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A theoretical model of nursing practice: Implications for a competence approach to nursing education

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ABSTRACT

This article puts forward a theoretical model of nursing practice, elaborating and illustrating how the model can be used by nursing practitioners, students, and educators. Experiences with using the model in a pilot study with a clinical supervisor and three nursing students is reported. Implications of the model for working with competence development is discussed, both in relation to issues raised by Weeks et al. (2017) specifically, and to competence-based approaches more generally. A key point is that a focus on competence alone may not provide students with adequate conceptual tools for interpreting and acting competently in practical situations. The proposed theoretical model is seen as providing such a tool.

1. Introduction

This article puts forward a theoretical model of nursing practice. Even though the model was not developed explicitly with a focus on competence, it can be used as an important analytic tool for supporting competence development among student and professional nurses. At the same time, this model provides a platform for addressing the important question raised by Weeks et al. (2017) about how to prepare nursing students adequately for the uncertain, changing future conditions of nursing practice. The proposed model provides an important supplement to a competence perspective in nursing education, implying that educational approaches should not be reduced solely to a focus on individual competence development. It is desirable to include a theoretical model of nursing practice as a component of pedagogical strategies for competence development, in relation to holistic educational processes mentioned by Weeks et al. such as clinical simulation, virtual authentic learning environments, and other innovative constructivist pedagogies. Because the phrase "model of nursing practice" can be interpreted in many different ways, we want to present the actual model as quickly as possible, and illustrate how it can be used.[1] Then we summarise some points about the actual use of the model in practice, based on the experiences of a clinical supervisor and three nursing students in their clinical practice period. The article concludes with a discussion that explicates relations between this model and the problem field of nursing education, and uses that analysis to discuss the integrated competence model presented in Weeks et al., showing ways in which the theoretical model can supplement the integrated competence model.

2. A theoretical model of nursing practice

What is the essence of nursing as a practice? The intention behind this question is to identify the main or central aspects that must always be present in actions that are considered to be manifestations of nursing practice. The theoretical model of nursing practice addresses this question by identifying two interrelated issues that a nurse must always address when engaged in any practice of nursing — regardless of whether the nurse is conscious of these issues or not. The first issue is (a) what is a nurse trying to achieve (or produce) in any given nursing situation? The second is (b) what general relationships must always be addressed in realising the result (or product) of the nursing process? Nursing, as a practice, is aimed at (a) enabling patients to continue their life situation with dignity, where (b) this realisation must respond to the patients' *medical condition* and *wishes,* in relation to the *resources* that are available. Competent nursing, in concrete situations, requires that the relationships among these three general categories (medical condition, wishes, and resources) must be coordinated in a way that serves to enable a patient to continue life with dignity. Fig. 1 shows these model relations graphically. The key idea is that in any particular nursing situation, actions are being organised in service of helping the

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[1] It is likely that other meanings of *nursing practice* are in common usage in different professional spheres. The intent here is only to put forward a clear explanation of the meaning being used in the present article, and to highlight the utility of the model of practice in relation to professional competence development. No attempt is made to account for existing usage of the expression *nursing practice*, or deny that other meanings can be intended with this expression.

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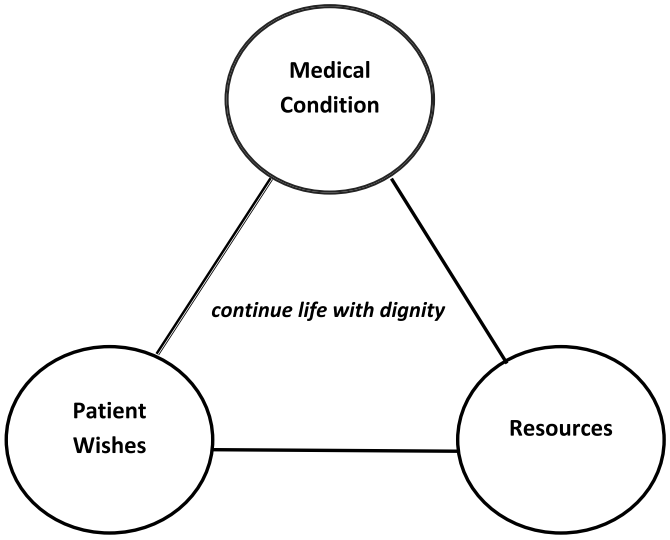

Fig. 1. Theoretical model of nursing practice.

patient continue his/her life situation with dignity, where it is necessary for the nurse to coordinate between the medical condition (and its demands), the patient wishes (which may also include wishes of close relatives), and the available resources. The diagram in Fig. 1 serves only to give a visual image of these analytic relations, while actions in response to those relations are implicit. It does not provide any information beyond that key idea.

