Australia & New Zealand
2nd Edition

DeLaune
Ladner
McTier
Tollefson
Lawrence

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fundamentals of nursing

Australia & New Zealand..

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Guide to the text

As you read this text you will find a number of features in every chapter to enhance your study of nursing and help you understand how the theory is applied in the real world.

CHAPTER OPENING FEATURES

Learning outcomes give you a clear sense of what topics each chapter will cover and what you should be able to do after reading the chapter.

The **Clinical Skills box** identifies relevant clinical skills covered in the Clinical Psychomotor Skills textbook, sold separately.

LEARNING OUTCOMES

1 Discuss the purposes of assessing a person throughout their health care.
2 Describe the preparation of the person required for performing a physical examination.
3 Discuss the adaptation of skills to physically assess a person who is morbidly obese.
4 Explain the techniques used in conducting a physical examination.
5 Describe common invasive and non-invasive diagnostic procedures and laboratory studies and discuss the relevant care of the person before, during and after diagnostic testing, including teaching guidelines.
6 Describe the physical examination and the significance of assessment findings obtained from a physical examination of each of the following areas: head and neck, thorax and lungs, heart and vascular system, breasts and axillae, abdomen, musculoskeletal, neurological, reproductive, rectum and anus.
7 Outline the care of the person following their physical examination.
8 Discuss the documentation of data obtained from a physical examination.

CS CLINICAL SKILLS

The following procedures are to be found in CPS7:

- 15 Mental status assessment
- 16 Focused cardiovascular health history and physical assessment
- 18 Focused respiratory health history and physical assessment
- 19 Focused neurological health history and physical assessment
- 21 Focused gastrointestinal health history and abdominal physical assessment
- 24 Focused musculoskeletal health history and physical assessment and range of motion exercises

FEATURES WITHIN CHAPTERS

Learn about the importance of evidence and clinical research in nursing with the **Evidence-Based Practice** boxes which link research to nursing practice.

EVIDENCE-BASED PRACTICE

Title of study
Patterns of intimate partner violence victimization among Australia and New Zealand female university students: An initial examination of child maltreatment and self-reported depressive symptoms across profiles

Authors
J. Cale, S. Tzoumakis, B. Leclerc and J. Breckenridge

Abstract
The aim of this study was to examine the relationship between child abuse, depression, and patterns of intimate partner violence victimisation among female university students in Australia and New Zealand. Data were based

Intimate Partner Violence profiles were identified that differed according to the variety, degree, and severity of Intimate Partner Violence. Furthermore, the combination of child maltreatment and self-reported depressive symptoms differed across profiles. The results highlighted differential pathways from child maltreatment to specific Intimate Partner Violence victimisation patterns. These findings provide further evidence for the importance of early intervention strategies to prevent Intimate Partner Violence, and specifically for children who experience abuse and neglect to help prevent subsequent victimisation experiences in intimate relationship contexts.

Identify important client health and safety issues and the appropriate response to critical situations with the **Safety First** boxes.

SAFETY FIRST

ASSESSMENT FOR ALLERGIES
It is essential that you explore possible allergies prior to administering any medications. Always ask if the person is allergic to the medication. Allergic reactions can be life-threatening and can occur even with very low dosages of medications or if the medication has been safely taken previously.

Consider approaches to respectful care for clients from diverse backgrounds with the **Respecting our Differences** boxes.

RESPECTING OUR DIFFERENCES

Experience of dialysis for people with Greek backgrounds
A study by Tranter (2016) used a descriptive qualitative methodology to explore the factors that inform decisions of people from Greek backgrounds regarding dialysis and to identify the enablers and barriers to choosing home dialysis for this group. An audit of dialysis patients in the renal service revealed that 20 per cent of hospital-based patients

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FEATURES WITHIN CHAPTERS

Learn key information and issues in nursing with the **Nursing Highlights** boxes.

NURSING HIGHLIGHTS

DETERMINING EVIDENCE-BASED NURSING PRACTICE

A nurse working on an intensive care unit notices that *Clostridium difficile* infection has become prevalent among surgical patients in the hospital and is interested in finding out if there is a reliable screening tool to assess the risk of infection so that preventative measures can be taken.

1. **Step 1**. Review and critique research reports related to the use of screening tools for risk of infection in surgical patients.
2. **Step 2**. Based on the critique of the literature on the results of the use of screening tools in identifying at risk of surgical infections and associated

Review and revise useful lists of important concepts in nursing, client teaching and the nursing process with the **Nursing Checklist** boxes.

NURSING CHECKLIST

Steps in the research process

- Formulating a research question or problem
- Defining the purpose of the study
- Reviewing relevant literature
- Developing a **conceptual framework** (structure that links global concepts together to form a unified whole)
- Developing research objectives, questions and hypotheses
- Defining research variables
- Selecting a **research design** (overall plan used to conduct the research)
- Defining the population, sample and setting
- Conducting a pilot study

Follow an individual person's case and the process of planning care, identifying problems, performing interventions and evaluating outcomes for that person with the detailed **Nursing Care Plans** and associated visual **Nursing Concept Maps**.

NURSING CARE PLAN

PERSON AT RISK FOR INJURY

Case presentation

Mr Simon, aged 75, is admitted to the hospital with coronary heart disease (CHD). He has a family history of CHD. He smokes two packs of cigarettes a day, has diabetes mellitus, and is obese.

Assessment

- Weight gain of 3 kg in past month
- Blood cholesterol 320 mg/dL
- High-density lipoproteins (HDL) 28 mg/dL
- Blood pressure 186/116 mmHg
- Diminished visual acuity
- Decreased bladder tone
- Weakness and syncope
- Glasgow Coma Scale (GCS) score of 12

Problem identification: *Risk for injury* related to sensory dysfunction, weakness, and altered level of consciousness.
Goal: Mr Simon will not be injured during the hospitalisation.
Intervention: Assess for risk of falls and use fall-prevention strategies.

