Starting as a recently graduated nurse I have experienced many mixed emotions including feeling happy, excited, nervous, scared and eager to be finally practising as a registered nurse. I have been studying for the past three years, and now the time has come when I’m no longer a student and I can finally sign RN after my name: it’s quite a surreal feeling. I believe working as a nurse is all about providing the best possible holistic care to individuals in their time of need. The needs and wellbeing of the individual patient will be the centre and focus of my nursing care. My aim as a nurse is to help each individual I care for achieve the best possible health outcomes and live a fulfilled life. Achieving this aim will provide me with a great sense of satisfaction and self-worth.

As this new chapter of my life begins I am ready to take part in a giant learning curve and to have the confidence in myself to put into practice the knowledge and skills which I learnt at university. I am also very aware that I am still learning and will continue to learn for the rest of my nursing career. I therefore plan to stay open to new ideas and practices and will incorporate the best of them into my nursing care in the future.

During the next year as a new graduate nurse I will be rotating through various wards and looking after patients with a variety of health problems. After experiencing the many and varied aspects of nursing and nursing care, I will be able to start thinking about which area I would like to specialise in. No matter which area I decide on, my work will be guided by a basic principle of nursing which I developed during my undergraduate education: to treat each individual in my care in the same manner as I would like to be treated if in the same situation.

Florence Nightingale’s philosophy and the core values outlined in the following quotation will also continue to guide me in providing the highest standard of care to my patients: ‘Nature alone cures…. And what nursing has to do … is to put the patient in the best condition for nature to act upon him.’

Gemma Carty, RN
St Vincent’s Hospital, Sydney
Nursing and midwifery are professions that use specialised knowledge and skills to care for people in health and illness and in a variety of practice settings. Unit I introduces the richness of the professions through an explanation of the concepts that provide the foundation for person-centred practice, by defining nursing and midwifery practice and by outlining the contexts in which practice occurs.

An understanding of basic human needs and the individualised definitions of health, wellness and illness prepare nurses and midwives to integrate the human dimensions—the physical, intellectual, emotional, sociocultural, spiritual and environmental aspects of each person—into the care given to promote wellness, prevent illness, restore health, and facilitate coping with altered function or death. Chapters in this unit explain how these basic needs of individuals, their families and the community underpin the care provided by nurses and midwives.

Knowledge of the varied methods of care delivery is necessary in today’s complex healthcare system. This unit provides information about the various settings in which care is provided. The healthcare system as a whole, including settings and services, financial aspects of health care, and selected trends and issues, are detailed. Factors that influence health care such as questions about cost containment, consumer rights, fragmentation of care and changing patient populations and needs are discussed.

As patients move among healthcare settings, the nurse or midwife is most often the member of the healthcare team responsible for coordinating care. This unit provides information on how nurses and midwives ensure continuity of care as more and more health care is provided to patients in their own homes.

Health care is now provided in a global environment as the movement of people has accelerated. This means that nurses and midwives encounter many different cultures. At the same time, the special needs of indigenous people have become increasingly evident and are a concern to health professionals. The need for cultural sensitivity and safety is a necessary component of care, and this unit explores the concepts and provision of health care from a cultural perspective.

Nursing and midwifery are person-centred services, based on relationships with patients, their families, colleagues and other members of the healthcare team. By developing effective interpersonal skills and using therapeutic communication skills, nurses and midwives can establish and maintain helping relationships. As educators, they use communication skills to teach individuals and families. As counsellors, they provide information, make appropriate referrals and assist the patient in developing a systematic approach to problem solving and decision making. Unit I, therefore, enables students to understand how caregivers enrich their professional practice by integrating the roles of communicator, teacher and counsellor.
CHAPTER 1

Introduction to Nursing, Midwifery and Person-Centred Care

LEARNING OUTCOMES

After completing this chapter, the learner should be able to accomplish the following:

1. Discuss the definitions of nursing and midwifery with reference to their applicability to contemporary practice
2. Identify the aims of nursing and midwifery
3. Illustrate professional practice
4. Describe the concept of personhood
5. Relate how personhood is translated into person-centredness and practice
6. Summarise the components of thoughtful practice
7. Explain how to complete the learning activities that develop knowledge and skills for practice
8. Appraise the role of portfolios and lifelong learning in professional growth.

KEY TERMS

clinician competency empowerment health health consumer holism holistic care learning portfolio midwife/midwifery moral agency nurse/nursing partnership approach person personhood person-centred care person-centredness principles therapeutic relationship thoughtful practice transition to practice woman-centred care
The professional disciplines of nursing and midwifery are characterised by the application of scientific knowledge in the creative humanistic care of people in wellness and in illness. The primary goal of the care provided by clinicians working within these disciplines is to maximise health and wellbeing in order to optimise the quality of people’s lives. The needs of the person being cared for determine the responses and activities undertaken by the health professional, the nurse or the midwife. Care activities may be directed towards promoting or preserving wellness, or towards restoring health and equilibrium after a crisis or illness. These activities range in complexity from care that involves complicated technology and machinery to simply being present in a human relationship. The information in this text provides the foundation for the essentials of care delivered within many different healthcare environments. The specific care provided within a particular specialty may require additional knowledge.

The disciplines of nursing and midwifery have expanded in a wide variety of healthcare environments, with nurses and midwives now working as expert members of healthcare teams. The development of specific bodies of knowledge and the conduct and publication of research has increased the recognition of the roles of the nurse and the midwife in promoting health.

Nursing is generally held to mean caring for others across the lifespan, whereas midwifery has a more specific scope. Despite this difference, the two disciplines have many features in common. They are bound together by similar primary goals that emanate from a profound respect for the person—the actual self or individual personality of a human being (The Macquarie Dictionary, 2005). Emanating from this tenet is a belief in the power of the therapeutic relationship and a dedication to the use of person-centred processes of care. In order to meet these goals, nurses and midwives require a knowledge base that covers the physical, emotional, social and spiritual aspects that make up the person and the person’s environment. The knowledge base required by both disciplines is therefore fundamentally the same, as outlined in Box 1-1.

In Australia, the preparation required for becoming a midwife has traditionally been a postgraduate program following an undergraduate nursing degree. However, this is changing, with many learning organisations now offering direct-entry midwifery programs, and in some instances double degrees with nursing. Since 1990, direct-entry midwifery programs have also been recognised in New Zealand. Nursing and direct-entry midwifery programs, as preparation for professional practice, have many common pathways.