The apparent simplicity of this model belies its significance and analytic power. First, it has the important virtue of embodying the central aspects of nursing as a practice, because all concrete instances of nursing always involve these relations. In this sense, it is a *holistic* model, providing a way to conceptualise the essential focus of action in nursing practice. Second, because of its simplicity, it is realistic for students and professionals to readily acquire an understanding of the model and how to use it. Third, this approach to modelling practice is grounded in philosophical traditions that trace their roots back to Aristotle's discussions of the relation of form to matter and its elaboration in a dialectic perspective that holds that the essence of a thing or phenomenon is expressed in the process of its development (e.g., Davydov, 1972/1990, pp.294–296). The idea is for the model to express the essential relations that underlie a phenomenon, where the general relations in the model are manifested through the concrete details in a particular situation. In the present case, the "thing" or "phenomenon" is competent nursing practice. The process by which competent nursing practice comes to expression always involves a focus on the outcome ("continuing life with dignity"), which always involves working with the basic (or essential) relations (medical condition, wishes, resources) in realising this outcome. In other words, a person is practising nursing if one is addressing the relationships among medical condition, wishes, and resources, with an aim to enable the patient to continue life with dignity. This way of characterising nursing practice — as responding to the relations among these three categories in relation to the product — is motivated by two main ontological assumptions about practices in general, namely that (a) all practices arise from attempts to produce something needed in societal life, and (b) that adequate products from this production process must accommodate necessary material conditions in the concrete situation (Chaiklin, 2011). This theoretical approach has important conceptual and pedagogical consequences, which will be discussed after the meaning of the components of the theoretical model of nursing practice are elaborated and illustrated.

3. Elaboration of the model

A basic objective of the theoretical model is to identify the essence of nursing as a practice in a way that is meaningful and useful for practitioners. In the model's point of view, to practise nursing is to have a direction or orientation for action, where action is always conducted in relation to some material conditions. The key insight of the model is that it identifies a direction for action in relation to categories of material conditions that are always present in all nursing situations. The universality of these relations provides a practitioner with a useful analytic tool that can be used for organizing professionally-informed action in all concrete situations in practice.

All forms of nursing work are directed toward helping persons (who come into contact with a health service) with continuing life with dignity. While each individual case may be unique in its complex, actual details, the basic focus of nursing action is still always aimed at helping the patient to continue life with dignity. For present purposes, we have assumed that it is possible to identify this single feature as the object (or product) of nursing. But we remain open to the possibility that other or additional features are also valued as universal objectives in this production. Reasonable professionals can disagree about how to characterise the "product" of nursing. For example, the International Council of Nurses draws on a definition formed by Henderson (1977), which includes a point "to do this in such a way as to help them gain full or partial independence as rapidly as possible" (International Council of Nurses, n.d.). In relation to our proposal, we would raise a question about the possible interaction of 'achievement of full or partial independence as rapidly as possible' with 'continuing life with dignity'. The essential point for now is that a practice is aimed at a product. Even if our particular proposal is rejected or modified, it does not change the claim that a practice is always defined in part by what it is trying to produce, regardless of the concrete conditions of the practical situation, and regardless of changes in that situation (e.g., requirements for cost-saving).

Three main kinds of categories are always present in any nursing practice situation: medical condition, patient wishes, and resources. The first category refers to the physical, psychological, social and existential conditions for the patient, understood within the nursing discipline. The second category refers to the preferences and expectations from the patient and/or their close relatives. These preferences can be explicit or hidden, well or ill-informed. The third category refers to all the concrete conditions and resources (e.g., laws, medical equipment, treatment procedures, social networks) that give actual conditions and demands on treatment and care, as well as resources that can be drawn upon.[2]

An important assumption in the model is that every nursing situation always involves all three of these categories, where the particular aspects of an actual case are exemplified in these three general categories. A second important assumption is that the particular aspects in these three categories are always in relation to and interaction with each other.