Expected outcome

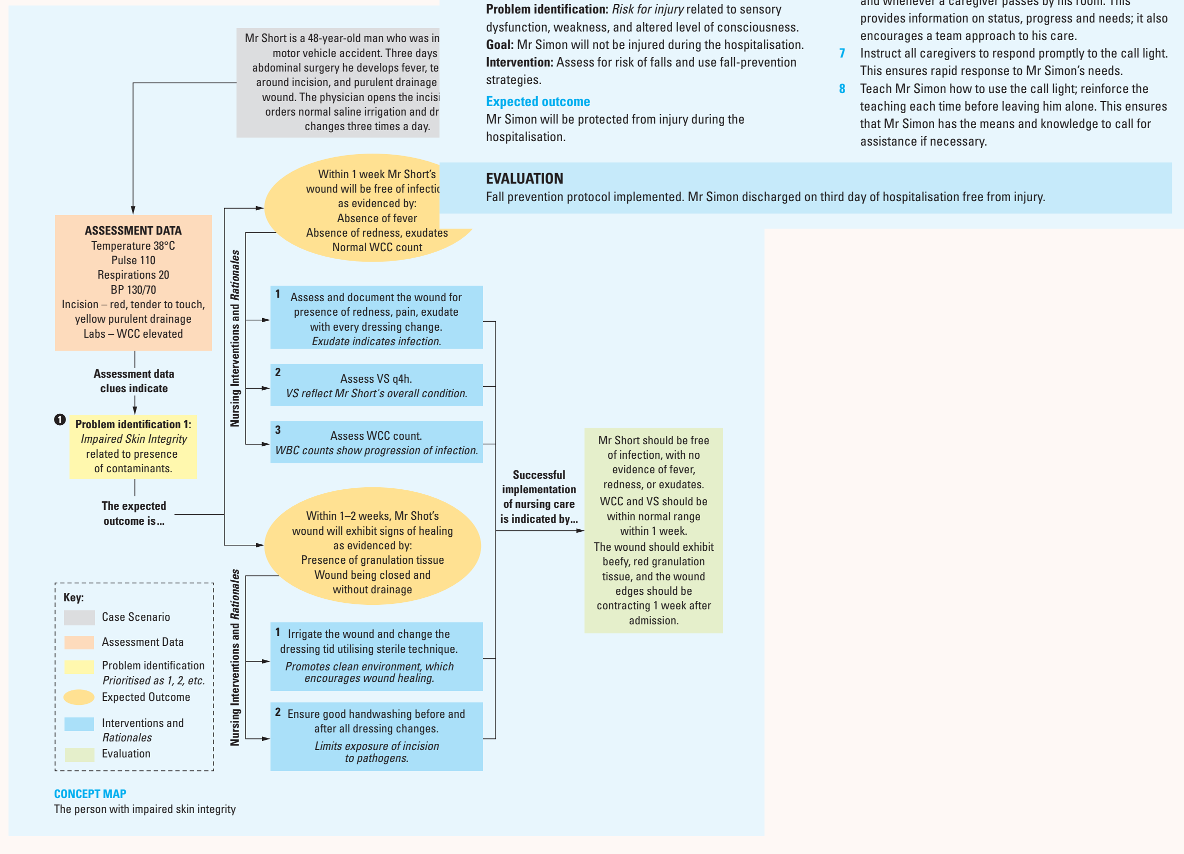
Mr Simon will be protected from injury during the hospitalisation.

Interventions/rationales

1. Initiate the fall prevention protocol. This identifies and reduces risk for injury.
2. Reassess Mr Simon's injury status every four hours. This identifies changes and highlights the need to modify plan of care.
3. Place Mr Simon in a room as close as possible to the nurses' station. This facilitates faster response time to his needs.
4. Place fall alert signs on Mr Simon's door and the head of his bed. The signs alert other health care workers to the risk status.
5. Turn on the bed alarm. This helps monitor Mr Simon's status and facilitates a prompt response if he tries to get out of bed unassisted.
6. Monitor Mr Simon and the environment every two hours, and whenever a caregiver passes by his room. This provides information on status, progress and needs; it also encourages a team approach to his care.
7. Instruct all caregivers to respond promptly to the call light. This ensures rapid response to Mr Simon's needs.
8. Teach Mr Simon how to use the call light; reinforce the teaching each time before leaving him alone. This ensures that Mr Simon has the means and knowledge to call for assistance if necessary.

EVALUATION

Fall prevention protocol implemented. Mr Simon discharged on third day of hospitalisation free from injury.



CONCEPT MAP
The person with impaired skin integrity

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ICONS

Link theory to key clinical skills with the **Clinical Skills icon** throughout the chapters. These CPS icons direct you to corresponding clinical skills in more detail in Clinical Psychomotor Skills 7th edition textbook by Joanne Tollefson and Elspeth Hillman.

See CPS7, Clinical Skill 78: Caring for a person who is unconscious

END OF CHAPTER FEATURES

At the end of each chapter you'll find several tools to help you to review, practise and extend your knowledge of the key learning outcomes.

- The **Summary** section highlights the important concepts covered in the chapter and links back to the learning outcomes.

SUMMARY

- Nursing is an art and a science in which people are assisted in learning to care for themselves whenever possible and cared for when they are unable to meet their own needs. The professionalisation of nursing has been influenced by key issues such as: the status of women, the development of the biomedical model, employment opportunities, class structures and religion. New Zealand was the first nation to register nurses.
- As the nursing profession continues to evolve and respond to the challenges within the health care system, nurses will
- The complexity of theoretical frameworks are categorised as grand-theory, middle-range theory, and micro-range theory. Grand theories, or conceptual models, focus on phenomenon of concern to the discipline. Middle-range theories provide a bridge from grand theories to effectively describe and explain specific nursing phenomenon. Micro-range theories view phenomena in the everyday practice of nurse–patient interactions.
- The work of early nursing theories focused on the traditional tasks of nursing. Challenged to create synergy between the

- **Review questions** give you the opportunity to test your knowledge and consolidate your learning. Answers to review questions can be found at the back of the book.

REVIEW QUESTIONS

1 Since the formalisation of nursing, notably with Florence Nightingale, sociopolitical influences on the role of nursing have included (select all that apply):
   a the cost of living for sick people.
   b the role of women in society.
   c technological advances improving health outcomes.
   d access to clean water, hygiene and employment.
   e registration and professionalisation of nurses.
2 In the 19th century, the Anglican High Church nuns:
   a began training nurses at St Thomas' Hospital.

   c providers, standards, models and patients.
   d the person, environment, health and nursing.
   e theory, health, environment, person.
6 A micro-range theory:
   a is composed of concepts representing global and complex phenomena.
   b is the most concrete and narrow of theories that establishes nursing care guidelines.
   c describes, explains and predicts complex situations and directs interventions.

- **Spotlight on Critical Thinking** questions challenge you to reflect on and discuss complex issues in relation to nursing.

SPOTLIGHT ON CRITICAL THINKING

It has been argued that nursing history has been presented from a feminist perspective.
1 How could this have impacted the role of men in the nursing and midwifery profession?
2 Explain how this could imply that 'caring' is a female trait?
3 Explain why you think nursing history, until recently, has excluded groups of nurses from its history.

