# A Care Plan for Nursing

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**Abstract:** What could be learned if we viewed our profession with the same compassion and understanding that we give to our patients? Applying caring science theory to the nursing profession offers a framework that is broad enough to hold the complex and broad narratives of every nurse. Using the caritas process of loving kindness and creative problem-solving, a care plan for the nursing profession evolved. A care plan for nursing provides nurses with a common lens, invites them to heal their profession from their own praxis, and creates hope and optimism for a collective path forward.

**Keywords:** framework; healing; caritas; nursing; perception

The profession of nursing is on a ventilator. Its blood supply is the dwindling academic workforce, and there are no more bags of blood to hang. Nursing's oxygen level is represented in the life energy that is required to work in the current environment, and nurses are so desaturated that they are leaving. Something has made us toxic. Insidiously over time, unknown organisms have taken over. To heal, nurses must acknowledge and respond to these toxins. But how and where do we begin this vital healing process? Perhaps by the willingness to authentically listen to each other's stories (Caritas 5) (Watson, 2008).

In January 2021, I decided to clip all U.S. health-related information from a news magazine, *The Week*, published throughout 2020, including articles that were not related to the COVID pandemic. The statistics and facts fell into five major categories:

- Poisoned and insufficient food supply
- Extremely sick Americans
- Social and economic factors
- Business-for-profit healthcare model
- Polarized political environment

I was shocked, dismayed, and confused. Why was this extremely relevant information, not general knowledge, or portrayed in various media sites? How could the health of Americans be in such bad shape in a country that spends almost 19% of its gross domestic product on health care? What were the forces preventing 4.6 million nurses from stepping into their full autonomy and power to prevent this downward trend?

For more than 20 years, I have spoken to nurses at all levels in the United States and Canada about the culture of health care, teamwork, incivility, communication, and leadership. After each presentation, nurses shared their lived experiences as nurses. Every one of these stories is etched in my heart: nurses crying as they talked about the critical lack of resources, burned-out nurses telling me why they were leaving, or proud nurses sharing how they saved a patient's life. The stories are not anecdotal but rather the lived experiences of thousands of nurses that reveal common threads. Woven together, they could reveal a tapestry of information, but as individual threads, a pattern was challenging to perceive.

In 2010, I discovered a framework that was comprehensive and broad enough to

hold every story I had ever heard: *the Failures of Group Decision-Making* by Jared Diamond (2008). I later presented this material as a poster at the Sigma Theta Tau International Conference in Vienna. The theory was then applied to practice in a viewpoint article in the *American Journal of Nursing*, "A Failure to Rescue Ourselves" (Bartholomew, 2010), pointing out that nurses were ineffective at establishing consensus on making major decisions and, therefore, still functioning as an oppressed group (e.g., entry-level college requirements into practice).

But the answer to my questions was still elusive until I reduced the problem to a single entity. What would I do if my profession was my patient? What would happen if I applied the caritas of loving kindness (Watson, 2008) to heal our profession? If we could collectively listen to nurses' stories and acknowledge our profession's vulnerabilities with the same sense of deep respect, curiosity, and acceptance that we give to our patients, the obvious solution would be to create a care plan for nursing. By healing our profession, we could advance, sustain, and preserve "human caring as a way of fulfilling its mission to society and (the) broader humanity" (Watson, 2008).

Any framework is inherently constructed from a set of values. The proposed care plan (Table 1) requires the values of caring, inclusivity, integrity, agency, equity, collaboration, service, creativity, self-awareness, optimism, and ethical action. These humanistic values sit at the core of our nursing profession and reflect nursing's great love for humanity. Jean Watson has said that the process of caring is a moral ideal committed to a specific end (Watson, 1985). What could be learned if we extended this process of "protection, enhancement, and preservation … to restore inner harmony and potential healing" (Watson, 1985, p. 58) to our profession?

This was exactly the reframing needed to perceive and embrace the big picture. Reframing is a technique used by therapists to create a different way of looking at a situation or person by changing its meaning (Robson Jr & Troutman-Jordan, 2014). Suddenly the puzzle pieces assembled; the threads were woven into a tapestry that told a bigger story. I could zoom out and frame the challenges that all nurses faced in a way that made the solutions obvious. If we could agree on the diagnosis and assessment, every nurse in any role would be empowered. Instead of being directed, mandated, recruited, or organized, nurses could apply the tenets of complexity theory (Notarnicola et al., 2017) and act within their own praxis, designing interventions that could address and eliminate the symptoms in their own specialties within their own unique environments.

