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Original article

What is nursing in the 21st century and what does the 21st century health system require of nursing?

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Abstract

It is frequently claimed that nursing is vital to the safe, humane provision of health care and health service to our populations. It is also recognized however, that nursing is a costly health care resource that must be used effectively and efficiently. There is a growing recognition, from within the nursing profession, health care policy makers and society, of the need to analyse the contribution of nursing to health care and its costs. This becomes increasingly pertinent and urgent in a situation, such as that existing in Ireland, where the current financial crisis has lead to public sector employment moratoria, staff cuts and staffing deficits, combined with increased patient expectation, escalating health care costs, and a health care system restructuring and reform agenda. Such factors, increasingly common internationally, make the identification and effective use of the nursing contribution to health care an issue of international importance. This paper seeks to explore the nature of nursing and the function of the nurse within a 21st century health care system, with a focus on the Irish context. However, this analysis fits into and is relevant to the international context and discussion regarding the nursing workforce. This paper uses recent empirical studies exploring the domains of activity and focus of nursing, together with nurses perceptions of their role and work environment, in order to connect those findings with core conceptual questions about the nature and function of nursing.

Keywords: nursing, role of nursing, health service, patient care, safe humane care.

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Introduction

It is frequently claimed that nursing is vital to the safe, humane (in this context largely meaning compassionate and attentively caring) provision of health care and health services to our populations <Aiken *et al.,* 2002; Institute of Medicine (IoM), 2004; Needleman *et al.,* 2006, 2011; Dall *et al.,* 2009; Griffiths *et al.,* 2010; National Health Service (NHS) Futures Forum, 2011; Papastavrou *et al.,* 2011; You *et al*., 2013>. It is also recognized however, that nursing is a costly health care resource that must be used effectively and efficiently. There is a growing recognition, from within the nursing profession, health care policy makers and society at large, of the need to analyse the contribution of nursing to health care and its costs (Clark & Lang, 1992; Epping *et al*., 1996; Aiken *et al*., 2012). The need to describe nursing care systematically in terms of nursing phenomena, activities and outcomes of nursing care also has been identified internationally (Sermeus & Delesie, 1994, 1997; Mortensen, 1997). This becomes increasingly pertinent and urgent in a situation, such as that existing in Ireland, where the current financial crisis has lead to public sector employment moratoria, staff cuts and staffing deficits (Thejournal.ie, 2012), combined with increased patient expectation, escalating health care costs, and a health care system restructuring and reform agenda.

Such factors, increasingly common internationally, make the identification and effective use of the nursing contribution to health care an issue of international importance.

Background

It seems that some necessary steps in learning how to use the nursing resource effectively in any health system involves the following: (1) a consideration of the nature of nursing, (2) identifying and exploring the potential contribution of the nursing resource, and (3) examining how that resource is being used currently in our health systems. It is important, for example to examine the focus of clinical nursing practice. What are the phenomena that nurses deal with, what kinds of interventions do nurses engage in? What is known with regards to the impact and effectiveness of nursing interventions on patient outcomes such as patient perception of the quality nursing care?

This paper seeks to explore the nature of nursing and the function of the nurse within the context of the Irish health care system. However, this analysis fits into and is relevant to the international context and discussion regarding the nursing workforce (see, for example, Needleman *et al*., 2011; Van den Heede & Aiken, 2013). It is deemed necessary to consider the nature and function of nursing in some depth. This is in order to provide a firm conceptual and empirical base from which to consider the most effective use of the nursing resource, and to develop health service and manpower planning scenarios and projections for the Irish health system, as for other systems. This paper uses recent empirical studies in order to connect the empirical findings with core conceptual questions about the nature and function of nursing.

Such an exercise is particularly relevant in the context of the current national budgetary environment, combined with the recent Irish Health Service Executive articulated policy to reduce the current nursing workforce to 2007 levels by 2015; despite a projected population growth during this period of 8.5% and a changing demographic to an increasing elderly population. Overall, this policy will lead to approximately a 7% reduction in the current nursing workforce <from 36 782 whole time equivalent (WTE) nurses in 2011 to 34 313 WTEs>, giving rise to a reduction of both the density of nurses per 1000 of the population and potentially a direct diminution of nurse-patient ratios at the bed-side, unless direct care staff numbers are protected. Protecting direct-care nursing numbers, however, assumes that there is spare capacity of nurses in indirect-care roles, for which there is no available evidence.

