Kozier & Erb's

Eleventh Edition

Fundamentals of Nursing

Concepts, Process, and Practice

Audrey Berman • Shirlee Snyder • Geralyn Frandsen

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Dedication

Audrey Berman dedicates this eleventh edition to her mother, Lotte Henrietta Julia Sarah Rosenberg Berman Isaacs (1926–2017), who raised two strong daughters and served as a role model to each of them and also to her grandchildren, Brian and Jordanna, and great-grandsons, Benjamin and Adam. May her memory be a blessing.

Shirlee Snyder dedicates this eleventh edition in memory of her older brother, Ted Snyder, whose legacy is his loving and caring family; to her younger brother, Dan Snyder, who enjoys his retirement with his wife, children, and grandchildren; to Kelly Bishop, the best daughter ever and her first great-grandchild, Oliver; to her stepson, Steven Schnitter; to all the nurses who contribute to the nursing profession; and always, to her husband, Terry J. Schnitter, for his continual love and support.

Geralyn Frandsen dedicates this eleventh edition to her loving husband and fellow nursing colleague, Gary. He is always willing to answer questions and provide editorial support. She also dedicates this edition to her children, Claire and Joe; son-in-law, John Conroy; and daughter-in-law, Allyson Angelos.

About the Authors

Audrey Berman, PhD, RN

A San Francisco Bay Area native, Audrey Berman received her BSN from the University of California–San Francisco and later returned to that campus to obtain her MS in physiologic nursing and her PhD in nursing. Her dissertation was entitled *Sailing a Course Through Chemotherapy: The Experience of Women with Breast Cancer*. She worked in oncology at Samuel Merritt Hospital prior to beginning her teaching career in the diploma program at Samuel Merritt Hospital School of Nursing in 1976. As a faculty member, she participated in the transition of that program into a baccalaureate degree and in the development of the master of science and doctor of nursing practice programs. Over the years, she has taught a variety of medical–surgical nursing courses in the prelicensure programs on three campuses. She served as the dean of nursing at Samuel Merritt University from 2004 to 2019 and was the 2014–2016 president of the California Association of Colleges of Nursing.

Dr. Berman has traveled extensively, visiting nursing and healthcare institutions in Australia, Botswana, Brazil, Finland, Germany, Israel, Japan, Korea, the Philippines, the Soviet Union, and Spain. She is a senior director of the Bay Area Tumor Institute and served 3 years as director on the Council on Accreditation of Nurse Anesthesia Educational Programs. She is a member of the American Nurses Association and Sigma Theta Tau and is a site visitor for the Commission on Collegiate Nursing Education. She has twice participated as an NCLEX-RN item writer for the National Council of State Boards of Nursing. She has presented locally, nationally, and internationally on topics related to nursing education, breast cancer, and technology in healthcare.

Dr. Berman authored the scripts for more than 35 nursing skills videotapes in the 1990s. She was a coauthor of the sixth, seventh, eighth, ninth, tenth, and eleventh editions of *Fundamentals of Nursing* and the fifth, sixth, seventh, eighth, and ninth editions of *Skills in Clinical Nursing*.

Shirlee J. Snyder, EdD, RN

Shirlee J. Snyder graduated from Columbia Hospital School of Nursing in Milwaukee, Wisconsin, and subsequently received a bachelor of science in nursing from the University of Wisconsin–Milwaukee. Because of an interest in cardiac nursing and teaching, she earned a master of science in nursing with a minor in cardiovascular clinical specialist and teaching from the University of Alabama in Birmingham. A move to California resulted in becoming a faculty member at Samuel Merritt Hospital School of Nursing in Oakland, California. Shirlee was fortunate to be involved in the phasing out of the diploma and ADN programs and development of a baccalaureate intercollegiate nursing program. She held numerous positions during her 15-year tenure at Samuel Merritt College, including curriculum coordinator, assistant director–instruction, dean of instruction, and associate dean of the Intercollegiate Nursing Program. She is an associate professor alumnus at Samuel Merritt College. Her interest and experiences in nursing education resulted in Shirlee obtaining a doctorate of education focused on curriculum and instruction from the University of San Francisco.

Dr. Snyder moved to Portland, Oregon, in 1990 and taught in the ADN program at Portland Community College for 8 years. During this teaching experience she presented locally and nationally on topics related to using multimedia in the classroom and promoting the success of students of diverse ethnic backgrounds and communities of color.

Another career opportunity in 1998 led her to the Community College of Southern Nevada in Las Vegas, Nevada, where Dr. Snyder was the nursing program director with

responsibilities for the associate degree and practical nursing programs for 5 years. During this time she coauthored the fifth edition of *Kozier & Erb's Techniques in Clinical Nursing* with Audrey Berman.

In 2003, Dr. Snyder returned to baccalaureate nursing education. She embraced the opportunity to be one of the nursing faculty teaching the first nursing class in the baccalaureate nursing program at the first state college in Nevada, which opened in 2002. From 2008 to 2012, she was the dean of the School of Nursing at Nevada State College in Henderson, Nevada. She is currently retired.

Dr. Snyder enjoyed traveling to the Philippines (Manila and Cebu) in 2009 to present all-day seminars to approximately 5000 nursing students and 200 nursing faculty. She is a member of the American Nurses Association. She has been a site visitor for the National League for Nursing Accrediting Commission and the Northwest Association of Schools and Colleges.

Geralyn Frandsen, EdD, RN

Geralyn Frandsen graduated in the last class from DePaul Hospital School of Nursing in St. Louis, Missouri. She earned a bachelor of science in nursing from Maryville College. She attended Southern Illinois University at Edwardsville, earning a master of science degree in nursing with specializations in community health and nursing education. Upon completion, she accepted a faculty position at her alma mater Maryville College, which has since been renamed Maryville University. In 2003 she completed her doctorate in higher education and leadership at Saint Louis University. Her dissertation was *Mentoring Nursing Faculty in Higher Education*.

She is a tenured full professor and currently serves as assistant director of the Catherine McAuley School of Nursing at Maryville. Her administrative responsibilities include the oversight of three pre-licensure tracks and the online Baccalaureate Completion program in the Robert E. and Joan Luttig Schoor Undergraduate Nursing Program. When educating undergraduate and graduate students, she utilizes a variety of teaching strategies to engage her students. When teaching undergraduate pharmacology she utilizes a team teaching approach, placing students in groups to review content. Each student is also required to bring a completed ticket to class covering the content to be taught. The practice of bringing a ticket to class was introduced to her by Dr. Em Bevis, who is famous for the *Toward a Caring Curriculum*.

Dr. Frandsen has authored textbooks in pharmacology and nursing fundamentals. In 2013 she was the fundamentals contributor for *Ready Point* and *My Nursing Lab*. These are online resources to assist students in reviewing content in their nursing fundamentals course. She has authored both *Nursing Fundamentals: Pearson Reviews and Rationales* and, in 2007, *Pharmacology Reviews and Rationales*.

Dr. Frandsen has completed the End-of-Life Nursing Education Consortium train-the-trainer courses for advanced practice nurses and the doctorate of nursing practice. She is passionate about end-of-life care and teaches a course to her undergraduate students. Dr. Frandsen is a member of Sigma Theta Tau International and the American Nurses Association, and serves as a site visitor for the Commission on Collegiate Nursing Education.

Acknowledgments

We wish to extend a sincere thank you to the talented team involved in the eleventh edition of this book: the contributors and reviewers who provide content and very helpful feedback; the nursing students, for their questioning minds and motivation; and the nurses and nursing instructors, who provided many valuable suggestions for this edition.

We would like to thank the editorial team, especially John Goucher, for his continual support; Melissa Bashe, Managing Producer, Health Science and Career and Student Success; and most of all Teri Zak, development editor, for keeping our noses to the grindstone and especially for her dedication and attention to detail that promoted an excellent outcome once again. Many thanks to the production team of Michael Giaccobe, Content Producer, and Meghan DeMaio and Patty Donovan, editorial project managers, for producing this book with precision.

Audrey Berman

Shirlee Snyder

Geralyn Frandsen

Thank You

We would like to extend our heartfelt thanks to our colleagues across the country who have given their time generously to help us create this learning package. These individuals helped us develop this textbook and supplements by reviewing chapters, art, and media, and by answering a myriad of questions right up until the time of publication. *Kozier & Erb's Fundamentals of Nursing, Eleventh Edition*, has benefited immeasurably from their efforts, insights, suggestions, objections, encouragement, and inspiration, as well as from their vast experience as teachers and nurses. Thank you again for helping us set the foundation for nursing excellence.

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Preface

The practice of nursing continues to evolve . . . *the practice of caring is timeless.*

Nurses today must grow and evolve to meet the demands of a dramatically changing healthcare system. They need skills in science, technology, communication, and interpersonal relations to be effective members of the collaborative healthcare team. They need to think critically and be creative in implementing nursing strategies to provide safe and competent nursing care for clients of diverse cultural backgrounds in increasingly varied settings. They need skills in teaching, leading, managing, and the process of change. They need to be prepared to provide home- and community-based nursing care to clients across the lifespan—especially to the increasing numbers of older adults. They need to understand legal and ethical principles, holistic healing modalities, and complementary therapies. And, they need to continue their unique client advocacy role, which demands a blend of nurturance, sensitivity, caring, empathy, commitment, and skill founded on a broad base of knowledge.

Kozier & Erb's Fundamentals of Nursing, Eleventh Edition, addresses the concepts of contemporary professional nursing. These concepts include but are not limited to caring, wellness, health promotion, disease prevention, holistic care, critical thinking and clinical reasoning, multiculturalism, nursing theories, nursing informatics, nursing research, ethics, and advocacy. In this edition, every chapter has been reviewed and revised. The content has been updated to reflect the latest nursing evidence and the increasing emphasis on aging, wellness, safety, and home- and community-based care.

ORGANIZATION

The detailed table of contents at the beginning of the book makes its clear organization easy to follow. Continuing with a strong focus on nursing care, the eleventh edition of this book is divided into 10 units.

Unit 1, *The Nature of Nursing*, clusters four chapters that provide comprehensive coverage of introductory concepts of nursing.

In Unit 2, *Contemporary Healthcare*, four chapters include contemporary healthcare topics such as healthcare delivery systems, community-based care, home care, and informatics.

In Unit 3, *The Nursing Process*, six chapters introduce students to this important framework with each chapter dedicated to a specific step of the nursing process. Chapter 9 applies critical thinking, clinical reasoning, and the nursing process. A Nursing in Action case study is used as the frame of reference for applying content in all phases of the nursing process in Chapter 10, *Assessing*; Chapter 11, *Diagnosing*; Chapter 12, *Planning*; and Chapter 13, *Implementing and Evaluating*. Chapter 14 covers documenting and reporting.

Unit 4, *Integral Aspects of Nursing*, discusses topics such as caring; communicating; teaching; and leading, managing, and delegating. These topics are all crucial elements for providing safe, competent nursing care.

In Unit 5, *Health Beliefs and Practices*, four chapters include health-related beliefs and practices for individuals and families from a variety of cultural backgrounds.

Unit 6, *Lifespan Development*, consists of five chapters that discuss lifespan and development from conception to older adults.

Unit 7, *Assessing Health*, addresses vital signs, health assessment, and pain assessment and management skills in three separate chapters, to allow beginning students to understand normal assessment techniques and findings.

In Unit 8, *Integral Components of Client Care*, the focus shifts to those components of client care that are universal to all clients, including asepsis, safety, hygiene, diagnostic testing, medications, wound care, and perioperative care.

Unit 9, *Promoting Psychosocial Health*, includes six chapters that cover a wide range of areas that affect the individual's health. Sensory perception, self-concept, sexuality, spirituality, stress, and loss are all aspects that a nurse needs to consider to properly care for a client.

Unit 10, *Promoting Physiologic Health*, discusses a variety of physiologic concepts that provide the foundations for nursing care. These include activity and exercise; sleep; nutrition; elimination; oxygenation; circulation; and fluid, electrolyte, and acid–base balance.

HIGHLIGHTS OF THE ELEVENTH EDITION

- **QSEN linkages**. The delivery of high-quality and safe nursing practice is imperative for every nurse. The QSEN competencies were developed to address the gap between nursing education and practice. There are expectations for each of the six QSEN competencies and these expectations relate to knowledge, skills, and attitudes. Nursing students are expected to achieve these competencies during nursing school and use them in their professional role as RNs. This edition has incorporated QSEN competencies and specified expectations in most chapters. This QSEN content will guide students to learn and maintain safety and quality in their provision of nursing care.

- **Assignment:** Recognition of the evolving legal aspects of assigning and delegating nursing care, especially to assistive personnel.
- Current examples of nursing literature guiding evidence-based practice.
- Up-to-date samples of electronic health records that support nursing care.
- Updated and additional photos to assist the visual learner.
- **Standards of care.** This edition continues to value and update standards of care as evidenced by incorporating the latest National Patient Safety Goals; Infusion Nursing Society *Standards of Practice*; American Nurses Association (ANA) *Scope and Standards of Practice*; National Council of State Boards of Nursing *National Guidelines for Nursing Delegation*; current hypertension guidelines; pressure injury prevention guidelines; ANA *Safe Patient Handling and Mobility: Interprofessional National Standards Across the Care Continuum*; Occupational Safety and Health Administration and Centers for Disease Control and Prevention bloodborne pathogens and infection prevention standards; and cancer screening guidelines.

FEATURES

For years, *Kozier & Erb's Fundamentals of Nursing* has been a gold standard that helps students embark on their careers in nursing. This new edition retains many of the features that have made this textbook the number-one choice of nursing students and faculty. The walk-through at the beginning of the textbook illustrates these features.

Supplements That Inspire Success for the Student and the Instructor

Pearson is pleased to offer a complete suite of resources to support teaching and learning, including:

- TestGen Test Bank
- Lecture Note PowerPoints
- Instructor's Manual
- Image Library.

Features of the Eleventh Edition

SPECIAL FEATURES

provide the opportunity to link QSEN competencies and to think critically to make a connection to nursing practice. These features provide guidance on maintaining safety and quality of nursing care.

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

What Is the Impact of Chlorhexidine Bathing on Healthcare-Associated Infections?

According to Denny and Munro (2017), approximately 4% of hospitalized clients contract a healthcare-associated infection (HAI) during their hospitalizations. These infections frequently result in increased morbidity, mortality, and length of hospital stay. Skin bacterial colonization aids in the transmission and development of HAIs. Nurses frequently use bathing with chlorhexidine gluconate (CHG) to reduce bacterial colonization on the client's skin. Studies have shown that bathing with CHG products has had mixed results in the prevention of HAIs. As a result, the authors performed a literature review to examine the current evidence on the impact of CHG bathing on HAIs. The literature search identified peer-reviewed studies and meta-analyses that examined the impact of CHG bathing in preventing HAIs, specifically surgical site infections (SSIs), central line–associated bloodstream infections (CLABSIs), ventilator-associated pneumonias (VAP), catheter-associated urinary-tract infections (CAUTIs), and *Clostridium difficile*–associated disease. The search resulted in 23 articles for review.

The findings concluded that there was good evidence to support using a CHG bathing regimen to reduce the incidence of CLABSIs, SSIs, vancomycin-resistant enterococci (VRE), and methicillin-resistant *Staphylococcus aureus* (MRSA) HAIs.

The authors, based on the literature search, raised questions for further research, including the value of using CHG liquid soap versus CHG-impregnated washcloths. Research has shown that application of CHG on the client's body without rinsing has greater impact than applying CHG followed by rinsing the body. Do CHG-impregnated washcloths have an advantage because the CHG in the wipes is not rinsed from the skin? Another issue raised by the authors was that most studies were conducted in targeted populations (e.g., intensive care units). They suggest that more research is needed on the benefits of bathing all clients versus a targeted (bathing only at-risk clients) approach.

IMPLICATIONS

Hospitals are beginning to replace the traditional soap and water bathing with CHG bathing in order to prevent HAIs. As the authors suggested, nurses need to assess for adverse reactions to the use of CHG and increase their awareness that, with the increasing use of CHG, organisms may develop resistance to the antiseptic.

Safety Alert! **SAFETY**

Side rail entrapment, injuries, and death do occur. When side rails are used, the nurse must assess the client's physical and mental status and closely monitor high-risk (frail, older, or confused) clients.

LIFESPAN CONSIDERATIONS Diagnosing

CHILDREN

Many developmental issues in pediatrics are not considered problems or illnesses, yet can benefit from nursing intervention. When applied to children and families, nursing diagnoses may reflect a condition or state of health. For example, parents of a newborn infant may be excited to learn all they can about infant care and child growth and development. Assessment of the family system might lead the nurse to conclude that the family is ready and able, even eager, to take on the new roles and responsibilities of being parents. An appropriate diagnosis for such a family could be willingness for improved family dynamics, and nursing care could be directed to educating and providing encouragement and support to the parents.