4. Using the theoretical model of nursing practice

The theoretical model describes the essential structure of nursing action, considering medical condition, wishes, and resources in relation to supporting the patient to continue life with dignity. Use of the model in a particular situation involves concretising these three categories in relation to the particular case, considering the specific interactions among medical condition, wishes, and resources, and seeking to find ways to respond to the demands and needs of the particular aspects in

[2] We debate internally whether to differentiate the meaning of *resources* into *resources* (which can be used) and *conditions* (which must be accepted and unchanged). For now we work with an undifferentiated version, which has been adequate in practice so far. Experience will show whether the differentiation will be advantageous. This illustrates how the model can be adjusted, while preserving essential features of relations and purpose.

each of these categories, while maintaining a focus on enabling a patient to continue life with dignity. There is no standard or fixed sequence for concretising the model. It is common to move back and forth between the concrete details in the actual case, and the general structuring relations in the model.

This theoretical model can be used in all nursing situations. For example, the concrete situation might be:

- the seriously ill, dying person in his/her own home
- the child who comes to the emergency room after an apparently minor injury (e.g., an uncomplicated fracture or sprain)
- the patient undergoing an elective surgical procedure
- the citizen who comes into the clinic with many discomforts in daily life as a consequence of several chronic illnesses such as ischaemic heart disease, type-2 diabetes, overweight, mobility problems, and pains
- the severely traumatised patient.

Despite the variations in these situations, and the different treatments and interventions that are likely to be carried out, the purpose is always the same — to support the patient to continue life with dignity. The meaning of *dignified life* must be adapted to the concrete circumstances, and can come to expression in many different ways. For example, the meaning will be different for the 8-year-old who is having a minor fracture treated in the emergency room compared to the person with a psychiatric problem, who does not want to remain hospitalised, despite best medical evaluation. Part of developing competence in nursing is understanding how to formulate an image of what it would mean for a person to continue life with dignity in the concrete situation.

Furthermore in each case, in order to act toward the goal of enabling the patient to continue life with dignity, it is necessary to consider the demands of the medical conditions, the demands or wishes of the patient, and how to introduce resources to create a situation that enables the patient to continue life with dignity. The choice of action that is appropriate is always mediated in relation to the concrete relations in the situation.

When these three categories are concretised in particular cases, and their interactions considered, then contradictions, tensions or oppositions often arise, which must be addressed in a plan of action. Mcilfatrick (2004) discusses some of these tensions as paradoxes, but seems to present them as oppositions to be overcome — without recognizing that these paradoxes and their “overcoming” reflect a permanent condition of nursing practice. In other words, the critical dynamic in nursing action is to concretise the categories in the theoretical model, consider their interaction, and respond to the tensions that arise in a way that aims to create conditions that enable the patient to continue life with dignity. This point is applicable regardless of the variations found among the different persons and diverse situations in which nursing is carried out.

5. A concrete example of using the theoretical model

To illustrate how the model could be used concretely, we discuss an imagined case that could be recognized as relevant within nursing practice. (For ethical reasons we have not used an actual patient case.)

An example from home nursing. A nurse is visiting an 82-year-old man/client living at home. The man has been diagnosed with arteriosclerosis and Chronic Obstructive Pulmonary Disease (COPD), which is being treated medically. At the moment he has a problem with leg ulcers, which initiated the nurse's visit to dispense medication. The nurse finds the man sitting on the floor next to a chair in his kitchen. The man is conscious but does not know if he fell or for how long he has been sitting on the floor. He says that he has been in the house all day. The nurse determines that the man is in no pain and has not hurt himself, but is a bit confused. Nothing indicates that the man has eaten or ingested fluid recently, but he has taken his medicine as prescribed. The nurse measures blood pressure, heart rate and temperature (normal) and observes that he is a bit dehydrated. His leg ulcers look fine with no discomfort to him. The nurse gives him new bandages. The doctor is contacted, but no treatment is required for now. After having a short conversation and something to eat and drink the man says he feels okay. He does not want to drink a lot, because he will have to go to the toilet all the time, which gives him respiratory difficulties. He wishes to lie down on the sofa for a while and he walks unaffected by himself to the living room. He mentions that he wishes he could sleep better at night, so he would not be so tired in the daytime and thereby manage to meet a little more with other people. The nurse assesses that the man's psychological well-being is positive and his physical condition as stable.