The nature of nursing and the role of nursing within a modern health system

Let us consider therefore the nature of nursing, and the role the nurse has within a modern health system. Consideration of the international literature uncovers a clear assumption that nursing, if not exactly the same, has essential core elements internationally. This is evidenced for example by the much cited use of Henderson's definition of the nurse:

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'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.' (Henderson, 1966, p. 15)

Written in the USA of the 1960s, this definition is cited throughout the international nursing literature as reflective of nursing internationally. A similar claim may be made of international codes for nurses – such as the International Council of Nurses Code (ICN 2006). By definition, the existence of an international code suggests sufficient similarity of focus and practice to make such a code meaningful. The Royal College of Nursing (RCN) in 2003 makes a further attempt to describe nursing:

'The use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.' (RCN 2003, p.3)

However, what are nurses actually doing and what is nursing's contribution in the 21st century? What is required of the practising nurse in our health systems? Is there in fact sufficient similarity in clinical nursing roles across the world to assume a common core of nursing practise, to make something like the ICN code meaningful to nurses internationally?

There are some voices of concern:

"... the tendency to consider nurses as a homogeneous group is to mistake the scope of nursing practice. Nursing covers such a wide variety of activities that it is difficult to encapsulate what nurses do in any single statement ... there is no simple definition of either what it means to be a nurse or of what is understood by the term 'nursing'. (Sellman, 2011, p. 22)

Sellman's point is well made and in fact is as relevant to national health systems as it is to the international context. However, it seems reasonable to suggest that there appears to be sufficient similarity in nursing roles and functions internationally to enable, with some short period of orientation, a nurse who has been educated to nurse registration level within an African or Asian context to successfully adjust and practice as a nurse in Europe, the US or Australia and vice versa. This once again raises the question 'What is nursing'?

Conceptualizations of nursing are found in our professional rhetoric, literature and educational texts. We, for example, have an extensive, international, nursing literature that claims the importance, or centrality, of care and caring in nursing practice (Morse, 1991; Benner & Wrubel, 1989; Gastmans, 1999; Edwards, 2001; Scott, 2006, 2007; Corbin, 2008; Griffiths, 2008; Mayben, 2008; Edinburgh Napier University & NHS Lothian, 2012). Empirical work over the past decade shows support for this conceptualization of nursing practise in terms of psychosocial support, and a recognition of the patient/client as a whole person, with psychological, social and physical care requirements (Jinks & Hope, 2000; Buller & Butterworth, 2001; Scott *et al*., 2006; Wysong & Driver, 2009; Morris *et al*., 2013). Such conceptualizations describe nursing as essentially a humane practice focused on the psychosocial and spiritual as well as the physical needs of a patient (Begley *et al*., 2004; Pesut, 2005). Recent national reports and policies in the UK, US and Ireland also appear to demand and support such conceptualizations of nurses and nursing practice <Care Quality Commission (CQC), 2011; IoM, 2004, 2011; Government of Ireland, 2008; Health Information and Quality Authority (HIQA), 2012a; Francis, 2013>.

Patients, however, are not simply passive automata. They actively participate in and often shape or resist the practitioner's practise interactions (Bryans, 1998). From the point of the first interaction, patients are scanning and assessing staff for cues that will enable the patient to build trust. The first signs of this are likely to be perceived staff competence (Papastavrou *et al.,* 2011). Patients also seek cues from staff regarding the level of interest the staff member has in the patient as a person with his/her particular issues <Bryans, 1998; IoM, 2004; Moran, 2008; Parliamentary and Health Service Ombudsman (PHSO), 2011; Kane, 2012>.

Gaining patient trust and confidence is related to personal factors in the practitioner such as how one is in one's role (Scott, 1995a; Bryans, 1998; Kane, 2012). Patients need to develop trust and emotional

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confidence in the practitioner. However, it is also the case that technical competence is very important to patients in terms of evidencing the caring aspect of nursing (Björk, 1995; Johansson *et al.*, 2002; Papastavrou *et al.*, 2011). In addition, patients hope for compassion and a sense of being recognized and cared for as an individual (Fosbinder, 1994; Thorsteinsson, 2002; Niven & Scott, 2003; Wysong & Driver, 2009; PHSO 2011). Patients' satisfaction with their health care experience is directly correlated with their perceptions of nursing care; which is mediated through patient interaction with nursing staff (Larrabee *et al.*, 2004; Kutney-Lee *et al.*, 2009).

