**A post-modern nursing model**

**Summary**

For some time, nursing has been based on the structure of the nursing process and nursing models. However, in an age where the old order of science and medicine can no longer answer all of society's questions, can a nursing model, with its roots firmly based in the modernist structure of the nursing process, be post-modern?

The opening in spring 1996 of an 18-bed inpatient unit at Shipley Community Hospital in West Yorkshire gave the new nursing team an opportunity to develop innovative practice. The unit was designed to cater for those with non-acute care needs, being rehabilitative, recuperative and palliative in nature.

The need to form a cohesive care delivery system and assessment strategy which would meet the needs of the patient group led to the formation of a project team to develop a model for practice. The team was enhanced with the support of a lecturer from Bradford University, a benefit of the unit’s Nursing Development Unit status.

The first step was to devise a philosophy of care, recognised as the cornerstone of a nursing model and of good practice (Wright 1990). The unit’s philosophy of care was based on the beliefs and values of the nursing team. A number of core concepts were identified, including respect for the individual, a collaborative approach to patient care (being both multidisciplinary and patient-centred) and holistic care.

The team’s view of nursing was that it should be person-centred. If the patient’s goals were to be met then care plans should be negotiated with the patient and his or her significant others. Practice would centre on a partnership with the patients through primary nursing, a culture of empowerment and a holistic approach to care. To achieve this, the link between effective practice and education was recognised, as was the need to develop a culture where innovation and excellence could thrive – this could be achieved through transformational leadership (Bowles and Bowles 1999).

The view of health was to be much broader than the mere absence of illness. The team liked the view of Pearson *et al* (1996): ‘[health is]... a subjective state perceived by individuals about themselves and influenced by what the community they live in think about what is normal.’

The environment of the patient group had to be more than the patients’ internal environment and the clinical area. If care was to be tailored to meet individual needs and help patients to meet their personal goals – two key components of the unit philosophy – then the environment would also need to include emotional, intellectual, social and spiritual dimensions.

These core concepts, together with the make-up of the patient group, gave the project team a framework on which to base the practice model. No ‘off the shelf’ model seemed to fit, so it was decided to look at combining aspects of different models which best reflected the team’s beliefs and values and the patient group’s needs. The ‘five dimensions of self’ (Beck *et al* 1988) view of a person was chosen as it matched the perception of the individual as having physical, emotional, intellectual, social and spiritual dimensions. This view of the person is arguably holistic, fitting with the move away from the mechanistic perspective of the medical model. The assessment strategy was based on the Burford model (Johns 1996), with its emphasis on being patient-centred, having the core question of ‘what information do I need to nurse this patient?’ This is followed by a series of cue questions, which the project team built around each of the five dimensions of self. It was decided that there needed to be a measurable element to the assessment if the team was to demonstrate the outcomes of therapeutic interventions. To do this, a number of validated assessment tools were added to the document to provide a benchmark of the patient’s ‘five dimensions of self’.

Between 1996 and 1998 the model was piloted and evaluated. The patient-centred nature of the assessment document allows the patient to identify his or her own problems. The patient and nurse can then together negotiate a plan of care. So the patient will help to evaluate the model through ongoing evaluation of care plan goals.

**Choosing a model for practice**

The modernist paradigm

Marks-Maran (1999) describes how the term modernism is used to describe the thinking by which traditional authority was rejected in favour of the present time. Modernism is thus a way of thinking which is opposed to the established order of things, including the authority of the past. It was a time when traditional authority was rejected in favour of the present time. Modernism is thus a way of thinking which is opposed to the established order of things, including the authority of the past. It was a time when traditional authority was rejected in favour of the present time.
of reason and science, objectivity being the only truth. This train of thought has been dominant throughout most of this century and is said to be the prevailing paradigm. A paradigm is said to be where a critical mass of people in professions and areas of society must be thinking in the same way (Marks-Maran 1999). When deviations from the rule arise, which the accepted paradigm cannot explain, some individuals will devise a new principle or law to account for the anomaly. If peers broadly acknowledge this, then the new account will become the accepted truth and that area of science will undergo a ‘paradigm shift’.

The modernist paradigm has been firmly embraced by medicine to help explain diseases and has used empirical science to determine its methods and practices. Nursing has increasingly sought professional credibility and status by mimicking the medical tradition. Griffin (1993) describes how despite medicine’s spectacular successes, it has not found cures for stress-related illnesses such as hypertension, insomnia, depression and alcohol abuse. Medicine cannot explain human beings by their most basic biological processes, as with the medical model, does not work.

The nursing process was based on the assumption that nurses assess, plan, implement and evaluate with the patient and/or his or her carers. However, while this approach is arguably valid and holistic, it is based on the assumption that nurses assess, plan, implement and evaluate strategy, which, as argued, does not wholly represent the way in which nurses think. In practice, nursing staff do use the assessment

confirmed by systematic, rationalistic observation. The widespread use of the nursing process has emerged from the emphasis on rationalistic research by nurses. The nursing process has provided a structure that can be used to uniformly define practice and to conduct quantitative research.