OLDER ADULTS

Older adults tend to have multiple problems with complex physical and psychosocial needs when they are ill. If the nurse has done a thorough and accurate assessment, nursing diagnoses can be selected to cover all problems and, at the same time, prioritize the special needs. For example, if a client is admitted with severe con-

gestive heart fa
cardiac status a
to improve thes
other nursing di
knowledge relat
tive heart failure
outcomes and
be an essential

CLIENT TEACHING Developing Written Teaching Aids

- Keep language level at a fifth- to sixth-grade level.
- Use active, not passive, voice (e.g., "take your medicine before breakfast" [active] versus "medicine should be taken before breakfast" [passive]).
- Use plain language; that is, easy, common words of one or two syllables (e.g., *use* instead of *utilize*, or *give* instead of *administer*).
- Use the second person (*you*) rather than the third person (*the client*).
- Use a large type size (14 to 16 point).
- Write short sentences.
- Avoid using all capital letters.
- Place priority information first and repeat it more than once.
- Use bold for emphasis.
- Use simple pictures, drawings, or cartoons, if appropriate.
- Leave plenty of white space.
- Focus material on desired behavior rather than on medical facts.
- Make it look easy to read.

ENHANCED PHOTO PROGRAM

shows procedural steps and the latest equipment.

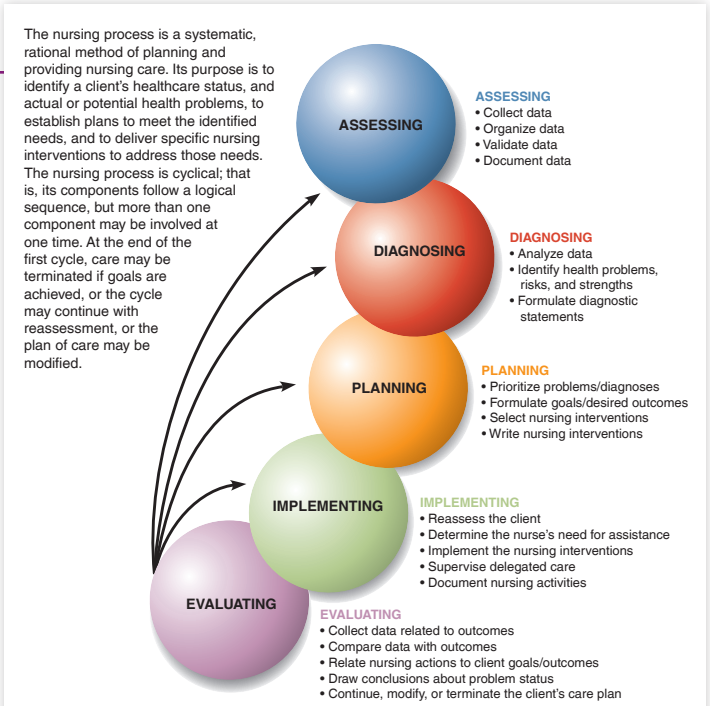


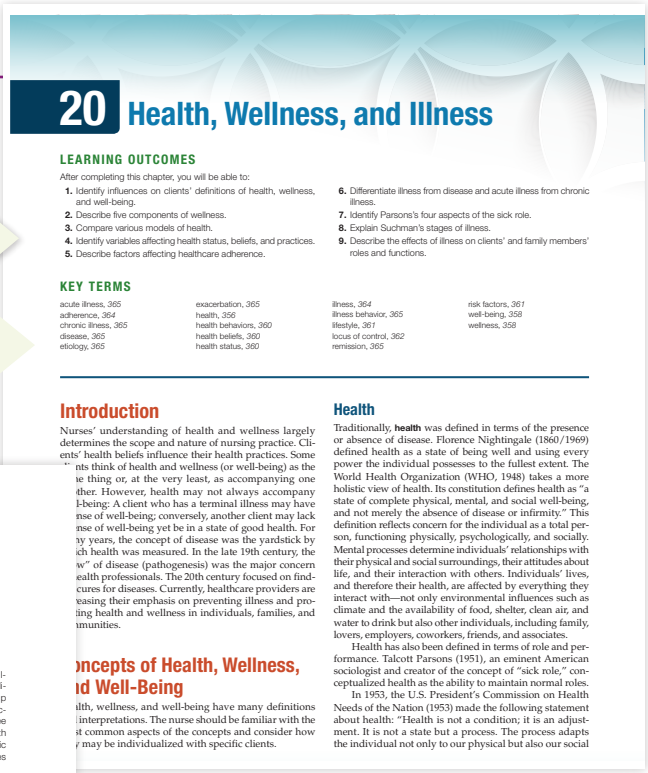
Figure 10.1 ■ The nursing process in action.

HALLMARK FEATURES

This eleventh edition maintains the best aspects of previous editions to provide the most valuable learning experience.

LEARNING OUTCOMES help identify critical concepts.

KEY TERMS provide a study tool for learning new vocabulary. Page numbers are included for easy reference.



20 Health, Wellness, and Illness

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Identify influences on clients' definitions of health, wellness, and well-being.
2. Describe five components of wellness.
3. Compare various models of health.
4. Identify variables affecting health status, beliefs, and practices.
5. Describe factors affecting healthcare adherence.
6. Differentiate illness from disease and acute illness from chronic illness.
7. Identify Parsons's four aspects of the sick role.
8. Explain Suchman's stages of illness.
9. Describe the effects of illness on clients' and family members' roles and functions.

KEY TERMS

acute illness, *365*
adherence, *364*
chronic illness, *365*
disease, *365*
etiology, *365*
exacerbation, *365*
health, *356*
health behaviors, *360*
health beliefs, *360*
health status, *360*
illness, *364*
illness behavior, *365*
lifestyle, *361*
locus of control, *362*
remission, *365*
risk factors, *361*
well-being, *358*
wellness, *358*

Introduction

Nurses' understanding of health and wellness largely determines the scope and nature of nursing practice. Clients' health beliefs influence their health practices. Some nts think of health and wellness (or well-being) as the e thing or, at the very least, as accompanying one ther. However, health may not always accompany l-being: A client who has a terminal illness may have nse of well-being; conversely, another client may lack nse of well-being yet be in a state of good health. For y years, the concept of disease was the yardstick by ich health was measured. In the late 19th century, the w" of disease (pathogenesis) was the major concern ealth professionals. The 20th century focused on findcures for diseases. Currently, healthcare providers are easing their emphasis on preventing illness and proting health and wellness in individuals, families, and munities.

oncepts of Health, Wellness, d Well-Being

lth, wellness, and well-being have many definitions interpretations. The nurse should be familiar with the t common aspects of the concepts and consider how may be individualized with specific clients.

Health

Traditionally, **health** was defined in terms of the presence or absence of disease. Florence Nightingale (1860/1969) defined health as a state of being well and using every power the individual possesses to the fullest extent. The World Health Organization (WHO, 1948) takes a more holistic view of health. Its constitution defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." This definition reflects concern for the individual as a total person, functioning physically, psychologically, and socially. Mental processes determine individuals' relationships with their physical and social surroundings, their attitudes about life, and their interaction with others. Individuals' lives, and therefore their health, are affected by everything they interact with—not only environmental influences such as climate and the availability of food, shelter, clean air, and water to drink but also other individuals, including family, lovers, employers, coworkers, friends, and associates.

Health has also been defined in terms of role and performance. Talcott Parsons (1951), an eminent American sociologist and creator of the concept of "sick role," conceptualized health as the ability to maintain normal roles.

In 1953, the U.S. President's Commission on Health Needs of the Nation (1953) made the following statement about health: "Health is not a condition; it is an adjustment. It is not a state but a process. The process adapts the individual not only to our physical but also our social

MEETING THE STANDARDS end-of-unit activities provide the opportunity to think through themes and competencies presented across chapters in a unit and think critically to link theory to nursing practice.

UNIT 5 Meeting the Standards

In this unit, we have explored concepts related to health, health promotion, wellness, illness, culture and heritage, and complementary and alternative healing modalities. These topics heighten awareness of the individualistic nature of the relationship between the nurse and the client and the importance of assessing the breadth of factors that affect health decisions and behaviors. In the case described here, you will see how one client demonstrates complicated, interrelated, personal definitions of health and illness influenced by her medical condition, her heritage, and her demographic characteristics (e.g., age and family structure). These definitions and perspectives in turn influence her choices for care and support—including the role of her nurses.

CLIENT: Manuela **AGE:** 55
CURRENT MEDICAL DIAGNOSIS: Still's Disease

Medical History: Manuela has experienced some type of health challenge for most of her adult life. She was diagnosed with adult-onset Still's disease (AOSD) at about age 35 after several years of tests to try to determine exactly what syndrome her symptoms reflected. She complained of joint pain, rash, and fevers, which came and went, and she had an enlarged spleen and liver. This disease shares many similarities with rheumatoid and autoimmune diseases, but those conditions were all removed from consideration because the tests were negative. AOSD is a chronic condition for which there is no known cure. In addition to joint deterioration, it can progress to affect the lungs and heart. Initial treatment consists of steroids and nonsteroidal anti-inflammatory drugs (NSAIDs). If those are ineffective, other medications, such as gold and chemotherapeutics are used; however, they have severe side effects, such as kidney damage and bone marrow suppression. The condition worsens when the individual is under physical or emotional stress. Manuela underwent a hip replacement about 4 years ago and recently has had several hospitalizations for respiratory failure.

Personal and Social History: Manuela has never married and has lived near or with her parents or siblings for all her life. She has many friends, drives, and has an active social life when she is feeling well. She uses the computer extensively for communication, especially when having visitors or talking by phone is too exhausting. She must follow a strict diet of food and liquids that are easy to swallow and digest. She is a spiritual individual but not overly religious. She is quick to laugh and generally has an optimistic outlook, but she expresses awareness that her life could end at any time—certainly long before her full life expectancy.

Manuela is a college graduate but has been able to work only part time for most of her life. Recently, she was declared permanently disabled, which allows her access to financial and other support systems. She is creative in adapting her living situation to her disabilities and unwilling to give up her beloved pet dog.

Questions

American Nurses Association Standard of Practice #3 *is Outcomes Identification: The nurse collaborates with the healthcare consumer to define expected outcomes integrating the healthcare consumer's culture, values, and ethical considerations. As you learned in Chapter 19* Manuela's needs fall into the category of tertiary prevention in which rehabilitation and movement toward optimal levels of functionality within the individual's constraints are the focus.

1. What are some outcomes for Manuela that would reflect this focus?
2. Do you need to know her personal definitions of health and health beliefs (Chapter 20) before you can work with her to set expected outcomes?

American Nurses Association Standard of Practice #5b *is Health Teaching and Health Promotion: The nurse employs strategies to promote health and a safe environment.*

3. What are some aspects of Manuela's situation that you would consider incorporating into a teaching plan f environment for her?

American Nurses Association Standard of F formance #10 *is Collaboration: Nurses partner to create, implement, and evaluate a comprehe*

4. Which healthcare team members other than p would likely be important to include in Manue

American Nurses Association Standard of F formance #13 *is Evidence-Based Practice and*

5. What evidence might you have or seek to sup tive or complementary treatment modalities in

American Nurses Association. (2015). *Nursing: Scope and stan* Silver Spring, MD: Author.

Answers to Meeting the Standards questions are available on t Please consult with your instructor.

NURSING CARE PLANS help you approach care from the nursing perspective.

NURSING CARE PLAN Margaret O'Brien

Nursing Diagnosis: Altered respiratory status related to viscous secretions secondary to alteration in fluid volume and shallow chest expansion secondary to pain and fatigue

DESIRED OUTCOMES*/INDICATORS	NURSING INTERVENTIONS	RATIONALE
Respiratory Status: Gas Exchange [0402], as evidenced by • Absence of pallor and cyanosis (skin and mucous membranes) • Use of correct breathing/coughing technique after instruction	Monitor respiratory status q4h: rate, depth, effort, skin color, mucous membranes, amount and color of sputum. Monitor results of blood gases, chest x-ray studies, and incentive spirometer volume as available. Monitor level of consciousness.	*To identify progress toward or deviations from goal*. Altered repiratory status *leads to poor oxygenation, as evidenced by pallor, cyanosis, lethargy, and drowsiness*.
• Productive cough • Symmetric chest excursion of at least 4 cm	Auscultate lungs q4h. Vital signs q4h (TPR, BP, pulse oximetry, pain).	*Inadequate oxygenation and pain cause increased pulse rate. Respiratory rate may be decreased by narcotic analgesics. Shallow breathing further compromises oxygenation*.

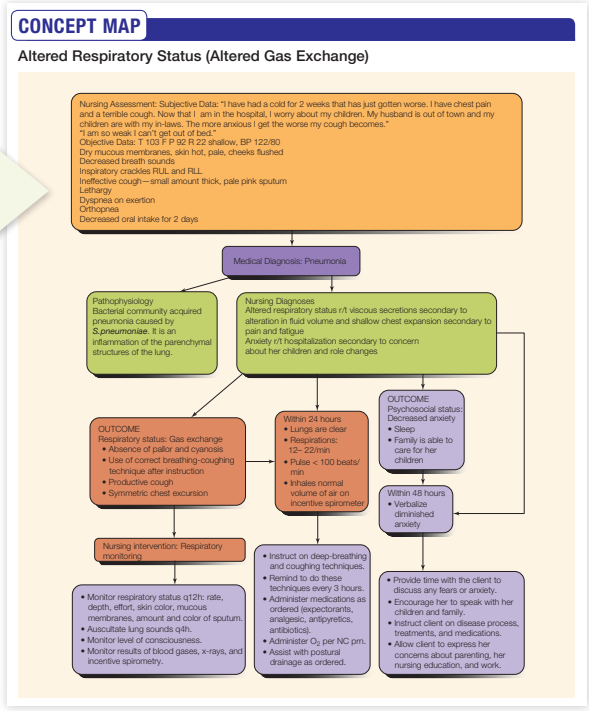
APPLYING CRITICAL THINKING questions come at the end of select sample Nursing Care Plans to encourage further reflection and analysis.

APPLYING CRITICAL THINKING

1. What assumptions does the nurse make when deciding that using a standardized care plan for impaired fluid volume is appropriate for this client?
2. Identify an outcome in the care plan and its nursing intervention that contribute to discharge care planning. What evidence supports your choice?
3. Consider how the nurse shares the development of the care plan and outcomes with the client.
4. Not every intervention has a time frame or interval specified. It may be implied. Under what circumstances is this acceptable practice?
5. In Table 12.1, altered respiratory status is Margaret's highest priority nursing diagnosis. Under what conditions might this diagnosis be of only moderate priority in Margaret's case?

Answers to Applying Critical Thinking questions are available on the faculty resources site. Please consult with your instructor.

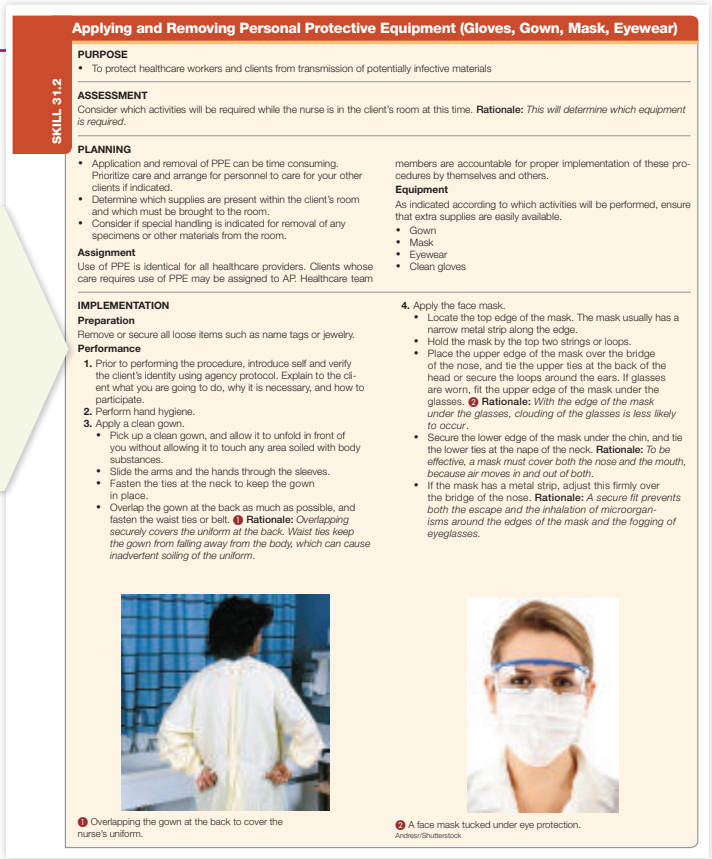
CONCEPT MAPS provide visual representations of the nursing process, nursing care plans, and the relationships between difficult concepts.



SETTING THE FOUNDATION FOR CLINICAL COMPETENCE!