Nursing history is reflecting a more comprehensive under-

6 Many nurses state 'they want to help people' as a reason for entering the nursing profession. Explain how nurses might 'help' people who are unwell using one nursing theorist from the following:
   - Grand nursing theory
   - Middle-range theory
   - Micro-range theory

Consider the theories discussed in this chapter.

7 State why a particular theory might appeal to you. What

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Guide to the online resources

FOR THE INSTRUCTOR

Cengage is pleased to provide you with a selection of resources that will help you to prepare your lectures and assessments, when you choose this textbook for your course.
Log in or request an account to access instructor resources at cengage.com.au/instructors for Australia or cengage.co.nz/instructors for New Zealand.

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INSTRUCTOR'S MANUAL

The Instructor's Manual includes:

- instructional strategies
- resource aids
- evaluation strategies
- links to useful online resources
- solutions to end of chapter review and spotlight on critical thinking questions.

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PREFACE

We are very excited to share this second edition of *Australian and New Zealand Fundamentals of Nursing* with you! We hope this text will encourage you to develop an inquiring stance based on the joy of discovery and a love of learning.

Nursing is facing new challenges in delivering quality care to vulnerable peoples in a variety of settings. These settings are rapidly expanding and challenge all nurses to think creatively in applying best practices based on current research. This edition presents the most current advances in nursing care, nursing education and research relative to the demands of delivering care across a continuum of settings. Multiple theories of nursing are embraced, and nursing's elements of theory metaparadigm – human beings, environment, health and nursing – are threaded throughout this text. The organisation of units and chapters is sequential; however, every effort has been made to allow for the varying needs of diverse curricula and students. Each chapter may be used independently of the others according to the specific curriculum design.

This comprehensive edition addresses fundamental concepts to help prepare novice graduate nurses to apply an understanding of human behaviour to issues encountered in clinical settings. Physiological and psychosocial responses of both an individual and their nurse are addressed in a holistic manner. Integrative modalities are presented in an environment that encourages the individual to participate in determining their own care.

Skills and procedures have been relegated to another text: J. Tollefson and E. Hillman's *Clinical Psychomotor Skills: Assessment Tools for Nursing Students* (seventh edition), published by Cengage in 2018. This was done to decrease the size of this textbook and permit more discussion of the individual skills. Using contemporary clinical information based on sound theoretical concepts, and scientific evidence, the skills in the latest edition of Tollefson and Hillman both supplement and complement the material in this text. Therapeutic nursing interventions reflect the current Registered Nurse Standards of Practice (2016) and emphasise safety, communication skills, clinical reasoning and interdisciplinary collaboration in delivering nursing care. You will be referred to the appropriate procedure within the text.

CONCEPTUAL APPROACH

This edition presents in-depth material in a clear, concise manner using language that is easy to read, by linking related concepts. Nursing knowledge is formulated on the basic concepts of scientific and discipline-specific theory, health and health promotion, the environment, holism, health care teaching, spirituality, research and evidence-based practice, and the continuum of care. Emphasis is placed on cultural diversity, care of the older adult, and ethical and legal principles.

The nursing process provides a consistent approach for presenting information. Assessment tools specific to selected topics are presented to assist you with pertinent data collection. Critical thinking and reflective reasoning skills are integrated throughout the text. The safe and appropriate use of technology has been incorporated throughout the text to reflect contemporary nursing practice.

The conceptual approach used as an organisational framework for this Australian and New Zealand edition falls into four categories:

1 **Individuals** are viewed as holistic beings with multiple needs and strengths, and the abilities to meet those needs. Holism implies that individuals are treated as whole entities rather than fragmented parts or problems. Each person is a complex entity who is influenced by cultural values, including spiritual beliefs and practices. Every person has the right to be treated with dignity and respect regardless of race, ethnicity, age, religion, socioeconomic status or health status. Traditional terms for people who are being treated for their health care such as 'patient' or 'client' are avoided as these terms do not reflect the conceptual value of the individual.
2 **Environment** is a complex interrelationship of internal and external variables. Internal variables include one's self-concept, self-efficacy, cognitive development and psychological traits. The external environment affects an individual's health status by facilitating or hindering the person's achievement of needs.
3 **Health** is viewed as a dynamic force that occurs on a continuum ranging from wellness to death. An individual's actions and choices effect changes in their health status. Individuals who are experiencing illness have strengths that may

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improve their health status. On the other hand, individuals who are experiencing a high degree of health generally have areas that can be improved.

4 **Nursing** is an active, interpersonal, professional practice that seeks to improve the health status of individuals. Nursing's focus is person-centred and communicates a caring intent. Caring and compassion are demonstrated through nursing interventions. Nursing is a professional practice based on scientific knowledge and is delivered in an artful manner.

Other important conceptual threads used to direct the development of this book include the following:

- **Health promotion** encourages individuals to engage in behaviours and lifestyles that facilitate wellness.
- **Standards of practice** are discussed, with information from national and specialty organisations (both from Australia and New Zealand) incorporated into each chapter as appropriate.
- **Critical thinking** is an essential skill for blending science with the art of nursing.
- **Evidence-based practice** derived from scientific research is emphasised across chapters.
- **Cultural diversity** is defined as individual differences among people resulting from racial, ethnic, religious and cultural variables.
- **Continuum of care** is viewed as a process for providing health care services in order to ensure consistent care across practice settings.
- **Community**, as both an aggregate focus for health care and as the setting for the delivery of care, is evidenced in Chapter 16 and is threaded throughout the text.
- **Holism** recognises the body–mind connection and views the person as a whole rather than as fragmented parts.
- **Spirituality** encompasses the relationship with oneself, a sense of connection with others, and a relationship with a higher power or divine source. It is discussed in depth in Chapter 27.
- **Caring**, a universal value that directs nursing practice, is incorporated throughout the text, and is described in depth in Chapter 13.
- **Alternative and complementary modalities** are treatment approaches that can be used in conjunction with conventional medical therapies. Chapter 34 is dedicated to this integrative approach, and related information featuring integrative concepts is included throughout the text.

ORGANISATION

This textbook provides you with a bridge that presents theory to support clinical practice. The intent of the authors is to help you become a proficient critical thinker who is able to use the nursing process with diverse individuals in a variety of settings. Research-based knowledge that reflects contemporary practice is presented in a reader-friendly, practical manner.

Features that challenge you to use critical-thinking skills are incorporated into each chapter, and critical-thinking questions appear at the end of each chapter. Critical information is highlighted throughout the text in a format that is easily accessed and understood. Similar concepts have been grouped together to encourage you to learn through association; this method of presentation also prevents the duplication of content.

