

Personal paradigm of nursing practice



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My personal paradigm of nursing practice that will be discussed in this paper has come about due to many years of practice and continuous refinement. My paradigm has developed from multiple modes of learning. These modes of learning include practical skill application, attendance of education symposia, and structured didactic formal education. The process of developing my paradigm has come about with conscious knowledge acquisition and to some extent unconscious skill acquisition.

Nursing knowledge can be obtained in many ways. According to Chinn and Kramer (1999), knowing is the process of gathering understanding of self and surroundings and exemplifying the ways of knowing on a conscious level. Not all levels of knowing may be explained or put into a written format. The knowing that can be shared or communicated and then documented becomes the knowledge of that specific profession.

Knowing can be developed in many subparts to create a whole of knowledge. In the text of Chinn and Kramer these subparts include empirical, personal, ethical, aesthetic, spiritual, socio-political and cultural approaches. Empirical knowledge development is the part of science that can be seen, touched, smelled or otherwise measured. Personal knowing concerns the individual ability to utilize self as a therapeutic modality, and understand one's own worth. Aesthetic knowing is concerned with the art or beauty of an act. Aesthetics is the emotional component or perception of an experience. Ethical knowing is based upon moral code and involves principals and codes of conduct. Cultural knowing according to Campinha-Bacote involves assessment of culturally based actions and also culture in the context of perception. Socio-political knowing and knowledge stem from experiences

and formal requirements of a specific practice act, and setting which these acts are concerned (Campinha-Bacote 2002).

Epistemological knowledge or how knowledge is created is based on ontological knowing. Ontological knowing is which pertains to the experiences of being and perspectives on existence (Chinn and Kramer 1999). Ontological knowledge development consists of all ideas that one acquires in everyday nursing practice. This acquisition of skills and experiences creates embedded knowledge that becomes the reference for future situations. Embedded knowledge is the use of past situations to provide a guide for dealing with future situations of a like kind (Benner 1984).

I am involved in knowledge development every day. This knowledge development occurs in many forms. The workplace affords me the opportunity to apply ethics, empiricism, personal and aesthetic knowledge, while gaining insight to cultural and socio-political concerns. As I apply knowledge I have gained in the past, I acquire new knowledge that I incorporate into my praxis. As I study to become an advanced practitioner, I hope to gain insight to the motives of my actions and thoughts. I feel by finding this stem to my learning I can then enhance my skills and relieve the possibility of professional negligence and improve health and healing within my self and others.

I will analyze these factors in reference to my own nursing praxis in a brief, concise way. I will explain my thoughts in the form of exemplars. The first area of interrogation of my own practice will be in the realm of Empirics.

According to Chinn and Kramer (1999), Empirics is the fundamental pattern of using the senses, in order to know. Empirics require a scientific approach to the gathering of knowledge. The expression of this knowledge comes in the terms of theories and models. This area of knowledge development has had the greatest effect on my personal practice of Nursing. I have had the long held belief that if the medicine was good enough, and the science correct, we could potentially solve any human issue. As I have gained experience, I have come to realize that empiricism alone can not be applied to every situation. The grieving of the newly diagnosed cancer patient and the fear of the cardiac surgical patient are emotions that Empirics can't measure.

To illustrate the shortcomings of the use of empirical data and treatment based primarily on science, I would like to share a personal experience. The Intensive care unit where I work is involved in the education of medical students, residents, nurses and assorted health professionals. This teaching environment has led to a very scientific culture. In this example, a client of advanced age came into the unit with a diagnosis of Diabetic Keto-acidosis. This patient had what was reported to be a very routine and easy problem to treat. The plan included fluid, insulin and routine nursing care. The patient arrived with an extremely high blood glucose level and did not look at all well. This presentation immediately changed the treatment plan to include the possibility that hyper-osmolar; hyperglycemic, non-ketotic acidosis may actually be the diagnosis. The residents examined the patient, prescribed treatment and quickly left the unit. The nurses made the initial contact with the family, so as to complete the paperwork. After all the data was collected,

the family decided to not resuscitate the patient if a cardiac crisis should occur. As we collected data and formed a plan, I realized this patient was not going to live through the shift. As we counseled the family, nobody had noticed the patient had awakened and was attentively listening to the plans for her own funeral. The patient stated “ I know I may look dead, but don’t bury me til I am”. I believe this illustrates the fact that empirical data may not reflect the true health of the client. The reason for the patient’s recovery may not have been empirically measured, but it had certainly occurred. The advanced practice nurse (APN) education that I have undertaken will lead me to develop better assessment skills that are not based solely upon empirical data. I will use these skills to look beyond the surface data to see the patient and thereby provide a holistic approach.