Framing is a critical strategy that can help people understand highly charged and opaque issues, but it is often overlooked (Koon et al., 2016). Nursing is highly specialized and diverse and holds such breadth of practice that the frame is an enormous panorama. The result is that nurses do their best to comprehend their own reality, but a common focused viewpoint remains elusive. A care plan for nursing, however, could serve as a universal framework that could enable all nurses to step back and take stock of not only what is but what could be. In addition, the care plan provides a common foundational language so that nurses could work together to heal our profession. See Table 1.

## Assessment/Symptoms

With my profession as my patient, I began by assessing the symptoms which surfaced repeatedly in the narratives of thousands of nurses. These stories fell into four major categories:

- Oppressed group behavior
- Collective learned helplessness
- Knowledge deficit
- Dwindling workforce

### Oppressed Group Behavior

In "Pedagogy of the Oppressed," Freire (2000)) wanted to know what happens in groups of people when some have more power than others. After studying several civilizations, he noted recurring patterns. When a dominant group exists, it exerts so much power downward that the oppressed group cannot direct its power upward, and thus, unconsciously, the oppressed group begins to attack each other.

Examples of oppression in the nursing profession abound. Nurses disagree over college entry-level requirements for becoming a registered nurse. When a Gallup poll in 2010 of 1,500 thought leaders across the country asked, "Who has the most impact on health care reform and its implementation?" nurses came in last—even after the patient

**TABLE 1.** Outline of Care Plan

| Patient | Condition | Diagnosis |
|---|---|---|
| Nursing profession | Critical | A failure to mobilize resulted in the health of Americans spiraling downward despite 4.3 million nurses<br>A failure to actualize the potential in the caring–healing profession of nursing (Jean Watson) |
| **Symptoms/assessment** | | |
| 1. Oppressed group behavior as evidenced by | • Disagreement over entry-level college requirements for registered nurses<br>• Diverse curriculum that varies per institution, per instructor, or per location<br>• License scope and definition that differ by state<br>• Numerous nursing organizations yet no significant collective impact<br>• Peer-to-peer hostility at every level and between organizations<br>• Politically fractured leadership | |
| 2. Collective learned helplessness | • Lack of support and inadequate funding by our institutions, government, and public<br>• 12-Hour task-saturated shifts, nurses reporting inadequate meals and breaks<br>• Extremely low salary for faculty, which has led to a lack of sufficient faculty<br>• Overwhelming staffing issues—nurses have no voice in the number of patients<br>• Lack of proper equipment, resources, and most of all time<br>• Human adaptability—we have adapted to a frenetic pace which has been normalized | |
| 3. Knowledge deficit | • No shared common language to define the role of a nurse<br>• Inaccurate or missing branding, public confusion on nurses' role, for example, medical assistants introduced as "nurses"<br>• Communication deficit—self-silencing—missing skill set of assertive communication related to self-esteem and power<br>• Nurses are assimilated into the old culture; no knowledge of what is known about nursing and hospital culture<br>• The framework of nursing theory is irrelevant, or absent, for example, several schools are dropping the class altogether | |
| 4. Dwindling workforce | • The projected shortfall of 510,394 nurses by 2030 (the Hechinger Report)<br>• The average age of nurses is 50, with one million retiring before 2030<br>• Last year 80,407 qualified applicants for BSN and MSN programs were rejected<br>• Shortage of faculty due to gross salary disparity (e.g., California teacher 60K and new nurse 130K)<br>• The average age of bedside nurses in key areas is 59 with 500,000 nurses retiring by 2022 (e.g., cardiac)<br>• Shortage of 75,000 primary care physicians—72,472 retiring by 2025<br>• Only 15% of nurse practitioners have their own practices—authority in 23 states<br>• U.S. Bureau of Labor Statistics projects the need for 1.1 million new registered nurses for expansion and replacement of retirees and to avoid a nursing shortage | |

(Robert Wood Johnson Foundation [RWJF], 2010). Rather than cooperate and collaborate, humans in oppressed groups *unknowingly* compete against each other, focusing on their own survival in a world of inadequate resources. For example, two universities in the same state decided not to partner on a grant because they perceived that they were competing for the same *intellectual territory*. Another example is when the president of a national nursing organization was refused admittance to a state leaders conference. This well-documented pattern of oppression plays out from frontline nurses to our largest organizations.

