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Advanced Nursing: remembering the past, appreciating the present and perspecting the future

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Abstract

Introduction
This article arises from the analysis of care practice as a Nurse, in a sense of continuous improvement. Thus, by understanding the professional history, the paradigms of the profession and the positioning of Nursing in terms of society in today's world, it is possible to envision possible paths for the profession.

Objective
This article aims to reflect on the historical evolution of Nursing in Portugal and to envision the future of Portuguese Nursing in the light of international influences.

Development
The historical perspective and the implications in Nursing care practice, Person/Client-Centred Care and the individualisation of the intervention and, finally, Advanced Nursing and Advanced Practice Nursing were addressed. Analysing the historical perspective of Nursing over the centuries, from its abnegated period, through the romantic era, medicine and the technicist phase, we understand some current practices and doubts regarding the perspective of the future. The development of knowledge and practice in Nursing should go through the recognition and advancement of the core competencies of the discipline.

Conclusion
An approximation between scientific production and care practice is essential for the development of Nursing. Facilitating this process is the development of the Nursing specialties as a master's degree course, promoting not only different practices, but also the critical look and thinking of professionals. In this process, the existence of other sciences – health, social and human sciences, among others – that will promote the development of the Nursing body should not be relegated to second place, but it is also crucial to disseminate scientific production in Nursing, in order to give visibility to the science and practice of the discipline.

Keywords
Nursing; History of Nursing; Person-centered Nursing; Advanced Practice Nursing.

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Introduction

Care has existed since life came into existence: it is necessary to 'care' for life so that it can remain. [1 (p.117)] Nursing cannot be detached in its focus or in its history from people. Looking back at the past, one can state that Nursing and its development as an art and science is intricately entwined with the care of Women. Women have always played the role of carers within the family, promoting the harmonious development of children, ensuring the hygiene and maintenance of the home/household, helping in the collection and preparation of food, to name but a few. These responsibilities embedded in the role of the Woman-Mother are still present to this day, despite the significant social changes that family and its representation are currently undergoing. Historically, Women have had a less active social role until the twentieth century – the century of wars. Despite this social erasure, Women have not ceased to be a cornerstone of society over the centuries, not only for their critical role in the family – the structural and fundamental unit of society – but also for their involvement in social, solidarity and merciful causes. [2,3]

Furthermore, the historical relationship between Nursing and religion cannot be denied. In the case of Portugal, Christianity, with its altruistic and fraternal basis, is associated with caring for others. Looking at the works of mercy spread by the Catholic Church, the seven corporal works of mercy (to feed the hungry, to give drink to the thirsty, to clothe the naked, to shelter the homeless, to visit the sick, to visit the imprisoned and to bury the dead) and the seven spiritual works of mercy (to instruct the ignorant, to counsel the doubtful, to admonish the sinners, to bear wrongs patiently, to forgive offences, to comfort the afflicted, to pray for the living and the dead) are highlighted. [4] From the description of the works of mercy, it can be stated that the fundamental values or principles of Nursing are embedded in these religious principles. This intimate relationship between Nursing and Religion was further strengthened during the Middle Ages due to epidemics, war and famine, which worsened social and health conditions. In this regard, religion emerged as a safe haven for medieval society, providing the necessary healthcare through the intervention of religious orders. [5]

Despite this role of religion in society, the expression of this care in most cases was done by Women, involved in the action of the religious orders of the time. Hence, one can see the triad Nursing – Women – Religion, whose pinnacle is assumed in Florence Nightingale – the mother of modern Nursing. In the nineteenth century, during the Crimean war, the lack of assistance conditions to the military led Nightingale to reformulate and restructure the existing conditions – hygiene and cleanliness, food, ventilation, lighting, organization and separation of circuits and spaces, among other things. This laboratory served as a catapult to her contribution in modern healthcare. [5–7]

This reflection arises following the analysis of everyday practice as a Nurse, in a sense of continuous improvement. Thus, by understanding the professional history, the paradigms of the profession and the positioning of Nursing in terms of society in today's world, it is possible to envision possible paths for the profession. This article aims to reflect on the historical evolution of Nursing in Portugal and to envision the future of Portuguese Nursing in the light of international influences. For its development, the abridged historical path will be discussed: from Nightingale to the biomedical model and the Nursing models – implications for Nursing care practice; Person/Client-Centred Care and the individualisation of the intervention; and Advanced Nursing and Advanced Practice Nursing.