The ethical component of nursing is a blend of codes and values. Morality is at the root of all relationships that humans carry on with one another. The morals and “ values” that I developed as a child, adolescent, and now as an adult have all blended into a discursive heap of human emotions and guide my day to day actions. Chinn and Kramer (1999) stated that morality and ethics interrelate, in that ethics can guide behaviors related to morality. This statement demonstrates an interrelationship between the ways of knowing, and the concept that the whole is more important than the parts.

The family of the diabetic client discussed earlier, was the one with the voice and the one able to make the decisions. These decisions were not actually the wishes of the patient, but the wishes of the family. Jill White (1995) believes that moral knowing requires a personal relationship between the nurse and the patient. The above example I think clearly identifies this issue

and statement. In this example the patient, family, Nurse and medical staff never in any manner engaged the patient. The fact that no form of relationship between caregiver and client developed led to a treatment failure.

The moral judgment made by myself regarding adequate life span, resource utilization, and quality of life, remain an everyday dilemma. This dilemma cannot be solved with the arbitrary use of euthanasia, or the limitation of treatment due to age or disease, but must be approached on a very individual basis. An example of ethics in practice is the patient who is ninety years old and is in need of coronary bypass surgery. From the surface view this seems a waste of limited resources. The patient can no longer get up out of the chair and go to the mailbox due to chest pain. But, when a personal relationship is initiated as more in depth view of the patient reveals that he receives a letter from his eighty-five year old sister daily. This ritual brings joy, fulfillment, and peace of mind for the patient. If the medical establishment can return this patient to his prior functioning status, we may have served an ethical mission to heal when we can, and whomever we can. This service should be based upon merit of the situation, status of the patient and expected outcome, not age alone. As an advanced practice nurse I will be at the forefront of treatment decisions and resource utilization. I hope that with the expanded role and education of the APN I will be able to affect change in the way the resources are allocated and utilized, while using ethics and morals as a guidepost. Through continued experiences and observation I hope to build knowledge that will increase the value and meaning of my personal nursing care.

Personal knowing is one of the most difficult areas for me to explain; yet I believe I have indeed accomplished this feat, without ever knowing what it was called. Chinn and Kramer (1999) view personal knowing as the nurses' ability to use themselves as a healing tool by being aware of their own worth and appreciating the clients worth. One way of using personal knowing is using personal presence as a healing tool. The article by Godkin (2001) details presence as a complex set of behaviors that transcend science alone. This approach of seeing the patient on more than one plane is effective in recognizing the importance of the physiological aspect of nursing care. The patient can give many clues to the inner workings, fears, strengths that will enable and assist the nurse caring for that patient. Godkin (2001) represents presence as the patients knowing the nurse is present without the nurse's actual physical presence. Presence is very important to the patient's sense of well being and security.

The way that I personally use presence in my practice is to identify with the patient on some other plane than the disease or problem at hand. This enables my patients to know that I too am human. They now learn that I can be reached out to as a sounding board and as a reference to frame of mind. I hand the patient the call light, demonstrate its use and then tell them very clearly while making eye contact " use this as often as you need, I always have time for you and I need your involvement to help me help you". When the patient uses the call light for something I make a point of being there quickly. This, I feel, gives the patient the security they need to rest, knowing they have a professional nurse attending to them. This is a method that I developed and can now see how it relates to the Godkin's (2001) notion of

presence. As Godkin (2001) highlighted in her hierarchy, uniqueness is good for the bedside as a novice nurse, but being present even when your physical presence is absent is the realm of the “ expert” nurse. The APN role with advance knowledge on the patterns of knowing and knowledge will allow me to better serve my patients in a holistic multidimensional fashion. I hope to further develop my skills in personal knowing by further understanding myself and presence in this world.

Nursing aesthetics has long eluded my own practice. I am sure that I have witnessed aesthetics and may have even practiced aesthetic nursing, yet never realized it. Chinn and Kramer (1999) view aesthetic knowing as the deeper meaning or the realization of what is possible.