Discussion of the example. If the nurse was using the theoretical model in this situation, then there would be considerations about how to support the client to continue his life with dignity. The initial assessment of the medical condition does not identify any significant changes from the existing conditions, and there does not appear to be new discomforts or pains that have appeared. Similarly, there does not appear to be any significant psychological discomfort, but the client does express some wishes in relation to sleep, to have more social contact, and to reduce the number of toilet visits because of his respiratory problems. All of these wishes seem relevant to continuing life with dignity, which motivates reasoning about possible interactions between medical conditions and these wishes, as well as considerations about what resources might be drawn upon to address these interactions.

For example, there is a complex interaction between the medical condition of a respiratory problem coupled with a wish to reduce toilet use, which is likely to reduce fluid intake. Is this complex interaction a possible source of a constant threat of dehydration? Are there interactions between the client's medications and the frequency of urination? What resources can be drawn upon here? It may be possible to make changes or adjustments in medications. There may be technological ways to facilitate his access to the toilet. Similarly, is the client's COPD reducing his mobility, which is exacerbating his arteriosclerotic problem? Is there relevant medical equipment that might be offered in relation to these interactions?

A similar question about medications could also be considered in relation to his sleep. In relation to social contact, the nurse might investigate whether the problem is only tiredness, or whether other resources might need to be brought into play. Does the current treatment procedure of his leg ulcers bother him in a way that prevents him from going out? Are their public services that might give the client assistance in transport? Does the client want and need help with involving the client's existing social network? In these examples, the nurse is considering the complex interaction of medical condition and wishes in relation to continuing life with dignity, and considering resources that might be used to address these interactions. Finally, the nurse may consider whether all the client's wishes have been identified, given that the client was confused at the moment. Perhaps it will be appropriate to have a follow-up contact.

The discussion of this example has shown that even in a fairly routine case, the theoretical model provides a way to structure interpretations of the complex interactions among medical condition, wishes, and resources in a nursing situation, which in turn can motivate ideas about how to form appropriate nursing actions in the concrete situation.

6. Experience with using the theoretical model in practice

The model was used by a clinical supervisor in a pilot project with three nursing students, who were in different semesters of their study (Sievert and Chaiklin, 2015). Before this pilot started, the model was evaluated positively by the person responsible for clinical education at the nursing school and two clinical education consultants from the regional psychiatric health service. Then the model was presented to two

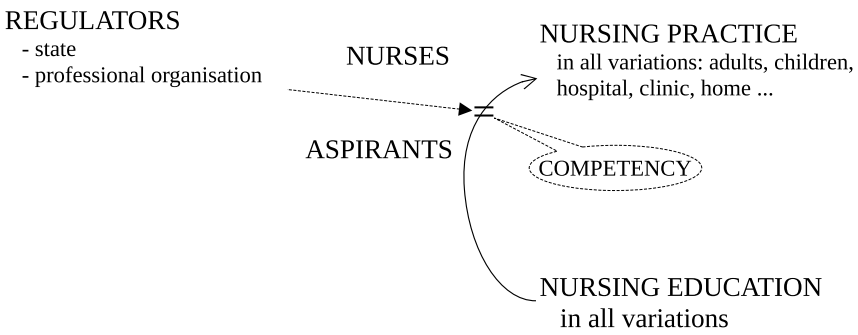

Fig. 2. Problem field for nursing education.

clinical supervisors within psychiatry, again with a positive evaluation. After the model was used by the clinical supervisor, a follow-up conversation was conducted with the supervisor and two of the students, with a focus on their experience with using the model.

Based on their experience, assessed through interview, we can report that they did not encounter any situations where the model could not be used, or where there was a perceived need to change the categories in the model. This experience strengthens our belief that the model has in fact identified essential relations in nursing practice.

The model was experienced as useful for helping to activate and organise relevant nursing knowledge in relation to concrete clinical situations. The three main categories in the model provided a way to organize discussions between supervisor and student, including discussions about whether they had come to the same assessment about medical condition and patient wishes. These discussions provided good opportunities for the student to draw on existing knowledge, such as knowledge of diseases, psychology, communication and nutrition, thus gaining insight into how current knowledge is used in a particular situation within the given area of nursing. At the same time, the students gained insight into whether he or she needed to acquire specific knowledge in some disciplines.