Formatted for holistic care since the beginning of training, creating a distance from the biomedical model, focused on signs and symptoms, professional practice was guided by the individualisation of care. In this regard and in that of competencies development, it became evident to rethink professional practices to advance the Nursing care provided in the transition phase from generalist nurse to nurse specialist.

Abridged Historical Path: From Nightingale to the Nursing Models – Implications for Nursing Care Practice

The World Health Organization (WHO) defines health as "not merely the absence of illness but a state of complete physical, mental and social well-being"[8]. This mid twentieth century definition of health attempts to encompass more than the physical realm of health, i.e., the absence of illness, originating in classical, mechanistic physics. This dualistic view between health and illness can be at the root of the biomedical model, focused on signs and symptoms - objective, measurable aspects - and on the healing process. [9]

The biomedical model guided Nursing training because of the intimate professional and formative relationships between the Doctor and the Nurse. According to this model, Nursing care focuses on routines or tasks that meet the physical needs of the patient. Following this line of thought, the image of Nursing emerged as being subordinate to Medicine, with the aim of curing or controlling the illness, while the doctor was the main person responsible for health care. [9]

Returning to the influence of religion – Christianity – in Nursing, the biomedical model came to add the values of romanticism and pragmatism to Nursing. Embedded since its genesis in asceticism, Nursing has always had a focus on donations and total dedication to others. With scientific evolution and the consolidation of the biomedical model, subjugation to the doctor and the technicality of the profession also became predominant in Nursing. With these underlying conceptions, it can be stated that Nursing

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lies between the care for the body, influenced by Medicine, and the care for the spirit or soul, the result of religious weight. [9]

With Nightingale's revolution, Nursing added Science to its Art[1]. The development of Nursing's own body of knowledge can be said to have been initiated by Nightingale's work.[10] In the multidisciplinary context of health, the influence that the various disciplines have amongst each other cannot be ignored. In constant development, Nursing's own body of knowledge, a requirement for the definition of the profession and discipline, undergoes mutations that develop Nursing practice[10,11] For Florence Nightingale, Nursing focuses on caring for the person, rather than on the Nursing process, the therapeutic relationship, or the Nurse. In this way, Nursing *shapes itself* to meet the needs of each person. The Nurse and the person being cared for are influenced by environmental factors that should be addressed in order to modify them so as to provide better care to the person according to their needs. It was with Nightingale's work that training in Nursing was developed, because according to her perspective Nurses should have specific training and instruction for their work, allowing for the improvement of the care provided. [10,11]

During the twentieth century, several conceptual models of Nursing were developed. Pepin et al.[10] classify Nursing theory into five schools of thought:

- School of Needs: focused on situations of dependence, Nursing supplements or complements the person to meet fundamental needs, promoting independence (Roper, Henderson);
- School of Interaction: focused on the interpersonal and therapeutic process between the Nurse, the person and the context, in order to facilitate the processes of transition and to maximise health functionality (Peplau, King);
- School of Results: focused on the adaptation of the person to the environment (internal or external), promoting appropriate adaptive responses (Roy, Neuman);
- School of the Unitary Human Being: focused on the well-being of the person, maximising individual health potential in every moment and place (Newman, Rogers);
- School of Caring: focused on the phenomenological process of sharing between the Nurse and the person being cared for (Leinninger, Watson).

Theoretical models in Nursing serve as a lens to look at and understand the reality of Nursing care. In its conception, there are four metaparadigm concepts that are the basis for the theoretical model – Nursing, Person, Health and Environment. Resulting from the influence of the current paradigms, the various schools of thought in Nursing gave body to the Science produced. [10]

In the current Nursing care provided, it may be stated that the holistic paradigm and holistic Nursing are guiding the professional reality. Thus, *Nursing encompasses the care of individuals, families, groups and communities, ill or healthy and in all environments. [...] It includes health promotion, illness prevention and care for ill people, people with disabilities and people in the process of dying. Protection, promotion of a safe environment, research, participation in the formulation of health policies and in the management of patients and health systems and education are also important roles of Nursing.* [12] In this regard, the person is much more than a source of signs and symptoms, they have a prior history and experience (culture, religion, spirituality, relationships, among others) that influence the way of being and interacting with others (in this case with the Nurse). It is during this interaction that the Nurse reinforces the existence and singularity of the person in the illness process. [13,14]