**Box 1-1 Knowledge Base Required for Nursing and Midwifery**

- **Knowledge required for physical care**
  - Anatomy and physiology
  - Physics and chemistry
  - Microbiology
  - Pharmacology
  - Clinical skills
  - Assessment skills
  - Human development

- **Knowledge required for emotional care**
  - Culture
  - Sexuality
  - Self-concept

- **Knowledge required for social care**
  - Ethics
  - Law
  - Family relationships
  - Human rights
  - Societal norms

- **Knowledge required for spiritual care**
  - Spirituality
  - Beliefs and values
  - Traditions and rituals

This text provides the foundation information in the areas where these two disciplines overlap. Although there are many commonalities, there are also differences between the disciplines in terms of their scope of practice and the technical skills required. This text considers the broad scope of professional practice of each discipline through its central focus on the person.

For the purposes of this text, a clinician is defined as ‘a health professional whose practice is based on direct observation and treatment of a patient, as distinguished from other types of health workers, such as laboratory technicians and those employed in research’ (Harris, Nagy & Vardaxis, 2006). There are places in this text where the term ‘clinician’ is used to describe a nurse or midwife. This occurs where the information is relevant to both disciplines. Where a practice is specific to nursing, the term ‘nurse’ is used, and where it relates only to midwifery, the term ‘midwife’ is used.

The purpose of this text is to guide you on your journey towards the attainment of professional thoughtful practice.
through an understanding of and an ability to apply person-centred practices within the disciplines of nursing and midwifery.

This chapter covers each discipline, its aims and definitions and its principles and practices. An increased emphasis on knowledge as the basis for practice has led to the growth of the professional disciplines defined as follows.

DEFINITIONS OF NURSING AND MIDWIFERY

The essentially person-centred nature of nursing and midwifery is evident from the fact that the central focus of the definition of each discipline is the patient, or person receiving care. As discussed earlier, this care includes the physical, emotional, social and spiritual dimensions of the person. This is referred to as holistic care, and sometimes also as ‘integrated care’. Whatever it is called, this type of care addresses each of these parts, which come together to make up the whole unique person (Dossey, 2008). While this text provides information on each of these parts, the central focus is on the whole—the person. The term ‘person-centred care’ is therefore used to describe this focus. The term will be explained more fully later in this chapter.

**Nursing**

As a person-centred discipline, nursing is no longer considered to be concerned primarily with illness care. Concepts and definitions of nursing have expanded to include a wider view of health that has resulted from medical and nursing research into the nature of disease prevention and management. The concept of health now includes both the prevention of illness and the promotion and maintenance of health for individuals, families and communities.

The word ‘nurse’ originated from the Latin word *nutrix*, meaning ‘to nourish’. Most definitions of the terms ‘nurse’ and ‘nursing’ describe the nurse as a person who nourishes, fosters and protects, and who is prepared to take care of sick, injured and older people. With the expanding roles and functions of the nurse in today’s society, however, any one such definition is too limited. The International Council of Nurses’ definition of nursing underpins many Australian and New Zealand educational programs, and is presented in Box 1-2.

**Midwifery**

In midwifery, the person being cared for is referred to as a ‘woman’, so person-centred care in this context is often called woman-centred care—not forgetting, of course, the midwife’s role in the care of the unborn and newborn baby, and in family support. Definitions of midwifery are usually couched in terms of a description of a professional midwife, such as the definition from the International Confederation of Midwives that has been adopted by the Australian College of Midwives, which provides a definition of midwifery through a portrayal of the midwife, as presented in Box 1-3.

The Midwifery Council of New Zealand’s description encompasses the unique perspective of the Māori in the following description.

The midwifery relationship enhances the health and well-being of the woman/wahine, the baby/tamaiti, and their family/whānau. The onus is on the midwife to create a functional partnership. The balance of ‘power’...
within the partnership fluctuates but it is always understood that the woman/wahine has control over her own experience.

This text will guide you through your development towards professional practice, but all journeys must begin with an understanding of why you are undertaking the journey in the first place. Therefore your initial step begins with understanding the broad aims of nursing and midwifery practice.

AIMS OF NURSING AND MIDWIFERY

The aims of nursing and midwifery are to promote, maintain and restore health, as well as to prevent further health breakdown. It is assumed by nurses and midwives that every person, no matter how ill, has strengths or positive characteristics that the nurse or midwife can maximise to promote health. Identifying and analysing peoples’ strengths is a component of promoting health, preventing illness (primary prevention), restoring health (secondary prevention) and facilitating coping with disability or death (tertiary prevention). Identifying and using these strengths helps the person to reach maximum function and quality of life or death.

Promoting Health

Health is a state of optimal functioning or wellbeing. As defined by the World Health Organization (1998), ‘one’s health includes physical, social, and mental components and is not merely the absence of disease or infirmity’. Health is ‘a product of reciprocal interactions between individuals and their environment’ (McMurray, 2007, p.7) and is achieved through balance and harmony in their physical, social, emotional and spiritual lives and their social surroundings. Health can be objectively measured and rated. The related term wellness refers to the relationship between the individual and his or her environment (McMurray, 2007). Wellness is a subjective state—a person may be medically diagnosed with an illness but still consider himself or herself well or healthy. Health and wellness are terms that are often used interchangeably, and both terms are used in this text.

Health promotion is motivated by a desire to increase a person’s wellbeing and health potential (Pender, Murdaugh & Parsons, 2006; McMurray, 2007). A person’s level of health is affected by many different interrelated factors that either promote health or increase the risk of illness. These factors include genetic inheritance, cognitive abilities, educational level, ethnicity, culture, age and gender, developmental level, lifestyle, environment and socioeconomic status.

In health promotion it is necessary to understand that the milieu in which nurses and midwives work is influenced by societal, economical and political systems. The Australian and New Zealand governments both have healthcare systems that offer widespread coverage. The key health issues that have become the focus of discussion and debate in both countries are the problems associated with chronic illness, healthcare needs of the Indigenous communities and (in Australia) rural health. Debate and concern also relates to escalating care costs as health systems struggle to provide access to effective care provision (Davidson, Elliott & Daffurn, 2004).

Health promotion should be the focus of nursing and midwifery activities when providing information and referrals. The roles of clinicians within the healthcare system are both collaborative and interdisciplinary. When providing care, the clinician considers the person’s self-awareness, health awareness and use of resources, thus health promotion is an integral part of every care plan. Through knowledge and skill, the clinician:

- Facilitates decisions about lifestyle that enhance quality of life and encourage acceptance of responsibility for one’s own health
- Increases health awareness by assisting in the understanding that health is more than just not being ill, and by teaching that certain behaviours and factors can contribute to or diminish health
- Teaches self-care activities to maximise achievement of goals that are realistic and attainable; serves as a role model (Fig. 1-1).