There are also indications in the literature which suggests that patients perceptions of their needs and of good nursing is not the same as nurses perceptions of patient needs – or indeed of good nursing (Wysong & Driver, 2009; Papastavrou *et al*. 2011). Caring behaviours, as perceived by patients, is likely to influence, significantly, overall patient satisfaction. This is clearly evidenced, for example, in the ten cases investigated and reported in PHSO (2011). Moran, for example, in exploring the experience of patients on long term renal dialysis in the Irish health system found that nurses were perceived by patients to be persistently 'busy'. Nurses rarely spent time listening or talking to patients. They only interacted with patients when managing physical/technical aspects of care. From the patients perspective, 'absence of nurse – patient communication left patients feeling isolated and invisible' (Moran, 2008, p. 222). Kane (2012) in exploring nursing practice within the context of a busy accident and emergency unit also identified discrepancies between patients and nurses in terms of good care. Patients in this case clearly perceived integration between physical care and the humane, emotional support they received from the nursing staff.

'You would know by the way she held me', "you'd know by the trouble they took with me . . . they wouldn't go to that bother, would they, if they didn't care" (Patient 2). 'There was one nurse, she was really lovely . . . you know she went out of her way, she held my head when I was vomiting and her hands were cool on my head . . . she put her arm around me when I got upset . . .she really went out of her way to look after me . . . and they were so busy . . . when I was feeling better she helped me to have a wash and that made me feel better too.' (Patient 1) (Kane, 2012, p. 121).

The nursing staff involved in this study felt that the care they provided had deficits in psychological support skills. They were of the view that the patients required a mental health liaison nurse to meet patient needs for emotional and psychological support. Such a deficit or requirement did not appear visible to the patients interviewed in Kane's study. Perhaps, nurses underestimate the importance, for patients, of simple, physical 'caring' acts such as taking a patient's hand or holding a person who is being sick. Such physical acts evidence connection and human understanding.

Wysong & Driver (2009) found that patients tended to focus primarily, and some entirely, on the salience of the interpersonal skills of the 'good' nurse, potentially failing to recognize the crucial importance of other nursing skills such as technical, clinical skills required for delivery of safe care to patients. A crucial point here may be that, as de Raeve (2002) reported in, patients tend to assume clinical, technical competence from health care workers until we prove them wrong. However, patients are perhaps aware that compassion, fellow feeling, human understanding and support are somewhat less consistently forthcoming from nurses and other health care practitioners. Such engagement is also perhaps perceived as more person – based, and in some sense discretionary on the part of the practitioner. The literature suggests that from the perspective of the patient, when feeling unwell and particularly vulnerable, receiving such care – human understanding, compassion and support – is what makes nursing most valuable. It is this that humanises patients (and relatives) illness and health service experience (e.g. PHSO, 2011). As argued previously (Scott, 1995b), there are at least four dimensions of the concept of care that is relevant in nursing practice: 'care for', 'having care of', 'care about' and 'care that'. A nurse may not always have an emotional connection of affection for a particular patient – i.e. may not always 'care for' a particular patient in terms of affection, although if it is present, it likely makes one's work easier and more fulfilling. However the professional nursing role

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demands that the nurse 'has care of' (i.e. has responsibility for providing the required patient care), cares about and cares that (i.e. the nurse is concerned with and invested in) patients receive appropriate, skilled and humane care. The 'having care of' dimension perhaps places the focus on the clinical, technical element of nursing care. The 'care about' and 'care that' dimensions, i.e. those dimensions that focus on the nurse's personal investment in the nursing role, is likely to be most closely linked with the elements of nursing care that patients place significant value upon.

Empirical work such as Jinks & Hope (2000); Buller & Butterworth (2001); Wysong & Driver (2009) and Papastavrou *et al*. (2011) clearly indicates that at the core of nursing practice is very skilled interaction. These skills may have a physical, clinical focus, a psychosocial, supporting focus, a co-ordination of care focus – or there may be elements of all of these dimensions (Buller & Butterworth, 2001; Niven & Scott, 2003; Begley *et al*., 2004; Scott *et al*., 2006). For example, in a recent Delphi study of mental health and general nurses in Ireland, which sought to identify the core elements of nursing practice, the following tables portray the core phenomena (core patient problems) that according to the nurse participants, comprise their practice (Table 1), and (Table 2) the core interventions that nurses engage with, in their nursing practice (Scott *et al*., 2006):