Aesthetics in my own personal practice can best be explained by a short story. A patient that I provided care for had a diagnosis of bowel cancer that had progressed to the terminal stage. The patient required intensive nursing treatment of every type. The family consisted of a devoted husband and two young daughters. The family was very involved in the patient’s care and provided great comfort to the patient. The patient summoned me to her room one afternoon and told me of her wishes to return home for Christmas. I explained that the trip would be risky and difficult, and we needed to discuss the matter with her primary care provider. The Physician in charge agreed to the plan and we hastily made arrangements for the trip home. On Christmas evening the patient called the hospital and asked to have her daughters tell the nurses some important information. The woman’s children took to the phone and told the staff thank-you for giving us their mommy back for Christmas. It made us all realize that we were working for the

purpose of making people as happy, and comfortable as possible, not for the paycheck. We all gathered a collection and sent the family a gift of appreciation, they had made our Christmas that much more meaningful too. The “art” or aesthetic of Nursing was very powerful and very obvious during this experience and made me realize that healing may not always be in the form of a measurable value. The APN role will assist me in helping others by appreciating the gift of the human spirit and mind. By obtaining advanced knowledge, I will be able to better recognize and appreciate the role of aesthetics in nursing, and I will be able to utilize aesthetics in my practice to become a more effective healing force.

Spiritual knowing as a force in healing is very complementary to aesthetic knowing. Spirituality is often commingled and confused with religion. Spirituality is the concepts based on meaning and purpose of existence while religion is the rituals and following of a higher power (Tanyi, 2002).

Spirituality in practice can be observed readily in the aged. It would seem that towards the end of biological life, the individual becomes comfortable with their existence. In this, one will observe patient’s lack of fear of death and disease. This lack of fear provides peace in their soul and a personality that is relaxed and at ease. A patient that I personally cared for demonstrated an example of this relaxed state of mind. This patient was of very advanced age and had little time to live. After several days of building a relationship, I asked the patient if he had fear of dying. The patient replied “son, if I were you, I be afraid of how long I had to live”. I thought about this statement a long time, and believe the patient was telling me I had more to fear in a long life than the fear of death. This spirituality that I observed was

not connected to religion, but related to comfort with life and ultimately death. This spirituality may allow one to be at ease with monumental decisions and or crushing defeats (Tanyi, 2002). This comfort allows for energy to be directed to healing or comfort rather than fear of the unknown. Spirituality is closely related to culture. There are cultures that do not observe a certain religion, but enjoy a relationship with their surroundings and the people they are involved with. I believe that spirituality in an individual is as important if not a precursor to religious beliefs and practices. As an APN I will gain further understanding of how the relief of worldly worries may enhance healing. I hope to focus these tools to better understand my self and other cultures. Only by involvement in personal relationships with others can spirituality be understood and cultured.

In my paradigm, cultural competence holds a special meaning. Cultural competence is an ongoing process, not a single event. In this process, the nurse attempts to achieve a relationship of knowing with the individual, community and the family (Campinha-Bacote 2002). Campinha-Bacote (2002) views cultural competence as several constructs. These constructs being cultural knowledge, cultural skill, cultural encounters, and cultural desire.

Cultural knowledge may well be the most difficult construct to master. Information can be obtained from the community library, internet resources and other forms of established communication, but all of these forms lack true personal involvement. To obtain this cultural knowledge there must be cultural desire on the part of the nurse. To know and understand a culture, you must immerse yourself in it. These two constructs go hand in hand, one

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without the other leads to no real understanding and no real learning.

Cultural encounters are a process that we are involved in every day. The cultures we encounter are not only reflected by skin color, but by religion, education, economic status, geographic location and host of other factors. Knowledge can be gained concerning cultures simply by recognizing that certain sets of beliefs and actions are founded in cultural practice. Cultural competence includes trying to overcome language and communication barriers. This includes understanding diverse mechanisms of healing like folk medicine, religious rites or superstitions.

Cultural skill is probably the most elusive of the goals spelled out by Campinha-Bacote (2002). Cultural skill was an ever-ongoing relationship with cultural encounters. The more encounters you have with a culture the more skilled you can become. In the hospital I worked at in California, we were all given a handbook that delineated all the relevant cultural groups that were represented in the San Francisco area. There were references to the races of many, religions of many, but no mention of the culture itself that the community as a whole represented.