STEP-BY-STEP SKILLS provide an easy-to-follow format that helps you to understand techniques and practice sequences.

- Includes a complete **Equipment** list for easy preparation.
- Clearly labeled **Assignment** boxes assist you in assigning tasks appropriately.
- Easy-to-find **rationales** give you a better understanding of why things are done.
- Critical steps are visually represented with **full-color photos** and **illustrations**.



SKILL 31.2

Applying and Removing Personal Protective Equipment (Gloves, Gown, Mask, Eyewear)

PURPOSE
- To protect healthcare workers and clients from transmission of potentially infective materials

ASSESSMENT
Consider which activities will be required while the nurse is in the client's room at this time. **Rationale:** *This will determine which equipment is required.*

PLANNING
- Application and removal of PPE can be time consuming. Prioritize care and arrange for personnel to care for your other clients if indicated.
- Determine which supplies are present within the client's room and which must be brought to the room.
- Consider if special handling is indicated for removal of any specimens or other materials from the room.

Assignment
Use of PPE is identical for all healthcare providers. Clients whose care requires use of PPE may be assigned to AP. Healthcare team members are accountable for proper implementation of these procedures by themselves and others.

Equipment
As indicated according to which activities will be performed, ensure that extra supplies are easily available.
- Gown
- Mask
- Eyewear
- Clean gloves

IMPLEMENTATION

Preparation
Remove or secure all loose items such as name tags or jewelry.

Performance
1. Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how to participate.
2. Perform hand hygiene.
3. Apply a clean gown.
   - Pick up a clean gown, and allow it to unfold in front of you without allowing it to touch any area soiled with body substances.
   - Slide the arms and the hands through the sleeves.
   - Fasten the ties at the neck to keep the gown in place.
   - Overlap the gown at the back as much as possible, and fasten the waist ties or belt. ❶ **Rationale:** *Overlapping securely covers the uniform at the back. Waist ties keep the gown from falling away from the body, which can cause inadvertent soiling of the uniform.*
4. Apply the face mask.
   - Locate the top edge of the mask. The mask usually has a narrow metal strip along the edge.
   - Hold the mask by the top two strings or loops.
   - Place the upper edge of the mask over the bridge of the nose, and tie the upper ties at the back of the head or secure the loops around the ears. If glasses are worn, fit the upper edge of the mask under the glasses. ❷ **Rationale:** *With the edge of the mask under the glasses, clouding of the glasses is less likely to occur.*
   - Secure the lower edge of the mask under the chin, and tie the lower ties at the nape of the neck. **Rationale:** *To be effective, a mask must cover both the nose and the mouth, because air moves in and out of both.*
   - If the mask has a metal strip, adjust this firmly over the bridge of the nose. **Rationale:** *A secure fit prevents both the escape and the inhalation of microorganisms around the edges of the mask and the fogging of eyeglasses.*

❶ Overlapping the gown at the back to cover the nurse's uniform.

❷ A face mask tucked under eye protection.

Andresr/Shutterstock

Clinical Alert!

Older adults may not show the classic signs of infection (e.g., fever, tachycardia, increased WBC count); instead there may be an abrupt change in their mental status.

CLINICAL ALERTS highlight special information useful for clinical settings.

PRACTICE GUIDELINES provide instant-access summaries of clinical dos and don'ts.

PRACTICE GUIDELINES Long-Term Care Documentation

- Complete the assessment and screening forms (MDS) and plan of care within the time period specified by regulatory bodies.
- Keep a record of any visits and of phone calls from family, friends, and others regarding the client.
- Write nursing summaries and progress notes that comply with the frequency and standards required by regulatory bodies.
- Review and revise the plan of care every 3 months or whenever the client's health status changes.
- Document and report any change in the client's condition to the primary care provider and the client's family within 24 hours.
- Document all measures implemented in response to a change in the client's condition.
- Make sure that progress notes address the client's progress in relation to the goals or outcomes defined in the plan of care.

DRUG CAPSULE boxes provide a brief overview of drug information, nursing responsibilities, and client teaching to help you understand implications of pharmacotherapy in different situations.

DRUG CAPSULE

Benzodiazepine: midazolam hydrochloride (Versed)

THE CLIENT UNDERGOING ANESTHESIA

IV anesthetic agent used to induce general anesthesia.

Commonly used prior to conscious sedation to produce anxiolytic, hypnotic, anticonvulsant, muscle relaxant, and amnesic effects.

NURSING RESPONSIBILITIES

- Obtain baseline vital signs and level of consciousness before administration.
- Monitor vital signs, level of consciousness, and oxygen saturation q3–5min intraoperatively and postoperatively. Notify primary care provider or CRNA if there are any changes.
- Have resuscitative equipment readily available.
- A too rapid IV administration or excessive dose increases the risk of respiratory depression or arrest.
- Dosage must be individualized based on age, underlying disease, and desired effect. Too much or too little a dosage or improper administration may result in cerebral hypoxia, agitation, involuntary movement, hyperactivity, and combativeness.

Note: Prior to administering any medication, review all aspects with a current drug handbook or other reliable source.

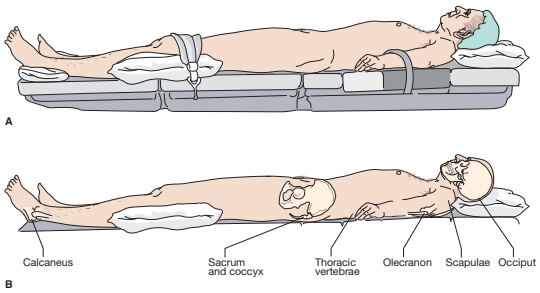
ANATOMY & PHYSIOLOGY REVIEW

ANATOMY & PHYSIOLOGY REVIEW

Client Positioning

The most common position for a client during a surgical procedure is the supine position. This position provides approaches to the cranial, thoracic, and peritoneal body cavities as well as to all four extremities and the perineum. Proper body alignment and padding of potential pressure areas are essential to preventing client risk for injury during surgery.

The potential pressure areas are the occiput, scapulae, olecranon, thoracic vertebrae, sacrum, coccyx, and calcaneus. The nursing intervention is to pad and protect bony prominences, pressure sites, and vulnerable nerves with pressure-reducing devices made of foam or gel. Proper positioning must provide optimal exposure to the surgical site as well as provide for client comfort and safety.



A, Supine position during a surgical procedure; *B*, potential pressure points noted.

QUESTIONS

A 78-year-old male client scheduled for a colon resection is brought to the operating room. He weighs 82 kg (180 lb), has type 2 diabetes, and has a history of arthritis in his hips and shoulders.

1. What baseline assessments would you gather before taking this client to the operating room?
2. What areas on this client are most likely to be injured as a result of poor positioning or inadequate padding?
3. What is the priority nursing diagnosis and outcome for this client?

Answers to Anatomy & Physiology Review Questions are available on the faculty resources site. Please consult with your instructor.

CRITICAL THINKING CHECKPOINTS provide a brief case study followed by questions that encourage you to analyze, compare, contemplate, interpret, and evaluate information.

Critical Thinking Checkpoint

Mr. Teng is a 77-year-old client with a history of COPD. Currently his respiratory condition is being controlled with medications and he is free of infection. He has just been transferred to the PACU following a hernia repair performed under spinal anesthesia. His blood pressure is 132/88 mmHg, pulse 84 beats/min, respirations 28/min, and tympanic temperature 36.5°C (97.8°F). He is awake and stable.

1. What factors place Mr. Teng at increased risk for the development of complications during and after surgery?
2. Speculate about why Mr. Teng's surgeon and anesthesiologist decided to perform Mr. Teng's surgery under regional anesthesia as opposed to general anesthesia.
3. What preparations were taken during the preoperative period to protect Mr. Teng from possible complications during and after his surgery?
4. How will Mr. Teng's postoperative assessments differ from those of a client who received general anesthesia?
5. What postoperative precautions are especially important to Mr. Teng in view of his chronic lung condition?

Answers to Critical Thinking Checkpoint questions are available on the faculty resources site. Please consult with your instructor.

EXTENSIVE END-OF-CHAPTER REVIEW

CHAPTER HIGHLIGHTS focus your attention and review critical concepts.

TEST YOUR KNOWLEDGE helps you prepare for the NCLEX® exam. Alternative-style questions are included. Answers and rationales are in Appendix A.

Chapter 28 Review

CHAPTER HIGHLIGHTS

- Vital signs reflect changes in body function that otherwise might not be observed.
- Body temperature is the balance between heat produced by and heat lost from the body.
- Factors affecting body temperature include age, diurnal variations, exercise, hormones, stress, and environmental temperatures.
- Four common types of fever are intermittent, remittent, relapsing, and constant.
- During a fever, the set point of the hypothalamic thermostat changes suddenly from the normal level to a higher than normal level, but several hours elapse before the core temperature reaches the new set point.
- Hypothermia involves three mechanisms: excessive heat loss, inadequate heat production by body cells, and increasing impairment of hypothalamic thermoregulation.
- The nurse selects the most appropriate site to measure temperature according to the client's age and condition.
- Pulse rate and volume reflect the stroke volume output, the compliance of the client's arteries, and the adequacy of blood flow.
- Normally a peripheral pulse reflects the client's heartbeat, but it may differ from the heartbeat in clients with certain cardiovascular diseases; in these instances, the nurse takes an apical pulse and compares it to the peripheral pulse.
- Many factors may affect an individual's pulse rate: age, sex, exercise, presence of fever, certain medications, hypovolemia, dehydration, stress (in some situations), position changes, and pathology.
- Although the radial pulse is the site most commonly used, eight other sites may be used in certain situations.
- The difference between the apical and radial pulses is called the pulse deficit.
- Respirations are assessed by observing respiratory rate, depth, rhythm, quality, and effectiveness.
- Blood pressure reflects the pumping action of the heart, peripheral vascular resistance, blood volume, and blood viscosity.
- Among the factors influencing blood pressure are age, exercise, stress, race, sex, medications, obesity, diurnal variations, medical conditions, and temperature.
- Orthostatic hypotension occurs when the blood pressure falls as the client assumes an upright position.
- A blood pressure cuff that is too narrow or too wide will give false readings.
- During blood pressure measurement, the artery must be held at heart level.
- A pulse oximeter measures the percent of hemoglobin saturated with oxygen. A normal result is 95% to 100%.
- Pulse oximeter sensors may be placed on the finger, toes, nose, earlobe, or forehead, or around the hand or foot of the neonate.

TEST YOUR KNOWLEDGE

1. The client's temperature at 8:00 A.M. using an oral electronic thermometer is 36.1°C (97.2°F). If the respiration, pulse, and blood pressure were within normal range, what would the nurse do *next*?
   1. Wait 15 minutes and retake it.
   2. Check what the client's temperature was the last time it was taken.
   3. Retake it using a different thermometer.
   4. Chart the temperature; it is normal.
2. Which client meets the criteria for selection of the apical site for assessment of the pulse rather than a radial pulse?
   1. A client who is in shock
   2. A client whose pulse changes with body position changes
   3. A client with an arrhythmia
   4. A client who had surgery less than 24 hours ago

READINGS AND REFERENCES give you a source for evidence-based material and additional information.

READINGS AND REFERENCES

Suggested Reading

Fuchs, V. R. (2018). Is US medical care inefficient? *JAMA*, *320*(10), 971–972. doi:10.1001/jama.2018.10779
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Related Research

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Contents

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UNIT 1

The Nature of Nursing

1 Historical and Contemporary Nursing Practice

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Discuss historical factors and nursing leaders, female and male, who influenced the development of nursing.
2. Discuss the evolution of nursing education and entry into professional nursing practice.
3. Describe the different types of educational programs for nurses.
4. Describe the major purpose of theory in the sciences and practice disciplines.
5. Identify the components of the metaparadigm for nursing.
6. Identify the role of nursing theory in nursing education, research, and clinical practice.
7. Explain the importance of continuing nursing education.
8. Describe how the definition of nursing has evolved since Florence Nightingale.
9. Identify the four major areas of nursing practice.
10. Identify the purposes of nurse practice acts and standards of professional nursing practice.
11. Describe the roles of nurses.
12. Describe the expanded career roles of nurses and their functions.
13. Discuss the criteria of a profession and professional identity formation.
14. Discuss Benner's levels of nursing proficiency.
15. Describe factors influencing contemporary nursing practice.
16. Explain the functions of national and international nurses' associations.

KEY TERMS

Alexian Brothers, *4*
caregiver, *17*
case manager, *18*
change agent, *17*
Clara Barton, *8*
client, *15*
client advocate, *17*
communicator, *17*
consumer, *15*
continuing education (CE), *14*
counseling, *17*
Dorothea Dix, *4*
environment, *14*
Ernest Grant, *10*
Fabiola, *4*
Florence Nightingale, *7*
governance, *19*
Harriet Tubman, *4*
health, *14*
in-service education, *14*
Knights of Saint Lazarus, *4*
Lavinia L. Dock, *9*
leader, *17*
Lillian Wald, *8*
Linda Richards, *8*
Luther Christman, *9*
manager, *17*
Margaret Higgins Sanger, *9*
Mary Breckinridge, *9*
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metaparadigm, *14*
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patient, *15*
Patient Self-Determination Act (PSDA), *23*
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Sojourner Truth, *4*
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teacher, *17*
telehealth, *22*
telenursing, *23*
theory, *13*

Introduction

Nursing today is far different from nursing as it was practiced years ago, and it is expected to continue changing during the 21st century. To comprehend present-day nursing and at the same time prepare for the future, one must understand not only past events but also contemporary nursing practice and the sociologic and historical factors that affect it.

Historical Perspectives

Nursing has undergone dramatic change in response to societal needs and influences. A look at nursing's beginnings reveals its continuing struggle for autonomy and professionalization. In recent decades, a renewed interest in nursing history has produced a growing amount of related literature. This section highlights only selected aspects of events that have influenced nursing practice. Recurring themes of women's and men's roles and status, religious (Christian) values, war, societal attitudes, and visionary nursing leadership have influenced nursing practice in the past. Many of these factors still exert their influence today.

Women's Roles

Traditional female roles of wife, mother, daughter, and sister have always included the care and nurturing of other family members. From the beginning of time, women have

cared for infants and children; thus, nursing could be said to have its roots in the home. Additionally, women, who in general occupied a subservient and dependent role, were called on to care for others in the community who were ill. Generally, the care provided was related to physical maintenance and comfort. Thus, the traditional nursing role has always entailed humanistic caring, nurturing, comforting, and supporting.

Men's Roles

Men have worked as nurses as far back as before the Crusades. Although the history of nursing primarily focuses on the female figures in nursing, schools of nursing for men existed in the United States from the late 1880s until 1969. Male nurses were denied admission to the Military Nurse Corps during World War II based on gender. It was believed at that time that nursing was women's work and combat was men's work. During the 20th century, men were denied admission to most nursing programs.

In 1971, registered nurse Steve Miller formed an organization called Men in Nursing, and in 1974, Luther Christman organized a group of male nurses. The two groups reorganized into the National Male Nurses Association with the primary focus of recruiting more men into nursing. In 1981, the organization was renamed the American Assembly for Men in Nursing (AAMN). The purpose of the AAMN is to "provide a framework for nurses, as a group, to meet, to discuss and influence factors, which affect men as nurses" (AAMN, n.d., "Vision," para. 2).

The percentage of men included in the nation's nursing workforce does vary. For example, a survey by the National Council of State Boards of Nursing (Smiley et al., 2018) indicated a total of 9.1% male nurses in the workforce, an increase of 2.5% compared to the previous 2013 report. In 2017, the Health Resources and Services Administration (HRSA) reported 9.6%, which is less than the 12% male RNs as reported by Buerhaus, Skinner, Auerbach, and Staiger (2017b, p. 231).

Men do experience barriers to becoming nurses. For example, the nursing image is one of femininity, and nursing has been slow to adopt a gender-neutral image. As a result, people may believe that men who choose the profession of nursing are emasculated, gay, or sexually deviant, which is not true (Hodges et al., 2017). Other barriers and challenges for male nursing students include the lack of male role models in nursing, stereotyping, and differences in caring styles between men and women (Zhang & Liu, 2016).

Improved recruitment and retention of men and other minorities into nursing continues to be needed to strengthen the profession. This is illustrated by professional surveys. A 2016 National League for Nursing (NLN, 2017a) survey found that men in basic registered nursing programs represented 14% of the total enrollment, a 1% decrease compared to the 2012 survey. In comparison, bachelor of science in nursing (BSN) programs enrolled 15% male students, a 2% increase from 2012. In addition, a 2016 survey by the American Association of Colleges of Nursing (AACN, 2017) reflected that only 12% of students in baccalaureate and graduate programs were male.

EVIDENCE-BASED PRACTICE

Evidence-Based Practice

What Motivates Men to Choose Nursing?