Australian and New Zealand Fundamentals of Nursing presents 43 chapters organised in six units:

- **Unit 1: Nursing's perspectives: past, present and future** provides a comprehensive discussion of nursing's evolution as a profession and its contributions to health care based on standards of practice. The theoretical frameworks for guiding professional practice and the significance of incorporating research into nursing practice are emphasised. Chapters are reflective of the parallel evolution of nursing and nursing education. Examples are provided showing the incorporation of theory into the nursing process. The concept of evidence-based practice is emphasised along with research utilisation. Quality is discussed from the perspective of health care delivery and the continuum of care.
- **Unit 2: Nursing process: the standard of care** discusses recognised competencies and standards of care established by Australian and New Zealand nursing registration bodies, the Australian Nursing and Midwifery Federation, and nursing specialty organisations. Each stage of the nursing process is discussed, with an emphasis on critical thinking.
- **Unit 3: Professional accountability** describes the nurse's responsibilities to the individual in their care, the community and the profession. Nursing leadership is discussed in Chapter 10. Chapter 11 combines legal and ethical aspects of nursing practice to reflect the interfacing of these concepts. An in-depth discussion of informatics appears in Chapter 12, which focuses on documentation.
- **Unit 4: Promoting health** was created to integrate information on health promotion, consumer demand and facilitating empowerment for the person seeking health care. Chapter 13 provides nursing theoretical perspectives on caring. Chapter 15 emphasises the nurse's role in empowering the person seeking health

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care to assume more personal accountability for their own health-related behaviours. Chapter 16 addresses the health needs of families and communities.
- **Unit 5: Responding to basic psychosocial needs** stresses the importance of the holistic nature of nursing. Spirituality is spotlighted in order to emphasise its impact on individuals' health.
- **Unit 6: Responding to basic physiological needs** discusses aspects of nursing care that are common to every area of nursing practice. Concepts such as safety and infection control, medication administration, assessment of the person, their comfort, mobility, fluid and electrolyte balance, oxygenation, skin integrity, nutrition and elimination are all described within the nursing process framework.

NEW TO THE SECOND AUSTRALIAN AND NEW ZEALAND EDITION

All the material has been settled into an Australian and New Zealand context, using culturally appropriate and relevant examples, Australian and New Zealand government and non-government organisation information, research, legal and ethical material and laws, evidence-based practice information, and ratified nursing standards. All chapters have been extensively rewritten to reflect contemporary Australian and New Zealand nursing practice.

Contributions for specific chapters were sought from Australian and New Zealand nurses who are expert in their fields.

Some chapters were condensed, and some expanded. Specifically, the pre-existing chapters on nursing theory and nursing education were folded into Chapter 1, and the life cycle material is now presented over Chapters 17 and 18, giving more prominence to the topic of nursing children.

Additional chapters were written:

- Chapter 20: Palliative care, presents material to help you understand and assist the person who is nearing the end of their life.
- Chapter 21: Cultural diversity, although not new, has been extensively adapted to reflect the contemporary societies of Australia and New Zealand.
- Chapter 22: Aboriginal and Torres Strait Islander health, addresses the problems and solutions that are specific to Indigenous Australians.
- Chapter 23: Rural and remote health, looks at the unique circumstances that face people who live in the regional, rural and remote areas of Australia.
- Chapter 29: Mental health, presents some of the issues that beginning nurses can expect to encounter in their practice.

Additional features include the following:

- At the end of every chapter, a set of 'Review questions' is presented. For this second edition, the rigour of the Review questions have been increased. The answers and rationales are located in the Instructor's Manual.
- 'Spotlight on critical thinking' at the end of the chapter focuses attention on issues relating to the caring, compassion, legal, ethical and professional components of nursing practice.
- 'Safety first' identifies critical health and safety situations and highlights strategies for the appropriate nursing response and management.
- 'Evidence-based practice' emphasises the importance of clinical research by linking theory to practice. We have added an additional Evidence-based practice box to most chapters in this second edition.
- 'Respecting our differences' challenges you to consider approaches to respectful and appropriate care for populations of people who may differ in a variety of ways, including culture, gender, age and developmental level.
- 'Nursing highlights' provide key information on nursing practice.
- 'Nursing checklists' are provided to assist you with the revision of information.

EXTENSIVE TEACHING/LEARNING PACKAGE

The complete supplements package was developed to achieve two goals:

1. to assist you in learning the essential skills and competencies needed to secure a career in nursing
2. to assist your instructors in planning and implementing their programs for the most efficient use of time and other resources.

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LANGUAGE AND TERMINOLOGY

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

This textbook has a full chapter on health issues pertaining to Aboriginal and Torres Strait Islander peoples, as well as integrated material throughout the book relating to issues, events, policies and groups. We have sought to use inclusive, appropriate and non-discriminatory terminology throughout, and for this purpose we have followed the published guidelines provided by NSW Health in *Communicating Positively: A Guide to Appropriate Aboriginal Terminology*.

CULTURAL SAFETY IN NEW ZEALAND

New Zealand has a bicultural society by legislation. This diversity creates a vibrant, rich background to daily living. Issues may arise when people of a different culture, ethnicity or religion interact and do not understand each other. These misunderstandings can result in insult, feelings of isolation and inequality of service. Culturally unsafe practices are those that 'diminish, demean or disempower the cultural identity and well-being of an individual' (NCNZ, 2012, p. 9). This definition is supported by laws on antidiscrimination that are made at the national level in New Zealand. In Australia legislation exists at Commonwealth, state and territory levels, which make it an offence to discriminate against a person because of their race, ethnicity, culture or religion.

NURSING DIAGNOSIS

Fry (1953) first used the term 'nursing diagnosis', but it was not until 1974, after the first meeting of the North American Nursing Diagnosis Association (NANDA), that nursing diagnosis was added as a separate and distinct step in the nursing process. Prior to this, nursing diagnosis had been included as a natural conclusion to the first step in the nursing process – assessment.

While the notion of nursing diagnosis is imperative for the Australian and New Zealand nursing context, the specific language used by NANDA and the term 'nursing diagnosis' are not widely used in clinical practice. In the Australian and New Zealand setting, the term 'nursing diagnosis' is routinely replaced with 'problem identification', the term we have chosen to use in this text. The exact language used to name the problem is not as important as ensuring that all problems are identified in a systematic way.