Because the model is meant to focus on the essence of nursing practice, it helped students to reflect about interactions among essential relations in a concrete situation, and provided a structure for the supervisor and student to discuss and clarify reasons for taking certain decisions in planning nursing actions. The students reported that the model gave them a helpful way to collect and organise information about a situation, and to remember details in a situation.

The simplicity of the model proved to be a strength, because it was easy to use, but at the same time it provided an overview of the main aspects that needed to be considered. The model gave the supervisor and the student an explicit and common framework for structuring and interpreting specific clinical situations. This shared framework supported reflection about relevant nursing knowledge, and gave clear opportunities to understand how to mobilise this knowledge in relation to concrete situations.

7. Relating the theoretical model of nursing practice to integrated models of competence

The theoretical model of nursing practice and the integrated model of competence (Weeks et al., 2017) are focused on different issues within the broad problem field that encompasses professional nursing education. Because the two models are not alternative approaches to the same problem, it is more meaningful to understand their significance and possible relationships by first clarifying their relation to the problem field of nursing education in general. A simple characterisation of this problem field is introduced and used to discuss each model.

Problem field is not a systematic term. It is adopted here to give a simple, neutral way to refer to the system of societal relations within which nursing education operates. The basic problem that engenders the field is that societal units (e.g., professional organisations, juridical units such as national or federal states, regional governments) want to regulate who is allowed to present themselves as "nurse" in typical situations where nursing practice is conducted. Although there are variations in or disputes about the ways in which societal units define this competency (including only educational qualifications in some cases), the important points for now are that no one seems to deny the value of (a) attempting to establish an ideal of what it means to be competent, or (b) using such ideals to regulate, in part or whole, who is allowed to be a nurse. The term *competency* is used here both to refer to this formal or legal idea and to the content of concrete attempts to formulate a competency standard. Most (if not all) nursing education around the world is conducted today in relation to these institutionalised legal or professional constraints, aiming to help persons meet the applicable competency standards for nursing practice. From a societal perspective, the basic relations in this problem field are expressed graphically in Fig. 2, where the competency standard established by the regulatory unit is symbolised with the " = ." From a nursing educator perspective, the basic problems that nursing education must address in this problem field are shown graphically in Fig. 3, where the " = " (the legal or professional ideal of the competent practitioner) is now represented with the *competency* category. If we assume that a competency standard is valid (or necessary), then an ideal for nursing education is to develop *pedagogical strategies* (e.g., content and teaching approaches) that help persons gain the *capabilities* that underpin this competency. As noted in Fig. 3, some pedagogical strategies may produce intended capabilities that are not required by a competency standard, while in other cases, it is unclear what a pedagogical strategy is producing.

The diagram, which is applicable both to initial nursing education and continuing professional development programmes, avoids getting

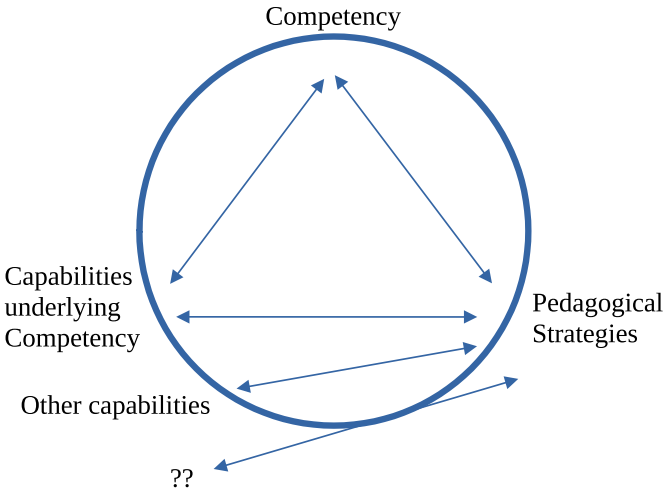

Fig. 3. Problem field for nursing educators.

tangled in difficulties about defining competence because it only highlights the general structural challenges embedded in the "problem field" of nursing education, without providing or presupposing any concrete ideas about satisfactory ways to address those structural relations. The phrase *capabilities underlying competency* gives an informal way to refer to the idea that a person has developed some capabilities that enable her/him to display competency (however it is defined), without actually having a theoretical account that explains what underlies these capabilities. The use of competence concepts is one theoretical approach for concretising what underlies these capabilities, but other theoretical models are also possible.