The contribution of nursing in the health service of the 21st century

A study using the Irish Nursing Minimum Dataset tool (which is derived from the Delphi study quoted above) in general medical and general surgical wards in six Irish hospitals, identifying the nursing interventions with the highest mean scores (indicating a higher level of intensity of intervention; range: 0 = no intervention to 4 = intensive level of intervention) indicates that these interventions include 'Monitoring, assessing and evaluating physical condition (mean = 2.09), developing and maintaining trust (mean = 2.03), monitoring psychological condition (mean = 2.05), documenting patient care (mean = 2.22) and admitting and assessing patients (mean = 2.22) (Morris *et al*., 2013). Findings show clearly that nursing interventions significantly reduce the level of physical health problems, including bleeding, infection and physical mobility problems, particularly from days 1–3 of a patient's stay in the acute medical and surgical units within which the study was carried out.

Further insights of 'what nurses do' can be found in recent nursing workforce planning research

Table 1. Top ranking patient/client physical, psychological and social problems for the combined mental health and general nurse respondents round 3 Delphi Survey (Scott *et al*., 2006)

Patient physical problems	Patient psychological problems	Patient social problems
1. Nutrition	1. Anxiety/fear in response to current stressors	1. Level of social support received from significant others
2. Negative physical side effects of treatment/medication	2. Coping and adjustment	2. Inability to provide sufficient levels of support to dependents
3. Breathing	3. Mood	3. Social skills
4. Dependence with hygiene needs	4. Anxiety – more longstanding feature	4. Home environment
5. Pain	5. Non-adherence to treatment/medication	5. Family knowledge deficits regarding illness or treatment
6. Fluid balance	6. Thought and cognition – perception or beliefs	6. Stigma
7. Weakness/fatigue	7. Substance misuse or dependence	7. Social disadvantage
8. Elimination	8. Aggression towards oneself/others	8. Care environment
9. Physical discomfort	9. Negative psychological side effects of medications	9. Delayed discharge
10. Physical safety	10. Acute confused states	

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Table 2. Consensus nursing interventions across mental health and general nursing with a 25th percentile score of 6 and above found in round 3 Delphi Survey (Scott et al., 2006)

Physical nursing interventions	Psychological interventions	Social interventions	Co-ordination and organization of care activities
1. Administration of medication, fluids and/or blood products.	1. Developing and maintaining trust	1. Providing social support to families (or significant others) through presence and communication	1. Working and communication with other nurses
2. Monitoring, observing and evaluating patient/client's physical condition	2. Providing client with information on illness or treatment, skills teaching and health promotion	2. Providing family (or significant other) with information regarding illness or treatment, skills teaching and health promotion	2. Documentation and planning of client's care
3. Hygiene	3. Encouraging adherence to treatment or interventions		3. Admitting and assessing clients
4. Encouragement and guidance with physical care and physical independence	4. Providing informal psychosocial support		

Table 3. Non-nursing work carried out by nurses on the most recent shift (reproduced from Scott et al., 2013)

Item	Task	Never	Sometimes	Often
C.11.2	Performing non-nursing care	5%	52%	43%
C.11.7	Filling in for non-nursing services not available on off-hours	31%	42.5%	26.5%
C.11.9	Answering phones, clerical duties	1%	11%	88%

conducted in Ireland (Scott *et al*., 2013). This Irish study is part of European Commission – Research: The Seventh Framework Programme (2007–2013) funded RN4CAST: nurse forecasting in Europe consortium project described by Sermeus *et al*. (2010). Table 3 below indicates the percentage responses of nurses regarding the frequency of carrying out certain tasks during their last shift which could be identified as non nursing work. These data were gathered in a survey of nurses working in medical and surgical wards in large acute hospitals in Ireland during 2009–2010. Carrying out non-nursing work may take nurses away from patient care and reduce the quality of care patients receive. Equally, performing non-nursing tasks may reduce patient surveillance time, thus impacting on patient safety.