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Joanne Lawrence works in private practice as a neurological continence and wound clinical consultant. Originally hospital-trained, she has since completed a Bachelor of Applied Science (Nursing) from the University of Sydney, a Master of Arts (Research) from Macquarie University and a PhD (Medicine) from the University of Sydney. Joanne's PhD explored the neurological presentation of bowel and bladder dysfunctions experienced by people with Parkinson's disease. In 2012, Joanne was recognised by the Australian Rehabilitation Nurses Association with an award for Excellence in Clinical Nursing Research. Joanne has worked as a registered nurse since 1981, with most of her clinical experience focusing on people who have either an acquired or congenital neurological condition.

Joanne has an extensive educational track record working in large private health care organisations and tertiary settings, where she taught undergraduate and postgraduate students of nursing. Joanne holds a strong interest in health assessment and evidence-based clinical practice. Her research interests include: the transition of research into clinical practice, the provision of health care to vulnerable groups of people, and neurological bowel and bladder dysfunction. She is a Fellow of the Australian College of Nursing and the President of the NSW and ACT Chapter of Continence Nurse Society Australia.

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Sue is a member of Sigma Theta Tau, the National League for Nursing, and the American Nurses Association. She has been recognised as one of the 'Great 100 Nurses' by the New Orleans District Nurses Association. Sue is a prolific author, having written several professional journal articles and textbook chapters in the areas of nursing education and mental health nursing.

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UNIT 01

NURSING PERSPECTIVES: PAST, PRESENT AND FUTURE

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CHAPTER 01

EVOLUTION OF NURSING EDUCATION AND THEORY

LEARNING OUTCOMES

1. Explore the evolution of nursing, identify the major historical events leading to current nursing education, and describe the impact of 19th- and 20th-century nursing leadership on current nursing practice in Australia and New Zealand.
2. Describe the trends in nursing education specifically relating to the issues of competency development and delivery of care.
3. Define the terms 'theory', 'concept' and 'proposition'.
4. Describe the three scopes of theory: grand theories, middle-range theories and micro-range theories, and discuss knowledge development in nursing.
5. Identify and interpret major nursing theories in relation to practice.

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INTRODUCTION

This chapter will incorporate an historical overview of both the foundation of modern nursing and nursing education in the 19th, 20th and 21st centuries. It will also explore the development of nursing theory and how these theories support and define nursing practice in Australia and New Zealand today. Examining social forces that have influenced the development of the professional nurse and nursing education will provide foundation knowledge of how contemporary nurses have evolved. This will be followed by the stages of modern nursing education highlighting the acknowledged role of the forerunner of formalised nursing education – Florence Nightingale. It is important at this stage to mention how nurses have been regulated by law and to introduce the concept of Scope of Practice. Combining art and science to care for people and the wider community in a humane manner is based on scientific knowledge combining critical thinking skills with caring behaviours. As nurses, our profession is defined by our unique contribution to health care and this is based in nursing theory. An overview of the contribution of nursing theorists will be explored giving the reader an understanding of each theorist and their contribution to the profession. Your understanding of these concepts will lead to ongoing professional responses to a changing world.

EVOLUTION OF NURSING EDUCATION IN AUSTRALIA AND NEW ZEALAND

It is important to acknowledge that nursing has a long history with origins in religious orders and the military (Roux & Halstead, 2018). As a result, the framework of early nursing education reflects characteristics of each. The following discussion will provide a brief overview of nursing education in Britain followed by a focus on the Australian and New Zealand perspectives. The evolution of nursing education demonstrates that educational opportunities and approaches are continuing to develop and to be challenged. Understanding our past directs our perceptions of the present and assists us in planning for our profession's future.

Nursing history has traditionally been presented using familiar stories of famous nurses, nursing leaders and events. It has been explored from a *grand narrative* perspective, describing the 'big picture' of nursing history and practice. However, expectations and interpretations of what a nurse is and does have altered based on the influence of sociopolitical factors. The delivery of nursing education in Australia began with the arrival of the Nightingale nurses in 1838. The basis of practice for these nurses was both religious and military. Areas of conflict such as the Crimean War and both World Wars have also served to shape the changes in education of nurses in Australia and New Zealand. It has helped to change the skills and knowledge of nurses from handmaidens for doctors to nurses with specific specialties. Although the role of the male nurse is very important in our history, aligning with the emancipation of women, nurses began to reflect and theorise about what nurses 'do'. This has led to increasing self-determination, expansion of their role, and the professionalisation of nursing. Finally, the shift from nursing schools to modern tertiary education has cemented the perception of nursing as its own pursuit.

When reading this chapter, consider nursing from the historical viewpoint influenced by nursing theory and how you will contribute to this body of knowledge.

Theory and practice globally, nationally and locally have been shaped by political, social, cultural, economic and gender perspectives. These perspectives and influences explain how the modern landscape of nursing practice occurs and provides insight into future potential development by emerging nurse leaders. The dichotomy of art and science within nursing is explored, demonstrating the importance of both premises to the continuing development of nursing theory and practice. There are polarised viewpoints about the role of Florence Nightingale, yet the value of contributions cannot be ignored. Her influences both past and present will be discussed providing a basis for future nurse contributions in theory, practice and research. Adding to Nightingale's contributions, early nurse leaders in Australia and New Zealand provide the narrative for ongoing development of the nursing education system. The role of nursing theorists in this context has led to a reputable profession valued internationally due to unique influences. The contributions of First Australians and male nurses are now being more fully explored. This approach places nursing within the wider context of the societies that it is practised within.

Geographic, sociopolitical will and economic structures added to nursing theory in Australia and New Zealand have developed an almost parallel practice. Contemporary nurses are a mix of how nursing began and the influences since that time up until the present day. The evolution of these influences and development of theories have resulted in nursing today in Australia and New Zealand. These theories suggest nursing individuals and communities as being a delicate balance between promoting a person's independence and dependence. The approach focuses on illness, the person's response to illness or disability, defines caring and supports the delivery of

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care across the life span. This aspect of nursing also includes assisting a person with a terminal illness to maintain comfort and dignity in the final stage of life. **Table 1-1** highlights some of the key moments in the development of nursing practice and nursing education, identifying early aspects of nursing development while concentrating on New Zealand and Australian nursing educational history.