Yi and Keogh (2016) state that "knowledge of the factors that motivate men to choose nursing will assist in the development of evidence-based recruitment strategies to increase the number of men entering the nursing profession" (p. 96). As a result, they conducted a systematic literature review of data from qualitative studies that described male nurses' motivations for choosing nursing. A comprehensive search of over 11,000 citations and screening for inclusion criteria resulted in six studies being included in the review. Analytic processes resulted in four themes.

The first theme described how early exposure to nursing and other healthcare professionals influenced the male nurses' decision to become nurses. Examples consisted of where the men received encouragement from female and male friends and relatives who were nurses. Some men were exposed to nursing through experiences of caring for a sick or dying loved one, which became a factor in their decision-making process. The second theme described how the men chose nursing by chance, based on their circumstances at the time of the decision. For example, some men were looking for work and had friends who were nurses and thus decided to try nursing. Some chose nursing because they were not accepted into their preferred program. The third theme described extrinsic motivating factors such as job opportunity and salary. The fourth theme described intrinsic motivating factors such as personal satisfaction and enjoyment with helping people. Other intrinsic motivating factors included a sense of altruism and caring and their perception of nursing as a vocation.

Implications

A limitation expressed by the researchers was that the review would have provided a more comprehensive description if both quantitative and qualitative studies had been included. Three of the themes were congruent with previous literature reviews. However, the theme of entering nursing by chance, depending on the men's circumstances, was new. As a result, the authors recommended that strategies to enhance retention within the nursing program be developed for those males who pursued nursing by chance. Examples could include providing male role models during clinical experiences and supporting male nurses' caring abilities in a welcoming environment to promote intrinsic motivating factors during the program.

Religion

Religion has also played a significant role in the development of nursing. Although many of the world's religions encourage benevolence, it was the Christian value of "love thy neighbor as thyself" and Christ's parable of the Good Samaritan that had a significant impact on the development of Western nursing. During the third and fourth centuries, several wealthy matrons of the Roman Empire, such as **Fabiola**, converted to Christianity and used their wealth to provide houses of care and healing (the forerunner of hospitals) for the poor, the sick, and the homeless. Women were not, however, the sole providers of nursing services.

The Crusades saw the formation of several orders of knights, including the Knights of Saint John of Jerusalem (also known as the Knights Hospitalers), the Teutonic Knights, and the Knights of Saint Lazarus (Figure 1.1 ■). These brothers in arms provided nursing care to their sick and injured comrades. These orders also built hospitals, the organization and management of which set a standard for the administration of hospitals throughout Europe at that time. The **Knights of Saint Lazarus** dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions.

During medieval times, there were many religious orders of men in nursing. For example, the **Alexian Brothers** organized care for victims of the Black Plague in the 14th century in Germany. In the 19th century, they followed the same traditions as women's religious nursing orders and established hospitals and provided nursing care.

Figure 1.1 ■ The Knights of Saint Lazarus (established circa 1200) dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions. From the time of Christ to the mid-13th century, leprosy was viewed as an incurable and terminal disease.
Florilegius/Alamy Stock Photo.

The deaconess groups, which had their origins in the Roman Empire of the third and fourth centuries, were suppressed during the Middle Ages by the Western churches. However, these groups of nursing providers resurfaced occasionally throughout the centuries, most notably in 1836 when Theodor Fliedner reinstituted the Order of Deaconesses and opened a small hospital and training school in Kaiserswerth, Germany. Florence Nightingale received her training in nursing at the Kaiserswerth School.

Early religious values, such as self-denial, spiritual calling, and devotion to duty and hard work, have dominated nursing throughout its history. Nurses' commitment to these values often resulted in exploitation and few monetary rewards. For some time, nurses themselves believed it was inappropriate to expect economic gain from their "calling."

War

Throughout history, wars have accentuated the need for nurses. During the Crimean War (1854–1856), the inadequacy of care given to soldiers led to a public outcry in Great Britain. The role Florence Nightingale played in addressing this problem is well known. Nightingale and her nurses transformed the military hospitals by setting up sanitation practices, such as hand washing. Nightingale is credited with performing miracles; the mortality rate, for example, was reduced from 42% to 2% in 6 months (Donahue, 2011, p. 118).

During the American Civil War (1861–1865), several nurses emerged who were notable for their contributions to a country torn by internal conflict. **Harriet Tubman** and **Sojourner Truth** (Figures 1.2 ■ and 1.3 ■) provided care and safety to slaves fleeing to the North on the Underground Railroad. Mother Biekerdyke and Clara Barton searched the battlefields and gave care to injured and dying soldiers. Noted authors Walt Whitman and Louisa May Alcott volunteered as nurses to give care to injured soldiers in military hospitals. Another female leader who provided nursing care during the Civil War was **Dorothea Dix**

Figure 1.2 ■ Harriet Tubman (1820–1913) was known as "The Moses of Her People" for her work with the Underground Railroad. During the Civil War she nursed the sick and suffering of her own race.
Universal Images Group/Getty Images.

Figure 1.3 ■ Sojourner Truth (1797–1883), abolitionist, Underground Railroad agent, preacher, and women's rights advocate, was a nurse for more than 4 years during the Civil War and worked as a nurse and counselor for the Freedmen's Relief Association after the war.
National Portrait Gallery, Smithsonian Institution/Art Resources, NY.

(Figure 1.4 ■). She became the Union's superintendent of female nurses responsible for recruiting nurses and supervising the nursing care of all women nurses working in the army hospitals.

The arrival of World War I resulted in American, British, and French women rushing to volunteer their nursing services. These nurses endured harsh environments and treated injuries not seen before. A monument entitled "The Spirit of Nursing" stands in Arlington National Cemetery (Figure 1.5 ■). It honors the nurses who served in the U.S. armed services in World War I, many of whom are buried in Section 21, which is also called the "Nurses Section" (Arlington National Cemetery, n.d.). Progress in healthcare occurred

Figure 1.4 ■ Dorothea Dix (1802–1887) was the Union's superintendent of female nurses during the Civil War.
North Wind Picture Archives/Alamy Stock Photo.

Figure 1.5 ■ *A*, Section 21 in Arlington National Cemetery honors the nurses who served in the Armed Services in World War I. *B*, "The Spirit of Nursing" monument that stands in Section 21. *C*, Monument plaque.
Photos by Sherrilyn Coffman, PhD, RN.

Figure 1.6 ■ Recruiting poster for the Cadet Nurse Corps during World War II.
John Parrot/Stocktrek Images, Inc./Alamy Stock Photo.

during World War I, particularly in the field of surgery. For example, advancements were made in the use of anesthetic agents, infection control, blood typing, and prosthetics.

World War II casualties created an acute shortage of caregivers, and the Cadet Nurse Corps was established in response to a marked shortage of nurses (Figure 1.6 ■). Also at that time, auxiliary healthcare workers became prominent. "Practical" nurses, aides, and technicians provided much of the actual nursing care under the instruction and supervision of better prepared nurses. Medical specialties also arose at that time to meet the needs of hospitalized clients.

During the Vietnam War, approximately 11,000 American military women stationed in Vietnam were nurses. Most of them volunteered to go to Vietnam right after they graduated from nursing school, making them the youngest group of medical personnel ever to serve in wartime (Vietnam Women's Memorial Foundation, n.d.). Near the Vietnam Veterans Memorial ("The Wall") stands the Vietnam Women's Memorial (Figure 1.7 ■).

Nurses served in the Afghanistan and Iraq wars. A total of 6,326 nurses deployed to Afghanistan, Iraq, or both between September 1, 2001 and July 31, 2015. Of these deployed nurses, 55% were male. During this time six army nurses were killed, four in Afghanistan and two in Iraq (Berry-Caban, Rivers, Beltran, & Anderson, 2018).

Figure 1.7 ■ Vietnam Women's Memorial. Four figures include a nurse tending to the chest wound of a soldier, another woman looking for a helicopter for assistance, and a third woman (behind the other figures) kneeling while staring at an empty helmet in grief.
Courtesy of Sherrilyn Coffman, PhD, RN.

Societal Attitudes

Society's attitudes about nurses and nursing have significantly influenced professional nursing.

Before the mid-1800s, nursing was without organization, education, or social status; the prevailing attitude was that a woman's place was in the home and that no respectable woman should have a career. The role for the Victorian middle-class woman was that of wife and mother, and any education she obtained was for the purpose of making her a pleasant companion to her husband and a responsible mother to her children. Nurses in hospitals during this period were poorly educated; some were even incarcerated criminals. Society's attitudes about nursing during this period are reflected in the writings of Charles Dickens. In his book *Martin Chuzzlewit* (1844), Dickens reflected his attitude toward nurses through his character **Sairey Gamp** (Figure 1.8 ■). Mrs. Gamp was portrayed as a drunk, disreputable nurse who neglected, stole from, and physically abused the sick. This literary portrayal of nurses greatly influenced the negative image and attitude toward nurses in the 19th century.

In contrast, the *guardian angel* or *angel of mercy* image arose in the latter part of the 19th century, largely because of the work of Florence Nightingale during the Crimean War. After Nightingale brought respectability to the nursing profession, nurses were viewed as noble, compassionate, moral, religious, dedicated, and self-sacrificing.

Another image arising in the early 19th century that has affected subsequent generations of nurses and the public and other professionals working with nurses is that of the *doctor's handmaiden*. This image evolved when women had yet to obtain the right to vote, when family structures were largely paternalistic, and when the medical profession increasingly applied scientific knowledge that, at that time, was viewed as a male domain. Since that time, several images of nursing have been portrayed. The *heroine* portrayal evolved from nurses' acts of bravery in World

Figure 1.8 ■ Sairey Gamp, a character in Dickens' book *Martin Chuzzlewit*, represented the negative image of nurses in the 1800s.
Historia/Shutterstock.

War II and their contributions in fighting poliomyelitis—in particular, the work of the Australian nurse Elizabeth Kenney. Other images in the late 1900s include the nurse as sex object, surrogate mother, and tyrannical mother.

The nursing profession has taken steps to improve the image of the nurse. In the early 1990s, the Tri-Council for Nursing (the American Association of Colleges of Nursing, the American Nurses Association [ANA], the American Organization of Nurse Executives, and the National League for Nursing [NLN]) initiated a national effort, titled "Nurses of America," to improve the image of nursing. Launched in 2002, Johnson & Johnson corporation's "Campaign for Nursing's Future" promotes nursing as a positive career choice. Through various outreach programs, this campaign increases exposure to the nursing profession, raises awareness about its challenges, and encourages people of all ages to consider a career in nursing.

Nursing Leaders

Florence Nightingale, Clara Barton, Linda Richards, Mary Mahoney, Lillian Wald, Lavinia Dock, Margaret Sanger, Mary Breckinridge, Luther Christman, and Ernest Grant are among the leaders who have made notable contributions both to nursing's history and to American history. These nurses were all politically astute pioneers. Their skills at influencing others and bringing about change remain models for political nurse activists today.

Nightingale (1820–1910)

The contributions of **Florence Nightingale** to nursing are well documented. Her achievements in improving the standards for the care of war casualties in the Crimea earned her the title "Lady with the Lamp." Her efforts in reforming hospitals and in producing and implementing public health policies also made her an accomplished political nurse: She was the first nurse to exert political pressure on government. Through her contributions to nursing education—perhaps her greatest achievement—she is also recognized as nursing's first scientist-theorist for her work *Notes on Nursing: What It Is, and What It Is Not* (1860/1969).

Figure 1.9 ■ Considered the founder of modern nursing, Florence Nightingale (1820–1910) was influential in developing nursing education, practice, and administration. Her publication *Notes on Nursing: What It Is, and What It Is Not*, first published in England in 1859 and in the United States in 1860, was intended for all women.
David Cole/Alamy Stock Photo.

Nightingale (Figure 1.9 ■) was born to a wealthy and intellectual family. She believed she was "called by God to help others . . . [and] to improve the well-being of mankind" (Schuyler, 1992, p. 4). She was determined to become a nurse in spite of opposition from her family and the restrictive societal code for affluent young English women. As a well-traveled young woman of the day, she visited Kaiserswerth in 1847, where she received 3 months' training in nursing. In 1853 she studied in Paris with the Sisters of Charity, after which she returned to England to assume the position of superintendent of a charity hospital for ill governesses.

When she returned to England from the Crimea, a grateful English public gave Nightingale an honorarium of £4500. She later used this money to develop the Nightingale Training School for Nurses, which opened in 1860. The school served as a model for other training schools. Its graduates traveled to other countries to manage hospitals and institute nurse training programs. These training schools, at the time, accepted only females because Nightingale viewed nursing as being unsuitable for men. It is believed, unfortunately, that this perception has played a role in the invisibility of male nurses (Yi & Keogh, 2016, p. 95).

Despite poor health that left her an invalid, Florence Nightingale worked tirelessly until her death at age 90. As a passionate statistician, she conducted extensive research and analysis. Nightingale is often referred to as the first nurse researcher. For example, her record keeping proved

Figure 1.10 ■ Clara Barton (1821–1912) organized the American Red Cross, which linked with the International Red Cross when the U.S. Congress ratified the Geneva Convention in 1882.
Library of Congress.

that her interventions dramatically reduced mortality rates among soldiers during the Crimean War.

Nightingale's vision of nursing changed society's view of nursing. She believed in personalized and holistic client care. Her vision also included public health and health promotion roles for nurses.

Barton (1821–1912)

Clara Barton (Figure 1.10 ■) was a schoolteacher who volunteered as a nurse during the American Civil War. Her responsibility was to organize the nursing services. Barton is noted for her role in establishing the American Red Cross, which linked with the International Red Cross when the U.S. Congress ratified the Treaty of Geneva (Geneva Convention). It was Barton who persuaded Congress in 1882 to ratify this treaty so that the Red Cross could perform humanitarian efforts in times of peace.

Richards (1841–1930)

Linda Richards (Figure 1.11 ■) was America's first trained nurse. She graduated from the New England Hospital for Women and Children in 1873. Richards is known for introducing nurse's notes and doctor's orders. She also initiated the practice of nurses wearing uniforms (ANA, n.d.c). She is credited for her pioneering work in psychiatric and industrial nursing.

Figure 1.11 ■ Linda Richards (1841–1930) was America's first trained nurse.
National League for Nursing. National League for Nursing Records. 1894–1952. Located in: Archives and Modern Manuscripts Collection, History of Medicine Division, National Library of Medicine, Bethesda, MD; MS C 274.

Figure 1.12 ■ Mary Mahoney (1845–1926) was the first African American trained nurse.
Schomberg Center for Research in Black Culture/NYPL/Art Resource.

Mahoney (1845–1926)

Mary Mahoney (Figure 1.12 ■) was the first African American professional nurse. She graduated from the New England Hospital for Women and Children in 1879. She constantly worked for the acceptance of African Americans in nursing and for the promotion of equal opportunities (Donahue, 2011, p. 144). The ANA (n.d.e) gives a Mary Mahoney Award biennially in recognition of significant contributions in interracial relationships.

Wald (1867–1940)

Lillian Wald (Figure 1.13 ■) is considered the founder of public health nursing. Wald and Mary Brewster were

Figure 1.13 ■ Lillian Wald (1867–1940) founded the Henry Street Settlement and Visiting Nurse Service (circa 1893), which provided nursing and social services and organized educational and cultural activities. She is considered the founder of public health nursing.
National Portrait Gallery, Smithsonian Institution/Art Resources, NY.

the first to offer trained nursing services to the poor in the New York slums. Their home among the poor on the upper floor of a tenement, called the Henry Street Settlement and Visiting Nurse Service, provided nursing services and social services, and organized educational and cultural activities. Soon after the founding of the Henry Street Settlement, school nursing was established as an adjunct to visiting nursing.

Dock (1858–1956)

Lavinia L. Dock (Figure 1.14 ■) was a feminist, prolific writer, political activist, suffragette, and friend of Wald. She participated in protest movements for women's rights that resulted in the 1920 passage of the 19th Amendment to the U.S. Constitution, which granted women the right to vote. In addition, Dock campaigned for legislation to allow nurses rather than physicians to control their profession. In 1893, Dock, with the assistance of Mary Adelaide Nutting and Isabel Hampton Robb, founded the American Society of Superintendents of Training Schools for Nurses of the United States, a precursor to the current National League for Nursing.

Figure 1.14 ■ Nursing leader and suffragist Lavinia L. Dock (1858–1956) was active in the protest movement for women's rights that resulted in the constitutional amendment in 1920 that allowed women to vote.
Courtesy of The Gottesman Libraries at Teachers College, Columbia University.

Sanger (1879–1966)

Margaret Higgins Sanger (Figure 1.15 ■), a public health nurse in New York, has had a lasting impact on women's healthcare. Imprisoned for opening the first birth control information clinic in America, she is considered the founder of Planned Parenthood. Her experience with the large number of unwanted pregnancies among the working poor was instrumental in addressing this problem.

