse perform?
   A. Supportive educative system
   B. Partly compensatory system
   C. Nurse supportive system
   D. Dependent system
   E. Wholly compensatory system
3. The nurse is assessing a family with an elderly person. The nurse assesses the patient's age, health status, culture, and self-care habits. What is the theory underlying the nurse to explore the assessment data?
   A. Science of Unitary Human Beings
   B. Transcultural Nursing
   C. Selfcare Deficit Theory of Nursing
   D. Health Expanding Consciousness
   E. The Theory of Self-care
4. Based on data from one of the cadres in her working area, the nurse will conduct further assessment related to reports that in her area currently many toddlers are hospitalized due to dysentery. What community nursing assessment model does the nurse use?
   A. Roy Theory
   B. Newman Theory
   C. Leininger Theory
   D. Roger Theory
   E. Friedman Theory
5. One of the factors that influence health behavior is the culture adopted by the community. What is the nursing theory that underlies this statement?
   A. Roy Theory

B. Newman Theory
C. Leininger Theory
D. Roger Theory
E. Friedman Theory

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CHAPTER 5.

HOLISTIC NURSING

KEY TERMS

- Biological
- Psychological
- Socio-cultural
- Spiritual
- Holistic nursing
- Complementary Therapies

LEARNING OBJECTIVES

After completing learning this chapter:

1. Student can understand the definition of holistic nursing
2. Student can understand the history of holistic nursing
3. Student can understand the standards of holistic nursing
4. Student can understand complementary/alternative modalities (CAM) theories

INTRODUCTION

Healthcare is constantly undergoing changes in accordance with the advancement of health science and technology. In addition to that, the complexity of health issues faced by society also demands an effective response from health services and health forces. The ability of healthcare professionals to anticipate public needs for quality healthcare services, and meet the needs with scientifically proven interventions are the key to success and quality of effective healthcare services. The current global health issues require holistic

care as there are a variety of problems experienced by patients such as increased antibiotic resistance. economic factors, the environment, and social which affect health Holistic nursing for chronic diseases globally has not been developed. Hence, it is very necessary in the service corresponding to the problems faced by the patient is not only physical, psychosocial and Spiritual. Healthcare is currently trying to implement a holistic concept. It is an approach to the whole human being, it includes bio-psycho-socio-cultural and spiritual. This holistic concept should be understood and applied by health practitioners, including the nurse.

DEFINITION OF HOLISTIC NURSING

Holistic nursing is defined as all nursing practice that has healing the whole person as its goal. Holistic definition is comprehensive or thorough that consists of body to body, mind to mind and spirit to spirit or it might also be said bio, psycho, social and cultural (Dossey & Keegan, 2013). In order to help nurse become therapeutic partners with patients and improve human reactions to speed up the healing process and achieve completeness, the specialty practice of holistic nursing draws on nursing knowledge, philosophies of nursing and wholeness, expertise, and intuition. Through the assessment and management of human reactions, holistic nursing aims to safeguard, promote, and optimize health and wellbeing, aid healing, avoid sickness and injury, lessen suffering, and support individuals in finding peace, comfort, harmony, and balance (Dossey & Keegan, 2013).

In contrast to an orientation toward diseases and their remedies, holistic nursing care is healing-oriented and focused on the relationship with the patient. When it comes to facilitating healing and modeling wellbeing in others, holistic nursing places a strong emphasis on self-care practices, intentionality, presence, and mindfulness. All nursing practice may have a biopsychosocial perspective, making it possible for all nursing practice to be comprehensive in a certain sense. Holistic nursing practices are a specialty because they are

based on a philosophy, a body of knowledge, and a highly developed set of nursing skills that acknowledge the interconnectedness of the body, mind, emotion, spirit, and energy as well as society, culture, relationships, context, and environment. Both conventional nursing and complementary/alternative/integrative modalities (CAM) therapies are used in the practice of holistic nurses.

Holistic are closely linked to the well-being believed to have had an impact on health status. To achieve holistic health and well-being, there are five dimensions that must be noticed (Holistic Nursing UNDIP, 2015):

1. Physical dimension: the ability of a person to perform daily activities in general to carry out positive habits of life.
2. Social dimension: performing social activities and being able to interact with other.
3. Emotional Dimensions: expressing Emotions and Controlling Stress
4. Intellectual dimension: cognitive ability to learn
5. Spiritual dimension: associated with belief in some things like: nature, science, religion or higher power that helps humans to reach the purpose of life. Including morals, value, and the ethics of a person

The holistic approach of nursing involves interventions that focus on the patient's responses that cure people completely and help balance, therapy, and the art of healing itself is not the essence of holism and health. Holistic nurse helps patients to be responsible for personal health by engaging as health role models that integrate self-care in life and are done in everyday life. Based on American holistic nurses association, This will help patients cope with stress and give them a lot of energy to help patients by forming a balance between what is given to themselves and what is given to others.

HISTORY OF HOLISTIC NURSING

Nursing has been based on holistic principles and has included natural medicine and healing therapies since the 1700s.

Use of compressors, plaster, oil, drugs, ointment, and tea made from medicinal plants are common practices in early nursing. Until the mid1900s, American nursing texts routinely incorporate plant medicine theories in their curriculum.

The modern nurse, Florence Nightingale, understand that one health and the environment cannot be separated. She emphasized the importance of pure air, pure water, cleanliness, and light in creating and maintaining health. Early nursing methods were based on holistic ideas and the use of natural remedies, but they were mostly abandoned in the middle to late 1900s. Technology began to replace interpersonal interactions in the latter part of the 20th century, and the health care industry began to transition from a service industry to a non-profit enterprise. A developing culture that prioritizes efficiency and profit margins subjugates the caring and healing relationship that is essential to nursing. The inability of nurses to deliver high-quality care and fully meet the demands of patients frustrates them. The American Holistic Nurses Association was founded as a result of this.

The first meeting of American Holistic Nurses Association (AHNA) was held in January 1981,17 in Houston, Texas where 33 the nurse from eight state gathered to share a story and the creation of a vision for the future. Currently AHNA served more than 166 5500 members through the local network in the U.S. and abroad. Its main mission is progress AHNA holistic health care through education, of nurses and community building, other health professionals, and the community.

In 1997, the American Holistic Nurses Certification Corporation (AHNCC) was formed to provide a credential program in holistic nursing. At present, AHNCC offers several certification options for registered nurses based on the level of education. Certification for nursing trainer is also available via AHNCC. To this moment, 2,433 nurses have obtained holistic nursing certification. In addition to that, AHNCC supports 14 nursing programs at universities across the country whose curriculum meets specific criteria to integrate concepts.

In 2006, American Nurses Association (ANA) officially recognizes holistic nursing as a nursing specialty that differs with the scope and standards of established practice. Holistic nurses employ a range of complementary therapies. For patients in hospitals and private offices, image, visualization, relaxation, deep breathing methods, stress management, aromatherapy, and smooth energy therapy are commonly used. Holistic nurses are aware of the range of services provided by both conventional and alternative medical practitioners. To help people coordinate their treatments and handle the complexity that occurs across many health-care and healing professions, they are providing information, guidance, and counseling.