Person/Client-Centred Care and the Individualisation of the Intervention

The Person-Centred Nursing Model reflects the ideals of humanistic care, in which there is a moral component and Nursing practice is based on a therapeutic intentionality, which translates into relationships built upon effective interpersonal relationships. [15] According to the model, Nursing is an approach to the practice established through the formation and promotion of therapeutic relationships, based on respect for people; the individual right to self-determination; and mutual respect and understanding, through cultures of empowerment that promote humanistic development[15]. According to McCormack & McCance [15], Person-Centred Nursing is focused on 3 major aspects:

- Nurses' competencies (professional competencies, personal competencies, commitment to work and personal traits);
- Organisational aspects (time, combination of competencies and the role of the nurse);
- Client attributes.

In addition to the focus on technical competence, it is extremely important to develop humanistic and holistic care practices to embrace all forms of knowledge and action

[1] For Hesbeen (43), *to care is an art, a therapeutic art, (...) that will enable you to help someone in their unique situation* p.37).

to promote choice and partnership in care decision-making. [15]

The middle-range theory of Person-Centred Nursing is characterised by four fundamental aspects[15,16]:

- Pre-Requirements: these focus on the attributes of the nurse and include being professionally competent; having developed interpersonal skills, self-knowledge; being committed to the job; being able to demonstrate clarity of beliefs and values, and knowing oneself;
- Care Environment: focuses on the context in which care is delivered and includes an appropriate mix of skills; systems that facilitate shared decision-making; effective relationships between staff members; a responsible sharing of power; physical environment; supportive organisational systems; potential for innovation and risk-taking;
- Person-Centred Processes: focus on delivering care through activities that operationalise person-centred Nursing and include working with the client's beliefs and values; sharing decision-making; authentic engagement; empathetic presence; holistic care delivery;
- Expected Outcomes: include a positive experience with the care provided; involvement in care/care giving; feeling of well-being; the existence of a healthy culture.

Person-Centred Care develops from the communication between the person and the professional. Therefore, nurses' interventions should focus on listening to people's narratives about their experience of falling ill, the personal meaning they attach to the illness and the social restrictions caused by suffering and symptoms. By understanding these experiences, nurses can strengthen the person's involvement in care decision-making. [17]

When effective communication is established, interest is shown in listening and the professional is available to understand the person's perspective, this leads to greater trust in the person, a caring environment is created in which there is greater sharing of their feelings and greater engagement in the decision-making process. [17]

The person-centred model emphasises the meaningful interaction between the nurse and the person. In this aspect, McCormack & McCance[15], when describing the person-centred processes, describe the *Engagement*[2] as a mirror of the quality of the nurse-person relationship. According to the ability to jointly solve problems and/or work together, the authors describe three levels: full engagement, partial disengagement, and complete disengagement.

In the 2017 review, McCormack & McCance[16] rename the process to *Engagement Authentically*[3]. In its description, Engagement Authentically is considered as the Nurse's connection with the patient/person and family (or significant others), determined by the person's knowledge, clarity of beliefs and values, self-knowledge and professional experience. This interaction between nurse and person is unique, both for the individuals that comprise it and for the moment in which it is established. Despite this change, the authors maintain the levels of engagement described previously.

By analysing the care practice, the presence of the biomedical model is observed in the Nursing records. Although the theoretical Nursing model adapted by the institution is that of Roper, Logan and Tierney about Activities of Daily Living, the Nursing records produced in most situations give response/visibility to the tasks performed, to symptomatic control, to continuous improvement programmes and/or to the needs or obligations of the directive/management component. In terms of organisation and structure, the records are based on the satisfaction of needs/activities of daily living. However, the record on functionality is noted.

It is considered that the Nursing records document the care provided, making it visible. Despite their importance, they are sidelined in more complex or work overload situations. [18–20]

Indeed, the above is in line with what is described by Kärkkäinen et al. [21] Records often seem to reflect the tasks performed by nurses, rather than personalised care. In addition, there is reference to the way records are made, which is recommended by the institutions, and which may hinder the production of records focused on individualised care. Hence, the content of Nursing records does not meet comprehensive and person-centred criteria.