7.1. Discussion of the theoretical model of nursing practice in relation to the problem field

The theoretical model of nursing practice is relevant to all the relations in Fig. 3, even though it does not correspond to any of the three categories. The theoretical model is not a competency standard per se, but an argument could be made for its value as part of a competency standard. As a concrete illustration, examine the *Standards for Competence for Registered Nurses* (Nursing and Midwifery Council, 2014). Although numerous characteristics or criteria for competent performance in nursing practice are listed in these standards, it is difficult to identify a central direction for nursing action in actual situations (i.e., the essence of nursing practice). An explicit formulation of nursing practice (after appropriate professional analysis and debate), such as found in the theoretical model, is likely to improve the quality of competency standards, which in turn should help nursing educators better understand what capabilities they are trying to help their students develop.

The theoretical model provides an important analytic tool for educators and students to think about what kinds of capabilities (or competences) they might want or need to develop in order to improve their ability to work in ways that are relevant for competency. The model was first developed in the context of project motivated by the idea that pedagogical strategies in nursing education should reflect a coherent integration of educational purposes (not just specific learning objectives, but societal and professional expectations), professional practice, and professional content knowledge (Chaiklin and Sievert, 2009). The model itself is not a pedagogical strategy, but it can be used profitably in many different strategies because it provides a way to conceive the whole of nursing practice, so that it is easier to understand what capabilities need to be developed in relation to competency standards, and the significance of specific knowledge components for helping support the development of capabilities. With explicit attention to the essence of professional practice, educators and students do not have to guess about how to integrate specific topics to practice. The model also has the potential to become an analytic tool for nursing students and nurses, which can be used to structure their analysis and interpretation of clinical situations, reflect about possible courses of action, and explain or justify their decisions for action.

In sum, the theoretical model provides an integrated perspective of nursing practice that is meaningful psychologically and pedagogically. The model is obviously not a total pedagogical approach to nursing education, because it does not address the myriad knowledge about care, disease, ethics, communication and other topics needed for competent performance, such as enumerated by the Nursing and Midwifery Council (2014). The model is meant for contexts where one can presuppose that users are already learning about, oriented to and concerned with these topics. The model provides a structure to help mobilise and motivate knowledge and interpret its significance in relation to nursing practice.

7.2. Discussion of the integrated model of nursing competence in relation to the theoretical model

The general pedagogical direction of Weeks et al. (2013) is to not isolate "knowledge construction from its application in practice settings" (p.e41), where the preference is to work with authentic situations and systematic strategies to support the development of capabilities. We agree with and support this general perspective, but in the spirit of developing adequate theoretical formulations in service of these general goals, we want to raise some questions specific to the "integrated model of nursing competence" (Fig. 1 in Weeks et al., 2017; hereafter *integrated competence model*). Two main relations from Fig. 3 are in focus here: (a) the relation between competency and capabilities, where it seems like Weeks et al. have operationalised those capabilities in terms of the integrated competence model, and (b) proposed pedagogical strategies, motivated in relation to that operationalisation, even if not a part of the integrated competence model per se. The discussion includes comments about possible relations with the theoretical model of nursing, with focus on achieving an integrated understanding in relation to competency, the meaning of holistic, and the role of authentic situations teaching in competence development.

It would be valuable to understand the role of the integrated competence model in the relationship between competency and capabilities underlying competence. This issue is not discussed in Weeks et al. so one can only speculate about how they conceive this situation. The integrated competence model is developed from a generic framework, which Cheetham and Chivers (1996) used for describing competency (in the sense used here). *Generic* means that the categories (e.g., cognitive, functional, ethical) do not engage with the substantive content of nursing itself, but are used to characterise forms of knowledge. There is no question that one can make analytically meaningful decompositions — in a descriptive sense — of the competences that underlie competency, and use these categories to describe integrated performance. Critical questions are what a particular decomposition is being used for, and whether it is fit for purpose. Here are some particular concerns:

- It appears that the integrated competence model makes a critical conceptual shift from using the generic framework as a competency model, to conceiving it as a theoretical model of what underlies capabilities for competency. As Cheetham and Chivers (1996) noted, some competency standards assume that mastering lists of individual competences will lead to overall competent performance (p.21), and even though Weeks et al. introduce the need for integration among competences, there is a still a question about the relation between these competences and competency.
- The ways that one describes theoretically the psychological characteristics that underpin the capabilities that underlie competency have consequences for how one designs pedagogical strategies for developing these capabilities. If a logical description of competence or competency has been equated with a theoretical or psychological description of what underlies integrated performance, then it should be justified explicitly. Until then, it is not clear whether such unmediated decompositions are a useful model for guiding pedagogical strategies.