Breckinridge (1881–1965)

After World War I, **Mary Breckinridge** (Figure 1.16 ■), a notable pioneer nurse, established the Frontier Nursing Service (FNS). In 1918, she worked with the American Committee for Devastated France, distributing food, clothing, and supplies to rural villages and taking care of

Figure 1.15 ■ Nurse activist Margaret Sanger (1879–1966), considered the founder of Planned Parenthood, was imprisoned for opening the first birth control information clinic in Baltimore in 1916.

sick children. In 1921, Breckinridge returned to the United States with plans to provide healthcare to the people of rural America. In 1925, Breckinridge and two other nurses began the FNS in Leslie County, Kentucky. Within this organization, Breckinridge started one of the first midwifery training schools in the United States.

Christman (1915–2011)

Luther Christman, one of the founders of the AAMN, graduated from the Pennsylvania Hospital School of Nursing for Men in 1939 and experienced discrimination while in nursing school. For example, he was not allowed a maternity clinical experience, yet he was expected to know the information related to that clinical experience for the licensing exam. After becoming licensed, he wanted to earn a baccalaureate degree in nursing but was denied access to two universities because of his gender. After receiving his doctorate, he accepted the position as dean of nursing at Vanderbilt University, making him the first man to be a dean at a university school of nursing.

Figure 1.16 ■ Mary Breckinridge (1881–1965), a nurse who practiced midwifery in England, Australia, and New Zealand, founded the Frontier Nursing Service in Kentucky in 1925 to provide family-centered primary healthcare to rural populations.
T. Tso KRT/Newscom.

He accomplished many firsts: (a) the first man nominated for president of the ANA; (b) the first man elected to the American Academy of Nursing (AAN), which presented him with its highest honor by naming him a "Living Legend"; and (c) the first man inducted into ANA's Hall of Fame for his extraordinary contributions to nursing. The ANA currently bestows the Luther Christman Award, which acknowledges the valuable role of men in nursing (ANA, n.d.d).

Grant (1958–)

Ernest Grant made professional nursing history when he became the first male president of the American Nurses Association in January 2019. He is also the first African American man to serve as ANA vice president (Trossman, 2018). Grant began his distinguished nursing career as a student in a licensed practical nurse (LPN) program and progressed through baccalaureate and graduate nursing programs to earning a PhD in nursing from the University of North Carolina–Greensboro. After working early in his career at a burn center, he made this work his mission and is now recognized as an internationally known expert on burn care and fire safety. In 2002, President George W. Bush gave Grant a Nurse of the Year Award for his work treating burn victims from the 2001 terrorist attack on the World Trade Center in New York. His top priorities include ensuring that nurses have the educational opportunities and tools needed for the best client outcomes, encouraging nurses to become more politically involved, and encouraging young nurses to become involved with their national and state nursing associations (Nelson, 2019, p. 66).

Political Nurse Activists Today

The nursing profession continues to provide dynamic challenges to all nurses to keep current with the needs of the public and the role of the nurse. Current nursing leaders include presidents of national professional organizations; members of national foundations that contribute to high-quality, safe, client-centered care; and nurses who serve in public office. For example, in 2017 three nurses served in Congress (ANA, n.d.f) and a nurse, Dr. Trent-Adams, became the first individual who is not a physician to serve as surgeon general (NLN, 2017b). Nursing leader Linda Burnes Bolton was vice chair of the Institute of Medicine Commission on the Future of Nursing and in 2011 was named one of the top 25 women in healthcare. Dr. Linda Cronenwett led the Quality and Safety Education in Nursing (QSEN) project, which identified the knowledge, skills, and attitudes (KSAs) that nurses must possess to deliver safe, effective care (AACN, n.d.b). In the 2018 midterm elections, Eddie Bernice Johnson (D-Texas), a former psychiatric nurse and the first nurse elected to Congress, was re-elected to a 14th term, and Lauren Underwood (D-Illinois), an RN who specializes in public health nursing and is a health policy expert, won the race for Illinois' 14th Congressional District. These are just a few examples of contemporary nursing leaders.

Nursing Education

The practice of nursing is controlled from within the profession through state boards of nursing and professional nursing organizations. These groups also determine the content and type of education that is required for different levels or scopes of nursing practice. Originally, the focus of nursing education was to teach the knowledge and skills that would enable a nurse to practice in a hospital setting. However, as nursing roles have evolved in response to new scientific knowledge; advances in technology; and cultural, political, and socioeconomic changes in society, nursing education curricula have been revised to enable nurses to work in more diverse settings and assume more diverse roles. Nursing programs are based on a broad knowledge of biological, social, and physical sciences, as well as the liberal arts and humanities. Current nursing curricula emphasize critical thinking and the application of nursing and supporting knowledge to health promotion, health maintenance, and health restoration as provided in both community and hospital settings (Figure 1.17 ■).

There are two types of entry-level generalist nurses: the registered nurse (RN) and the licensed practical or vocational nurse (LPN or LVN). Responsibilities and licensure requirements differ for these two levels. The majority of new RNs are graduates of associate degree or baccalaureate degree nursing programs. In some states, an individual can be eligible to take the licensure exam through other qualifications such as completing a diploma nursing program or challenging the exam as a military corps person or LVN after completing specified coursework. The U.S. Navy and Marine Corps have a pathway to a commission in the Nurse Corps. Qualified enlisted men and women serving on active duty can apply to participate in the Medical Enlisted Commissioning Program (MECP). This program has been successful in increasing the diversity of nursing within the military. There are also "generic" master's and doctoral programs that lead to

Figure 1.17 ■ Nursing students learn to care for clients in community settings.
Tyler Olson/123RF.

eligibility for RN licensure. These latter programs are for students who already have a baccalaureate degree in a discipline other than nursing. On completion of the program, which may be from 1 to 3 years in length, graduates obtain their initial professional degree in nursing. Graduates of these programs are eligible to take the licensure examination to become an RN and may continue into specialty roles such as nurse practitioner or nurse educator.

Although educational preparation varies considerably, all RNs in the United States take the same licensure examination, the National Council Licensure Examination (NCLEX-RN). This examination is administered in each state, and the successful candidate becomes licensed in that particular state, even though the examination is of national origin. To practice nursing in another state, the nurse must receive reciprocal licensure by applying to that state's board of nursing. Some state legislatures have created a regulatory model called *mutual recognition* that allows for multistate licensure under one license. Nurses who have received their training in other countries may be granted registration after successfully completing the NCLEX. Both licensure and registration must be renewed regularly in order to remain valid. For additional information about licensure and registration, see Chapter 3.

The legal right to practice nursing requires not only passing the licensing examination, but also verification that the candidate has completed a prescribed course of study in nursing. Some states may have additional requirements. All U.S. nursing programs must be approved by their state board of nursing. In addition to state approval, the Accreditation Commission for Education in Nursing (ACEN) provides accreditation for all levels of nursing programs, and the Commission on Collegiate Nursing Education (CCNE) accredits baccalaureate and higher degree programs. Accreditation is a voluntary, peer review process. Accredited programs meet standard requirements that are evaluated periodically through written self-studies and on-site visitation by peer examiners.

Types of Education Programs

Education programs available for nurses include practical or vocational nursing, registered nursing, graduate nursing, and continuing education. All levels of nursing are needed in healthcare today. Each has a unique scope of practice and by working collaboratively can help meet the often complex needs of clients.

Licensed Practical (Vocational) Nursing Programs

Practical or vocational nursing programs are housed in community colleges, vocational schools, hospitals, or other independent health agencies. These programs generally last 9 to 12 months and include both classroom and clinical experience. At the end of the program, graduates take the NCLEX-PN to obtain licensure as a practical or vocational nurse. Some LPN and LVN programs articulate with associate degree programs. In these *ladder programs*, the practical or vocational education component constitutes the first year of an associate degree program for registered nursing, and, if successful in passing the NCLEX-PN, students can work while continuing their registered nurse education.

Practical nurses work under the supervision of an RN in numerous settings, including hospitals, nursing homes, rehabilitation centers, home health agencies, ambulatory care, and hospice. Although the scope of practice varies by state regulation and agency policy, LPNs usually provide basic direct technical care to clients. Employment of LPNs has shifted away from acute care settings to care of older adults in community-based settings, including long-term care.

Registered Nursing Programs

Currently, three major routes lead to eligibility for RN licensure: completion of a diploma, associate degree, or baccalaureate program.

DIPLOMA PROGRAMS

After Florence Nightingale established the Nightingale Training School for Nurses at St. Thomas Hospital in England in 1860, the concept traveled quickly to North America. Hospital administrators welcomed the idea of training schools as a source of nursing staff for free or inexpensive staffing for the hospital. In early years, nursing education largely took the form of apprenticeship programs. With little formal classroom instruction, students learned by doing—that is, by providing direct care to clients. There was no standardization of curriculum and no accreditation. Programs were designed to meet the service needs of the hospital, not the educational needs of the students.

Three-year diploma programs were the dominant nursing programs and the major source of nursing graduates from the late 1800s until the mid-1960s. Today's diploma programs are hospital-based educational programs that provide rich clinical experiences for nursing students. These programs often are associated with colleges or universities. Approximately 12% of RNs obtained their initial nursing education in diploma programs in 2017, which is a decrease of 5.4% since 2013 (Smiley et al., 2018, p. S15).

ASSOCIATE DEGREE PROGRAMS

Associate degree nursing programs, which originated in the early 1950s, were the first and only educational programs for nursing that were systematically developed from planned research and controlled experimentation. Most of these programs take place in community colleges. The graduating student receives an associate degree in nursing (ADN) or an associate of arts (AA), associate of science (AS), or associate in applied science (AAS) degree with a major in nursing. Several trends and events prompted the development of these programs: (a) the Cadet Nurse Corps, (b) the community college movement, (c) earlier nursing studies, and (d) Dr. Mildred Montag's proposal for an associate degree.

The Cadet Nurse Corps of the United States was legislated and financed during World War II to provide nurses to meet both military and civilian needs. The corps demonstrated that qualified nurses could be educated in less time than the traditional 3 years of most diploma programs.

After World War II, the number of community colleges in the United States increased rapidly. The low tuition and open-door admission policy of these colleges, as well as their location in towns and cities lacking 4-year colleges and universities, made higher education accessible to more individuals by offering the first 2 years of a 4-year college program, as well as vocational programs that addressed community needs.

Studies of nursing education, such as the Goldmark Report in 1923, the Committee on the Grading of Nursing Schools in 1934, and the Brown Report in 1948, also had a significant influence on the development of 2-year nursing programs. The recommendations in these reports supported the idea of independent schools of nursing in institutions of higher learning separate from hospitals.

In the United States, associate degree nursing programs were started after Mildred Montag published her doctoral dissertation, *The Education of Nursing Technicians*, in 1951. This study proposed a 2-year education program for RNs in community colleges as a solution to the acute shortage of nurses that came about because of World War II. Dr. Montag conceptualized a "nursing technician" or "bedside nurse" able to perform nursing functions broader than those of a practical nurse, but lesser in scope than those of the professional nurse. At the end of the 2 years, the student was to be awarded an ADN and be eligible to take the state board examination for RN licensure. The first ADN program was established at Columbia University Teachers College in 1952 under the direction of Dr. Montag. Currently, 36.3% of all new RNs each year are initially educated in associate degree programs, which is a decrease of 1.9% since 2013 (Smiley et al., 2018, p. S15).

Dr. Montag's original idea that these graduates be nursing technicians and that the degree become a terminal one did not last. In 1978, the ANA proposed that associate degree programs no longer be considered terminal, but part of a career upward-mobility plan. Today many students enter an associate degree program with the intention of continuing their education to the baccalaureate or higher level. Many community colleges have articulation agreements with college and university bachelor of science in nursing (BSN) programs to facilitate the upward mobility toward the BSN. RN to master of science in nursing (MSN) programs are also available to the associate degree nurse.

BACCALAUREATE DEGREE PROGRAMS

The first school of nursing in a university setting was established at the University of Minnesota in 1909. This program's curriculum, however, differed little from that of a 3-year diploma program. It was not until 1919 that the University of Minnesota established its undergraduate baccalaureate degree in nursing. Most of the early baccalaureate programs were 5 years in length. They consisted of the basic 3-year diploma program plus 2 years of liberal arts education. In the 1960s, the number of students enrolled in baccalaureate programs increased markedly.

Almost 42% of RNs in the United States are initially educated in baccalaureate programs (Smiley et al., 2018, p. S15). Baccalaureate programs are located in senior colleges and universities and are generally 4 years in length. Programs include courses in the liberal arts, sciences, humanities, and nursing, including nursing leadership, nursing research, and community health nursing. Graduates must complete both the degree requirements of the college or university and the nursing program before being awarded a baccalaureate degree. The usual degree awarded is a BSN. Partially in response to the significant shortage of RNs, some schools have established accelerated BSN programs. These programs may include summer coursework in order to shorten the length of time required to complete the curriculum or may be a modified curriculum designed for students who already have a baccalaureate degree in another field. These "second degree" or "fast track" BSN programs can be completed in as little as 12 to 18 months of study.

Many baccalaureate programs also admit RNs who have a diploma or associate degree. These programs typically are referred to as BSN completion, BSN transition, 2 + 2, or RN-BSN programs. Most RN-BSN programs have a special curriculum designed to meet the needs of these students. Many accept transfer credits from other accredited colleges or universities and award academic credit for the nursing coursework completed previously in a diploma or associate degree program. An increasing number of RN-BSN programs are offered online. In the four years between 2007 to 2011, there was an 86% increase in RN to BSN graduates (HRSA, 2013, p. 48).

Because of changes in the practice environment, the nurse who holds a baccalaureate degree generally experiences more autonomy, responsibility, participation in institutional decision making, and career advancement than the nurse prepared with a diploma or associate degree. Some employers have different salary scales for nurses with a baccalaureate degree, as opposed to an associate degree or diploma. In addition, the American Nurses Credentialing Center (ANCC) requires a baccalaureate degree for initial basic certification in most nursing specialties, and certification often is rewarded with a salary increase. The Magnet Recognition Program, developed by the ANCC to recognize healthcare organizations that provide nursing excellence, requires that 75% of nurse managers hold at least a baccalaureate degree. Also, the Institute of Medicine's (IOM) publication *The Future of Nursing* (2010) recommended that 80% of RNs be baccalaureate prepared by 2020. All of these points provide an incentive for nurses with diplomas and associate degrees to continue their formal preparation in baccalaureate completion programs. This is

reflected in the increasing enrollment in RN to BSN programs.

Graduate Nursing Programs

Although graduate schools differ, typical requirements for admission to a graduate program in nursing include the following:

- Licensure as an RN or eligibility for licensure.
- A baccalaureate degree in nursing from an approved college or university. Some graduate programs accept individuals with a diploma or associate degree in nursing and a baccalaureate degree in another field of study. Some accept individuals with an associate degree in nursing as their only postsecondary education.
- Evidence of scholastic ability (usually a minimum grade point average of 3.0 on a 4.0 scale).
- Satisfactory achievement on a standard qualifying examination such as the Graduate Record Examination (GRE) or Miller Analogies Test (MAT).
- Letters of recommendation from supervisors, nursing faculty, or nursing colleagues indicating the applicant's ability to do graduate study.

MASTER'S DEGREE PROGRAMS

The growth of baccalaureate nursing programs encouraged the development of graduate study in nursing. Approximately 18.9% of licensed RNs hold a master's or higher degree in nursing (Smiley et al., 2018, p. S17). Master's prepared nurses work in a variety of roles, including clinical nurse specialist (CNS), nurse practitioner (NP, also called advanced practice registered nurse [APRN]), nurse midwife (CNM), and nurse anesthetist (CRNA). The emphasis of master's degree programs is on preparing nurses for advanced leadership roles in administration, clinical practice, or teaching (Figure 1.18 ■).

A nursing role developed by the AACN is the clinical nurse leader (CNL). The CNL is a master's degree–prepared clinician who oversees the integration of care for a specific group of clients. CNLs are prepared for practice across the continuum of care in any healthcare setting (AACN, n.d.a).

Figure 1.18 ■ A nurse practitioner holds a master's degree and assumes an advanced practice role.
Custom Medical Stock Photo/Alamy.

DOCTORAL PROGRAMS

Doctoral programs in nursing began in the 1960s in the United States. Before 1960, nurses who pursued doctoral degrees chose related fields such as education, psychology, sociology, and physiology. The two primary doctoral degrees in nursing are the PhD and DNP (doctor of nursing practice). Nurses who earn a PhD in nursing generally assume faculty roles in nursing education programs or work in research programs. The DNP, a practice-focused doctorate, has been increasing in popularity and is the highest degree for nurse clinicians. Nurses with a DNP received additional education in evidence-based practice, quality improvement, and systems leadership to promote improved client outcomes. Doctorates in related fields such as education or public health are still highly relevant for nurses depending on their practice role.