STANDARDS OF HOLISTIC NURSING

1. Basic Standard Development

The Standards of Holistic Nursing Practice were first created by the American Holistic Nurses Association (AHNA) in 1990, and they were amended in 1995. The Inventory of Professional Activities and Knowledge of a Holistic Nurse (IPAKHN survey), a three-year role delineation research project, was carried out between 1994 and 1997 by the American Holistic Nurses Association (AHNA). Through the delivery of a systematic inventory to a representative sample of holistic nurses, the behaviors and knowledge fundamental to current holistic nursing practice were identified in this practice analysis study.

A four-member AHNA task force completed this three-year project successfully, and it was then reviewed by the AHNA leadership council, a few AHNA members, and other recognized holistic nurses who are both members and nonmembers and represent the diversity of holistic nurses' representation in practice, education, research, and administration. Core values were established, and the 1995 AHNA Standards of Holistic Nursing Practice were revised using a comprehensive five-step approach (Dossey & Keegan, 2013).

a. Step 1: Literature Review, Inventory of Professional Activities and Knowledge of a Holistic Nurse (IPAKHN) Survey Data Analysis, and Expert Reviews.

b. Step 2: Review Process
c. Step 3: AHNA Standard of Practice Advisory Committee
d. Step 4: AHNA Standards of Practice Review Committee
e. Step 5: AHNA Standards of Practice Leadership Council.

2. Advance Standard Development

A nine-member task force to create guidelines for advanced practice was created by the AHNA leadership council in January 2000 in response to the rising number of graduate programs with a holistic nursing focus. The task committee worked to create standards for advanced holistic nursing practice from then until later in the fall of 2001. The task force members produced the final draft and approved its submission to the council in September 2001. Similar to how the fundamental practice standards were developed, the AHNA reviewed the advanced practice standards. To ensure that the draft standards' content was genuine, experts in holistic nursing and nursing education were requested to assess them in addition to the task force.

In the spring of 2000, the first draft was finished and circulated to the task force members for evaluation and input. After considering the feedback, a second draft was created for the task committee to evaluate. Although some nurses in practice have enlarged scopes due to certifications in specific specialties rather than graduate education, it was decided that the rules for advanced practice would still apply to those nurses with graduate degrees. The third draft was finished in the summer of 2000 and distributed to task force members in the fall. The fourth draft was created using the feedback from the task force members and distributed for evaluation and discussion to the responding and corresponding committees. The AHNA leadership council authorized and adopted the Standards of Advanced Holistic Nursing Practice for Graduate-Prepared Nurses in January 2002. A small adjustment was made in 2005.

The Standard of Holistic Nursing Practice (Dossey & Keegan, 2013).

1. Standard 1 (Assessment): The holistic nurse collects comprehensive data pertinent to the person's health or situation.
2. Standard 2 (Diagnosis or Health Issues): The holistic nurse examines the assessment results to identify trends, challenges, or requirements that are connected to health, wellness, disease, or illness, whether they are actual or potential.
3. Standard 3 (Outcomes Identification): A plan that is tailored to the individual or the circumstance is identified by the holistic registered nurse. The holistic nurse respects how the healing process develops and changes over time. This suggests that because the healing process is non-linear, the precise unfolding consequences may not become apparent right away. As a result, both predicted and emerging outcomes are taken into account.
4. Standard 4 (Planning): The holistic registered nurse creates a strategy that outlines methods and options for achieving goals.
5. Standard 5 (Implementation): The holistic registered nurse collaborates with the patient to put the chosen strategy into action.

   Standard 5A (Coordination of Care): The holistic registered nurse coordinated care delivery.

   Standard 5B (Health Teaching and Health Promotion): The holistic registered nurse employs strategies to promote holistic health, wellness, and a safe environment.

   Standard 5C (Consultant): The holistic advanced practice A licensed nurse offers advice to affect the chosen course of action, improve the capabilities of others, and bring about change.

   Standard 5D (Prescriptive Authority and Treatment): The holistic advanced practice registered nurse uses prescriptive authority, procedure, referrals, treatment, and therapies in accordance with state and federal laws and regulation.

6. Standard 6 (Evaluation): The holistic registered nurse assesses success in achieving outcomes while acknowledging and respecting the ongoing holistic character of the healing process.
7. Standard 7 (Quality of Practice): A registered nurse with a holistic approach systematically raises the caliber and efficacy of holistic nursing practice.
8. Standard 8 (Education): The registered holistic nurse acquires knowledge and competencies that reflect modern nursing practice.
9. Standard 9 (Professional Practice Evaluation): Registered nurses who practice holistically assess their own nursing practices in relation to professional practice standards and guidelines as well as any applicable laws, rules, and regulations. In order to practice holistically, registered nurses must apply their knowledge of current laws, statutes, rules, and regulations.
10. Standard 10 (Collegiality): The holistic registered nurse engages in interactions with peers and colleagues and contributes to their professional growth.
11. Standard 11 (Collaboration): The registered nurse who practices holistic nursing works in partnership with the patient, family, and other stakeholders.
12. Standard 12 (Ethics): The registered nurse integrated ethical provisions in all areas of practice.
13. Standard 13 (Research): The registered nurse integrates research into practice
14. Standard 14 (Resource Utilization): Licensed practical nurse When planning and delivering nursing services, the holistic registered nurse takes into account factors relating to safety, efficacy, cost, and impact on practice.
15. Standard 15 (Leadership): The holistic registered nurse serves as a leader in both the profession and the professional practice setting.

COMPLEMENTARY/ALTERNATIVE MODALITIES (CAM) THERAPIES

There are many different definitions of complementary therapies. Finding a definition that encompasses the breadth of this discipline is difficult due to the wide range of therapies and the numerous health professionals and therapists involved in their delivery. The National Center for Complementary and Integrative Health (NCCIH) defines complementary health methods as the use of non-mainstream activities and goods (Linquist, Tracy, & Snyder, 2018). Complementary/Alternative Modalities (CAM) is a broad set of healthcare practices, therapies, and modalities that address the whole person-body, mind, emotion, spirit, and environment, not just signs and symptoms and that may replace or be used as complements to conventional Western medical, surgical, and pharmacological treatment (Dossey & Keegan, 2013).

According to (Dossey & Keegan, 2013), Categories of Complementary/Alternative Modalities (CAM) Therapies are:

1. Natural Product

   Mental-physical medicine. The goal of mind-body practices is to use the mind to influence physical functioning and advance health. Mind-body practices concentrate on the relationships between the brain, mind, body, and behavior. This idea is embodied in many CAM techniques in various ways. Some methods that were previously regarded as CAM (such as patient support groups, psychotherapy, and cognitive-behavioral therapy) have entered the mainstream. Meditation, relaxation, visualization, hypnotherapy, yoga, biofeedback, and Tai Chi are examples of mind-body practices. Autogenic training, spirituality, prayer, mental healing, and therapies that involve creative outlets like painting, music, dancing, or journaling are additional forms of treatment. Acupuncture is seen as a component of energy medicine, manipulative and body-based therapies, and traditional Chinese medicine. It is also regarded as an element of mind-body therapy.