Nursing has no collective impact. There are hundreds of nursing organizations, but not one whose members represent more than 5% of all nurses. Organizational competition abounds. The result is politically fractured and ineffective leadership. On numerous occasions, I have asked staff nurses across the country to name a nursing leader. The first, and usually, only name is Florence Nightingale.

We have a diverse curriculum that varies per state, per institution and per instructor while license scopes differ by state. Individuals who work in systems, where they do not have a strong collective voice or identity, intensify their efforts to protect their own *territory* because they are human. Just as animals move from a cohesive group to warring tribes when food or territory is not available, humans too remain loyal to their own herd.

Peer-to-peer hostility has been documented at every level of nursing for decades, from faculty to frontline nurses and managers (Bartholomew, 2014). When nurses are consistently overpowered and prevented from accessing the resources needed to do their jobs, they unconsciously take it out on each other. These covert and overt learned behaviors then become the cultural norm over time. And the incivility that exists in our schools has proven to be a precursor of the culture new nurses will experience on the floors (Nelson et al., 2017).

### Collective Learned Helplessness

When an individual or a group asks for what it needs repeatedly and is ignored or rejected, they eventually stop asking. Over time, the lack of resources becomes normalized and is accepted as a group norm without being acknowledged or questioned.

The most obvious example of this is staffing grids established by hospitals. Nurses fight for staffing ratios, not realizing that there is another option. The only person who can make an ethically and clinically safe decision for hospital staffing for the next shift is the charge nurse. The charge nurse at the point of care is the only person in the organization who knows (a) the real-time acuity of all patients and (b) the experience level of the oncoming shift. Instead of fighting for charge nurses' authority we sell out to staffing grids which are yet another form of control by the dominant group.

For decades, nurses have witnessed low salaries and tolerated this inequity. University nursing faculty make an average of $84,320, while business faculty salaries start at $113,110 or more (Bureau of Labor Statistics, 2022). While I would have loved to teach, I could not support my family with the $47,000 cut in pay that I would've taken from my nurse manager position to work at a community college where I was offered a tenured track position. The result is a faculty shortage, with more than 80,000 qualified applicants for BSN and MSN programs rejected in 2020 (American Association of Colleges of Nursing, 2021). An estimated one-third of faculty will retire by 2025, and we have known this fact since 2017 (Fang & Kesten, 2017).

### Knowledge Deficit

If you ask a thousand nurses to define *nursing*, you will receive just as many answers or no answer at all. Nurses cannot possibly brand themselves as the highly skilled and compassionately caring people they are to the public while lacking a common language to define themselves. Until 2021, the American Nurses Association's definition of nursing has been a rarely used, never quoted 43-word paragraph, which does not resonate with nurses and is cryptic to the public.

The inability to define the nursing profession in terms that resonate with the public has resulted in confusing and misleading branding. Many examples are found in the media. Netflix just released a two-season series of *Nurse Ratched*, while *Gray's Anatomy* delivers care season after season with physicians alone. *The Good Doctor* reinforces the role of nurses as low-skilled physician lackeys (Summers & Summers, 2019). Uncertainty around the role of nursing is further compounded by clinics that refer to medical

assistants as nurses, as well as Doctor of Nursing programs that the public perceives as nurses trying to become doctors. If these misconceptions are not corrected, nurses can never take their rightful place as highly skilled and trained healers.

A second knowledge deficit is assertive communication. Even though the American Association of Critical-Care Nurses' standards stated that nurses should be as competent in their communication skills as they are in their clinical skills, communication remains an untested competency in most institutions (AmericanAssociation of Critical Care Nurses, n.d.). Over a 10-year period, I surveyed thousands of nurses (*N* = ~5,000) to determine the cause of self-silencing, which I have witnessed repeatedly as a patient safety and culture expert. Ninety-five percent of every audience from chief nurses to frontline nurses stated that they were avoiding a critical conversation. Surprisingly, when asked why they were self-silenced, the answers were predominantly fear-based: fear of making the situation worse, fear of being isolated from the group, and fear of retaliation were unanimous answers. Another one of the top four answers was "Why bother because nothing changes anyway." This is classic learned helplessness.

Nothing impacts the self-esteem of nurses more than their assertive communication deficit. Power, voice, and self-esteem are synonymous. When every nurse becomes a skilled communicator, individual and collective self-esteem will rise. Freire (2000) noted that this is one of the two actions that will free any group from oppression. The second action is to *lift the veil*, meaning that nurses perceive the power imbalance and how their own actions contribute to reinforcing their own powerlessness (for example, self-silencing).