Preventing Illness (Primary Prevention)

The objectives of illness-prevention activities—‘upstream action’—are to reduce the risk of becoming ill and to maintain optimal functioning throughout the life span by promoting healthy living behaviours and attitudes. The motivation for illness prevention is to avoid, or achieve early detection of, illness, or to maintain function within the constraints of an illness (Pender et al., 2002; McMurray, 2007). Nurses and midwives contribute to the prevention of illness primarily by educating and by personal example. Such activities include:

- Educational programs in areas such as prenatal care for pregnant women, smoking-cessation programs and stress-reduction seminars
- Community programs and resources that encourage healthy lifestyles, such as aerobic exercise classes, tai chi and healthy ageing programs
- Advice on healthy nutrition, obtaining adequate rest, exercise and the importance of good health habits
- Health assessments in hospitals, clinics and community settings that identify areas of strength and risks for illness.

The focus of primary prevention is on taking precautions and promoting actions to remain healthy and avoid illness or injury (McMurray, 2007). The activities of
clinicians participating in primary healthcare ‘upstream actions’ range from person-to-person activities such as immunisation programs to advocacy and involvement in policy formation as part of professional organisations such as the Australian Nursing and Midwifery Council and the Midwifery Council of New Zealand (McMurray, 2007).

Restoring Health (Secondary Prevention)

Secondary prevention—‘midstream action’—describes those activities that aim to restore health (McMurray 2007). These activities focus on the individual with an illness, and range from early detection of a disease, through monitoring through pregnancy and birth, to rehabilitation and teaching during recovery. Such activities include:

- Holistic assessment to determine care needs and support medical diagnosis
- Early detection and appropriate management of deteriorating patients by referring questions and abnormal findings to other healthcare professionals as appropriate
- Providing direct care of the person who is ill by such measures as giving physical care, administering medications and carrying out procedures and treatments
- Collaborating with other healthcare professionals in providing care
- Planning and teaching in rehabilitation programs for illnesses such as heart attacks, arthritis and strokes
- Providing counselling and group support in mental health and chemical-dependency programs.

Facilitating Coping with Disability and Death (Tertiary Prevention)

Although the healthcare goals of promoting, maintaining and restoring health are important, these goals are not always appropriate for the situation. Personal and family-level coping with altered function, life crisis and death can also be facilitated by clinicians. Some coping mechanisms are not always healthy; however, as altered function decreases a person’s ability to carry out usual activities of living and expected roles, an optimal level of function and coping can be facilitated through maximising the person’s strengths and potentials. This facilitation is described as ‘tertiary prevention’, or ‘downstream action’, and occurs through education and through referral to community support systems (McMurray 2007). Midwives facilitate care of women through death pre-birth, stillbirths and the birth of children with disabilities that are apparent at birth or soon after. Nurses provide care to both people and families during end-of-life care, and they do so in hospitals, long-term care facilities and homes. Nurses are active in palliative care programs, which assist people and their families in preparing for death and in living as comfortably as possible until death occurs.

HEALTHCARE ENVIRONMENTS

Both nursing and midwifery are practised within healthcare environments that are shaped by their designated role and function (Figure 1-2). Although the environment in which care takes place may not affect the global aims of the professions, it may affect which aim takes precedence. For
example, nurses participating in a school education program on the dangers of illicit drugs are primarily involved with preventing illness, whereas nurses working in palliative care are more involved with facilitating coping. These environments are dynamic, are responsive to the needs of society and are influenced by many factors, such as new knowledge, the emergence of new health issues, the availability of resources within the physical environment and the availability of the human resources comprising a skilled workforce. Despite these variable factors, there are universal issues that affect the practice of nursing and midwifery and are a reflection of society itself, such as cost containment and quality and safety issues.

The relationship between society and health care is dynamic. Change in one affects the other and, as a result, healthcare environments also change; an example can be seen in the growth of birthing centres as alternatives to hospitals for giving birth. Patterns of change, plotted through population trends, also influence practice. For example, new developments in fertility practices have influenced society and then health care, through changing patterns of contraception, pregnancy and childbirth. In addition, changes in the make-up of populations that occur due to events such as war or immigration patterns are reflected in the people now being cared for by nurses and midwives. As well, the fact that people can now move between countries with more ease than ever before means that the ability to provide culturally safe care has become essential for both nursing and midwifery.

Twenty-first century life in general is becoming more complex, with rapid change a feature of both the developed and the developing world. Changes in health care through increasing knowledge influence practice on a daily basis (Hardy, 2004). Technology has also transformed how care is delivered and recorded, and how information is transmitted and stored. Information technology has made vast amounts of information accessible to consumers. A proportion of consumers and healthcare professionals use this information and thus appear to be becoming more questioning of care and treatment modalities. These advances in health care, along with advances in knowledge generated through research, also influence healthcare environments. This can be seen in the range of diagnostic tests, surgical interventions and pharmaceutical products that are now available. For example, some surgical procedures that would once have required hospitalisation may now be performed in outpatient facilities.

Advances in medical technologies have also enabled people to live longer, and as a society we are ageing and so are experiencing longer periods of chronic illness. This has led to an enormous escalation in demand for health care for conditions such as chronic respiratory and renal illness.
Longer life spans have also exposed the impact on healthcare resources that preventable accidents, such as falls in older women, can have. These issues shape policy development and the national health priorities that are discussed in Chapter 4. The fact that people are living longer often means that they are experiencing illness for longer periods of time. This has resulted in changes to where care is delivered. As more people are requiring health care, healthcare environments have changed accordingly. No longer is the hospital setting the only place for healthcare delivery. People are now being discharged as early as possible, with some still requiring active treatment and support from a carer or community nurse (Claire & Hofmeyer, 2004). Nowadays care may be delivered in any number of different environments as new technologies for delivering treatments in a variety of settings have been developed. For example, drainage of seromas in breast cancer care can now be performed in the woman’s home using new equipment and techniques. Therefore, care can be delivered in the home, in a clinic or in a hospital, sometimes by an autonomous clinician such as a nurse practitioner, sometimes by a clinician working within a healthcare team.

Not only is the demand for cost containment a feature of modern health care, but the availability of the human resources that make up a skilled workforce is also an issue that is influenced by society. The ageing of the population, reflected in the nursing and midwifery workforce. The national shortage and ageing of the workforce is of concern in both Australia and New Zealand (Davidson, Elliott & Daffurn, 2004). As demand for nursing grows and fewer registered nurses are available, other levels of nurses and other roles are expanding in both Australia and New Zealand. Expanding roles for enrolled nurses and the introduction of nursing assistants are examples of such changes. This situation is counterbalanced by increasing recognition of expert roles such as consultant nurse/midwives and nurse practitioners.