Culture played a role in a patient situation that I observed in an intensive care unit where I was employed in California. A Native American was admitted to the hospital through the emergency room. As the patient was getting settled in the intensive care unit, one of the elders of the patient's tribe chanted and danced about in the room. After the patient recovered sufficiently enough to be moved out of the intensive care, we were instructed not to touch the feathers on the door, the elder would retrieve them. We questioned this, as we needed the room. The patient's family

informed the staff the feathers were from an Eagle and were sacred, only to be touched by a male elder of the tribe. Fortunately, we were able to honor the request and provide for cultural diversity in the hospital. The APN education (clinical and didactic) will expose me to many cultural differences. Through cultural exposure, I hope to build a knowledge base that I will be able to use to serve my clients. A better understanding of my own culture will enable me to accept the culture of others'.

Socio-political knowing as an entity of my own practice is very limited. This facet of nursing is concerned with the context where nursing takes place and the governance of the nursing profession (White 1995). Shared governance is a model that I am deeply interested in. It has for many years been the Medical Doctors or the politicians that have guided health policy in this country. The people, who are actually providing the care, have had little voice in how this is administered. The Nurse must be heard and have a voice in local, regional and national politics concerning the national healthcare debate.

In the world of healthcare with its ever-spiraling costs, the nurse must be at the forefront of the debate. As previous attempts have been made to replace the Nurse at the bedside with unlicensed and poorly trained caregivers, the Registered Nurse must be vigilant, not only to protect their professional license, but also to demonstrate the worth of the registered nurse. The hospital I currently work in employs technicians to provide some routine bedside care. The technicians are licensed by the state as Certified Nursing Assistants. These technicians must be monitored by the Registered Nurse who is ultimately responsible for the care these individuals provide. In the <https://assignbuster.com/personal-paradigm-of-nursing-practice/>

political viewpoint, the nursing shortage can be eased by use of the unlicensed caregivers. In the social agenda, the quality of care is suspect and society as a whole may lose confidence in the healthcare mechanism. As an APN I must be acutely aware of these political and social concerns. The public often compares the APN role to the physician assistant, although great differences in training exist. I hope to educate people to the role of the APN and establish common guidelines for independent practice.

Nursing paradigms or models have long been a source of controversy. A paradigm is current body of knowledge and accepted routines or concepts. These concepts may encompass ethics, Empirics, aesthetics and personal ways of knowing and knowledge, but are by no means proprietary (Monti & Tingen, 1999). The use of multiple or single a paradigm to explain nursing knowledge also has be a source for continued discussion.

The empiricist versus the interpretative paradigm is the most relevant issue. The possibility that one paradigm may fully explain the art of nursing care may be outmoded (Monti & Tingen, 1999). The empiricist views nursing as a science while the interpretive paradigm is concerned with the psychological or human realm. These two paradigms are actually very complementary rather than opposing views (Monti & Tingen, 1999). Using one paradigm only would leave a blind spot in the holistic art of nursing care. The individual will not be optimally able to care for clients unless they are aware of the science and the possibility of untested phenomena. The use of science and the human component will enable the nurse to look beyond the surface and possibly gain greater understanding to the issues facing the client.

As I obtain education in the both paradigms I will be better able to employ this view of holism and incorporate it into my daily practice. The process of self-awareness can only come from understanding all.

The Registered Nurse must be aware of all of dynamics that affect everyday practice. The art of nursing is not just the technical aspect or the cultural aspect, or any other single entity. The art of nursing enjoins all of the domains discussed to provide holistic and balanced care to all clients. There is always room for improvement in any practice and with tools like knowledge and acceptance, the nurse can build a better practice day by day and encounter by encounter. Much of nursing knowledge has yet to be expressed formally. As we continue to define and express this knowledge formally it will empower nurses with the tools to focus, to shape and to question what is accepted as sound, useful and valued (Chinn and Kramer 1999). The use of all the domains of knowing may allow a deeper understanding of nursing practice as it is today. With the use of a Multi-plane approach that includes such factors as Empirics, ethics, personal, spiritual and aesthetic knowing the professional nurse may be able to grow professionally and spiritually.