Weeks et al. argue for the need for pedagogical situations that enable students to integrate competences in relation to practice, and promote the value of using holistic educational approaches for supporting competence development, but do not discuss explicitly their meaning of *holistic*. Their examples imply that holistic education involves working with genuine situations that embody the characteristics and demands usually found in nursing practice (see also Weeks et al., 2013). There is a critical difference between this meaning of holistic (which refers largely to the contextual appearance of nursing situations) and the meaning of holistic introduced with the theoretical model, referring to the structural whole of the central relations that define nursing as a practice.

A critical question is whether it is sufficient to place persons in authentic practice situations — both in relation to developing

capabilities and in relation to developing competency. We do not doubt the value and utility of working with authentic situations, but it would be useful to be more explicit about how such pedagogical strategies serve to develop capabilities. Weeks et al. (2017) seem too optimistic when they refer to "natural synthesis" (p.A3).

Nursing care usually involves complex, ill-structured problems (Funke, 2012). How does a person know what to pay attention to in an authentic situation, especially in situations that require interpretation and independent action? Without an analytic perspective for interpreting authentic situations, it seems less likely for students to know what aspects should be in their attention, and how they should interpret and respond to those aspects in relation to the demands of competent practice.

As a small indicator that underlies this concern, Ter Maten-Speksnijder et al. (2015) report that in a study of 46 reflective case reports by Dutch nurse practitioner students, there was a strong tendency to focus on curative aspects (i.e., medical condition), while psychosocial aspects (e.g., patient's wishes) were often overlooked. This is also consistent with our own experience in Denmark. In contrast, in the pilot study, the supervisor and students noted that the model helped them to pay more attention to patient wishes.

The Ter Maten-Speksnijder et al. observations motivate a hypothesis that even if students have mastered different individual competences from their education, they are not usually able to integrate these competences when they find themselves in genuine situations. The theoretical model described here provides an important tool for orienting attention in the situation and a direction to interpret the significance of observations, while its comprehensiveness improves the likelihood that relevant aspects are taken into consideration in forming plans for action.

Another issue is generalisation. How do students recognize how to generalise what is important in authentic situations? Or does a particular experience simply become a set of facts about a particular case? The theoretical model is explicit, in advance, about the general features of the situation, and provides a structure for further reflection about what aspects in a particular case might be generalisable.

In sum, we hope these discussions have illustrated the importance of critical analysis of the relations described in Fig. 3, and justified the need to assess the theoretical adequacy of assumptions about what underlies capabilities for practice. We have tried to show that the integrated competence model is only part of a larger problem field, and raised some specific issues about (a) the underspecification of the relation between this model and nursing as a whole, and (b) a contrast between holistic (in the sense of authentic situation) and holistic (in sense of engaging fully with the demands an actual practice situation). These issues were raised to improve the likelihood that pedagogical efforts are proceeding with effective theoretical perspectives. The theoretical model of nursing practice could be a useful supplement to the focus on competence development and holistic educational processes, because of its analytic perspective on nursing as a whole. It may also be an interesting tool for designing authentic situations, especially if attention is made to introducing the kinds of tensions and contradictions that typically arise among the relations in the model.

8. Concluding comment

Weeks et al. (2017) raise a concern about the difficulties for preparing students for an uncertain future, under conditions of rapidly-changing technologies. Although they seem to frame the question as a temporary challenge to be overcome, it seems more appropriate to recognise this as a permanent condition of nurse education. More importantly, the theoretical model presented here provides a way to conceptualise the conundrum that Weeks et al. put forward. As far as we can tell, the theoretical model will continue to be valid for the foreseeable future, at least for the coming generation of nurses, because it identifies essential qualities that must be addressed in instances of competent nursing. These qualities — focus on product and interaction of aspects in relation to this product — provide a stable structure for nursing practice, even as particular treatments, technologies, populations, and other conditions change. If students acquire an ability to work skilfully with the theoretical model, they will gain a tool that they can use to develop and adapt their nursing practice under changing conditions.

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