2. Mind-Body Medicine
   The goal of mind-body practices is to use the mind to influence physical functioning and advance health. Mind-body practices concentrate on the relationships between the brain, mind, body, and behavior. This idea is embodied in a variety of CAM techniques. Some methods that were previously regarded as CAM (such as patient support groups, psychotherapy, and cognitive-behavioral therapy) have entered the mainstream. Meditation, relaxation, visualization, hypnotherapy, yoga, biofeedback, and Tai Chi are examples of mind-body practices. Autogenic training, spirituality, prayer, mental healing, and therapies that involve creative outlets like painting, music, dancing, or journaling are additional forms of treatment. Acupuncture is seen as a component of energy medicine, manipulative and body-based therapies, and traditional Chinese medicine. It is also regarded as an element of mind-body therapy.
3. Manipulative and Body-Based Practices
   Practices involving manipulation and the body's systems, including the lymphatic and circulatory systems, soft tissues, and bones and joints, are the main subjects of these techniques. This category includes massage and spinal manipulation, which includes chiropractic or osteopathic manipulation.
4. Movement Therapies
   Movement therapies, a wide variety of eastern and western movement-based modalities intended to foster physical, mental, emotional, and spiritual well-being, are also included in CAM.
5. Practices of Traditional Healers
   Indigenous theories, beliefs, and experiences are used by traditional healers as the foundation for their treatment regimens.

6. Energy Therapies
   Some CAM techniques manipulate different energy fields to have an impact on health. These fields can be classified as hypothetical (yet to be measured) or verifiable (measurable). Practices using electromagnetic fields, such as magnet therapy, light therapy, or alternating-current or direct-current fields, are based on actual sources of energy. The majority of putative energy field practices (also known as biofields) are founded on the idea that people are filled with subtle types of energy. Some types of energy therapy, such as acupressure, manipulate the body by placing the hands in or through these areas and applying pressure to the biofields. Gong, Reiki, therapeutic touch, and healing touch are a few examples.
7. Whole Medical System
   It is possible to classify CAM as comprehensive theories and practices that have developed over time in diverse cultures independent of conventional or Western medicine. Ayurvedic medicine and traditional Chinese medicine are two instances of complete prehistoric medical systems. Homeopathy and naturopathy are more recent systems that have emerged in the last few centuries.

According to The National Center for Complementary and Integrative Health (NCCIH), Categories of Complementary/Alternative Modalities (CAM) Therapies are (Linquist, Tracy, & Snyder, 2018):

8. Natural Products
   Natural resources are used in therapies. Examples include probiotic dietary supplements, plants (botanicals), vitamins, and minerals.
9. Mind and Body Practice
   Chiropractic and osteopathic manipulation, massage, yoga, acupuncture, relaxation exercises, guided imagery, hypnosis, movement therapies, and tai chi are some of the therapies that fall under this category.

10. Other Complementary Health Approaches
    The philosophy and practice that make up entire healthcare systems frequently developed before and independently of Western medicine. Everybody has their own treatments and methods. Examples include homeopathy, naturopathy, traditional healers, and TCM.

The nursing care standards used in Indonesia in planning nursing interventions, namely SIKI, have also included holistic therapy or complementary therapy. The interventions include (PPNI, 2018):

1. Self-hypnosis support:
   Facilitating the use of self-induced hypnotic states for therapeutic benefit
2. Meditating support:
   Facilitate the integration of beliefs into the treatment plan to support the recovery of health conditions.
3. Aromatherapy
   Giving essential oils by inhalation, massage, steam bath, or compress to relieve pain indicates blood pressure, increased relaxation and comfort.
4. Breath technique training
   Teaching breathing techniques to promote relaxation, relieve pain and discomfort.
5. Spiritual Support
   Facilitating increased feelings of balance and connection with a greater power

In Indonesia, several examples of holistic nursing therapy applications have been evidence based through research, including:

1. Mind fullness therapy to reduce work stress
2. Mind fullness meditation rain method to reduce anxiety
3. Spiritual emotional freedom technique to reduce anxiety and decrease insomnia
4. Progressive muscle relaxation to reduce psychophysiological stress response in college students

5. Physically oriented therapies for the self-management of chronic pain
6. Healing Touch Therapy
7. Hypno-therapy
8. Hypno-parenting
9. Hypno-birthing

SUMMARY

The definition of holistic is comprehensive or thorough which consisting of body to body, mind to mind and spirit to spirit or it can be said to be bio, psycho, social and cultural, also said bio, psycho, social and cultural. Spiritual processes that affect a person comprehensively. Every human being has an experience that includes body-mind-spirit components. This mind-body-spirit is an important component of the healing process including emotional, physical and spiritual issues are all inseparable and part of the healing process. Holistic nursing practice standards have been set up to guide nurses in providing nursing care. Complementary and alternative nursing is one type of therapy that nurses can do in providing holistic nursing care. Experts divide this type of therapy according to the characteristics and approach of the therapy.

REVIEW QUESTIONS

1. What characterizes holistic nursing?
   A. Bio, psycho, social, cultural
   B. Complementary and alternative
   C. Therapeutic nursing
   D. Emotional comfort
   E. Hypnotherapy
2. One of the complementary therapies is energy therapy. Which of the following is a type of therapy?
   A. Physical
   B. Social
   C. Emotional

D. Intellectual
E. Spiritual

3. One of the dimensions in holistic nursing is cognitive ability to learn. What is this dimension?
   A. Reiki
   B. Herbal
   C. Ayurvedic
   D. Guided imagery
   E. Hypnosis

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CHAPTER 6.

CONCEPT OF CHANGE IN NURSING

KEY TERMS

- Change in nursing
- Agent of changes
- Nurse

LEARNING OBJECTIVES

After completing learning this chapter:

1. Student can understand the definition of change
2. Student can understand the type of change in nursing
3. Student can understand the agent of change in nursing
4. Student can understand the strategies of change in nursing

INTRODUCTION

Change is part of everyone's life; it is how one grows, develops, and adapts. Everyone, including nurses, can change themselves and bring about change in others. This is especially important in leadership and management, especially in the nursing field. Change can certainly happen to anyone and at any time, regardless of time, place, and whoever the person is will definitely have the opportunity to change. Change is a process of making something different from before. Without change, there will be no growth and there will be no drive. Nurses in making changes can apply theories of change as needed. Leaders constantly try to move the system from one point to another to solve problems. Then continuously a leader also develops strategies to change others and solve a problem.

DEFINITION OF CHANGE

Change is making (something or someone) different; alter or modify. Change is replacing (something) with something else, especially something of the same kind is newer or better; substitution one thing for. Change is the act or instance of making or becoming different (Oxford Language Dictionary, 2023).