While changes in healthcare environments have been occurring, the focus on the person—the recipient of care—has remained constant. Person-centred care, which will be described later in this chapter, is an example of how this focus has developed into a systematic approach to care now emerging in many healthcare settings. In a literature review of person-centred care, the National Ageing Research Institute (2006) identified the following as essential for the development of a person-centred context.

- Skilled, knowledgeable and enthusiastic staff
- Opportunities to involve the service user, families and the community
- Provisions for staff to reflect on their own values and beliefs, and opportunities for them to express their concerns
- An environment of mutual respect and trust
- Dissolution of power structures and fostering of power sharing

The context in which care is provided has the potential to limit or enhance the person-centred nature of the healthcare environment, as it is easier to be person-centred in a person’s home than it is in a large complex hospital setting. Although the fluidity and diversity in healthcare environments is challenging, it is also exciting in the opportunities it presents. The range of possibilities for nurses and midwives is extensive. There is also increasing opportunity to move between disciplines, especially when working in healthcare environments such as rural settings. A range of skills is required in today’s diverse healthcare environments. Those skills that are common to both disciplines are outlined in Box 1-4.

The extensive body of knowledge and range of skills required in both disciplines demands a professional who is well prepared and who is committed to maintaining and developing personal knowledge that keeps pace with emergent technologies. Throughout this text, we will explore further the aims and skills of nursing and midwifery, with each chapter developing these from a different perspective. The following section outlines how the aims of nursing and midwifery are translated into the professional practice required in healthcare environments.

**PROFESSIONAL PRACTICE**

The professions of nursing and midwifery in Australia and New Zealand have rich histories, which are explored in Chapter 9. Each profession also has a theoretical basis (also discussed in Chapter 9). Theory gives meaning to practice, guides research, and guides the preparation of novices through education. Educational preparation for a registered nurse or midwife comprises an undergraduate degree. Preparation for other levels of nurse or midwife varies between registering authority jurisdictions, as discussed in Chapter 12. In Australia, a system of national registration projected to be implemented in 2010 should see greater uniformity in preparation for practice.

After graduating, each of you will undertake a personal pathway, choosing from the many different options available in nursing and midwifery. It is this diversity and variety of

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**BOX 1-4 Common Skills for Nurses and Midwives**

- Assessment skills
- Resuscitation skills
- Management of treatment modalities, including medication
- Fluid management and intravascular device skills
- Management of physiological dysfunction
- Education and counselling skills
- Empathic communication and interpersonal skills
- Advocacy skills
- Clinical reasoning skills
- Reflective skills
practice that makes these professions so rewarding for graduates. For many, this pathway will involve further study, pursuing interests in particular specialties. Choices in caring for particular groups of people or within specific settings can also be made. For example, you might choose to become a renal nurse caring for children in remote communities, or a neurology nurse caring for stroke patients in hospital or in community settings. Despite this potential for specialisation, all care activities in nursing and midwifery are underpinned by the knowledge that you will acquire as an undergraduate, supported in your learning by this text. Figure 1-3 provides an overview of the education required for professional practice.

In order to qualify for professional practice as a registered nurse or midwife or as an enrolled nurse, the candidate must demonstrate competency. The term competency may be defined as the knowledge, skills and attributes that the professional brings to the therapeutic relationship that takes place in a context of care. Table 1-1 summarises the national competency standards for registered nurses in Australia and New Zealand. Table 1-2 summarises the national competency standards for registered midwives in Australia and New Zealand. A complete list of competencies is available on the respective websites of the registering authorities, which are listed at the end of this chapter.

**PERSON-CENTRED CARE**

Most of the health disciplines profess a philosophy of person-centred care. Health disciplines are also influenced by a philosophy of holism, which is an appreciation that each individual is composed of a number of dimensions that operate together to form a whole person who interacts uniquely with his or her environment. Holistic care is discussed in Chapter 2 and developed further in Chapter 34. An appreciation of the many dimensions that make up a person has been present in Eastern systems of medicine for millennia. However, in Western medicine this holistic approach has been challenged by the acceptance by the medical profession of the philosophy of Descartes, a 17th-century philosopher who advocated the division of mind and body. This is explained further in Chapter 34. Consequently, while changes in modern thinking have led to many important discoveries and resultant changes in health care, the focus on Descartes’ model has also created an approach that concentrates on specialties based on bodily systems, such as neurology or gastroenterology, rather than on a holistic view of the whole person. This reduction of medicine into parts has made humanistic care more difficult to achieve (Walker, 2006).
TABLE 1-1 Summary of National Competency Standards for Registered Nurses in Australia and New Zealand

<table>
<thead>
<tr>
<th>Australia</th>
<th>New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>The competencies that make up the Australian Nursing and Midwifery Council's National Competency Standards for the Registered Nurse are organised into the following four domains.</td>
<td>The competencies that make up the Nursing Council of New Zealand’s National Competency Standards for the Registered Nurse are organised into the following four domains.</td>
</tr>
<tr>
<td><strong>Professional practice</strong></td>
<td><strong>Professional responsibility</strong></td>
</tr>
<tr>
<td>This domain relates to the professional, legal and ethical responsibilities that require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.</td>
<td>This domain contains competencies that relate to professional, legal and ethical responsibilities and cultural safety. These include being able to demonstrate knowledge and judgment and being accountable for own actions and decisions, while promoting an environment that maximises patient safety, independence, quality of life and health.</td>
</tr>
<tr>
<td><strong>Critical thinking and analysis</strong></td>
<td><strong>Management of nursing care</strong></td>
</tr>
<tr>
<td>This domain relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and on the consequences of these for individuals/groups is an important professional benchmark.</td>
<td>This domain contains competencies related to patient assessment and managing patient care, which is responsive to the patient’s needs, and which is supported by nursing knowledge and evidence based research.</td>
</tr>
<tr>
<td><strong>Provision and coordination of care</strong></td>
<td><strong>Interpersonal relationships</strong></td>
</tr>
<tr>
<td>This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/groups, planning, implementation and evaluation of care.</td>
<td>This domain contains competencies related to interpersonal and therapeutic communication with patients and other nursing staff, and interprofessional communication and documentation.</td>
</tr>
<tr>
<td><strong>Collaborative and therapeutic practice</strong></td>
<td><strong>Interprofessional health care and quality improvement</strong></td>
</tr>
<tr>
<td>This domain relates to establishing, sustaining and concluding professional relationships with individuals/groups. It also includes those competencies that relate to the nurse understanding their own contribution to the interdisciplinary healthcare team.</td>
<td>This domain contains competencies to demonstrate that, as a member of the healthcare team, the nurse evaluates the effectiveness of care and promotes a nursing perspective within the interprofessional activities of the team.</td>
</tr>
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</table>