Marks-Maran (1999) describes how the nursing process was based on the assumption that nurses think in a linear and ordered manner. However, nurses obviously do not all think in the same way. Some use protocols and routine, others use a problem-solving approach – both methods being evidence-based to a degree. Benner et al (1998) describe how expert nurses make decisions about care as ‘thinking-in-action’, which is said to be a process by which the nurse makes decisions based on an experienced understanding of a situation, as opposed to simply following rules and protocols. Thinking-in-action is said to describe how nurses respond effectively when assumptions in practice are flawed and beliefs about care are no longer felt to be true (Benner et al 1998).

The nursing process is argued to have been a useful process by which to record care retrospectively, but it has failed to represent the method by which nurses make decisions about care (Marks-Maran 1999). However, it would be impractical to detail the complex decision-making process that nurses use in day-to-day practice. Care plans can only outline the main points and stages in the process. There is, therefore, a need for expert nurses to articulate their thinking to educate learners and novices. This can require much skill on the part of the expert, as detailing this process is difficult without making ‘leaps’.

Nursing models

Nursing models have been used to provide systematic care delivery stemming from a desire to organise care coherently, enabling the plan of care to be used and continued by others. Prior to the introduction of nursing models, much practice was based on the mechanistic biomedical approach (Pearson et al 1996). It could be argued that since the introduction of models, nursing practice has become more patient-centred and holistic. Certainly, most nursing models allude to the concept of holism and discuss an appreciation of the ‘person’ in relation to others.

Although intended as a framework for caregiving, nursing models have, in practice, been used largely as an assessment on which the nursing process was founded. In particular, the assessment framework of the ‘activities of daily living’ model (Roper et al 1983) has been used extensively by nurses, perhaps in part due to its resemblance to the medical systems model. However, perhaps it is the case that any model becomes mechanistic if used mechanistically.

Rose (1997) describes how the nursing process is entrenched in the modernist view of the world – there being an absolute truth, which can be

Is the Shipley model post-modern?

The assessment sheet used in the Shipley model is now in use in other areas of the community trust in Bradford. It is felt to be easy to use and obtains a large amount of information – from the patient’s perspective and in terms of objective assessment data. This use of both qualitative and quantitative data is beneficial in attempting to describe nursing phenomena (Parahoo 1997).

The problems identified by the assessment enable a plan of care to be generated that is evaluated with the patient and/or his or her carers. However, while this approach is arguably valid and holistic, it is based on the assumption that nurses assess, plan, implement and evaluate strategy, which, as argued, does not wholly represent the way in which nurses think. In practice, nursing staff do use the assessment
tool to obtain the information needed to begin caring for the patient. However, thereafter it is difficult to gauge whether the process of care is adhered to along the lines of the individual having physical, emotional, intellectual, social and spiritual dimensions.

It is likely that nursing staff base decision-making processes on what Benner (1984) described as ‘expert knowledge’. Benner's work outlines how nurses develop from novices, where decision-making processes are based on strict protocols and policy, to experts, where expertise is developed through experience. This is supported by Rolfe (1997) who argues that an inexperienced nurse might use knowledge defined by research or evidence-based practice, which has been derived in a rational, analytical way. However, an experienced nurse might not wholly base decisions on defined protocols, but will recognise and use his or her experience gained from thousands of individual cases.

The Shipley model cannot, therefore, be said to be post-modern as it follows the linear nursing process route through assessment, planning, implementation and evaluation. While this is a useful method of documenting care retrospectively, it does not represent the way in which the nurse thought about and decided on that care. The assessment tools used in the model are research-based and therefore do not fit with the post-modern approach of nurses basing decision-making processes on past experiences of individual cases. The assessment tools used in the model are research-based and therefore do not fit with the post-modern approach of nurses basing decision-making processes on past experiences of individual cases.

It is possible for any nursing model to be post-modern if the way care is documented reflects the way in which it was developed. If nursing documentation is to reflect more closely the way in which the decision-making process occurs, then the nursing process must be abandoned. Nurses should have the courage to document clearly how they came to devise a plan of care. This will involve documenting what has been described as wisdom or tacit and intuitive knowledge (Marks Maran and Rose 1997), augmented with scientific knowledge. Novice nurses may struggle with this as they will not yet possess the ‘wisdom, intuition and tacit knowledge’ required. Yet novice nurses find it hard to develop these skills at present as the decision-making process used in practice is alien to the process taught in the classroom and espoused in practice. Once novice nurses see the ‘experts’ clearly documenting how they came to make nursing decisions, it will surely be easier for them to understand and develop these skills themselves.

Conclusion

It is possible for any nursing model to be post-modern if the way care is documented reflects the way in which it was developed. If nursing documentation is to reflect more closely the way in which the decision-making process occurs, then the nursing process must be abandoned. Nurses should have the courage to document clearly how they came to devise a plan of care. This will involve documenting what has been described as wisdom or tacit and intuitive knowledge (Marks Maran and Rose 1997), augmented with scientific knowledge. Novice nurses may struggle with this as they will not yet possess the ‘wisdom, intuition and tacit knowledge’ required. Yet novice nurses find it hard to develop these skills at present as the decision-making process used in practice is alien to the process taught in the classroom and espoused in practice. Once novice nurses see the ‘experts’ clearly documenting how they came to make nursing decisions, it will surely be easier for them to understand and develop these skills themselves.

REFERENCES