Furthermore, Kärkkäinen et al.[21] consider that the visibility of individualised care in Nursing records should take into account the experience, needs and wishes of the people being cared for and that care plans should be drawn up with the person/patient and family. Although this cooperation between nurse/person should exist, the documentation of care should not be to exclude the technical knowledge of the professional, the technology, the practice of care or the ethical principles.

[2] Free translation of the term Engagement described by McCormack & McCance[15].

3 Free translation of the term Engagement Authentically described by McCormack & McCance[16].

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Advanced Nursing and Advanced Practice Nursing in the Portuguese reality

Nursing in Portugal underwent a great development in the last century. This explosion occurred not only in its effective care practice, associated with the evolution of medical knowledge and the demands of the people cared for regarding the care provided, but also in its training, through the integration of Nursing as a higher education course (baccalaureate and later undergraduate degree) and the development of master's and doctoral degrees in Nursing Science. [22]

With the evolution in care practice, there was a need to regulate the profession - the Regulamento do Exercício Profissional dos Enfermeiros (Regulation for the Professional Exercise of Nurses) was developed and the Ordem dos Enfermeiros (Portuguese Order of Nurses) was created. In the Regulamento do Exercício Profissional dos Enfermeiros[23], the nurse develops two types of interventions: on the one hand, autonomous interventions, initiated by the nurse's prescription and, on the other hand, interdependent interventions, initiated by the prescription of another health professional.

In some countries, due to difficulties in medical assistance, the technical competencies of some nurses were developed, making them legally qualified for diagnosis, therapeutic prescription and prescription of complementary diagnostic tests and their interpretation. This increase in nurses' medical competencies led to the creation of the *Nurse Practitioner*[4]. [22,24,25]

According to the International Council of Nurses (ICN), Nurse Practitioners *"are generalist nurses who, after additional education (master's degree for entry level), are autonomous clinicians"*. [26] In the national reality, this advance in Nursing practice may be compared to the development of interdependent competencies of nurses. Gardner et al.[27] and Silva[22] also compared the Nurse Practitioner in their conception as a hybrid model between doctor and nurse, based on the biomedical model.

In light of this advancement in Nursing practice, it became urgent to define the path to where it was intended to develop the body, practice and science of Nursing. The Canadian Nurses Association defined Advanced Practice nurses as:

An umbrella term for registered Nurses and Nurse Practitioners who integrate graduate nursing educational preparation with in-depth, specialized clinical nursing knowledge and expertise in complex decision-making to meet the health needs of individuals, families, groups, communities and populations. [28]

These advanced practice nurses have the following competencies: comprehensive/extended in the provision of direct care; health systems optimisation; education/training; research; leadership; and consultation and collaboration. [28]

More recently, the ICN has defined Advanced Practice Nursing as:

Enhanced and expanded healthcare services and interventions provided by nurses who, in an advanced capacity, influence clinical outcomes and provide direct healthcare services to individuals, families and communities[26].

In the same document, the ICN defines the *Clinical Nurse Specialist*[5] as a professional with advanced knowledge in Nursing, beyond the knowledge developed in generalist or specialty training, in making complex decisions in a specific context, promoting quality and positively impacting the health services. [26] This professional designation arises in response to the development of the context of specialised care practice, requiring further education beyond the Nursing Speciality. Comparing with the Portuguese reality, the acquisition of a Nursing Specialty by a Master's degree – reference level for the attribution of the title of *Clinical Nurse Specialist*[26] – may be considered a path towards the development, or rather, the advancement of the Portuguese Nursing practice.

In this line of thought and in the national reality, Silva[22] described Advanced Nursing as a development of competencies in the area of caring and decision-making. Thus, the development of masters and doctoral degrees in Nursing has deepened the knowledge of human responses to the care provided, but also developed nurses' competencies for the effective delivery of care. [29] Within the scope of nurse specialists, the Portuguese Order of Nurses defined four domains of common competencies: Professional, ethical and legal responsibility; Continuous quality improvement; Care management; and Development of professional learning. [30]

With regard to the development of Nursing competencies, Benner[31] conceptualised it in five levels or phases, whereby the phases of Proficient and Expert may be framed with the competencies of nurse specialists. In her description, the proficient nurse apprehends and understands care situations as part of a life process, making decisions based on the holistic model and learning and modelling practice/decision-making with experience. Regarding the

[4] The decision was made to keep the original/international designation, as there is no equivalent in Portuguese practice.