The healthcare sector is characterized by constant change. Change is the process of altering or replacing existing knowledge, abilities, attitudes, frameworks, principles, or procedures. The outcomes of the transformation must be consistent with the organization's mission, vision, and values. Although change is a dynamic process that calls for behavioral modifications, potential conflict, and needs for behavioral adjustments, it may also stimulate positive behaviors and attitudes that improve organizational outcomes and worker performance. Change can also result of newly identified issues or through the adoption of new knowledge, management strategies, or leadership philosophies. To identify problems, difficulties can be located using a variety of sources, including accreditation survey results, staff performance appraisals, and quality improvement programs.

Nurse managers must deal with the fears and trepidations created by change. They should be conscious that not everyone will embrace change and that it might not be easy. Leaders should identify both individuals who will enthusiastically accept the change (known as "early adopters") and those who will resist it (known as "laggers"). To build momentum, early adopters should be involved, and obstacles should be found by taking into consideration the objections of resisters. Data should be obtained, analyzed, and disseminated in order to effectively explain the need for change and its projected implications. The need for the changes, how they will affect individuals, how they will help the company, and what they expect to accomplish must all be explained by managers.

Change management is the process of directing organizational change from start to finish, including planning, implementing, and

stabilizing changes in an organization. It has to deal with how companies handle transitions like implementing new technologies, enhancing current practices, and changing organizational structure. This method may look different depending on the type of update you're making. A corporation must undergo organizational restructuring. As a business grows, employees come and go, new teams and departments are formed, and businesses adopt cutting-edge technology to stay competitive.

The secret to making organizational transformation successful and fruitful is how you manage it. It's important to let employees know about changes and make sure they understand how they can affect them. Utilizing organizational change management techniques will help you keep the business running smoothly during the shift. For instance, offering effective training helps staff members learn new technology more quickly. This ensures that the technology is effectively utilized and prevents support issues and disgruntled users from impeding organizational change.

By deciding what kinds of organizational adjustments you will be making, you can plan a strategy for employee communication. To offer your team the support they need to maintain a positive attitude and support the change on their end, you can gather feedback as you implement the change and then tweak your change management plan.

TYPE OF CHANGE IN NURSING

Different types of organizational transformation necessitate various strategies. Everything from implementation to communication must be tailored to the sort of change being implemented. Following are the six most prevalent types of organizational change, along with illustrations of each type of change management:

1. Strategic change

   Different types of organizational change necessitate different strategies. Every aspect of the change, from implementation to

communication, must be tailored based on the sort of change being made.

2. People-centric organizational change
   Various types of organizational change necessitate various strategies. Everything from communication to implementation must be tailored based on the sort of change being undertaken.
3. Structural change
   The structure of the organization may change as a result of internal or external factors, and these changes frequently affect how business is carried out. Examples of structural changes include significant modifications to the administrative procedures, team structure, roles given to various departments, chain of command, and management hierarchy. Structural change is brought on by a variety of circumstances, including mergers and acquisitions, employment duplication, shifting markets, and modifications to procedures or rules. These modifications usually overlap with enhancements that are people-centric since they directly affect most, if not all, employees.
4. Technological change
   Changes to the organizational structure may be brought about by internal or external factors, and they frequently have an effect on how business is carried out. Structural changes can include, but are not limited to, significant modifications to the management hierarchy, team structure, duties given to various departments, chain of command, job structure, and administrative procedures. Some of the elements that lead to structural change include mergers and acquisitions, job duplication, shifting markets, and modifications to procedures or rules. These changes usually overlap with people-centric enhancements since they directly affect most, if not all, employees.

5. Unplanned change
   Unexpected change is defined as a necessary reaction to unexpected circumstances. Even if an unanticipated change cannot be planned for, it can be efficiently managed through change management.
6. Remedial change
   Corrective actions are retaliatory. When a problem is identified and a solution is required, this type of modification takes place. Since these changes are meant to solve an issue, they are urgently required.

According Marquis & Huston (2015), type of change:

1. Spontaneous Change
   Spontaneous change is also called reactive or unplanned change because it is not really anticipated; it is unavoidable and there is little to no anticipation. These changes are not really anticipated, cannot be avoided and there is little or no time to plan a response strategy or no time to plan a response strategy. Examples of spontaneous changes that affect individuals are acute viral infections, spinal cord injuries and voluntary offer of a new position.
2. Developmental Changes
   Developmental change refers to the physiopsychological changes that occur during the individual's life cycle or the development of an organization into a more complex one. Examples of individual developmental changes are the increase in size and complexity of the human embryo and fetuses and reduced physical abilities in the elderly.
3. Planned Changes
   According to Lippitt, planned change is a deliberate and purposeful effort by individuals, groups, organizations, or larger social systems to influence individuals, groups, organizations, or larger social systems to affect the status quo of itself, another organism, or a situation another organism, or a situation. Problem-solving skills, decision-making skills, and

interpersonal skills are important factors in planned change. Examples of planned change is an individual who decides to improve their health status by attending a smoking cessation program or doing an exercise program.

Ackerman (1997) has identified three different categories of change.:

1. Developmental:
   It might be planned or emergent, first-order or progressive. It is change that enhances or corrects already-existing organizational components, usually focusing on process or skill improvement.
2. Transitional
   Attempts to reach a predetermined ideal state that differs from the present one. It is radical, planned, episodic, or second-order. Based on this kind of analysis, the majority of the literature on organizational change
3. Transformational:
   Second-order or radical in nature; transformational It demands a shift in the assumptions held by the organizations and their members. The structure, practices, culture, and strategy of an organization may change significantly as a result of transformation. Therefore, it could result in the creation of a company that operates in a developmental mode, one that continuously learns, adapts, and gets better.

CHANGE NURSING THEORY

When implementing change, nursing leaders may use one of several change theories.

1. Kurt Lewin Change Theory:

Restraining forces, in line with Kurt Lewin's Force Field Theory, have an effect on both group and individual behavior, ultimately determining whether or not change will take place. The motivating factors support and point employees in the direction of the desired future state. By emphasizing potential resistance to change, the restraining forces act as the primary roadblocks to change initiatives.

According to Lewin, it's crucial to balance these pressures by giving employees training to fill the skill gap and using efficient change communication. Persuasive arguments, stress management techniques, and compliance monitoring are all necessary for change agents to use. To support his Force Field Theory, Lewin offered a straightforward, three-step transition paradigm that makes it easier for workers to adjust to change.

Stage 1: Unfreeze

The first stage of Lewin's paradigm, which deals with perception management, is to prepare the parties concerned for the upcoming organizational transformation. Change leaders must think about how to raise the organization's readiness for change and create a feeling of urgency, much like Kotter's change model. Gaining the desired team member buy-in and support of the change management team during this phase depends on effective change communication. If you do the following during the "unfreeze" stage, you'll be more receptive to change: Obtain organizational support; conduct a needs analysis to identify any gaps in your organization's current business procedures; develop a strategic change vision and change strategy; persuasively explain why change is necessary; and honestly and openly address employee concerns.

Stage 2: Change

When the status quo is disturbed, this phase deals with putting change into action. You must consider an agile and iterative strategy that takes employee feedback into account if you want to smooth the shift at this point. To avoid confusion, you might look at the concrete measures listed below in more detail: Keep the lines of communication open, plan change management training and workshops, give staff the freedom to tackle the change head-on, and produce little wins that will motivate your team to cooperate.