Nursing Theories

As a profession, nursing is involved in identifying its own unique body of knowledge essential to nursing practice—nursing science. To identify this knowledge base, nurses must develop and recognize concepts and theories specific to nursing. Because theories in some other disciplines were developed and used long before nursing theories, it is helpful to explore briefly how theory has been used by those disciplines before considering theory in nursing.

A **theory** may be defined as a system of ideas that is presumed to explain a given phenomenon. For now, think of a theory as a major, very well-articulated idea about something important. Theories are used to describe, predict, and control phenomena.

Most undergraduate students are introduced to the major theories in their disciplines. For example, psychology majors study Freud and Jung's theories of the unconscious; sociology majors study Marx's theory of alienation; biology majors are introduced to Darwin's theory of evolution; and physics majors are introduced to a historical progression of theorists including Copernicus, Newton, Einstein, and newer theorists in quantum mechanics.

The extent to which theories build on or modify previous theories varies with the discipline, as does the importance of theory in the discipline. Students in nursing, teaching, and management often take some courses in theory, but these students generally focus on learning their practice. The term **practice discipline** is used for fields of study in which the central focus is performance of a professional role (e.g., nursing, teaching, management, music). Practice disciplines are differentiated from the disciplines that have research and theory development as their central focus, for example, the natural sciences. In the practice disciplines, the main function of theory (and research) is to provide new possibilities for understanding the discipline's practice.

Context for Theory Development in American Universities

In the 19th century, Florence Nightingale thought that the people of Great Britain needed to know more about how to maintain healthy homes and how to care for sick family members. *Nightingale's Notes on Nursing: What It Is, and What It Is Not* (1860/1969) was nursing's first textbook on home care and community health. However, the audience for that text was the public at large, not a separate discipline or profession.

In the 20th century, nursing education in the United States took a different path from nursing education in Great Britain and Europe. The drive to establish nursing departments in colleges and universities exposed American nursing to the dominant ideas and pressures in American higher education at the time. During the latter half of the 20th century, disciplines seeking to establish themselves in universities had to demonstrate something that Nightingale had not envisioned for nursing: a unique body of theoretical knowledge.

The Metaparadigm for Nursing

In the late 20th century, much of the theoretical work in nursing focused on articulating relationships among four major concepts: person, environment, health, and nursing. Because these four concepts can be superimposed on almost any work in nursing, they are collectively referred to as the **metaparadigm** for nursing. The term originates from two Greek words: *meta*, meaning "with," and *paradigm*, meaning "pattern." Many consider the following four concepts to be central to nursing:

1. The individuals or clients are the recipients of nursing care (includes individuals, families, groups, and communities).
2. The **environment** is the internal and external surroundings that affect the client.
3. **Health** is the degree of wellness or well-being that the client experiences.
4. **Nursing** is the attributes, characteristics, and actions of the nurse providing care on behalf of, or in conjunction with, the client.

During this time, a number of nurse theorists developed their own theoretical definitions of nursing. Theoretical definitions are important because they go beyond simplistic common definitions. They describe what nursing is and the interrelationship among nurses, nursing, the client, the environment, and the intended client outcome: health.

Certain themes are common to many of these definitions:

- Nursing is caring.
- Nursing is an art.
- Nursing is a science.
- Nursing is client centered.
- Nursing is holistic.
- Nursing is adaptive.
- Nursing is concerned with health promotion, health maintenance, and health restoration.
- Nursing is a helping profession.

Role of Nursing Theory

Direct links exist among nursing theory, education, research, and clinical practice. In many cases, nursing theory guides knowledge development and directs education, research, and practice, although each influences the others. The interface between nursing experts in each area helps to ensure that work in the other areas remains relevant, current, and useful and ultimately influences health. Some nursing programs and healthcare delivery systems use a theoretical framework. Examples include Orem's General Theory of Nursing, Leininger's Cultural Care Diversity and Universality Theory, Neuman's Systems Model, and Roy's Adaptation Model. Nursing theory remains an important focus of nurses' work.

Continuing Education

The term **continuing education (CE)** refers to formalized experiences designed to enhance the knowledge or skills of practicing professionals. Compared to advanced educational programs, which result in an academic degree, CE courses tend to be more specific and shorter. Participants may receive certificates of completion or specialization.

CE is the responsibility of all practicing nurses. For example, one of ANA's Standards of Professional Performance is education, which states, "The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking," with one of the competencies describing a commitment to lifelong learning through self-reflection and inquiry for learning and personal growth (ANA, 2015b, p. 76). Constant updating and growth are essential to keep abreast of scientific and technologic changes and changes within healthcare and the nursing profession. A variety of educational and healthcare institutions conduct CE programs on site, via home study, and online.

CE programs usually are designed to meet one or more of the following needs: (a) to inform nurses of new techniques and knowledge; (b) to help nurses attain expertise in a specialized area of practice, such as critical care nursing; and (c) to provide nurses with information essential to nursing practice, such as knowledge about legal and ethical aspects of nursing. Some states require nurses to obtain a certain number of CE credits to renew their license. Required contact hours typically range from 15 to 30 hours per 2-year license renewal period. A few states also require a certain number of hours of practice, either independently or in lieu of study hours, before licensure renewal.

An **in-service education** program is a specific type of CE program that is offered by an employer. It is designed to upgrade the knowledge or skills of employees, as well

as to validate continuing competence in selected procedures and areas of practice. For example, an employer might offer an in-service program to inform nurses about a new piece of equipment or a new surgical procedure, new documentation procedures, or methods of implementing a nurse theorist's conceptual framework for nursing. Some in-service programs are mandatory on a regular basis, such as cardiopulmonary resuscitation and fire safety programs.

Contemporary Nursing Practice

An understanding of contemporary nursing practice includes a look at definitions of nursing, recipients of nursing, scope of nursing, settings for nursing practice, nurse practice acts, and current standards of clinical nursing practice.

Definitions of Nursing

Professional nursing associations have examined nursing and developed their definitions of it. In 1973, the ANA described nursing practice as "direct, goal oriented, and adaptable to the needs of the individual, the family, and community during health and illness" (ANA, 1973, p. 2). In 1980, the ANA changed this definition of nursing to this: "Nursing is the diagnosis and treatment of human responses to actual or potential health problems" (ANA, 1980, p. 9). In 1995, the ANA recognized the influence and contribution of the science of caring to nursing philosophy and practice. Research to explore the meaning of caring in nursing has been increasing. Details about caring are discussed in Chapter 15 ∞. The current definition of nursing remains unchanged from the 2003 edition of *Nursing's Social Policy Statement*: "Nursing is the protection, promotion, and optimization of health and abilities, preventions of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (ANA, 2010, p. 10; ANA, 2015b, p. 7).

Recipients of Nursing

The recipients of nursing are sometimes called consumers, sometimes patients, and sometimes clients. A **consumer** is an individual, a group of people, or a community that uses a service or commodity. People who use healthcare products or services are consumers of healthcare.

A **patient** is an individual who is waiting for or undergoing medical treatment and care. The word *patient* comes from a Latin word meaning "to suffer" or "to bear." Traditionally, the individual receiving healthcare has been called a patient. Usually, people become patients when they seek assistance because of illness or for surgery. Some nurses believe that the word *patient* implies passive acceptance of the decisions and care of health professionals. Additionally, with the emphasis on health promotion and prevention of illness, many recipients of nursing care are not ill. Moreover, nurses interact with family members and significant others to provide support, information, and comfort in addition to caring for the patient.

For these reasons, nurses increasingly refer to recipients of healthcare as *clients*. A **client** is an individual who engages the advice or services of another who is qualified to provide this service. The term *client* presents the receivers of healthcare as collaborators in the care, that is, as people who are also responsible for their own health. Thus, the health status of a client is the responsibility of the individual in collaboration with health professionals. In this book, *client* is the preferred term, although *consumer* and *patient* are used in some instances.

Scope of Nursing

Nurses provide care for three types of clients: individuals, families, and communities. Theoretical frameworks applicable to these client types, as well as assessments of individual, family, and community health, are discussed in Chapters 6 and 27 ∞.

Nursing practice involves four areas: promoting health and wellness, preventing illness, restoring health, and caring for the dying.

Promoting Health and Wellness

When health is defined broadly as actualization of human potential, it has been called wellness (Murdaugh, Parsons, & Pender, 2019, p. 12). Nurses promote wellness in clients who are both healthy and ill. This may involve individual and community activities to enhance healthy lifestyles, such as improving nutrition and physical fitness, preventing drug and alcohol misuse, restricting smoking, and preventing accidents and injury in the home and workplace. See Chapter 19 ∞ for details.

Preventing Illness

The goal of illness prevention programs is to maintain optimal health by preventing disease. Nursing activities that prevent illness include immunizations, prenatal and infant care, and prevention of sexually transmitted infections.

Restoring Health

Restoring health focuses on the ill client, and it extends from early detection of disease through helping the client during the recovery period. Nursing activities include the following:

- Providing direct care to the ill individual, such as administering medications, baths, and specific procedures and treatments
- Performing diagnostic and assessment procedures, such as measuring blood pressure and examining feces for occult blood

Figure 1.19 ■ Nurses practice in a variety of settings.
(Bottom middle) Lisa S./Shutterstock.

- Consulting with other healthcare professionals about client problems
- Teaching clients about recovery activities, such as exercises that will accelerate recovery after a stroke
- Rehabilitating clients to their optimal functional level following physical or mental illness, injury, or chemical addiction.

Caring for the Dying

This area of nursing practice involves comforting and caring for people of all ages who are dying. Palliative care nurses are part of a medical team that focuses on providing relief from the symptoms and stress of a serious illness (e.g., cancer). The goal is to improve the quality of life for both the client and the family. A hospice nurse provides end-of-life care by giving medical, psychologic, and spiritual support. The goal is to help people who are dying have peace, comfort, and dignity. Nurses carrying out these activities work in homes, hospitals, and extended care facilities.

Settings for Nursing

In the past, the acute care hospital was the main practice setting open to most nurses. Today many nurses work in hospitals, but increasingly they work in clients' homes, community agencies, ambulatory clinics, long-term care facilities, health maintenance organizations (HMOs), and nursing practice centers (Figure 1.19 ■).

Nurses have different degrees of nursing autonomy and nursing responsibility in the various settings. They may provide direct care, teach and support clients, serve as nursing advocates and agents of change, and help determine health policies affecting consumers in the community and in hospitals. For information about the models for delivery of nursing, see Chapter 5 ∞.

Nurse Practice Acts

Nurse practice acts, or legal acts for professional nursing practice, regulate the practice of nursing in the United States, with each state having its own act. Although nurse practice acts differ in various jurisdictions, they all have a common purpose: to protect the public. Nurses are responsible for knowing their state's nurse practice act as it governs their practice. For additional information, see Chapter 3 ∞.

Standards of Nursing Practice

Establishing and implementing standards of practice are major functions of a professional organization. The

purpose of the ANA **Standards of Practice** is to describe the responsibilities for which nurses are accountable. The ANA developed standards of nursing practice that are generic in nature, by using the nursing process as a foundation, and provide for the practice of nursing regardless of area of specialization. Various specialty nursing organizations have further developed specific standards of nursing practice for their area. The ANA **Standards of Professional Performance** describe behaviors expected in the professional nursing role.

Roles and Functions of the Nurse

Nurses assume a number of roles when they provide care to clients. Nurses often carry out these roles concurrently, not exclusively of one another. For example, the nurse may act as a counselor while providing physical care and teaching aspects of that care. The roles required at a specific time depend on the needs of the client and aspects of the particular environment.

Caregiver

The **caregiver** role has traditionally included those activities that assist the client physically and psychologically while preserving the client's dignity. The required nursing actions may involve full care for the completely dependent client, partial care for the partially dependent client, and supportive-educative care to assist clients in attaining their highest possible level of health and wellness. Caregiving encompasses the physical, psychosocial, developmental, cultural, and spiritual levels. The nursing process provides nurses with a framework for providing care (see Chapters 9 through 13). A nurse may provide care directly or assign it to other caregivers.

Communicator

Communication is integral to all nursing roles. Nurses communicate with the client, support individuals, other health professionals, and people in the community.

In the role of **communicator**, nurses identify client problems and then communicate these verbally or in writing to other members of the healthcare team. The quality of a nurse's communication is an important factor in nursing care. The nurse must be able to communicate clearly and accurately in order for a client's healthcare needs to be met (see Chapters 14 and 16).

Teacher

As a **teacher**, the nurse helps clients learn about their health and the healthcare procedures they need to perform to restore or maintain their health. The nurse assesses the client's learning needs and readiness to learn, sets specific learning goals in conjunction with the client, enacts teaching strategies, and measures learning. Nurses also teach assistive personnel (AP) to whom they assign care, and they share their expertise with other nurses and health professionals. See Chapter 17 for additional details about the teaching–learning process.

Client Advocate

A **client advocate** acts to protect the client. In this role the nurse may represent the client's needs and wishes to other health professionals, such as relaying the client's request for information to the healthcare provider. They also assist clients in exercising their rights and help them speak up for themselves (see Chapter 4).

Counselor

Counseling is the process of helping a client to recognize and cope with stressful psychologic or social problems, to develop improved interpersonal relationships, and to promote personal growth. It involves providing emotional, intellectual, and psychologic support. The nurse counsels primarily healthy individuals with normal adjustment difficulties and focuses on helping the individual develop new attitudes, feelings, and behaviors by encouraging the client to look at alternative behaviors, recognize the choices, and develop a sense of control.

Change Agent

The nurse acts as a **change agent** when assisting clients to make modifications in their behavior. Nurses also often act to make changes in a system, such as clinical care, if it is not helping a client return to health. Nurses are continually dealing with change in the healthcare system. Technologic change, change in the age of the client population, and changes in medications are just a few of the changes nurses deal with daily. See Chapter 18 for additional information about change.

Leader

A **leader** influences others to work together to accomplish a specific goal. The leader role can be employed at different levels: individual client, family, groups of clients, colleagues, or the community. Effective leadership is a learned process requiring an understanding of the needs and goals that motivate people, the knowledge to apply the leadership skills, and the interpersonal skills to influence others. The leadership role of the nurse is discussed in Chapter 18 .

Manager

The nurse manages the nursing care of individuals, families, and communities. The nurse **manager** also assigns and delegates nursing activities to ancillary workers and other nurses, and supervises and evaluates their performance. Managing requires knowledge about organizational

structure and dynamics, authority and accountability, leadership, change theory, advocacy, assignment, delegation, and supervision and evaluation. See Chapter 18 for additional details.

Case Manager

Nurse case managers work with the multidisciplinary healthcare team to measure the effectiveness of the case management plan and to monitor outcomes. Each agency or unit specifies the role of the nurse **case manager**. In some institutions, the case manager works with primary or staff nurses to oversee the care of a specific caseload. In other agencies, the case manager is the primary nurse or provides some level of direct care to the client and family. Insurance companies have also developed a number of roles for nurse case managers, and responsibilities may vary from managing acute hospitalizations to managing high-cost clients or case types. Regardless of the setting, case managers help ensure that care is oriented to the client, while controlling costs.

Research Consumer

Nurses often use research to improve client care. In a clinical area, nurses need to (a) have some awareness of the process and language of research, (b) be sensitive to issues related to protecting the rights of human subjects, (c) participate in the identification of significant researchable problems, and (d) be a discriminating consumer of research findings.

Expanded Career Roles

Nurses are fulfilling expanded career roles. APRNs are RNs who have advanced practice training and have completed a master's or higher education degree and certification in their specialty of advanced practice roles. APRN roles include certified nurse practitioner (CNP), certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS). Other expanded roles include nurse educator, nurse researcher, and informatics nurse specialist (INS). Expanded nursing roles allow greater independence and autonomy (see Box 1.1).

BOX 1.1 Selected Expanded Career Roles for Nurses

ADVANCED PRACTICE REGISTERED NURSE (APRN)

APRNs have a master's degree, post-master's certificate, or practice-focused DNP degree in one of four specific roles:

- Certified Nurse Practitioner (CNP)
  CNPs provide care, independently, in a range of settings and in one of six defined client populations: family and individual across the lifespan; adult-gerontology (acute care or primary care); women's health and gender-related health; neonatal; pediatrics (acute care or primary care); and psychiatric or mental health.
- Clinical Nurse Specialist (CNS)
  CNSs usually work in a specialized area of nursing practice defined by parameters such as disease or medical specialty (e.g., oncology, diabetes); population (e.g., children, seniors, women); setting (e.g., critical care, emergency department); type of care (e.g., rehabilitation, mental health); and type of problem (e.g., pain, eating disorders). CNSs may serve as educators or outcome managers, conduct research, supervise staff, or manage cases to ensure the best possible client treatment.
- Certified Registered Nurse Anesthetist (CRNA)
  CRNAs administer anesthesia for surgical and other procedures and provide pre- and postanesthesia care for individuals across the lifespan. This care is provided in diverse settings, including hospital surgical suites.
- Certified Nurse Midwife (CNM)
  CNMs provide primary healthcare for women from adolescence throughout the lifespan. In addition to general primary care, they also provide the following: gynecological and family planning services; pregnancy, childbirth, and postpartum care; healthy newborn baby care; and treatment of male partners for sexually transmitted diseases. It is a misconception that CNMs are primarily used in at-home births. More than half of CNMs are employed by hospitals (GraduateNursingEDU.org, n.d.).