[5] The decision was made to keep the original/international designation, as there is no equivalent in Portuguese practice.

expert nurse, they support their action based on intuition, thus having a high performance. [31]

Comparing with the Strong Model of Advanced Practice, [27,32] it can be stated that the common competencies of the nurse specialist meet the five areas of advanced practice, with the provision of specialty care[6] corresponding to Integral Direct Care[7] and the underlying processes of advanced practice.

Conclusion

The principles of quality and safety in health are underlying Lei de Bases de Saúde[33] (Basic Healthcare Law). Nursing, as a health science, seeks to answer to Quality and Safety in health. [25]

The WHO understands Quality in Health as a high degree of professional excellence, with minimum risks, positive health outcomes for patients and efficient use of available resources. [34] Additionally, quality in health is considered as a relationship between professionals and patients/populations that aims at the best desirable health outcomes according to current knowledge. [35]

On the other hand, health Safety is more than "the prevention of harm to patients". [35] For Mitchell[36], *patient safety* means the absence of preventable injuries and the reduction of the risk of unnecessary harm associated with healthcare to an acceptable minimum, based on current knowledge, available resources and the context where the care was provided, compared to the risk of non-treatment or other treatments. This way, quality and safety in health appear interconnected. This way, quality and safety in health appear interconnected.

In the sense of professional excellence and in the development of its body of knowledge as a science, it is essential for Nursing[8] to focus on the increase of competencies for person-centred performance – the primary target of Nursing care. [22] Looking at the historical evolution of Nursing and the current paradigm, it makes sense to understand the middle-range theory of Person-Centred Care. In the specific context of Rehabilitation, the person-centred approach becomes a practice of excellence: to approach the person in a holistic way, in order to solve their daily difficulties, considering them as an expert in their living experience; and emphasising the participation and empowerment, respecting the person beyond the impairment or ilness. [37]

In the reality of care giving, the main obstacles to person-centred care are in line with those described by Moore et al.[38], namely traditional practices and structures, time constraints and the documentation and organisation of the institution. Furthermore, the lack of documentation supporting person-centred care and the low visibility of the actual care provided in the records emphasise the difficulties in implementing this type of care.

The multidisciplinary intervention in health, not only of several medical specialties, but also of several health professionals, turns health care into a sea of interventions, in which the person may sink. Therefore, by applying the holistic paradigm to its practice, Nursing may be considered a safe foundation, or rather a safe haven, from which, alongside the person, strategies, processes, among others, are developed to improve their health and reduce the impact of their illness situation on their life path. [39]

Despite the needs felt in other countries to include medical competencies in nurses[40], in Portugal the average number of nurses is below the OECD[41] average. In this sense, it may be stated that, given the difficulty in providing Nursing care to the population, the acquisition of extraprofessional skills will not make sense. However, the literature highlights that nurses with added competencies – Nurse Practitioners – add value to the vision and provision of Nursing care to the population. [24,27]

In summary, analysing the historical perspective of Nursing over the centuries, from its abnegated period, through the romantic era[9], medicine and the technicist phase, we understand some current practices and doubts regarding the perspective of the future. [9] Thus, the development of knowledge and practice in Nursing should go through the recognition and advancement of the core competencies of the discipline. [22] An approximation between scientific production – from the academic domain - and care practice – from the community and hospital domain - is fundamental for the development of Nursing. Facilitating this process is the development of the Nursing specialty as a master's degree course, promoting not only different practices, but also the critical look and thinking of professionals.[29] In this process, the existence of other sciences – health, social and human sciences, among others – that will promote the development of the Nursing body should not be relegated to second place, but it is also crucial to disseminate scientific production in Nursing, in order to give visibility to the science and practice of the discipline. [22,40,42]

[6] In accordance with the various Regulations of the Specific Competencies of Nurse Specialists.
[7] Free translation of *Direct comprehensive care* used in Mick & Ackerman's model[32].
[8] Nursing, that is, nurses in the delivery of care, teachers in Nursing Schools and Nursing researchers.
[9] Term used by Pearson & Vaughan[9]

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Authors' contributions

JS: Drafting the manuscript; Critical revision of the manuscript.

Conflict of interests

The author declares no conflict of interest.

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