Stage 3: Refreeze

Workers go from the transition stage to stabilization or acceptance in the last “refreezing” step. If change leaders don’t support the change in organizational culture, workers could revert to old habits. The following activities will help you support the change: Identify and honor early adopters and change champions; explore digital adoption platforms as your change partner with easy features like interactive walkthroughs, customized popups, and multi-format self-help content. Provide on-demand personnel training and support. Regularly gather employee feedback.

Example Using Lewin’s Change Theory

A new nurse who works at a remote medical-surgical facility finds that shift reports are not currently done using bedside handoff reports.

Step 1: Unfreeze:

After understanding that a change is required for improved patient safety, the new nurse brings up the problem with nurse management. For patient safety, the most recent evidence-based practice is presented with regard to bedside handoff reports between shifts. The nurse manager sets the stage for actions like calling unit meetings to talk about the value of including bedside handoff reports and evidence-based practice.

Step 2: Change:

With the help of the director of nursing, the nurse manager sets up staff training on bedside report checklists and how to complete them in order to effect organizational change.

Step 3:

Refreeze As part of a new unit policy, the nurse manager implements bedside handoff reports and assesses employee performance.

2. Lippitt's Seven-Step Change Theory

Lippitt's Seven-Step Change Theory expands on Lewin's theory of change by highlighting the role of the change agent. A change agent is somebody with the ability to inspire, facilitate, and oversee the change initiative. Internal change agents include change managers and other personnel assigned to monitor the change process. Outside consulting companies are examples of external change agents. The status quo is questioned, and a new perspective is offered by external change agents since they are not restricted by business politics, culture, or traditions. This may, however, be a disadvantage if outside change agents are not familiar with the history, routines, and personnel of the agency. The following steps are part of the seven-step model:

a. Step 1: Diagnose the problem
   Examine potential outcomes, identify people who will be impacted, name key management personnel who will be in charge of resolving the issue, gather information from those who will be impacted, and make sure those impacted are committed to the change's success.
b. Step 2: Evaluate motivation and capability for change
   Identify the capability of the financial, human, and organizational resources
c. Step 3: Asses the change agent's motivation and resources, experience, stamina, and dedication
d. Step 4: Select progressive change objective
   Create action plans and the supporting strategies as you define the transformation process.
e. Step 5: Explain the role of the change agent to all employees and ensure the expectations are clear.
f. Step 6: Maintain change
   Enhance communication, encourage input, and plan the impacts of change.
g. Step 7: Gradually terminate the helping relationship of the change agent

Example Using Lippitt's Seven-Step Change Theory

Enhance communication, encourage input, and plan the impacts of change. Create action plans and supporting strategies as you define the transformation process.

a. The nurse manager gathers data from people who will be impacted by the changes to ensure the team members' commitment to success.
b. Early adopters are change agents on the unit who are dedicated to improving patient safety by implementing evidence-based practices like bedside handoff reporting.
c. Team members are informed of the deadlines, expectations, and action plans, as well as staff education and mentoring as goals for progressive transformation.
d. Early adopters receive specialized training to help them become "super-users," who instruct other nurses and staff on how to use bedside handoff checklists across all shifts.
e. As changes are made on the unit, the nurse manager promotes input and two-way conversation regarding problems.
f. As team members successfully adapt to changes, they receive encouraging feedback.
g. As part of the unit policy, accurate bedside handoff reporting is required, and all team members are in charge of enforcing it.

STRATEGIES OF CHANGE IN NURSING

Here are some suggestions to ensure a successful organizational transformation now that you have determined the kind:

1. Clear vision and goals

   It's important to comprehend the reasons for the adjustments, how they will impact company outcomes, and when they will be regarded effective. A change's "why" must be made and communicated clearly in order for staff members and leaders to comprehend it and for the change's implementation to be successful overall.

2. Prioritization
   It is imperative to establish priorities for the problems you want to resolve first because it is impossible to make all the necessary changes at once. For example, it wouldn't be appropriate to roll out three new company apps one at a time.
3. Secure buy-in from your entire organization
   It is essential to involve all significant stakeholders, from leadership and management to executives, to lessen an organization's resistance to change. Due to the fact that workers are made to feel heard, appreciated, and involved, conflicts can be raised early on in a project to accommodate them and be quickly handled. Make a detailed communication plan to let everyone know about the change. The plan needs to address every issue, including how the new business will appear. During a two-way conversation, employees must be given the opportunity to express their concerns and pose questions.
4. Build a change implementation plan
   Effective change implementation requires a detailed plan that methodically identifies key turning points. A flawless deployment will be made possible by carefully planning the project's scope, integrations, resources, communication, time, cost, procurement, and hazards. A practical implementation plan accelerates the pace of its implementation by anticipating and overcoming challenges and resistance to change.
5. Focus on training & support
   For change to last, it is crucial to have support and training at hand. For change management, there are several tools available that provide training, create knowledge bases, track progress, etc. Implement a digital adoption platform, for example, to facilitate tool switching for users.

RESISTANCE TO CHANGE

People's unwillingness to adapt to change is referred to as resistance to change. Employees may express openly or covertly their resistance to organizational change. This opposition can take a variety of forms, from openly expressing their disapproval to unintentionally obstructing progress by small-scale acts, words, or general behavior.

Here are the five most frequent causes of employee resistance to organizational change, while there may be more.

1. Mistrust and lack of confidence
   Employee resistance to change can be a major roadblock if they do not believe in or trust the individual implementing it. One of the most underappreciated causes of internal change resistance in business organizations, in the opinion of author and change counselor Rick Maurer, is a lack of trust in change-makers.
2. Emotional responses
   It is challenging to alter the status quo, and some people could become upset by anything that disturbs their routine. This is a normal and expected reaction. Ignoring it won't do anything but increase the opposition. Additionally, change agents should follow up periodically to offer assistance, get more input, and encourage acceptance and adoption of the change.
3. Lack of training and help resources
   Employee resistance to change frequently arises from a lack of resources for onboarding, upskill training, and end-user support that make employees feel unprepared to adapt and adopt new processes and help them navigate the initial learning curve and friction points in a new process, team structure, or software implementation.
4. Fear of failure
   If people are unsure of their capacity to adjust to a change, they won't support it. People will oppose change when they feel threatened by their flaws (actual or perceived), in an effort to

avoid failure. The key to knowledge is efficient training. Giving people the resources that they require to manage transitions and support change is the goal. Consider technological change as an example. If your business is implementing a new software system, staff need to be aware of how to transfer existing data into it and how to make the most of the system going forward. Ability is more about confidence in oneself. People need to feel confident using their newfound information after training.