TABLE 1-1
Historical events influencing the evolution of nursing

DATE	EVENT
800–600 BCE	Health religions of India.
390–407	Early Christianity, deaconesses.
1095	Antonines establish the Brothers of St Anthony Hospital.
1100	Ambulatory clinics, Spain (Muslims).
1522	Military nursing orders established.
1633	Sisters of Charity founded.
1811	Sydney Hospital opens.
1820	Florence Nightingale born.
1826	Foundation of the Deaconesses of Kaiserworth.
1838	Irish Sisters of Charity nurses arrive in Sydney, New South Wales (NSW).
1840	Treaty of Waitangi signed by the British Crown and Māori chiefs. Elizabeth Fry establishes the Institution of Nursing Sisters and a three-month nurse training course in England.
1854–56	Crimean War.
1859	Nightingale's *Notes on nursing* published in England.
1860	First Nightingale School of Nursing, St Thomas' Hospital, London.
1868	Lucy Osburn arrives in Sydney to develop a Nightingale-based training school for nurses at the Sydney Hospital.
1873	Grace Neill begins training at St John's Hospital in London.
1887	British Nurses Association (BNA) is founded.
1888	New Zealand and Australia are requested to form chapters of the BNA. BNA begins publishing the journal *The Nursing Record*.
1890	A royal commission examines Victoria's Charitable Institutions (RCCI).
1896	Mereana Tangata becomes the first Māori hospital-trained nurse in New Zealand.
1899	NSW-based Australasian Trained Nurses Association (ATNA) is established. International Council of Nurses (ICN) is founded.
1900	First issue of the *American Journal of Nursing (AJN)* is published.
1901	The *Nurses' Registration Act 1901* is passed in New Zealand. Ellen Dougherty, in New Zealand, becomes the first registered nurse in the world. Victorian Trained Nurses Association is established.
1908	Public health nursing commences in Melbourne and Sydney.
1909	The University of Minnesota commences the first three-year nursing diploma course.
1910	Akeneti Hei is the first Māori to become a registered nurse.
1911	Queensland becomes the first State in Australia to register general and psychiatric nurses and midwives.
1919	The *Nursing Act* is passed in Britain.
1939	New Zealand's *Nurses' Registration Act 1901* is amended to allow men to train and register as nurses.
1940	New Zealand assumes state responsibility for public general and psychiatric hospitals.
1943	The Australian hospital ship *Centaur* sinks off the Queensland coast.
1945	Psychiatric nurse qualification is acknowledged and administered by the Nurses and Midwifery Board in New Zealand.
1956	Faith Thomas is one of the first Aboriginal and Torres Strait Islander peoples to complete her nursing training in South Australia.
1970	Community health movement begins in Australia.
1971	The *Carpenter report* recommends the transfer of nursing education to the tertiary education sector in New Zealand. Nursing Council of New Zealand is established. Sally Goold, Fred Hollows and Dulcie Flower establish the Aboriginal Medical Service.

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DATE	EVENT
1973	Postgraduate nursing education commences at Victoria and Massey universities in New Zealand.
1974	The amended *Nurses' Registration Act 1974* (Tasmania) allows men for the first time to train, register and practise as midwives.
1976	John Chapman is the first male to qualify as a midwife in Tasmania.
1978	The Alma Ata Conference on Primary Health Care and Community Development, supported by the World Health Organization, is convened.
1983	Australia's first diploma-level course is introduced by the College of Nursing. NSW Government announces it will transfer pre-registration nursing to the tertiary sector by 1985. Medicare and universal health care is introduced by the Australian Government.
1984	Hawke Labor government announces that all Australian registered nursing education will be transferred to the tertiary sector by 1992.
1989	Last hospital training school closes in New Zealand.
1990	Last intake of hospital-trained nurses in Australia.
1991	Degree nursing programs replace Diploma in Nursing in Australia.
1992	Degree nursing programs replace Diploma in Nursing in New Zealand. Nursing Council of New Zealand introduces cultural safety as a curriculum requirement for all nursing students.
2004	Nurse practitioners receive practice rights in Australia and New Zealand.
2010	Establishment of the Australian Health Practitioner Regulation Agency, which implements a national registration and accreditation system for health professionals, including nurses and midwives. Pharmaceutical Benefits Scheme, prescribing rights for Nurse practitioners.
2011	Royal College of Nursing, Australia and the College of Nursing unite to form the Australian College of Nursing.
2016	Medication prescribing rights for designated specialist registered nurses in New Zealand.

It is important to acknowledge at this point that nursing and midwifery have a shared history and are not entirely separate entities. While this discussion will centre on nursing, some aspects of midwifery will be included because of their close association.

The introduction of nursing training and the development of nursing care are frequently attributed to Florence Nightingale, who remains a much-celebrated individual in nursing circles. The following section highlights her contribution to nursing practice and education. It also identifies some of the inconsistencies in her practice. While Nightingale's practices were innovative at the time, scientific and practice advances have outdated some of her ideas in relation to patient care.

Florence Nightingale (1820–1910)

Florence Nightingale was born on 12 May 1820 in Florence, Italy into an affluent British family. The way she conducted herself during her life consistently reflected the ideas of her time – the Victorian era. This was a period of economic, political and social expansion for Britain which contributed to the growth of the British Empire. Britain continued to colonise regions of the world, allowing the Empire to expand production and manufacturing at home. It was the time of the Industrial Revolution (Roux & Halstead, 2018).

In 1844, Nightingale began studying and then developed her nursing practice on the European continent with French and German religious orders. She was subsequently appointed the superintendent of an English hospital for ailing governesses, which gave her an opportunity to practise and develop her form of nursing care. Nightingale maintained that control of the environment was essential for the restoration of health, and her care regimen included fresh air and cleanliness. She advocated rest and a quiet environment for patients.

In 1853, the Crimean War began. Newspapers reported that resources were scarce and that soldiers were living and dying in squalid conditions. Political pressure required action, and Nightingale was asked to lead a team of 34 nurses to Turkey to oversee a military hospital at Scutari (Fee & Garofalo, 2010). This crucial time epitomises the popularised notion of Nightingale.

To understand Nightingale's nursing theory and the practices that led her to Turkey, it is essential to contextualise the woman within the time that she lived. One of the results of the Industrial Revolution in Britain was rapid urbanisation characterised by poor housing and sanitation, and the overpopulation of rapidly expanding city suburbs. These were filthy, diseased communities (Finkelman & Kenner, 2014). In 19th-century Britain there were two general theories relating to the spread of infections and disease. The theory of miasma, which originated in the Middle Ages, argued that the vapours released from rotting organic materials were poisonous and the offending smell was the cause of disease. The germ theory, which originated

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in the 18th century, was a newer development in understanding disease. It was gaining some momentum but did not become the accepted theory until the start of the 20th century. Considering the stench and poor sanitation that permeated suburban Britain in the 19th century, it is understandable that health reformers believed that cleanliness and fresh air was the key to good health.