Previously we stated that health is a product of the interaction of people with their environment. The impact that environment or place has on people can be observed through their interactions with healthcare systems, and the way their sense of self can alter when they enter a hospital environment. An examination of the history of the concept of person-centredness demonstrates this interdependence. The importance of the individual has always been fundamental to nursing and midwifery (Fitzgerald, 2006), but its primacy has altered according to where care is delivered. The carer’s respect for the cared for was described in the 1920s, when the context of care was primarily in the person’s home. As care environments gradually shifted to hospitals, the biomedical model that directed care according to medical diagnosis took hold, and a task-oriented focus to care developed, with a reduction in patient empowerment. The changes in society that developed through the 1960s saw a re-emergence of humanistic values, and these were reflected in many of the nursing theories developed in the 1970s. In the 1980s, the partnership approach to delivering health care, particularly within the nursing and midwifery context, was recognised by registering authorities in the UK. This evolved into the ‘practice development’ movement, which has since spread from the UK to Australia and New Zealand.

In order to help you understand the principles of person-centred care, we will explore the concept by examining the principles related to the concept of the person—personhood and person-centredness—and then translating this into the healthcare context and the concept of person-centred care.

**Principles of Person-Centred Care**

Although the disciplines of nursing and midwifery have different competency standards, they are united by a common set of principles. **Principles** are general truths on which other truths depend ([The Macquarie Dictionary](https://www.macquarie.com/), 2005). The concept of personhood, or being a person, is not new, nor is it unique to contemporary Western health care. Professional practices in most disciplines that aim to serve people are underpinned by a philosophy that advocates the uniqueness...
TABLE 1-2 Summary of National Competency Standards for Registered Midwives in Australia and New Zealand

<table>
<thead>
<tr>
<th>Australia</th>
<th>New Zealand</th>
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<tbody>
<tr>
<td>The competencies that make up the Australian Nursing and Midwifery Council’s National Competency Standards for the Registered Midwife are organised into the following four domains.</td>
<td>The competencies that make up the Midwifery Council of New Zealand’s National Competency Standards for the Registered Midwife are organised into the following four domains.</td>
</tr>
<tr>
<td><strong>Legal and professional practice</strong>&lt;br&gt;This domain contains the competencies that relate to legal and professional responsibilities including accountability, functioning in accordance with legislation affecting midwifery and demonstration of leadership.</td>
<td><strong>Competency One</strong>&lt;br&gt;The midwife works in partnership with the woman/wahine throughout the maternity experience.</td>
</tr>
<tr>
<td><strong>Midwifery knowledge and practice</strong>&lt;br&gt;This domain contains the competencies that relate to the performance of midwifery practice including assessment, planning, implementation and evaluation. Partnership with the woman is included in this domain.</td>
<td><strong>Competency Two</strong>&lt;br&gt;The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.</td>
</tr>
<tr>
<td><strong>Midwifery as primary health care</strong>&lt;br&gt;This domain contains the competencies that relate to midwifery as a public health strategy. Included are the notions of self-determination and the protection of individual and group rights.</td>
<td><strong>Competency Three</strong>&lt;br&gt;The midwife promotes practices that enhance the health of the woman/wahine and her family/whanau and which encourage their participation in her health care.</td>
</tr>
<tr>
<td><strong>Reflective and ethical practice</strong>&lt;br&gt;This domain contains the competencies relating to self-appraisal, professional development and the value of research.</td>
<td><strong>Competency Four</strong>&lt;br&gt;The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care.</td>
</tr>
</tbody>
</table>


of the person. Teachers, for instance, refer to ‘student-centred teaching’. Although each discipline may use different nomenclature, including ‘woman-centred care’ in midwifery, the principles remain the same. Figure 1-4 portrays how the mind, body and spirit interconnect to create the whole person and interact with the environment and the social world.

The Person at the Centre of Care

**Personhood**

**Personhood** relates to our being human, what makes us, what interests us, what challenges us, what we hold dear and what threatens our wellbeing. As humans, we are social beings who exist in a complex world, alternating between environments and relationships with many different places, people and groups. A lot has been written about personhood but there is no one single definition of this term. Essentially the concept of personhood is an expression of the humanity of each person. We are each unique beings with rich lives full of personal meaning that shapes our values and beliefs and finds expression through our attitudes and behaviour. Our internal make-up and our experiences, as we interact
with the world, colour the lens through which we see the world. This helps shape the meaning of our experiences and our relationships. Each of us is composed of many parts: our physical attributes, our personality, our spirituality and our sexuality but no one part should be considered separately, as we are more than just the sum of our parts.

Each individual has a concept of self that can be responsive to the environment and to others around us. Illness and disability can disrupt this self-concept and therefore our sense of being a person. It is an essential part of care that when this occurs the clinician works with the person to rebuild this sense of personhood. Although the ‘person’ is often referred to in healthcare literature, the term is rarely defined, and the person may also be referred to by many other terms in different contexts (National Ageing Research Institute, 2006). This can be seen in the following description of a person, which encapsulates the various terms that were developed for the Australian Nursing and Midwifery Council’s code of ethics.

**Person (health consumer):** refers to the person requiring or receiving health care, treatment, advice, information or other related services. It includes the full range of alternative terms such as client, resident and patient. This term may include the family, friends, relatives and other members of a person’s nominated social network, and people who are associated with the person who is the recipient of care (Australian Nursing and Midwifery Council, 2008).

A person receiving treatment in a hospital, may be referred to as a patient; if receiving treatment at home as a client; or if living in assisted care, as a resident; and when giving birth, she is referred to as a woman (Slater, 2006). Regardless of which term is used to describe the person, the concept of personhood and the uniqueness, the humanity and the value of each individual is presumed. This text follows this convention and uses the term relevant to the context.

**Person-Centredness**

Being person-centred refers to the demonstration of respect for personhood through the words and actions of the professional. **Person-centredness** requires the establishment of caring relationships between professionals, patients and significant others such as family members, based on mutual trust and the sharing of collective knowledge of the person (Ford & McCormack, 2000). Kitwood (1997, p.8) defined person-centredness as ‘a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being’. It implies recognition, respect and trust. This approach is consistent with theories based on human caring, which use a holistic approach to promote humanism, health and quality of living. Caring is viewed as universal, and is practised through interpersonal relationships.