5. Poor change communication
   Creating an engaging dialogue is the secret to successful change management communication. Pushback and resistance to change are inevitable when you speak to people rather than at them. Create a plan for changing communication first. Before implementing a change, you should have a number of communication strategies planned, including the announcement of the change, individual meetings, small group discussions, and techniques for receiving feedback.
6. Unrealistic timelines
   Strike a balance between conveying a sense of urgency and giving yourself time to adjust. Avoid pressing for change too rapidly, because when you do, it's easy to develop tunnel vision and forget crucial components of your change plan. Make a schedule for implementing the change first. To get a basic notion of how long the full transition will take, plan out every step and set deadlines. You may frequently find additional steps required to ease the transition by designing the route between the present state and change's adoption. Clearly, you shouldn't be reluctant to change things. Make it happen if your team requires extra time to comprehend the change or would benefit from further change management training.
7. Existing organizational culture and norms
   When existing organizational norms and company culture are deeply ingrained, resistance to change frequently results,

making it difficult for people to accept new leadership styles, team structures, processes, or technological advancements.

Here are a few of the best strategies to overcome change resistance in your organization.

1. Show value through education and training
   Provide evidence that a new procedure, tool, or change will significantly benefit your staff to reduce resistance to change. Make it a priority to inform your staff on how the new change will immediately benefit their lives and day-to-day activities, and offer ongoing training to make sure they feel competent and at ease navigating the new shift.
2. Collect employee input prior to change
   Employees frequently oppose change because they feel their opinions are unimportant and won't have any bearing on the decision to modify the organization. Conduct polls with your staff to find out how they feel about the change and what they would do to make it simpler.
3. Come to an agreement with your employees
   Never make a choice without first consulting your staff, who are the people performing the work. Determine the timetable and general strategy for managing and implementing a new change after talking with your team.
4. Include employees in the change management plan
   When employees are involved in procedures, they feel valued and that their opinions matter. Make sure to involve important team members in the change management and implementation processes so they feel invested in the outcome.
5. Support your employees during organizational transformation
   Do not abandon your staff; provide them with resources, change management tools, knowledge bases, and training on the new procedure or tool you're putting in place. This will enable your staff to immediately see the value of a new system, which will help them develop trust in you.

6. Communicate clearly and frequently
   Keeping employees informed about status quo changes as soon as feasible promotes communication between management and staff.
7. Measure the performance of your organizational change
   Because it enables organizations to understand how the implementation affects overall business performance, measurement is a crucial component of the change process. If something doesn't go as expected, there is a chance to fix it or incorporate it in the next stage of implementing the change.

CHANGE AGENT IN NURSING

An individual who promotes and facilitates change within a team or organization is referred to as a change agent or an agent of change. An effective change agent fills a specialized position within a change program as a supporter of change and a link between leadership and the rest of the company. A strong change agent can reduce resistance to change. Problem-solving and addressing issues before they derail an endeavor is another duty of a change agent in order to ensure the effective implementation and adoption of a new change project. The change agent is responsible for performing the specific change management tasks listed below: describing the causes of the shift and those who will be impacted;

1. Advocating for the change initiative;
2. Disseminating information;
3. Highlighting the potential benefits and drawbacks of the proposed initiative;
4. Anticipating and evaluating areas of potential dispute or disruption;
5. Developing strategies to counteract any potential areas of dispute or disruption;
6. Obtaining feedback to share with leadership and conveying responses;

7. Serving as a point person to hear others' concerns, ideas and questions;
8. Advising stakeholders, as well as the individuals the change affects;
9. Mediating points of contention; and
10. Tracking and managing objectives of the project.

There are three main types of change agents:

11. People-centric.
    These change agents assist in increasing staff motivation and morale. They aid in goal-setting, training, and skill-upgrading, and they support staff during times of change.
12. Structure-centric.
    These agents concentrate on modifying the infrastructure of an organization. They conduct systems analysis, investigate new technologies, and put them into practice.
13. Process-centric.
    These change agents concentrate on putting new change processes into place and promoting teamwork and communication.

There are change recipient category:

1. Innovator
   An innovator is a person who introduces new innovations, ideas, or methods. An innovator usually has the main characteristic of being an individual who likes challenges and dares to take risks. They also have economic capabilities that can support them to become an innovator. There are only 2.5% of individuals who dare to become an innovator.
2. Early Adopters
   A pioneer is defined as someone who starts doing something. This pioneer will be willing to initiate innovation in a group. They are usually characterized as someone who is respected and has followers in a social environment. There are about 13.5% of people who fall into the early adopters' category.

3. Early Majority
   Early followers are those who together become early followers in an innovation. Someone who is an early follower is characterized by careful consideration before making a decision. There are about 34% of people in a social group who fall into the early majority.
4. Late Majority
   Final followers are those who collectively become the last followers in an innovation. The characteristic of these late followers is that they are a group that has pragmatic considerations of the truth and usefulness of an innovation that they want to adopt. The number of categories of people who belong to the late majority is around 34% in a social group.
5. Laggards
   Laggards or conservative groups are the last group that is most difficult to accept a new innovation. This group amounts to about 16% in a social group. They have the main characteristic of being very difficult to see and accept a change. There are about 16% in a social group.

To ensure success, leadership should choose a change agent based on qualities that are often seen as the most effective for positions like chief transformation officers. These qualities consist of the following:

1. Diversified knowledge;
2. Experience in the business discipline impacted by the change effort;
3. A willingness to ask tough questions;
4. Flexibility, creativity and an openness to new ideas;
5. A strong network;
6. Trustworthiness and credibility;
7. An understanding of the organization’s corporate culture;
8. Courage;
9. The ability to tell a company narrative;
10. Excitement for new opportunities and potential; and

11. Comfort working through uncertainty.
12. Important change agent skills. A change agent must have the following skills to be successful:
    a. The ability to prioritize
    b. Strong relationship building capabilities
    c. Effective communication skills
    d. Good people skills

SUMMARY

In the healthcare industry, change is constant. The process of changing or replacing current information, skills, attitudes, systems, policies, or processes is referred to as change. The results of change must be in line with the purpose, vision, and values of the company. Although change is a dynamic process that necessitates behavioral adjustments and may elicit opposition and conflict, it may also encourage constructive behaviors and attitudes that enhance organizational outcomes and worker performance. Problems that have been discovered or the adoption of fresh information, management techniques, or leadership styles can also lead to change. Many other sources, such as quality improvement programs, staff performance reviews, or accreditation survey findings, can be used to identify problems. When implementing change, nursing leaders may use one of several change theories. Lewin's Unfreeze-Change-Refreeze Model and Lippitt's Seven-Step Change Theory are two examples of conventional change theories.

REVIEW QUESTIONS

1. According to Kurt Lewis at this stage, what can be done for someone who wants to carry out the process of change to have a strong motivation to change from the original situation by changing the existing balance. The stages in question are?
    A. Moving stage
    B. Unfreezing stage
    C. Evaluation stage

D. Awareness stage
E. Freezing stage

2. In the theories of change, there is a theory that mentions seven things that a manager must pay attention to in a change, one of which is “Diagnosing the problem, which is identifying all factors that might support or hinder change”. the theory is expressed by?
   A. Redin
   B. Lewin
   C. Lippit
   D. Havelock
   E. Spradley
3. What is the type of change where an individual decides to improve their health status by attending a smoking cessation program or undertaking an exercise program?
   A. Spontaneous Change
   B. Unplanned Change
   C. Developmental Change
   D. Planned Change
   E. Transformational Change

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CHAPTER 7.