### Dwindling Workforce

The Hechinger Report projects a shortage of 510,394 nurses by 2030. Today the average age of nurses is 50, with one million retiring before 2030. In some critical areas, such as cardiac, the average age of nurses is 59 (Krupnick, 2020). The stress of the pandemic has exacerbated this shortage as many senior nurses decided to take early retirement. The result is a brain drain of knowledge. One chief nurse from a major university hospital system shared that only 5% of her cardiac nurses now have more than 5 years' experience.

## Diagnosis

After observing the symptoms and reviewing the assessment, two possible diagnoses emerged:

- A failure to mobilize despite a workforce of 4.6 million nurses, resulting in the declining health of Americans.
- "A failure to actualize the potential of nursing as a caring–healing profession." (Watson, personal conversation, January 13, 2021)

These complimentary diagnoses are a result of a thorough assessment of the symptoms as validated by the narratives of thousands of nurses across the spectrum. To my knowledge, however, these symptoms have never been addressed in a single paper because of the complexity and breadth of the subject matter. Viewing the nursing profession through the lens of a patient allows nurses to not only visualize the entire profession but also provides a practical way with which nurses all over the world can identify with to address complicated, multisystem issues.

## Planning and Intervention

Because nursing has such a diverse collage of challenges that compete for our attention, resources, and time, it has been nearly impossible to identify how nurses can make a significant impact. As outside stressors increase, humans tend to put on their own life jackets, and their focus narrows to self-preservation. Nurses deserve more. Agreeing on a construct that empowers nurses and stimulates collaboration is the first step to getting back on the boat: mobilizing our resources and actualizing our potential.

The second step is acknowledging the power of culture in executing our interventions. The American overculture is organized and hierarchical. We are accustomed to acting in a linear fashion and being directed. Yet to unleash the innate wisdom of nurses, all that is needed is to accept the "creative use of self and all ways of knowing as part of the caring process" (Watson & Nelson, 2011). Nurses must know and trust that it is within their own state of authentic caring presence that they can speak their truth, source their wisdom, and discover an intervention unique to their practice. New behaviors will inspire us to stand up for our patients, our profession, and our nation because now we have what we previously lacked: a common framework from which to act.

Praxis for a national nurse leader might look like rebranding the profession as highly skilled, thereby addressing the knowledge deficit of nursing's pivotal role in creating a healthy nation. Nurse leaders would collaborate to sponsor a media marketing campaign designed to alter public perceptions and create a new meme for nurses as highly skilled, compassionate, and knowledgeable. As public perception shifts, more money and resources would be dedicated to supporting the profession. Nurse leaders would take a stance on health threats to our nation as their professional membership grows. For example, they could reject the race for the cure for cancer, which funnels billions into research and pharmaceuticals, and instead, shift the national focus to preventing cancer. While we heard repeatedly that 400,000 Americans died in 2020 from the pandemic, more than 600,000 died from cancer, which has been so normalized that this statistic was not newsworthy.

Nurse leaders would be frequently quoted in the news and print media and would be a critical resource to political leaders. Every board of directors from schools to businesses would have a nurse at the table. A common definition of nursing would be established, and this description would be used by all nurses as well as the public. An office of chief nurse would be established per state and full time for the nation. This advisory group would be trusted and respected by political leaders to keep their finger on the pulse of Americans' health. Nurse leaders would anticipate threats to the nation's health, such as the need for social media addiction education in schools or how to create a sense of community to reverse loneliness trends.

Faculty would apply Caritas 7 (Watson, 2008) and engage in transpersonal teaching and learning within the context of a caring relationship while using a coaching model to encourage health and wellness among themselves and their students. A faculty intervention might be demanding a salary commensurate with other disciplines, thereby uplifting the nursing faculty workforce to an "even place at the table." A nationally agreed upon curriculum for the first 2 years would be created to streamline education. Civility and communication competencies would become an important and integral part of the curriculum (Clark, 2022). As nurses learn to speak their truth, their sense of self-esteem would rise individually and collectively, thereby releasing nursing from oppression (Freire). New nurse education would include learning about the power of culture and the role of the individual in supporting or changing group norms (Bartholomew, 2014). Nurses would become recognized for practicing loving kindness and compassion with themselves and each other (Caritas 1) (Watson, 2008). This template of genuine caring would have a profound impact on the collective consciousness because it would elevate the value of caring in our society.