OTHER EXPANDED NURSING ROLES

Nurse Researcher

Nurse researchers investigate nursing problems to improve nursing care and to refine and expand nursing knowledge. They are employed in academic institutions, teaching hospitals, and research centers such as the National Institute for Nursing Research in Bethesda, Maryland. Nurse researchers usually have advanced education at the doctoral level.

Nurse Administrator

The nurse administrator manages client care, including the delivery of nursing services. The administrator may have a middle management position, such as head nurse or supervisor, or a more senior management position, such as director of nursing services. The functions of nurse administrators include budgeting, staffing, and planning programs. The educational preparation for nurse administrator positions is at least a baccalaureate degree in nursing and frequently a master's or doctoral degree.

Nurse Educator

Nurse educators are employed in nursing programs, at educational institutions, and in hospital staff education. The nurse educator usually has a baccalaureate degree or more advanced preparation and frequently has expertise in a particular area of practice. The nurse educator is responsible for classroom and, often, clinical teaching. There is now a process to become a certified nurse educator (CNE).

Nurse Entrepreneur

A nurse entrepreneur usually has an advanced degree and manages a health-related business. The nurse may be involved in education, consultation, or research, for example.

Forensic Nurse

The forensic nurse provides specialized care for individuals who are victims or perpetrators of trauma. Forensic nurses have knowledge of the legal system and skills in injury identification, evaluation, and documentation. After tending to the client's medical needs, the forensic nurse collects evidence, provides medical testimony in court, and consults with legal authorities. Forensic nurses work in a variety of fields including sexual assault, domestic violence, child abuse and neglect, mistreatment of older adults, death investigation, and corrections. They may be called on in mass disasters or community crisis situations (International Association of Forensic Nurses, n.d.). Nurses complete a certification process to become a forensic nurse.

Informatics Nurse Specialist (INS)

The INS is an RN with formal graduate-level education in informatics or an informatics-related field. The INS is responsible for implementing or coordinating projects involving multiple professions and specialties. They support other RNs to use data, information, knowledge, and technology in their practice (ANA, 2015a, p. 7).

Criteria of a Profession

Nursing is gaining recognition as a profession. A **profession** has been defined as an occupation that requires extensive education or a calling that requires special knowledge, skill, and preparation. A profession is generally distinguished from other kinds of occupations by (a) its requirement of prolonged, specialized training to acquire a body of knowledge pertinent to the role to be performed; (b) an orientation of the individual toward service, either to a community or to an organization; (c) ongoing research; (d) a code of ethics; (e) autonomy; and (f) a professional organization.

Specialized Education

Specialized education is an important aspect of professional status. Education for the professions has shifted toward programs in colleges and universities. Many nursing educators believe that the undergraduate nursing curriculum should include liberal arts education in addition to the biological and social sciences and the nursing discipline.

In the United States today, there are five means of entry into registered nursing: hospital diploma, associate degree, baccalaureate degree, master's degree, and doctoral degree.

Body of Knowledge

As a profession, nursing is establishing a well-defined body of knowledge and expertise. A number of nursing theories and conceptual frameworks contribute to the knowledge base of nursing and give direction to nursing practice, education, and ongoing research.

Service Orientation

A service orientation differentiates nursing from an occupation pursued primarily for profit. Many consider altruism (selfless concern for others) the hallmark of the profession. Nursing has a tradition of service to others. This service, however, must be guided by certain rules, policies, or codes of ethics. Today, nursing is also an important component of the healthcare delivery system.

Ongoing Research

Research in nursing is contributing to nursing practice. In the 1940s, nursing research was at a very early stage of development. In the 1950s, increased federal funding and professional support helped establish centers for nursing research. Most early research was directed at the study of nursing education. In the 1960s, studies were often related to the nature of the knowledge base underlying nursing practice. Since the 1970s, nursing research has focused on practice-related issues. Nursing research as a dimension of the nurse's role is discussed further in Chapter 2 .

Code of Ethics

Nurses have traditionally placed a high value on the worth and dignity of others. The nursing profession requires integrity of its members; that is, a member is expected to do what is considered right regardless of the personal cost.

Ethical codes change as the needs and values of society change. Nursing has developed its own codes of ethics and in most instances has set up means to monitor the professional behavior of its members. See Chapter 4  for additional information on ethics.

Autonomy

A profession is autonomous if it regulates itself and sets standards for its members. Providing autonomy is one of the purposes of a professional association. If nursing is to have professional status, it must function autonomously in the formation of policy and in the control of its activity. To be autonomous, a professional group must be granted legal authority to define the scope of its practice, describe its particular functions and roles, and determine its goals and responsibilities in delivery of its services.

To practitioners of nursing, autonomy means independence at work, responsibility, and accountability for one's actions. Autonomy is more easily achieved and maintained from a position of authority. For example, all states have passed legislation granting CNPs supervisory, collaborative, or independent authority to practice, and currently, 26 states do not require physician oversight of NPs to practice (American Association of Nurse Practitioners [AANP], 2018).

Professional Organization

Operation under the umbrella of a professional organization differentiates a profession from an occupation. **Governance** is the establishment and maintenance of social, political, and economic arrangements by which practitioners control their practice, their self-discipline, their working conditions, and their professional affairs. Nurses, therefore, need to work within their professional organizations.

The ANA is a professional organization that adopts high nursing practice standards, supports a safe work environment for nurses, encourages a healthy lifestyle of nurses, and calls attention to healthcare issues that affect the public and nurses (ANA, n.d.a).

Professional Identity Formation

The standards of education and practice for the profession are determined by the members of the profession, rather than by outsiders. The development of professional identity begins during one's nursing

education. **Professional identity** is a "sense of oneself that is influenced by characteristics, norms, and values of the nursing discipline, resulting in an individual thinking, acting, and feeling like a nurse" (Godfrey & Crigger, 2017, p. 1260). The term *professional identity* is replacing terminology such as *professional role* and *professionalism*.

Benner (2001) was the first to describe the development of professional expertise with the five levels of proficiency in nursing based on the Dreyfus general model of skill acquisition. The five stages, which have implications for teaching and learning, are novice, advanced beginner, competent, proficient, and expert. Benner writes that experience is essential for the development of professional expertise (see Box 1.2).

BOX 1.2 Benner's Stages of Nursing Expertise

STAGE I: NOVICE
No experience (e.g., nursing student). Performance is limited, inflexible, and governed by context-free rules and regulations rather than experience.

STAGE II: ADVANCED BEGINNER
Demonstrates marginally acceptable performance. Recognizes the meaningful "aspects" of a real situation. Has experienced enough real situations to make judgments about them.

STAGE III: COMPETENT
Has 2 or 3 years of experience. Demonstrates organizational and planning abilities. Differentiates important factors from less important aspects of care. Coordinates multiple complex care demands.

STAGE IV: PROFICIENT
Has 3 to 5 years of experience. Perceives situations as wholes rather than in terms of parts, as in Stage II. Uses maxims as guides for what to consider in a situation. Has holistic understanding of the client, which improves decision making. Focuses on long-term goals.

STAGE V: EXPERT
Performance is fluid, flexible, and highly proficient; no longer requires rules, guidelines, or maxims to connect an understanding of the situation to appropriate action. Demonstrates highly skilled intuitive and analytic ability in new situations. Is inclined to take a certain action because "it felt right."

From *Novice to Expert: Excellence and Power in Clinical Nursing Practice, Commemorative Edition*, by P. Benner, 2001. Electronically reproduced by permission of Pearson Education, Inc., Upper Saddle River, New Jersey.

As stated previously, it is within the nursing educational program that the student nurse develops, clarifies, and internalizes professional values as part of professional identity formation. Specific professional nursing values are stated in nursing codes of ethics (see Chapter 4 ∞), in standards of nursing practice (discussed earlier in this chapter), and in the legal system itself (see Chapter 3 ∞). Additionally, the National Student Nurses' Association (NSNA) has a code of ethics that includes a code of academic and clinical conduct (see Box 1.3).

BOX 1.3 NSNA Code of Academic and Clinical Conduct

Students of nursing have a responsibility to society in learning the academic theory and clinical skills needed to provide nursing care. The clinical setting presents unique challenges and responsibilities while caring for human beings in a variety of healthcare environments.

The *Code of Academic and Clinical Conduct* is based on an understanding that to practice nursing as a student is an agreement to uphold the trust with which society has placed in us. The statements of the code provide guidance for nursing students in their personal development of an ethical foundation and need not be limited strictly to the academic or clinical environment but can assist in the holistic development of the client.

As students are involved in the clinical and academic environments we believe that ethical principles are a necessary guide to professional development. Therefore, within these environments we:

1. Advocate for the rights of all clients.
2. Maintain client confidentiality.
3. Take appropriate action to ensure the safety of clients, self, and others.
4. Provide care for the client in a timely, compassionate, and professional manner.
5. Communicate client care in a truthful, timely, and accurate manner.
6. Actively promote the highest level of moral and ethical principles and accept responsibility for our actions.
7. Promote excellence in nursing by encouraging lifelong learning and professional development.
8. Treat others with respect and promote an environment that respects human rights, values, and choice of cultural and spiritual beliefs.
9. Collaborate in every reasonable manner with the academic faculty and clinical staff to ensure the highest quality of client care.
10. Use every opportunity to improve faculty and clinical staff understanding of the learning needs of nursing students.
11. Encourage faculty, clinical staff, and peers to mentor nursing students.
12. Refrain from performing any technique or procedure for which the student has not been adequately trained.
13. Refrain from any deliberate action or omission of care in the academic or clinical setting that creates unnecessary risk of injury to the client, self, or others.
14. Assist the staff nurse or preceptor in ensuring that there is full disclosure and that proper authorizations are obtained from clients regarding any form of treatment or research.
15. Abstain from the use of alcoholic beverages or any substances in the academic and clinical setting that impair judgment.
16. Strive to achieve and maintain an optimal level of personal health.
17. Support access to treatment and rehabilitation for students who are experiencing impairments related to substance abuse and mental or physical health issues.
18. Uphold school policies and regulations related to academic and clinical performance, reserving the right to challenge and critique rules and regulations as per school grievance policy.

From *Code of Ethics*, (pp. 6–16) by National Student Nurses' Association, Inc., 2018. New York, NY: Author.

Factors Influencing Contemporary Nursing Practice

To understand nursing as it is practiced today and as it will be practiced tomorrow requires an understanding of some of the social forces currently influencing this profession. These forces usually affect the entire healthcare system, and nursing, as a major component of that system, cannot avoid the effects.

Nursing Workforce Issues and Challenges

Registered nurses are the largest segment of the healthcare workforce. A historical perspective of the healthcare workforce reflects a cyclical pattern of nursing shortages and surpluses (Snavely, 2016). For example, nursing shortages in the hospital setting persist in good times and disappear during economic recessions (Johnson, Butler, Harootunian, Wilson, & Linan, 2016, p. 387).

One challenge to the nursing workforce is the expected retirement of one million RNs between 2017 and 2030. As these RNs exit the workforce, their years of nursing knowledge and experience will not be available to the nursing workforce (Buerhaus et al., 2017a). From an optimistic perspective, recent studies indicate that growth in the nursing workforce up to 2030 will be sufficient to replace the retiring RNs. The growth, however, will be uneven among the states, resulting in local shortages versus a national shortage (Buerhaus et al., 2017b).

Another challenge for nursing is the aging of the nation's baby boom generation. Baby boomers (individuals born between 1946 and 1964) will be 66 years and older by 2030. As a result, Medicare enrollment is projected to grow and lead to a big increase in demand for healthcare. This means an increasing demand for nurses *and* an increase in intensity and complexity of the required nursing care (Buerhaus et al., 2017a, pp. 40–41).

The 2017 National Nursing Workforce Survey (Smiley et al., 2018) concluded that "the workforce of tomorrow will be slightly younger, highly educated, with higher numbers working in the community providing primary healthcare and using technology and telehealth as a means to deliver healthcare" (p. S5). New environments and settings for the nursing workforce include microhospitals and pop-up clinics. The popularity of microhospitals (facilities of 8 to 15 beds) is increasing. They are part of a larger health system and found in communities that do not have a larger community hospital. The goal of the microhospital is to bring pre-acute care into neighborhoods with a higher level of service than found at an urgent care facility, such as scaled-down emergency departments, imaging and diagnostic suites, and dietary services (National Council of State Boards of Nursing [NCSBN], 2018, pp. S13–14).

Health insurance is either unavailable or unaffordable for many people. Pop-up clinics help provide healthcare access, often in regions with large uninsured populations. The clinics are usually held in convention centers and last for 1 to 2 days. They offer a wide variety of free services such as dental, vision, medical, and dietary counseling. Pop-up clinics are funded by donors and rely on volunteer providers (NCSBN, 2018). Healthcare delivery and the role of the nurse are constantly changing. As a result, the supply and demand for nurses will vary.

Healthcare System Reform

The ANA believes that all individuals have a right to quality healthcare and as an organization fights for meaningful healthcare reform. Since 2016 there have been many attempts to repeal the Affordable Care Act (ACA), and ANA had a part in stopping the proposed legislation that would have weakened the healthcare delivery system. The future of the ACA is uncertain and the discussions about healthcare will continue. The ANA will remain dedicated to informing the public about the relevant issues involved in future healthcare reform (ANA, n.d.b).

In 2010, an IOM report, *The Future of Nursing: Leading Change, Advancing Health*, provided recommendations on what nursing needed to do to provide better client care in the new systems that would be part of health reform. This report identified four key areas: nurses practicing to the fullest extent of their skills and knowledge; nurses achieving higher levels of education; nurses being full partners with physicians and other healthcare professionals; and improving data collection and information infrastructure (IOM, 2010, p. 4). The IOM evaluated the progress made from 2010 to 2015 and found that significant progress was made over the five years. The 2016 report, however, recommended future additional work in specific areas (see Box 1.4).

BOX 1.4 Assessing Progress on the Institute of Medicine Report *The Future of Nursing*

The following address the challenges that require additional focus and attention for continued progress in achieving the IOM landmark report on *The Future of Nursing* recommendations:

1. Remove scope-of-practice barriers for APRNs.
2. Expand opportunities for nurses to lead and increase interprofessional collaborative efforts to improve healthcare practice.
3. Explore funds to increase transition-to-practice nurse residency programs.
4. Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020.
5. Double the number of nurses with a doctorate by 2020.
6. Ensure that nurses engage in lifelong learning.
7. Prepare and enable nurses to lead change to advance health.
8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.
9. Increase the diversity of the nursing workforce.

Quality and Safety in Healthcare

Quality and safety are essential universal values on which healthcare is based. However, the report *To Err Is Human*, published by the IOM in 2000, revealed a gap between the status of American healthcare and the quality of care Americans should receive. The 2003 IOM report, *Health Professions Education: A Bridge to Quality*, called for a redesign of the education for healthcare professions and described six core competencies needed to improve 21st-century healthcare: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. In 2005, the Robert Wood Johnson Foundation funded a project called Quality and Safety Education for Nurses (QSEN). The goal for the QSEN project was to "meet the challenge of preparing future nurses who will have the knowledge, skills and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work" (QSEN Institute, n.d.). This project used the IOM's six competencies, along with the knowledge and experiences of QSEN faculty and a national advisory board, to define quality and safety competencies for nursing. The project also proposed KSAs for each competency that could be used as guides for curriculum development in prelicensure nursing programs (see the table at the QSEN website).

Consumer Demands

Consumers of nursing services (the public) have become an increasingly effective force in changing nursing practice. On the whole, people are better educated and have more knowledge about health and illness than in the past. Consumers also have become more aware of others' needs for care. The ethical and moral issues raised by poverty and neglect have made people more vocal about the needs of minority groups and the poor.

The public's concepts of health and nursing have also changed. Most now believe that health is a right of all people, not just a privilege of the rich. The media emphasize the message that individuals must assume responsibility for their own health by obtaining a physical examination regularly, checking for the seven danger signals of cancer, and maintaining their mental well-being by balancing work and recreation. Interest in health and nursing services is therefore greater than ever. Furthermore, many people now want more than freedom from disease—they want energy, vitality, and a feeling of wellness.

Increasingly, the consumer has become an active participant in making decisions about health and nursing care. Planning committees concerned with providing nursing services to a community usually have active consumer membership. Recognizing the validity of public input, many state nursing associations and regulatory agencies have consumer representatives on their governing boards.