SYSTEM CONCEPT AND SYSTEM CONCEPT APPROACH

KEY TERMS

- System concept
- System concept approach

LEARNING OBJECTIVES

After completing learn this chapter:

1. Student can understand the definition of system concept
2. Student can understand the definition of approach system

INTRODUCTION

System theory is very important in the world of nursing, because in this system theory we can study a framework that deals with all aspects of human social, the structure of organizational problems, as well as changes in internal relationships and the surrounding environment. The success of the health care system that is interwoven in nurses, doctors or other health teams will be perfectly successful if there is an attitude of mutual support in carrying out nursing practice. This system will provide effective quality health services by looking at the values that exist in society. In health care, nursing is an important part of health care.

DEFINITION OF SYSTEM CONCEPT

The system comes from Latin (*systema*) and Greek (*sustema*) is a unit consisting of components or elements that are connected together to facilitate the flow of information, material or energy. The system is a network of interconnected procedures, gathered together, procedures that are interconnected, to carry out activities with specific

goals. The system is a framework that deals with all human social aspects, structures, organizational problems, and changes in internal relationships and the environment around them. The system consists of goals, processes and content. A goal is something that must be implemented so that the goal can provide direction to the system. The process functions in fulfilling the goals to be achieved, and the content consists of parts that make up a system. In studying the system, you must first understand the theory of the system. Because the theory of the system will make it easier to solve problems that exist in the system. The system consists of subsystems that form a system that must influence each other.

The system is a component in which there are interconnected subsystems to achieve a clear goal. In nursing, system theory is a unity that must be learned by a nurse so that it can be applied in the process of health services to the community. In the system there are several subsystems that support each other. In this case the nurse must know what complaints or problems the patient is experiencing in community life, here a nurse must know how to study the problems that arise in people's lives because everyone's perception in responding to a problem that occurs is different. The process of action that nurses will take to change the input that has emerged in people's lives, nurses must change the way people think about the various inputs that arise. After providing health services, nurses see and understand how community members receive health services and the impact or consequences that arise in the community on the health services provided. Patients will provide feedback on health services provided by nurses, and patients will ask or criticize about a problem they face. It should be noted that if a system has lost one component, then the system will not run properly. A system will run well if it is done gradually and remains based on goals.

System types are (Bertalanffy, 1968; Hutahaean, 2015; Sutabri, 2012):

1. Open system
   A system characterized by the degree to which it interacts with its surroundings. An open system is contained within an environment with which it interacts, the open system takes in input and the system provides output to the environment. Environmental interaction is essential for the survival of the system. Based on this definition, a living system is an open system.
2. Closed system
   Theoretically, a closed system is different from an open system, it does not interact with the environment. Since it is survival, this system does not depend on continuous environmental exchange. Since no pure closed system has yet been demonstrated in reality, closedness implies a lack of energy exchange across the boundaries of a system.

According to Sutabri (2012), system characteristics include:

1. System components
   The system consists of components that make a unity, work to achieve a goal. These components are also known as subsystems. Each subsystem has different functions.
2. System boundary
   Every system must have a boundary that separates between one system and another. This boundary also separates system with the outside environment
3. External environment
   The external environment also affects the performance of a system. A good environment can be favorable for the system and unfavorable environment must be controlled.
4. System liaison (interface)
   Liaison is a medium that connects the system with subsystems. The liaison functions are to channel resources from a subsystem to other subsystems which later can occur as a system integration.

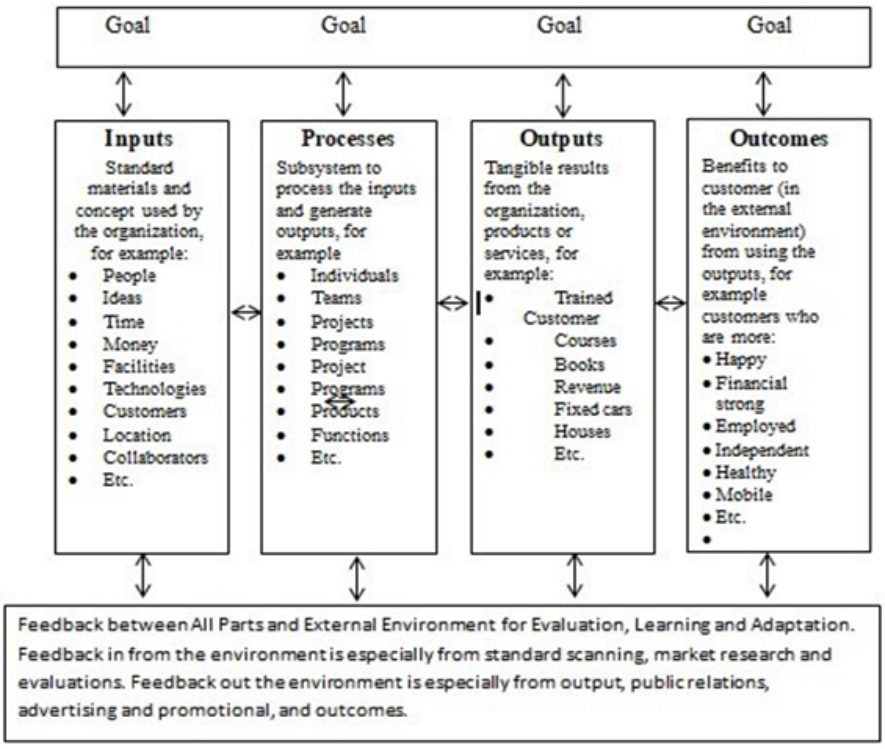
5. System input
   System input is energy that is put into the system which can be in the form of maintenance and signal input.
6. System output
   The result of energy that is processed into useful results or outputs. This output can be another subsystem input.
7. System process
   A system has a process that converts input into output.
8. System objective
   A system must have goals and objectives. If a system does not have goals or objectives then the system is useless. The system is said to be successful if the system can achieve its goals

System element include (Bertalanffy, 1968):

1. Objective
   Every system is equipped with a goal even if there is only one or even more. Undoubtedly, each system has different goals. Purpose is one of the system elements that acts as a motivator to direct the system. Without its existence, the system will not be well directed so that it is uncontrollable.
2. Input
   Input is everything that enters the system and will be used as material for processing to the next stage. Input can be in the form of tangible and physically visible things such as raw materials and in the form of something that cannot be seen by the eye such as service request information from customers.
3. Process
   Process is the most important part involved in the transformation or change of inputs into more valuable and useful outputs, such as products and information. However, it can also take the form of something useless such as waste or waste disposal that cannot be reused. The process varies depending on the input. In a drug manufacturing plant, the process involves processing

raw materials into medicine. Another process in a hospital could be the surgery of a patient.