As part of this survey (Scott *et al*., 2013), a list of patient care activities were provided. Nurses were asked to select activities which were necessary but left undone, due to time constraints during, their last shift. The graph below (Fig. 1) contains the percentages of nurse respondents who indicated that they left necessary nursing work undone on their last shift. For the purposes of presentation, the necessary work left undone has been divided into three categories: Direct Physical Care left undone, Direct Psychological Care left undone, and Indirect Care left undone. The graph illustrates the categories of necessary work which are most frequently left undone (direct psychological care). It also clearly shows the category of work which is reported as less likely to be left undone due to time constraints (direct physical care). Indirect care in the form of planning, evaluation and documentation of care by nurses in this study is also indentified as left undone due to lack of time. These Irish findings have been replicated across the RN4CAST consortium countries (Ausserhofer *et al*. in press).

Nurse-reported work left undone is relevant as it has the potential to compromise patient safety. It is also likely to impact patient and nurse perceptions of

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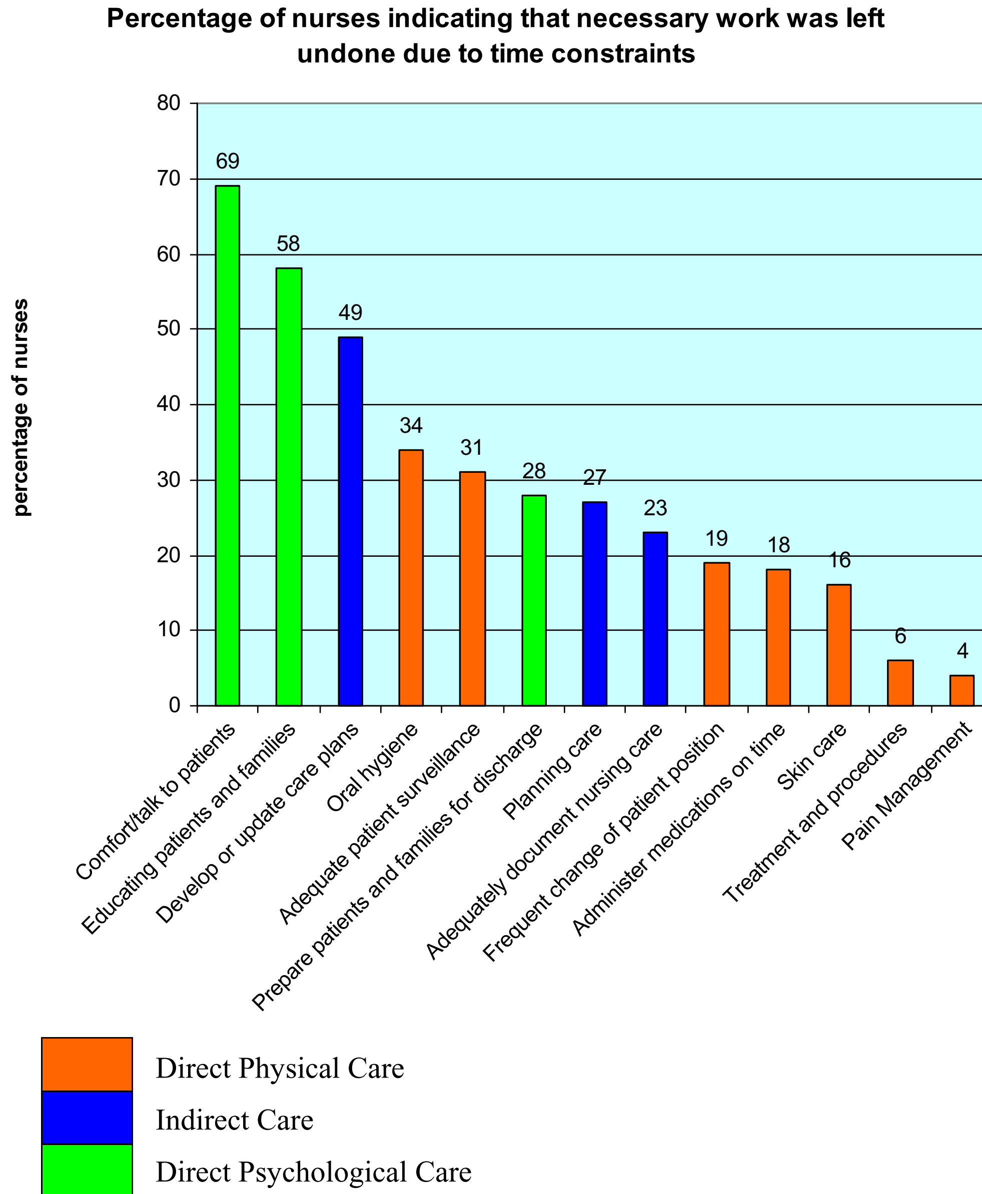

Fig. 1. Percentages of nurses who indicated necessary work was left undone due to time constraint

quality of nursing care (Wysong & Driver, 2009; Aiken *et al*., 2012) and patient and nurse satisfaction levels. As indicated above, psychological care and support, by which nurses tend to mean spending time engaging and talking with and generally offering human support to patients, is also an aspect of nursing much valued by people when they are ill and feeling particularly vulnerable.