When the relationship between the carer and the cared for is used for promoting or restoring the health and wellbeing of the individuals within the relationship, it becomes a therapeutic relationship (Pearson, 2000). In the context of the therapeutic relationship, some theorists and researchers believe that the personhood of the carer is as important as that of the person being cared for (McCormack 2003a; Nolan, et al. 2004). The relationship is described as therapeutic when communication is effective and the needs of the cared for are fulfilled. Therapeutic relationships must therefore be non-judgmental and must respect the power of each person within the relationship. In this way, power is not misused, and trust is built by recognising the humanity of people in a partnership approach to care (Figure 1-5). This relationship is imperative for quality care, as people view the clinical encounter as central to their health care and value it highly (Dieppe, Rafferty & Kitson, 2002). Although there are many factors that can affect the encounter, if the relationship between the carer and the cared for is good, then outcomes are more likely to be positive (Briggs et al., 2004). When a person-centred approach to care is undertaken, this means that the values and beliefs of both partners in the relationship are understood and preserved (McCormack, 2003a). Attention is paid to the relationship, time spent in the encounter and the context in which it occurs, so that trust is established and maintained (Nolan, Keary & Avrayard, 2001).

At the same time as respecting the person’s ‘self’, being person-centred means that ‘others’ are considered as well. As all people exist within a social context, ‘others’ in this context are the other people who occupy the social world of the person. This includes both family (in its many permutations) and community in both the geographical and the social sense (where the person lives, and who he or she lives with). Although the importance of the extended family (‘whanau’ in Maori) is an essential consideration for all people, it is especially vital when caring for Indigenous people in both Australia and New Zealand. By knowing the person, we can understand his or her present world and lived experience. This enables clinicians to enter into a relationship that aims to build on the strengths of the person and the positives within the experience, rather than finding meaning only in the illness.

Being person-centred applies to the behaviour of the clinician as an agent, one who ‘intentionally makes things happen through one’s actions’ (Bandura, 2001, p.1). **Moral agency** is the responsibility of the individual to translate moral principles into action, and is described more fully in Chapter 11. In a caring therapeutic relationship, there is a moral agency that demands that the notion of personhood be preserved through the actions of the healthcare professional. In order for clinicians to be person-centred, moral agency means that they must reflect on their own values and beliefs, review their knowledge base and rectify any deficits or omissions, and always review their practice (Ford & McCormack, 2000). Chapter 13 develops this in greater detail. In this way, clinicians can know themselves, demonstrating self-awareness, so that their own values, beliefs, biases and prejudices are understood and dealt with. This self-awareness leads to a respect for diversity and for therapeutic interactions.
Person-Centred Care

When the concepts of personhood and person-centredness are applied to the actual care that is delivered to people in times of need across their life span, in a range of settings, person-centred care occurs. Indeed, the concept of personhood encompasses the trust and respect that can only be maintained when processes of care are underpinned by these principles. Person-centred care is essential in every specialty and in every setting, whether it be mental health or aged care or community-based family practice. If person-centredness is understood and supported, person-centred processes can become the accepted practice of the healthcare environment regardless of its focus.

Person-centred care recognises individuality so that the care provided is in direct response to the needs of the person (Nolan, 2001). Therefore, the person-centred health professional needs to be both knowledgeable and skilled. However, person-centred care goes beyond simply individualising care through token adjustments to physical care. It permeates all aspects of care and is compatible with the values and beliefs of the person receiving care. Again, this requires knowing the person. For example, assessment must be undertaken with the purpose of getting to know the person, his or her story and the needs related to his or her whole being, not just those related to what brought the person to the healthcare environment.

Each individual interaction or intervention should be undertaken in the spirit of partnership and social justice. This partnership approach necessitates empowerment—a sharing of power by accepting the rights of people, acknowledging their autonomy and enabling the person and others that are part of the relationship to engage in informed decision making (National Ageing Research Institute, 2006). This allows the person being empowered to make decisions about his or her own health care and to take responsibility for those decisions.

BOX 1-5 Personal Attributes of a Person-Centred Clinician

- Open-mindedness
- Profound sense of the value of the individual
- Self-awareness and knowledge of own beliefs and values
- Sense of personal responsibility for actions (moral agency)
- Motivation to do the role to the best of one’s ability
- Leadership skills
- Bravery to question the ‘system’
Barriers to Person-Centred Care

As with all things, there are barriers that impede the implementation of person-centred care. This approach is sometimes criticised as being too individualistic and time-consuming. However, when care focuses on tasks or a case, it fails to optimise opportunities to promote person-centredness, and values the system rather than the person. As a result, it can lead to ritualised behaviour and ‘robotic’ care, where clinicians become disconnected and disengaged. However, when clinicians are skilled, committed and enthusiastic about implementing the principles of person-centred care, this therapeutic relationship naturally carries over into the care processes.

The principles that underpin person-centred care are also sometimes criticised as being idealistic and optimistic, and as being difficult to achieve in healthcare environments or other contexts in which care takes place, due to the many other competing priorities and pressures. However, these environments also need to be as therapeutic as possible. For example, physical surroundings must preserve peoples’ privacy and dignity so that their sense of self is not threatened. But person-centredness relates not just to physical surroundings but has a more expansive meaning. The culture of the healthcare environment must be conducive to working in this person-centred way, and services should be flexible, supportive and easy for users to navigate. McCormack (2003a) describes the crucial aspects of healthcare environments as being freedom for nurses to act autonomously, and organisational and decision-making systems that recognise power differences and tolerate innovation. Unfortunately, many healthcare environments are large and complex and do not facilitate person-centredness, as schedules and routines take precedence over people. This does not mean that person-centred care is impossible in such large organisations, but it does mean that it can be more difficult to achieve, and that it requires commitment to its principles.

Further, when integration and coordination between many different services is poor, this disorganisation can result in care that disregards the importance of the persons in the partnership.

THOUGHTFUL PRACTICE AND PROCESSES OF CARE

In Unit 3, you will be introduced to the conceptual framework of thoughtful practice, in which the care of the person is undertaken by a clinician who uses clinical reasoning and reflective practice to guide thoughtful actions and person-centred processes of care. These components are explained further in Chapters 13 and 14. At the centre of practice is the person, around whom the components of the model revolve in an interconnected manner. The situations that emerge in clinical practice require the clinician to reason through clinical problems, reach a judgment, make a decision and undertake an action. Although all clinicians’ actions should be underpinned by thinking and knowledge, some situations require only simple reasoning functions; for example, activities such as bathing and feeding. Other situations require higher-order clinical reasoning and critical thinking skills; for example, activities such as educating, guiding, facilitating and counselling (Porter-O’Grady, 2001). While clinical reasoning is an important component of thoughtful practice, a thoughtful practitioner also acquires knowledge learnt both for and from practice.