4. Output
   Output is the result obtained from processing. The form of output varies depending on the input given. For example, in information systems, the output being produced is information, printed reports, suggestions, etc.
5. Boundaries
   The boundary becomes a separator between the system and the environment or area outside the system. The boundary determines the scope, configuration and capabilities of the system.
6. Control mechanism and feedback
   The form of the control mechanism is feedback. Feedback is used in controlling inputs and processes. This is intended to manage the system so that it can run according to the goals to be achieved.
7. Environment
   The environment as one of the system elements includes everything outside the system. The environment affects the operation of the system. That is, it can be detrimental or on the contrary it provides many benefits. If the environment is detrimental then it must be controlled and restrained so that it will not interfere with the operation of the system. However, if it is beneficial then it must be maintained properly because it is a driver of the survival of a system.



Scheme 1: General System Theory
(Bertalanffy, 1968)

The system characteristics are as follows:

1. System components
   The system consists of several components that interact and work together to form a single unit. These components are in the form of subsystems or parts of the system.
2. System boundaries
   System boundaries are areas that become boundaries between one system and another or boundaries with the outside environment. The existence of this limitation makes the system seen as a unit and shows the scope of the system.

3. Outer environment of the system
   Everything that is outside the system boundaries that affects system operations. The external environment of the system has two characteristics, namely there are systems that are beneficial and detrimental. A favorable environment must be maintained and maintained, for example, is the energy of the system. Conversely, if the environment is detrimental then you must control and restrain it so that life in the system is not disturbed.
4. System connectors
   A medium that connects one subsystem with another. The existence of this connector allows resources to flow from one subsystem to a different subsystem. The output of a subsystem will turn into input for another subsystem with the help of a connector. Thus, one subsystem can integrate with other subsystems. As a result, a unity is created.
5. Systems inputs
   System inputs are energy that flows into the system. Input can be in the form of maintenance input, which is the energy entered so that the system can be operated. In addition, it is also in the form of signal input in the form of energy that is processed to produce output.
6. Systems output
   System outputs are the result of energy processing so that they can be classified into useful outputs. Outputs can be input for different subsystems.
7. Systems processing
   The system acts as a processing part that will turn inputs into outputs. Raw materials will be processed by the production system to produce finished materials that are ready for use.
8. Systems goal
   In the system, there must be goals that make system operations more useful. Both the system and the target greatly affect the

input required by the system and the results of the system. The system is considered successful if it is able to work on target.

DEFINITION OF APPROACH SYSTEM

Defining a systems approach is challenging. The approach has origins in a variety of disciplines, which have both diverged and converged over the past century. These range from mathematics to social science, and span both the physical and biological sciences.

Our working definition of a systems approach, which has been informed by Clarkson *et al*, is as follows “A systems approach to healthcare improvement is a way of addressing health delivery challenges that recognizes the multiplicity of elements interacting to impact an outcome of interest and implements processes or tools in a holistic way”

This view of a systems approach integrates perspectives on people, systems, design and risk in a way that is applicable to healthcare systems across all scales from local service systems through to organizational, cross-organizational and national policy levels.

A systems approach improves health by considering the multiple elements involved in caring for patients and the multiple factors influencing health. By understanding how these elements operate independently, as well as how they depend on one another, a systems approach can help with the design and integration of people, processes, policies, and organizations to promote better health at lower cost. These approaches can be useful for all levels of the health system patient-clinician interaction, health care unit, organization, community, and nation with different tools available for the needs at different levels and across levels. These tools include production system methods and other management systems to help organizations continuously improve their operations and identify problems; queuing theory and operations management to ensure that resources are available when patients need them; and human-factors engineering to spot safety, quality, and reliability challenges

by understanding how humans interact with technologies and processes. Spreading these systems principles more broadly will require specific technological supports, such as more advanced data systems and interoperable devices; supportive culture and leadership; engagement of patients, families, clinicians, and the broader public in these methods; and new incentive structures.

The basic approach in the system is divided into two, that is the approach to the design of the system analysis and approach to the synthesis system. The approach to analysis is an approach designed to modify the characteristics of a standard that exists in the system. The approach to synthesis is an approach designed to define the system directly from its specification. System approaches are also performed performance measurements that are judged by three aspects:

1. Efficiency is an internal process of the system that shows the amount of material it takes to create an external system or output
2. The effectiveness of the process of determine the success of a system to acquiring the process that become the destination of involving internal and external components.
3. The productivity is a function of effectiveness and efficiency that contributes to comparing output and input from the system

In the modern world, the patients that nurses care for are extremely complex. Today's patients typically have multiple issues going on at once. We are exposed to a wide range of systems as nurses. Healthcare systems, body systems, family systems, and even environmental systems may spring to mind. Any system has one thing in common: they all interact with one another. Systems theory is a non-nursing theory that a nurse can use in any circumstance. The environment has a significant impact on how each system reacts to various stimuli, according to system theory, which views a collection of components as a cohesive whole (Cordon, 2013).

Nursing system theory is one of the ancient parts of the development of nursing science and the development of the nursing

profession, which is expected to be able to provide reality faced in nursing services and for the knowledge and understanding of nursing action can continue to grow and develop. A change and health care system that exists in the community is very important and influential in their lives.

It is very important and influential in their lives, especially if a nurse succeeds in implementing good health practices in the community. Because it will make it easier for a nurse in completing the task as a nurse, and later in health services in the hospital, a nurse will feel proud to be a nurse, whatever the type and will feel that one has done his/her job professionally because it can provide the best service. These are nursing system theories (explanation of each theory that can be seen in chapter 4 about nursing theory):

1. General system theory (Bertanlaffy, 1986)
2. Betty Neuman system model
3. Selfcare theory (Dorothea E. Orem)
4. Unitary Human Being (Martha E. Rogers)
5. Conceptual system (Imogene M. King)
6. Adaptation model (Sister Calista Roy)
7. Behavioral system model (Dorothy E. Johnson)

SUMMARY

The system is a component in which there are subsystems that are interconnected to achieve a clear goal. In nursing, system theoryis a unity that must be learned by a nurse so that it can be applied in the process of health care to the community. In the system there are several subsystems thatsupport each other. In this case the nurse must know what complaints or problems the patient is experiencing in community life, here a nurse must know how to study the problems that arise in community life because studying the problems that arise in people's lives is essential and everyone's perception in responding to a problem that occurs is different. The action process that will be carried out is to change the input that has emerged in people's lives, nurses must change the way people think about various problems

that occur in society. must change the way people think about the various inputs that arise. After providing health services, nurses see and understand how community members receive health services and the impact or what consequences arise in the community on the health services provided. A system is to achieve a goal or achieve an objective. (objectives). Goals cover a broad scope, while objectives cover a narrow scope. scope. If a system does not have goals, then the system operation will be pointless. The goals of the system really determine the input needed by the system and the output that the system will produce.

REVIEW QUESTIONS

1. What is the theory underlying systems in nursing?
   A. General system theory
   B. Betty Neuman system model
   C. Adaptation model
   D. Behavioral system model
   E. Conceptual system
2. Patients are one of the components in nursing care services. What component of the system does the patient belong to?
   A. Objective
   B. Input
   C. Process
   D. Feedback
   E. Environment
3. One type of system shows interaction with the environment. What is this type of system?
   A. Open system
   B. Close system
   C. Borderline system
   D. Feedback system
   E. System theory

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