Necessary work left undone due to time constraints may be related to patient-staff ratios within a ward or hospital, and/or it may be associated with nurse outcomes such as burnout levels. Higher levels of

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emotional exhaustion (a component of burnout) in nurses have been linked to reduced quality of patient care (You *et al.*, 2013).

Reduced staffing levels increase workload and time pressure on staff during shift periods. However, in the current environment of budgetary retraction nursing jobs are often an easy target (RCN, 2010). This is no doubt due to the perceived paucity of hard evidence regarding the nursing contribution to patient care. However, as the RCN (2010, p. 4) clearly highlight, 'there is a growing body of research evidence which shows that both the work environment of nurses and nurse education and staffing levels make a difference to patient outcomes (mortality and adverse events), patient experience, quality of care, and the efficiency of care delivery.' European and international work builds on over 20 years of research led by Linda Aiken, University of Pennsylvania (Aiken *et al.*, 2002, 2003, 2008, 2011, 2012; Rafferty *et al.*, 2007; You *et al.*, 2013).

A number of these studies highlight what is termed the co-ordinating, connecting and surveillance role of nursing. An appreciation of such important functions of nursing has been available in the literature since the time of Nightingale (Nightingale, 1969; Jacques, 1993; Macleod, 1994; Benner *et al.*, 1996; Aiken *et al.*, 2002, 2003; Rafferty *et al.*, 2007). Recent work suggests that the viability of these important co-ordinating, connecting and surveillance roles of the nurse may be linked with patient-nurse ratios, nurse education levels and the quality of the practice environment (Aiken *et al.*, 2011). Serious concern regarding the impact of patient-nurse ratios on patient safety in hospitals has led a number of states to introduce mandated patient-nurse ratios – mandated minimum staffing levels (Coffman *et al.*, 2002; Gordon *et al.*, 2008).

'Time and again inadequate staffing is identified by coroners' reports and inquiries as a key factor in patient safety incidents. Health Select Committee report in 2009 says, "inadequate staffing levels have been major factors in undermining patient safety in a number of notorious cases". (RCN, 2010, p. 19)

This is entirely in keeping with the findings of Francis (2010, 2013).

The Francis Report into Mid Staffordshire NHS Trust provides a very graphic example where all elements of the expectation of humane care, and the professional and personal engagement and commitment of a nursing staff was increasingly undermined and ultimately completely disintegrated under the persistent strain of under-staffing, lack of trust in and support from hospital management, lack of clinical nursing leadership and exclusive focus on financial targets. This breakdown in nursing care and professional nursing culture had a profoundly detrimental effect on patient care, leading to basic physical and psychological neglect of very vulnerable patients, loss of dignity, distress, injury, and in extreme instances it led to patients' death.

The Mid Staffordshire case in fact can be seen to crystallize in one NHS Trust a compounding of many previous indicators of poor/dangerous care (e.g. World in Action, 1995; Rowinski, 1997; CQC, 2011; PHSO, 2011). It also however, can be seen to confirm the fundamentally important role that nursing staff and the nursing culture of an institution plays in ensuring appropriate, humane, professional health care provision. If the nursing culture and professional nursing care provision disintegrates patients suffer greatly and in extreme situations, as existed in Mid Staffordshire NHS Trust, patient are neglected, sustain injuries and die (Francis, 2010, 2013).