Learning occurs in preparation for professional practice through a combination of theory and practice in academic programs and clinical experience. Learning from practice, or critical reflection on and in practice, is a technique that is taught both at universities and in practice settings. This important source of learning from experience through reflection is an essential component of the clinician’s knowledge. However, reasoning and reflecting are not the only components of thoughtful practice, as they are only abstractions if they are not connected to the actions that clinicians take. If these actions are not person-centred, care loses its humanity. It is the constant movement through each of these components that makes practice thoughtful.

As you explore the information in this text that provides you with the knowledge you need for care delivery, you will also explore thoughtful practice—from its professional framework to its inner core of the person. You will undertake a journey towards professional growth from student to nurse or midwife. The text includes a number of ways of fostering this growth through learning, as follows.

PROFESSIONAL GROWTH THROUGH LEARNING

While it is important to remember that care takes place in a complex healthcare environment, some principles, such as person-centredness, are constant within the disciplines of nursing and midwifery. To engage effectively in the process of care within these environments, you will need to draw from a wide body of knowledge and skills that inform practice. In modern health care, change is ever present and technological advances in therapies are increasing exponentially. This creates challenges for you to keep pace with knowledge development and to master the technology required in order to improve the outcomes for the people you are caring for (Hardy, 2004). Knowledge for practice must also take into account the shifting nature of healthcare environments. Your development through the undergraduate experience is only the first step in learning to become a professional.

Learning Portfolios and Lifelong Learning

In Chapter 13, you will be introduced to professional portfolios that are required in practice. As a student you can start to build your professional portfolio by commencing with a
A learning portfolio is a compilation or continuous account of knowledge and skill acquisition that records your experiences and competency (Andre & Heartfield, 2007). The use of portfolios encourages both students and qualified practitioners to take responsibility for their individual learning and allows them to provide evidence of professional practice that can be measured against practice standards such as the Australian Nursing and Midwifery Council or Nursing Council of New Zealand competency standards. The competency standards also require evidence of personal learning from practice through reflections, as a portfolio is limited as a developmental tool if there is no evidence of this occurring (Andre & Heartfield, 2007). In all healthcare professions there is now an expectation that learning continues after graduation, due to the constantly evolving nature of practice (Dennis & Hardy, 2006). By using a portfolio, a professional can demonstrate evidence of his or her developing practice through learning that can be confirmed through the use of the competency standards (Emden, Hutt & Bruce, 2003-04; Karsenti, Villeneuve & Goyer, 2007). Portfolios may be constructed in different formats. Many of the professional organisations, such as the Royal College of Nursing, Australia (RCNA), provide portfolio models that include evidence of learning through reflection on and in practice. Table 1-3 illustrates one way of organising a portfolio that can be started during your undergraduate years and then converted into a professional portfolio following your transition to practice.

Portfolios may also be in electronic form (e-portfolios). An electronic portfolio serves the same purpose as paper-based models, but can take advantage of available technology and include web-based or multimedia components such as CD-ROM, DVD or mixed media. Many universities assist undergraduates with the skills required to create electronic portfolios.

However, a portfolio is not a haphazard collection of evidence; it is constructed in a purposeful way to demonstrate your learning. Throughout your learning journey you may collect a variety of material that can be added to your portfolio, such as those referred to in Table 1-3. As a student, this material may include case studies, patient stories, essays, presentations and group activities. You may also experience some subjects in your studies that explore learning through art, music or poetry; all of this learning is evidence of your growth and development. You may supplement this material through reflective pieces from your studies or from your clinical placements. In addition, as you work through this text you will be undertaking activities that demonstrate your critical reflection and learning experiences related to the clinical environment. As you collect this evidence of your learning, you are building your portfolio.

Each time you see the symbol 📚 it is a reminder to capture your learning for your portfolio. The development of a learning portfolio will equip you with the evidence of learning that you will need when you enter the realms of professional practice, and that you will require to produce your professional portfolio.

### TABLE 1-3 Suggested Portfolio Structure

<table>
<thead>
<tr>
<th>INTRODUCTION</th>
<th>SECTION ONE: Qualifications and Experience</th>
<th>SECTION TWO: Assessment of Competence</th>
<th>SECTION THREE: Continuing Professional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum vitae/biographical details</td>
<td>Qualifications</td>
<td>Self-assessment, using the ANMC or NCNZ competency standards</td>
<td>Clinical narratives, reflection, literature summaries</td>
</tr>
<tr>
<td>Professional goals</td>
<td>Employment history</td>
<td>Professional practice</td>
<td>Case studies from the literature</td>
</tr>
<tr>
<td>• Short term</td>
<td>Professional memberships</td>
<td>Critical thinking and analysis</td>
<td>Other relevant assignments</td>
</tr>
<tr>
<td>• Long term</td>
<td>Awards and commendations</td>
<td>Provision and coordination of care</td>
<td>Interpersonal and interdisciplinary communication</td>
</tr>
<tr>
<td>Certificates</td>
<td>Core competencies</td>
<td>Collaborative and therapeutic practice</td>
<td>Education sessions attended (in-services, conferences)</td>
</tr>
<tr>
<td>References/referees</td>
<td>Clinical assessment results</td>
<td>Formal feedback</td>
<td>Presentation of educational activities, papers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinical summary sheets</td>
<td>Further undergraduate/postgraduate studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Core competencies</td>
<td>Research undertaken</td>
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<td>Publications</td>
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<td></td>
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<td>Journal subscriptions, professional journals read</td>
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Source: Adapted from the Australian Nursing and Midwifery Council, 2007 and the Nurses and Midwives Board of Western Australia, 2004.
The ultimate goal of your professional learning is for you to take up the position of a registered practitioner. Once you have completed your student journey, you will enter the profession of nursing or midwifery. The phase of your metamorphosis from student to professional is called transition to practice.

**Transition to Practice**

Throughout this text, you will encounter the principles and approved standards that support and guide professional practice. These principles and standards of practice provide the expectations and boundaries of practice for nurses and midwives practising in Australia and New Zealand. When you register as a professional, you will have been deemed to have reached that standard. When transition to practice is achieved, you will have completed the change from student to clinician that is the first stage in your progression towards professional practice as a nurse or midwife of the future.

Certain skills permeate all aspects of care, such as those required for thoughtful practice. These include the skills of clinical reasoning and of reflection (see Chapters 13 and 14), which are the tools of the trade for registered practitioners in nursing and midwifery. These skills also enable you to develop the last two attributes on the list in Box 1-5, so that when you have completed your transition you may assume the responsibilities of practice as a leader and as a supervisor of other workers within healthcare teams.

Remember, however, that this text only assists you in the preparation for your professional journey, as your learning journey is lifelong. Nursing and midwifery offer many pathways that you may choose to follow, so your journey has only just begun.