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FIGURE 1-1
Florence Nightingale in the Crimea

The Nightingale principle of fresh air and light continued to dictate nursing care into the 20th century. The image of the Ipswich ward presented in **Figure 1-2a** shows how people were kept in open wards with high ceilings and large windows that provided natural light and fresh air. The image of the Nhill Hospital in **Figure 1-2b** demonstrates how people were encouraged to spend time outdoors. Note that one person has a camp stretcher to rest on and another has a chair with the capacity to support and elevate their leg.

IPSWICH HOSPITAL MUSEUM COLLECTION, PICTURE IPSWICH, QLD

FIGURE 1-2a
Male medical ward, Ipswich Central Hospital, Queensland, 1927

MUSEUM VICTORIA [MM 003512]

FIGURE 1-2b
Nurses with patients in the grounds of Nhill Hospital, Victoria, 1928

Nightingale supported the theory of miasma over the germ theory (Fee & Garofalo, 2010), remaining committed to the principles of fresh air and a clean environment while arguing against the new concepts of bacteria and viruses. As such, her achievements while in the Crimea remain contentious and a topic of historical debate. The standard accepted narrative is that she increased the survival rates of injured soldiers in her care (Fee & Garofalo, 2010). But this has been questioned in recent decades. It has been argued that infection and death rates at Nightingale's hospital actually rose following her arrival (McDonald, 2013). This occurred in what was not a very clean environment because the hospital was built over an open sewer, which was not unusual for 19th-century hospitals. Due to her understanding of infection control, Nightingale did not correlate sanitation and illness, and conditions only improved after the War Office sent the Sanitation Commission to investigate the high death rates and subsequently ordered that the sewers be flushed. Following this, the death rates dropped dramatically (Fee & Garofalo, 2010).

Regardless, on her return home Nightingale was celebrated. She was awarded prize money which she invested to develop nursing training at St Thomas' Hospital. Her model required strict discipline. It supported the notion that nursing was a vocation for women and that nurses should be unquestioningly obedient to senior staff and doctors. It was in Nightingale's time that nursing became increasingly identified as a female role offering middle-class women a respectable occupation and the opportunity of economic independence (McDonald, 2013).

Nightingale was a prolific writer who published a series of nursing texts and wrote letters to various individuals in search of data to understand health care needs, record statistics and to continue to reform practice across the Empire (Shellam, 2012). She also used a variety of techniques to advocate for improved health care, including political, administrative,

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NURSING CHECKLIST

Nightingale's basic principles of nursing education were:

- placement of the program in an institution supported by public funds and associated with a medical school
- affiliation with a teaching hospital but also independent of it
- a nursing program directed and staffed by trained nurses
- a residency to teach students discipline and character.

educational and statistical methods. She became an iconic figure in her own lifetime and remains a celebrated member of the nursing community today – we celebrate International Nurses Day each year on the anniversary of Nightingale's birthdate. Her nursing theory will be revisited later in this chapter.

The sisterhoods

Florence Nightingale's biographers have often presented her as the sole reformer of modern nursing – indeed, as its founder – but this is far from the truth. There are a number of other reformers who contributed to the education and training of nurses in Nightingale's time. While it is the experience of Britain, Australia and New Zealand that will be discussed here, it should be acknowledged that nursing reform occurred in various parts of the Western world during the same period.

In the early 19th century, hospitals were not places where individuals chose to go. Along with asylums, they were places of last resort, places where the poor, homeless and destitute went for assistance, for shelter and to die. The majority of individuals paid private nurses to care for them in their home when they were ill or in need of midwifery services. All classes of society sought the assistance of private nurses. They were autonomous practitioners and often competed with the medical profession for work (Finkelman & Kenner, 2014). Nursing was not regulated at this time. It was not until the late 19th century that the certificated, uniformed woman based in a clean hospital environment began to be the dominant image of a nurse. It is notable that men were excluded from this version of nursing.

In the 19th century, diverse approaches to nursing practice and training existed. The Nightingale system of nursing training was but one of many. Some religious orders offered limited training which was usually only available to members of the order. In London, Anglican High Church nuns, known as sisterhoods, were the dominant model of nursing reform. These orders acted as social service agencies for their communities, providing care for those who could not support themselves. The church and sisterhoods worked for specific hospitals and developed training methods to support a medical practice that was beginning to make advances in disease management and surgery (Helmstadter & Godden, 2011). The Anglican nuns had a vocational drive to care for the acutely sick, disabled and vulnerable in their communities. The nuns expanded their training beyond their order and trained lay nurses. Both Australia and New Zealand benefited from this model of nursing training. Benefits included larger numbers of nursing students for the workforce and the alignment with other health professionals.

Mary Weeden, who trained at London's Charing Cross Hospital from 1878 to 1881, immigrated to Australia and was appointed matron of the Brisbane Hospital. She established the first comprehensive training program for the colony of Queensland. Grace Neill, who was largely responsible for campaigning for nursing registration in New Zealand, has often been attributed as training at Nightingale's St Thomas' Hospital, but she actually trained under the Anglican nuns at St John's Hospital from 1873 to 1876 (Helmstadter & Godden, 2011). Similarly, it was an All Saints sister, Helen Bowden, who established the first training school in the United States.

For their time, the sisterhood hospitals took a unique approach to patient care, advocating for nurse–patient ratios to be established and for nurses to be self-directed, autonomous practitioners. But when the Anglican Church began to establish modern administrative practices in its hospitals, and because health care was funded by charitable organisations and by subscription, conflict arose between the sisterhood's principles of practice and the economic reality of supporting its model of patient care and nursing training. It was determined to be too expensive to continue to fund. Due to such conflict and different health agendas, the Anglican nuns increasingly withdrew their services and training programs from London's hospitals. This had two major outcomes. First, it allowed them to re-establish their practices in community-based environments (Helmstadter & Godden, 2011). Second, it opened the way for the Nightingale model to become more widely adopted. By the end of the 19th century, it had become the template for nursing training, creating a cheaper training program and more compliant nurses who infrequently challenged the decisions made by hospital administrators and medical officers.

Nursing registration

Professionalisation, training and education reform are common themes in nursing history. All three topics

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encompass the increasing demands made by nursing leaders in the late 19th century and into the early 20th century. Medicine had been regulated in Britain from the 1830s and was beginning to make advances in professional standing and political influence, and in improving health care outcomes for people. Utilising scientific advances, medical research was developing new surgical and medical treatments. To support the medical model of care, medicine required the support of nurses trained specifically for hospital work. It was in the late 19th century that medicine began to advocate for hospital care to be the linchpin of health care services. It was an efficient method of administering complex treatments (Helmstadter & Godden, 2011).