The challenge for nursing leadership, health policy makers and health service employers

Perhaps nursing leadership, health service management and health policy makers need to grasp this issue once and for all. If good nursing is key to safe, humane health care provision, then we should investigate how many nurses and what type of clinical nursing leadership are required to provide such care – at unit, hospital, community and national levels. We should employ the required number of nurses for this task and hold them accountable for such care provision. This means that nursing as a profession (practitioners, leaders, educators) must 'step up to the plate'. As Philip Darbyshire comments:

'Good nursing is crucial because its absence means a patient experience that verges on inhumane. When nurses get it right, we do no less than touch and transform people's lives at what is often their lowest ebb. Conversely, uncaring, negligent and "couldn't care

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less" nurses blight the lives, health and dignity of those who depend on them.' (Darbyshire, 2011, p. 3)

It seems reasonably clear that nurses must be willing not only to take on the job and be paid for it. They must be willing to be accountable for the level and nature of the care they provide; they must be willing to have their care open to peer-review and public scrutiny – and they must be willing and enabled to learn from mistakes, in order to improve care in the future. Poor or inadequate care, in addition to being the responsibility of individual nurses, is also a likely outcome of weak clinical nursing leadership (Duffield *et al*., 2007; CQC, 2011; Francis, 2010, 2013). Thus appropriate clinical nursing leadership is likely to be a vital component of consistent, high quality patient care.

However, it does seems clear, while Griffiths (2008) and PHSO (2011) point out resources may not be the only problem, that without the human resources necessary to provide safe, humane care nurses cannot reasonably be held accountable for the provision of inadequate care. This is a conclusion that seems controversial. Nevertheless, there is now clear evidence that inadequate nurse staffing levels can be dangerous for patients and pose many challenges for the nursing profession. Burnt-out, exhausted nurses are less likely to be able to be compassionate. As indicated above (Ausserhofer *et al*., in press), when under stress of time pressure and work nurses are likely to focus on completing the necessary work in order to meet the patient's perceived key physiological needs, leaving other important nursing care such as 'less important' physical needs and psychological support of patients unmet.

Accountability implies autonomy and choice. If there is no alternative to inadequate care, due to severe understaffing, then choice does not exist. Thus in order for patients, employers, nurse leaders and policy makers to reasonably demand that nurses 'step up to the plate' they must ensure the resources, culture and climate that facilitates such accountability.

This requires not only insight and action from health policy makers and health service leaders. Importantly, it requires leadership, openness and accountability from both nursing leadership and nurses themselves as individual practitioners. It also requires a 'listening system' that is prepared to not only require accountability but to support the whistle blower. There is clear historical evidence that neither the Irish nor UK health systems have a glowing record in this regard (see for example: Bristol Royal Infirmary Inquiry, 2001; Government of Ireland, 2006; Darbyshire, 2011). However, perhaps there is now growing evidence that countries such as England have learned from past mistakes in, for example, the development and work of the Care Quality Commission and the Parliamentary and Health Service Ombudsman. Ireland also appears to be beginning to move in this direction through the work of the Commission on Patient Safety and Quality Assurance (Government of Ireland, 2008) and the HIQA (2012b). However, the challenge for the Irish Government and the Irish Health Service is to find both the commitment and the resources required to implement effectively the recommendation of these bodies.

Conclusion

Internationally, governments, tax payers, health policy makers, and indeed Departments/Ministries of Health, must now consider carefully what is required by health services of its nurses and how this can be supported, facilitated and funded. Platitudes regarding person-centred, dignified, humane care will not be realized without adequate resourcing. Nursing is a vital part of such resources. Nursing is not an expendable cost to the health service – but a crucial element in care delivery and in the existence of a safe, effective, humane health service.

Do we share such an understanding of nursing practice and its place in our health system and in patient care? As indicated above, the literature would seem to emphasize at least two key themes – nursing, as important for safe, quality care provision and nursing as important for the humane, compassionate treatment of patients; inclusive of emotional/ psychological support of patients where necessary.

Such an understanding of nursing practice places demands not only on the technical competence of the nurse but also on the personhood of the nurse. It is demanding of the profession as a whole, on clinical nursing leaders and on nurse educators to ensure appropriate professional preparation – (including

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preparation regarding the core importance of sensitive human interaction as foundational to nursing practice with our patients, our students and colleagues). Such a conceptualization of nursing practice also places demands on health policy makers, on tax payers, on government and on the health service managers to plan and resource such practice. If the organizational culture and/or the staffing levels are such that this type of approach, this expectation of nursing practice, is frequently or constantly undermined, this is likely to impact not only on patient care but on the morale, commitment and engagement of nursing staff (Government of Ireland, 2006; RCN, 2010; Francis, 2010, 2013; CQC 2011; NHS Futures Forum, 2011) to the serious detriment of patient care and health service delivery. This should cause each of us, as actual or potential patients and as members of society, sufficient concern to impel constructive action.

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