**Developing knowledge skills**

In this chapter you have been learning about the professional disciplines of nursing and midwifery and about the principles that underpin person-centred care. In Box 1-1 the common knowledge requirements that are the foundation of practice for both nursing and midwifery are displayed. As you work through the text you will be developing knowledge in each of the areas in this list.

What have you learnt?

- The definitions of nursing and midwifery
- Knowledge of the aims of nursing and midwifery
- The ability to identify the issues that affect healthcare environments
- An understanding of professional practice and the role of competency standards
- An ability to understand and interpret the principles of personhood, person-centredness and person-centred care.

To enhance your learning and facilitate further understanding of this chapter, refer to thePoint online resource.

**Developing critical thinking skills**

1. Interview another student and ask what he or she thinks are the aims of nursing and midwifery. Compare the answers to the text, and discuss any areas that were not covered. Think about your experiences of health care to date, both as a student and as a consumer. Match these to the list and then make a new list identifying areas that you need to explore in order to gain a better appreciation of the aims of nursing and midwifery.

2. Arrange a group of students to discuss the principles of person-centred care and their own experiences to date, in clinical placements or in their personal encounters with healthcare personnel. Make a list of examples of practice that matched the principles and a list of those that didn’t. Then think about these examples and make a list of challenges for yourself to undertake in your next clinical placement.

**Review questions**

1. Which of the following best describes the science of nursing?
   a. The skilled application of knowledge
   b. The knowledge base for care
   c. Hands-on, such as giving a bath
   d. Respect for each in individual patient

2. Which of the following best describes a midwife?
   a. A person who instructs women in what to do during childbirth.
   b. A person who works in a hospital delivery suite.
   c. A person who works in partnership with women during pregnancy, labour and the post-partum period.
   d. A person who delivers babies.

3. A statement reflects a common assumption shared by nurses and midwives?
   a. People have strengths that may help them to maximise their own health and wellness.
   b. People have limited capacity to deal with illness and disability.
   c. People need nurses and midwives to provide all care when they are ill.
   d. People lose their strength and resilience when they become ill.
4. You are teaching a class of high school students about the effects of smoking. The educational program will meet which of the aims of nursing?
   a. Promoting health
   b. Preventing illness
   c. Restoring health
   d. Facilitating coping with disability and death

5. You are a midwife working with women who develop diabetes during their pregnancy. The educational program will meet which of the aims of midwifery?
   a. Promoting health
   b. Primary prevention
   c. Secondary prevention
   d. Tertiary prevention

6. Nursing and midwifery are disciplines that have to cope with disability, death and bereavement? Which option correctly states the veracity of this statement?
   a. The statement is totally correct.
   b. The statement is partially correct.
   c. The statement is totally false.
   d. The statement is partially false.

7. Which of the following statements best describes the challenges facing contemporary healthcare?
   a. Increasing healthcare costs, decreasing availability of a skilled workforce and rapid change are challenges for health care today.
   b. Increasing costs, technological advances and a surplus of workers are challenges for health care today.
   c. Rapid change, quality and safety issues and a surplus of resources are challenges for health care today.
   d. Technological advances, new knowledge and abundant resources are challenges for health care today.

8. What type of authority regulates the practice of nursing and midwifery?
   a. International standards and codes
   b. Federal guidelines and regulations
   c. State nurse practice acts
   d. Institutional policies

9. Which of the following best describes the meaning of competency?
   a. The knowledge the nurse or midwife has about practice
   b. The skills that the nurse or midwife has
   c. The personal attributes of the nurse or midwife
   d. All of the above

10. Personhood is a new concept that has developed in Western medicine since the 1980s. Which option correctly states the veracity of this statement?
    a. The statement is totally correct.
    b. The statement is partially correct.
    c. The statement is totally false.
    d. The statement is partially false.

11. Which of the following phrases best explains the term ‘moral agency’?
    a. An ethical principle that underpins relationships
    b. A concept that occurs accidentally in health care
    c. A rule or law introduced into health care
    d. The responsibility of each person to translate ethical principles into action

12. Which is the correct term when referring to an individual using the principles of Person-Centred Care?
    a. A patient
    b. A client
    c. A resident
    d. Any of the above depending on the context

13. Which of the following best describes a ‘Learning Portfolio’?
    a. A collection of learning exercises that may be used by a student.
    b. A collection of evidence demonstrating learning by a student.
    c. A list of competencies achieved by a student.
    d. An individual piece of work that demonstrates student learning.

14. Transition to Practice refers to?
    a. The final period of student learning prior to registration as a nurse or midwife
    b. Postgraduate studies undertaken by an experienced nurse or midwife
    c. Completion of an undergraduate degree in nursing or midwifery
    d. The change from student to clinician that heralds the progression to professional practice

Answers with rationales

1. The correct response is b. The science of nursing is the knowledge base for care that is provided. In contrast, the skilled application of knowledge is the art of nursing.

2. The correct response is c. A midwife works across a range of settings in partnership with women during pregnancy, labour and the post-partum period.

3. The correct response is a. Nurses and midwives base their practice on an assumption that people have strengths and positive characteristics that may be drawn upon to maximise their health even in the face of illness.

4. The correct response is b. Educational programs, such as the risk of smoking, can reduce the risk of illness and promote good health habits.

5. The correct response is c. Monitoring programs such as that described seek to restore the person to good health and reduce the risk of illness.

6. The correct response is a. Nurses have to work with people who are dying, their families and midwives work with women who have pre-birth deaths of a child or still births.

7. The correct response is a. Increasing healthcare costs, decreasing availability of resources such as a skilled workforce, technology advances and rapid change are challenges for health care today.
8. The correct response is c. Nurse Practice Acts are established in each state to regulate the practice of nursing.
9. The correct response is d. The term competency refers to the knowledge, skills and personal attributes of the clinician.
10. The correct response is c. The concept of Personhood is aligned to holistic care which is an ancient principle used in Western medicine that has emerged after a hiatus.
11. The correct response is d. The term moral agency refers to the responsibility of each person to translate ethical principles into action.
12. The correct response is d. A patient is a person receiving care in a hospital, a resident in an aged care facility and a client is the person receiving care in the community. All are correct within their context.
13. The correct response is b. The learning portfolio is a collection of evidence that demonstrates the learning of the student.
14. The correct response is d. Transition refers to the period when a new graduate commences practice as a registered clinician.

Bibliography

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Chapter 1 Introduction to Nursing, Midwifery and Person-Centred Care


Web resources

Australian Nursing and Midwifery Council: www.anmc.org.au

Nursing Council of New Zealand: www.nursingcouncil.org.nz

Midwifery Council of New Zealand: www.midwiferycouncil.org.nz