British nursing leaders had seen the advances made by medicine since it had become a formalised and regulated profession. They recognised the application and potential benefits for the nursing profession. Ethel Bedford Fenwick, matron of St Bartholomew's Hospital, was the chief advocate for nursing registration in Britain. In 1887 she formed the British Nurses Association (BNA), which lobbied for such registration. The vision of the BNA was that registration would define nursing as a recognised profession, offering equal ranking with other professions and improving nurses' social standing and rates of pay while disallowing non-trained nurses to continue to practise.

Fenwick's specific goal was to make nursing a legally recognised profession where only hospital-trained women could call themselves a nurse. She wanted nursing to become a self-regulated, self-determining profession where doctors were not able to credential or determine nursing practice. Yet due to the complexity of the issue and the lack of female influence in political and economic circles at this time, her ambitions for nursing were not realised. She had to compromise, due to her dependence on the support of the medical profession and its influence in holding key positions within the BNA (Helmstadter, 2007). The presence of medicine within the structures of the BNA resulted in it determining the function, role and credentialling of nurses. Doctors wanted nursing training to support their interests, and nurses to just follow their orders. It would be over 50 years before nurses were able to determine their profession without the presence of medical officers on nursing boards.

Nursing was being confined to hospital-based training and service delivery, and in the process it became increasingly subordinate to medicine. The educational structure of hospital training encouraged this subordination, isolating nursing from the communities that it had traditionally served – something medicine did not allow. Doctors maintained private practices that were based in the community and increasingly determined who was admitted to a hospital and who remained in their home.

In 1888, the BNA asked New South Wales and New Zealand to form chapters of the organisation to encourage an expansion of its vision for nursing training and practice within the British Empire (Helmstadter, 2007). Fenwick's world vision for advancing nursing was further apparent as she was the founder of the International Council of Nurses.

To achieve nursing registration, the unqualified and untrained private nurse had diminished areas of employment. However, the private nurse played a pivotal role in the community, attending births, caring for the sick and laying out of the dead. So there were a number of campaigns to discredit their work. Charles Dickens, the social commentator, social reformer and author, included an uncomplimentary depiction of the private nurse in *The life and adventures of Martin Chuzzlewit* (1844). Dickens characterised the private nurse as drunk, addicted to gin and snuff, immoral, and of low character. Those requesting reform, formalised training and regulation used the characterisation to their advantage. Only now are historians starting to explore the practices of the time and questioning the validity of the depiction of the private nurse by Dickens and the supporters of nursing regulation (Colins & Kippen, 2003).

Not everyone supported registration and the professionalisation of nursing. Florence Nightingale was one vocal critic of the plan. She did not support a written examination because it did not test a nurse's moral or personal character. It also excluded a large group of nurses, those from the working class, who at this time had marginal literacy and numeracy skills. Interestingly, New Zealand and Australian nurses would achieve registration prior to nurses in Great Britain.

An introductory history of nursing education in Australia and New Zealand

Australia and New Zealand had established societies prior to European settlement, and their traditional owners had instituted complex methods to care for and treat the sick and injured. The complexity of Aboriginal and Torres Strait Islander peoples' or Māori health care and treatments are only now beginning to be understood and appreciated (Best, 2018). New Zealand established the Treaty of Waitangi (Kani Kingi, 2007), with the original residents of the land. In contrast, First Australians were not given any constitutional status (Lam, 2011). The impact of this is seen in the ongoing disparity of health outcomes between traditional owners and their descendants and

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those not considered first nation persons. This history is important when considering nursing theorists such as Leininger (described later in this chapter) and the inclusion of first nation peoples permitted to enter nursing.

Upon European settlement in Australia, convicts and soldiers offered care to the sick, injured and infirm (Cushing, 1997). The disparate demographic in Australia of an overpopulation of men compared with women, which lasted into the early decades of the 20th century, was the consequence of the transportation of predominantly male convicts. As a result, Australia has a rich history, yet to be fully explored, of male nurses, or attendants as they were often known. In fact, the first trained nurses to reach Australia were five Irish Sisters of Charity, who arrived in Sydney in 1838. Their practice was based in the community and did not offer any nursing training.

It is important to acknowledge that men have always practised as nurses and there have only been very specific periods when they experienced social or legal exclusion from nursing. There are many traditional masculine working environments, such as religious orders, ships, armies and mines, where men have always been required to provide nursing care (O'Lynn & Tranbarger, 2007).

The Sydney Hospital was opened in 1811 and the majority of nurses were convict men and women. It was originally staffed by 23 male attendants and five female caregivers who were drawn from the reformed convict population. The hospital was managed by a board of directors who were elected annually by the subscribers. The administration was continually in conflict and mismanagement prevailed. The premises were in an awful state, with vermin, a lack of water and poor sanitation. The nurses were often reported as being drunk while on duty. So in 1867, Sir Henry Parkes, a prominent NSW politician, wrote to Florence Nightingale requesting the introduction of her model of nursing training to the Sydney Hospital (Godden, 2006). Consequently, Lucy Osburn (1836–1891), pictured in **Figure 1-3**, who trained at St Thomas' Hospital, arrived in Sydney in 1868 with five other Nightingale-trained nurses. Formal nursing training had arrived in Australia and it immediately impacted on how nursing care was offered.

The Nightingale model was predominantly a female model, so when Osburn became the matron of the hospital, she advocated the training of female nurses at the exclusion of males. This put her in conflict with previous administrators. Osburn also dismissed the older female staff and all but one male wardsman (Godden, 2006).

COLLECTION MUSEUM SYDNEY HOSPITAL/SYDNEY EYE HOSPITAL

FIGURE 1-3
Lucy Osburn

New Zealand does not share a history of convict transportation with Australia. Instead, it was settled by the British when convict transportation was in decline. Until the 1860s, New Zealand had limited health services, primarily cottage hospitals in the settled regions. By the end of the 19th century the role and function of nurses had become more defined as in Australia and the British model of nursing was introduced.

Historically, nursing care in New Zealand, as elsewhere, had been performed in various environments, including institutional care, with which it has a long association. Men and women have long worked together in institutions such as asylums and psychiatric hospitals. Asylum employees in the 19th century were given the title of attendant; although some women that worked in this environment were trained nurses. Asylum workers have often been represented as desperate individuals with no choice but to seek employment in such an institution. However, this is now being questioned. There were some attractive aspects of asylum work, such as it being an autonomous work environment with limited interference and supervision. It is often assumed that men were sought to work in asylums because of the need to restrain patients, but it has become evident that asylum administrators sought skilled employees who had carpentry skills and other trades, or who could teach music and literacy to assist in keeping patients busy and calm (Monk, 2009).

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