For frontline nurses, the biggest challenge would be speaking their truths about low staffing levels or refusing to work double shifts and overtime to pick up the burden of a dysfunctional system. Nursing services would be paid for in a separate invoice. The 12-hour shifts would be replaced by 10-hour shifts, with each nurse practicing 8 hours of clinical and 2 hours of support, such as quality improvement, research, or patient education. There would be a huge movement of nurses from hospitals to public health as key nursing leaders lead the paradigm shift from illness and disease to prevention and wellness.

State and national conferences would begin by addressing the care plan for our beloved profession. Members would identify and present their unique care plans for their roles and specialties, sharing interventions that alleviated the symptoms of oppression, knowledge deficit, dwindling workforce, and learned helplessness in their workplace. A digital care plan would be electronically assembled so that all nurses could participate, connect, learn, and literally feel what it would be like to alleviate our symptoms together.

## Evaluation

The most critical overarching outcome would be freedom from oppression, as demonstrated by nurses mobilizing to autonomously practice at their full scope while being acknowledged for their capacity to heal.

Oppression theory states that a group will transition out of oppression when the veil is lifted (Freire, 2000). Perhaps through the lenses of the caritas, we can summon the courage and love to allow both positive and negative feelings (Caritas 5). Then we could admit that we have not had the power we deserve in a system that is structured fundamentally as a business instead of a service (Bartholomew, 2021).

Evaluation would occur on three levels: individually, professionally, and nationally. Individually, the most notable healing outcome would be the increased self-esteem of nurses who as skilled communicators have developed loving, trusting, and caring relations with each other (Caritas 4). Nurses would prioritize creating a healing environment for themselves first knowing that psychological safety is required for authentic self-expression. Burnout and depression would decrease, and retention and recruitment would increase. From a position of self-care, nurses would care for each other. The phrase "nurses eat their young" would become obsolete because nurses would nurture and support each other.

Professionally, there would be a radical shift in role clarity by the public. Our professional role would retain a high level of trust but would now include respect for nurses' autonomy, skill, and an immense body of knowledge. Nurses' holistic approach to care would be recognized as the medicine our citizens need to address the social determinants of care. And because nurses care deeply for each other, they would lead a major shift in societal values, uplifting genuine caring as a template for humanity.

Nursing organizations would work together to transform health care from rewarding volume and quantity to rewarding quality and outcomes as evidenced by new health policies. Nurse practitioner-led clinics would provide primary care for all Americans in a model based on service, such as the public utility model. The average age of the nurses would fall dramatically, and there would be no more waiting lists for nursing schools because faculty salaries would be commensurate with other disciplines and the curriculum would be standardized. Community college programs would seamlessly transition to 4-year programs, and by the year 2025, the requirement for becoming a registered nurse would be a university degree.

Nationally, the trajectory of disease and illness in America would reverse directions as indicated by increasing longevity, decreasing maternal and infant mortality, and decreasing loneliness, depression, and suicide. The Gross Domestic Product (GDP) dedicated to health would shrink as the number of Americans suffering from cancer, obesity, diabetes, and the top five chronic conditions decreased. Because of the holistic model demonstrated by nurses, the public would redefine health itself as a basic human right, which includes mental, social, cultural, and physical well-being.

## Conclusion

The second caritas of "being authentically present: enabling sustaining and honoring faith and hope" (Watson & Nelson, 2011, p. 8) would be actualized in a care plan for nursing. Hope and meaning are intrinsically intertwined. As mainstream news abounds with stories of oppression, nurses struggle to understand their own personal role as well as the role of our profession in society. In addition, the thinking component of hope asks us to "visualize something meaningful that is not yet in existence" (Watson & Nelson, 2011). Therefore, a collective framework for healing our profession inspires hope, restores faith, and creates a realistic vision for the future.

We have both an opportunity and a challenge: to come together in a way that we have never done before to redefine and publicize our profession. A care plan for nursing can inspire nurses to collaborative action by illuminating and categorizing the many forces that are attacking our autonomy. What we have lacked previously is a common way to perceive our profession, a common vision; a familiar framework that is self-directed, empowering, and practical. A care plan for nursing has the potential to mobilize nurses, actualize nursing as a caring–healing profession, and elevate the value of caring to humanity.

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