Family Structure

Family structures influence the need for and provision of nursing services. More people are living away from the extended family and the nuclear family, and the family breadwinner is no longer necessarily the husband. Today, many single men and women rear children, and in many two-parent families both parents work. It is also common for young parents to live at great distances from their own parents. These young families need support services, such as daycare centers. For additional information about the family, see Chapter 27 ∞.

Adolescent mothers also need specialized nursing services, both while they are pregnant and after their babies are born. These young mothers usually have the normal needs of teenagers as well as those of new mothers. Many teenage mothers are raising their children alone with little, if any, assistance from the child's father. This type of single-parent family is especially vulnerable because motherhood compounds the difficulties of adolescence. Also, because many of these families may live in poverty, the children often do not receive preventive immunizations and are at increased risk for nutritional and other health problems.

Science and Technology

Advances in science and technology affect nursing practice. Biotechnology is affecting healthcare. For example, research in genetics and genomics has led to the development of precision medicine that aims to discover the right treatment for the right client at the right time. Prevention, diagnosis, and treatment are based on the client's genome, lifestyle, environment, and other personal characteristics to allow health professionals to focus their efforts on the individual (NCSBN, 2018, p. 58). This requires nurses to learn new skills and knowledge, such as genetics, pharmacogenomics, and use of new technology. As technologies change, nursing education changes, and nurses require increasing education to provide effective, safe nursing practice.

Internet, Telehealth, and Telenursing

The internet has affected healthcare, with more and more clients becoming well informed about their health concerns. As a result, nurses may need to interpret information from internet sources for clients and their families. Because not all internet-based information is accurate, nurses need to help clients access high-quality, valid websites; interpret the information; and evaluate the information and determine if it is useful to them.

The prefix *tele* means "distance" and is used to describe the many healthcare services provided via technology. **Telehealth** is the "delivery of health-related services and information via telecommunication technologies" (Lee & Billings, 2016, p. 252). The words

telemedicine and *telehealth* are often used interchangeably. Telemedicine is often associated with direct client clinical services, whereas telehealth has a broader definition of remote healthcare services. **Telenursing** is the use of technology to provide nursing practice at a distance (Asiri & Househ, 2016). The delivery of telehealthcare, however, is not limited to physicians and nurses; it includes other health disciplines such as radiology, pathology, and pharmacology. These disciplines also deliver care using electronic information and telecommunications technologies and are accordingly called *teleradiology*, *telepathology*, and *telepharmacy*. Nurses engaged in telenursing practice continue to use the nursing process to provide care to clients, but they do so using technologies such as the internet, computers, telephones, video teleconferencing, and telemonitoring equipment. Telenursing continues to grow, especially in home healthcare and in rural communities.

Telehealth recognizes no state boundaries and, subsequently, licensure issues have been raised. For example, if a nurse licensed in one state provides health information to a client in another state, does the nurse need to maintain licensure in both states? The National Council of State Boards of Nursing (NCSBN) endorses a change from single-state licensure to a mutual recognition model. Many state legislatures have adopted mutual recognition language into statutes and are currently implementing it (NCSBN, n.d.b). See Chapter 3 ∞.

Legislation

Legislation about nursing practice and health matters affects both the public and nursing. Legislation related to nursing is discussed in Chapter 3 ∞. Changes in legislation relating to health also affect nursing. For example, the **Patient Self-Determination Act (PSDA)** requires that all competent adults be informed in writing on admission to a healthcare institution about their rights to accept or refuse medical care and to use advance directives. See Chapter 3 ∞ for more information about the PSDA and advance directives.

Healthcare reform and the shortage of physicians calls for an increase in APRNs such as CNPs. APRN regulations are determined at the state level through legislation. This causes wide variations in state regulation of nurse practitioner practice (Lugo, 2016). As a result, CNPs cannot easily move from state to state, which decreases access to care for clients. The APRN Compact, approved in 2015, allows an APRN to hold one multistate license with a privilege to practice in other compact states. The APRN Compact will be implemented when 10 states have enacted the legislation. As of January 2019, three states have enacted the legislation (NCSBN, n.d.a). The American Medical Association and the American Society of Anesthesiologists oppose the APRN Compact (NCSBN, 2018).

Collective Bargaining

The ANA participates in collective bargaining on behalf of nurses through its economic and general welfare programs. Today, some nurses are joining other labor organizations that represent them at the bargaining table. Nurses have gone on strike over economic concerns and over issues about safe care for clients and safety for themselves.

Nursing Associations

Professional nursing associations have provided leadership that affects many areas of nursing. Voluntary accreditation of nursing education programs by the Accreditation Commission for Education in Nursing (ACEN) and Commission on Collegiate Nursing Education (CCNE) has also influenced nursing. Many nursing programs have steadily improved to meet the standards for accreditation over the years. As a result, nurse graduates are better prepared to meet the demands of society.

To influence policymaking for healthcare, a group of professional nurses organized formally to promote political action in the nursing and healthcare arenas. Nurses for Political Action (NPA) formed in 1971 and became an arm of the ANA in 1974, when its name changed to Nurses' Coalition for Action in Politics (N-CAP). In 1986, the name was changed to American Nurses Association—Political Action Committee (ANA-PAC). Through this group, nurses have lobbied actively for legislation affecting healthcare. A number of nursing leaders hold positions of authority in government. Attaining such positions is essential if nurses hope to exert ongoing political influence.

Nursing Organizations

As nursing has developed, an increasing number of nursing organizations have formed. These organizations are at the local, state, national, and international levels. The organizations that involve most North American nurses are the ANA, the National League for Nursing, the International Council of Nurses, and the National Student Nurses' Association. The number of nursing specialty organizations is also increasing, for example, the Academy of Medical Surgical Nursing, the National Association of Hispanic Nurses, the National Black Nurses Association, Philippine Nurses Association of America, and the American Assembly for Men in Nursing. Participation in the activities of nursing associations enhances the growth of involved individuals and helps nurses collectively influence policies affecting nursing practice. See Table 1.1 for examples of major nursing organizations.

TABLE 1.1 Examples of Major Nursing Organizations

Organization	Description
American Nurses Association (ANA)	• The national professional organization for nursing in the United States. • The purposes are to foster high standards of nursing practice and to promote the educational and professional advancement of nurses so that all people may have better nursing care. • In 1982, the organization became a federation of state nurses' associations. Individuals participate in the ANA by joining their state nurses' associations. • The official journal of the ANA is *American Nurse Today*, and *The American Nurse* is the official newspaper.
National League for Nursing (NLN)	• The NLN is an organization of both individuals and agencies. • Its objective is to foster the development and improvement of all nursing services and nursing education. • People who are not nurses but have an interest in nursing services, for example, hospital administrators, can be members of the league. This feature of the NLN—involving non-nurse members, consumers, and nurses from all levels of practice—is unique. • The official journal of the NLN is *Nursing and Health Care Perspectives*.
International Council of Nurses (ICN)	• The council is a federation of national nurses' associations, such as the ANA and Canada Nursing Association. • The ICN provides an organization through which member national associations can work together for the mission of representing nursing worldwide, advancing the profession, and influencing health policy. • The official journal of the ICN is *International Nursing Review*.
National Student Nurses' Association (NSNA)	• The official preprofessional organization for nursing students. • Exposes student nurses to issues impacting the nursing profession while promoting collegiality and leadership qualities. • To qualify for membership in the NSNA, a student must be enrolled in a state-approved nursing education program. • The official journal of the NSNA is *Imprint* magazine.
International Honor Society: Sigma Theta Tau	• The international honor society in nursing. • The Greek letters stand for the Greek words *storga*, *tharos*, and *tima*, meaning "love," "courage," and "honor." • The society's purpose is professional rather than social. Membership is attained through academic achievement. Students in baccalaureate programs in nursing and nurses in master's, doctoral, and postdoctoral programs are eligible to be selected for membership. • Potential members, who hold a minimum of a bachelor's degree and have demonstrated achievement in nursing, can apply for membership as a nurse leader in the community. • The official journal is the *Journal of Nursing Scholarship*. • The society also publishes *Reflections*, a quarterly newsletter that provides information about the organization and its various chapters.

Chapter 1 Review

CHAPTER HIGHLIGHTS

- Historical perspectives of nursing practice reveal recurring themes or influencing factors. For example, women have traditionally cared for others, but often in subservient roles. Religious orders left an imprint on nursing by instilling such values as compassion, devotion to duty, and hard work. Wars created an increased need for nurses and medical specialties. Societal attitudes have influenced nursing's image. Visionary leaders have made notable contributions to improve the status of nursing.
- Although the history of nursing primarily focuses on female figures, men have worked as nurses as far back as before the Crusades. During the 20th century, men were denied admission to most nursing programs. There has been a gradual increase in the number of male nursing students and male nurses in the workforce. Improved recruitment and retention of men and other minorities continues to be needed to strengthen the profession.
- Originally, the focus of nursing education was to teach the knowledge and skills that would enable a nurse to practice in a hospital setting. Today, nursing education curricula are continually undergoing revisions in response to new scientific knowledge and technologic, cultural, political, and socioeconomic changes in society to enable nurses to work in more diverse settings and assume more diverse roles.

- In the practice disciplines, the main function of theory (and research) is to provide new possibilities for understanding the discipline's focus.
- During the latter half of the 20th century, disciplines seeking to establish themselves in universities had to demonstrate something that Nightingale had not envisioned for nursing—a unique body of theoretical knowledge.
- In the late 20th century, much of the theoretical work in nursing focused on articulating relationships between four major concepts: person, environment, health, and nursing. Because these four concepts can be superimposed on almost any work in nursing, they are sometimes collectively referred to as a *metaparadigm* for nursing.
- Continuing education is the responsibility of each practicing nurse to keep abreast of scientific and technologic change and changes within the nursing profession.
- The scope of nursing practice includes promoting health and wellness, preventing illness, restoring health, and caring for the dying.
- Although traditionally the majority of nurses were employed in hospital settings, today the numbers of nurses working in home healthcare, ambulatory care, and community health settings are increasing.
- Nurse practice acts vary among states, and nurses are responsible for knowing the act that governs their practice.
- Standards of nursing practice provide criteria against which the effectiveness of nursing care and professional performance behaviors can be evaluated.
- Every nurse may function in a variety of roles that are not exclusive of one another; in reality, they often occur together and serve to clarify the nurse's activities. These roles include caregiver, communicator, teacher, client advocate, counselor, change agent, leader, manager, case manager, and research consumer.
- With advanced education and experience, nurses can fulfill advanced practice roles such as clinical nurse specialist (CNS), certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), certified nurse educator (CNE), administrator, informatics nurse specialist (INS), and researcher.
- The nursing profession requires specialized education; a unique body of knowledge, including specific skills and abilities; a service orientation; ongoing research; a code of ethics; autonomy; and a professional organization.
- Professional identity formation begins during one's nursing education. It is the process whereby the values and norms of the nursing discipline are internalized into the nurse's own behavior and self-concept.
- Contemporary nursing practice is influenced by nursing workforce issues and challenges; healthcare reform; quality and safety in healthcare; consumer demands; family structure; science and technology; the internet, telehealth, and telenursing; legislation; collective bargaining; and the work of nursing associations.
- Participation in the activities of nursing associations enhances the growth of involved individuals and helps nurses collectively influence policies that affect nursing practice.

TEST YOUR KNOWLEDGE

1. Which women made significant contributions to the nursing care of soldiers during the Civil War? Select all that apply.
1. Harriet Tubman
2. Florence Nightingale
3. Fabiola
4. Dorothea Dix
5. Sojourner Truth

2. Curricula for nursing education are strongly influenced by which of the following? Select all that apply.
1. Physician groups
2. Professional nursing organizations
3. Individual state boards of nursing
4. Hospital administrators
5. The National Council of State Boards of Nursing

3. Individuals or clients, environment, health, and nursing constitute the metaparadigm for nursing because they do which of the following?
1. Provide a framework for implementing the nursing process
2. Can be used in any setting when caring for a client
3. Can be used to determine applicability of a research study
4. Focus on the needs of a group of clients

4. Which is an example of continuing education for nurses?
1. Attending the hospital's orientation program
2. Completing a workshop on ethical aspects of nursing
3. Obtaining information about the facility's new computer charting system
4. Talking with a company representative about a new piece of equipment

5. Health promotion is best represented by which activity?
1. Administering immunizations
2. Giving a bath
3. Preventing accidents in the home
4. Performing diagnostic procedures

6. Who were America's first two trained nurses?
1. Barton and Wald
2. Dock and Sanger
3. Richards and Mahoney
4. Henderson and Breckinridge

7. A nurse with 2 to 3 years of experience who has the ability to coordinate multiple complex nursing care demands is at which stage of Benner's stages of nursing expertise?
1. Advanced beginner
2. Competent
3. Proficient
4. Expert

8. Which professional organization developed a code for nursing students?
1. ANA
2. NLN
3. AACN
4. NSNA

9. Which social force is most likely to significantly impact the future supply and demand for nurses?
1. Aging
2. Economics
3. Science/technology
4. Telecommunications

10. A registered nurse is interested in functioning as a healthcare advocate for individuals whose lives are affected by violence. This nurse will be investigating which expanded career role?
1. Clinical nurse specialist
2. Forensic nurse
3. Nurse practitioner
4. Nurse educator

See Answers to Test Your Knowledge in Appendix A.

READINGS AND REFERENCES

Suggested Readings

Pollitt, P. (2018). Nurses fight for the right to vote. *American Journal of Nursing*, *118*(11), 46–54. doi:10.1097/01.NAJ.0000547639.70037.cd
The author provides a look at the lives of four nurse suffragists—Lavinia Lloyd Dock, Mary Bartlett Dixon, Sarah Tarleton Colvin, and Hattie Frances Kruger—who were arrested for their involvement in the women's suffrage movement.

Strickler, J. (2018). Clara Barton: Angel of the battlefield. *Nursing*, *48*(3), 43–45. doi:10.1097/01.NURSE.0000529805.60418.26
This article, a part of the Pioneers in Nursing series, celebrates the life and accomplishments of Clara Barton.

Strickler, J., & Farmer, T. (2019). Dorothea Dix: Crusader for patients with mental illness. *Nursing*, *49*(1), 49–51. doi:10.1097/01.NURSE.0000549724.14939.d8
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Evidence-Based Practice and Research in Nursing

2

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Explain the relationship between research and evidence-based nursing practice.
2. Apply the steps of change used in implementing evidence-based practice.
3. Describe limitations in relying on research as the primary source of evidence for practice.
4. Differentiate the quantitative approach from the qualitative approach in nursing research.
5. Outline the steps of the research process.
6. Describe research-related roles and responsibilities for nurses.
7. Describe the nurse's role in protecting the rights of human participants in research.

KEY TERMS

comparative analysis, *33*
confidentiality, *37*
content analysis, *33*
cost–benefit analysis, *33*
critique, *35*
dependent variable, *31*
descriptive statistics, *32*
ethnography, *30*
evidence-based practice (EBP), *27*
extraneous variables, *30*
grounded theory, *30*
hypothesis, *31*
independent variable, *31*
inferential statistics, *32*
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measures of central tendency, *32*
measures of variability, *32*
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validity, *32*

Introduction

All nurses need a basic understanding of the research process and its relationship to evidence-based practice. Current standards of professional performance for nurses include using evidence and research findings in practice. At the minimum, all nurses are expected to use evidence and research to determine proper nursing actions, to engage in research activities as appropriate to their abilities, and to share knowledge with other nurses (American Nurses Association, 2015). Additionally, nurses today are actively involved in generating and publishing evidence in order to improve client care and expand nursing's knowledge base. These activities support the current emphasis on practice that is based on evidence and on all nurses needing to be able to locate, understand, and evaluate both research findings and nonresearch evidence.

Evidence-Based Practice

Evidence-based practice (EBP), or evidence-based nursing, occurs when the nurse can "integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal healthcare" (Cronenwett et al., 2007). See Figure 2.1 ■. Thus, as evidence changes, so must practice. One model for changing practice as a result of evidence (Melnyk & Fineout-Overholt, 2019) uses the following seven steps:

- ***Cultivate a spirit of inquiry.*** Nurses need to be curious and willing to investigate how various practices compare and which might be best for a specific client.
- ***Ask clinical questions.*** For consistency and efficiency, nurses should state the question in a standard format such as PICOT (see page 31).
- ***Search for the best evidence.*** In the previous step, key terms are identified that facilitate identifying relevant evidence in the literature.
- ***Critically appraise the evidence.*** Several toolkits or schema are available to assist the nurse in determining the most valid, reliable, and applicable evidence. In some cases, relevant studies may already have been synthesized (see Box 2.1).
- ***Integrate the evidence with clinical expertise and client/family preferences and values.*** Evidence must not be automatically applied to the care of individual clients. Each nurse must determine how the evidence fits with

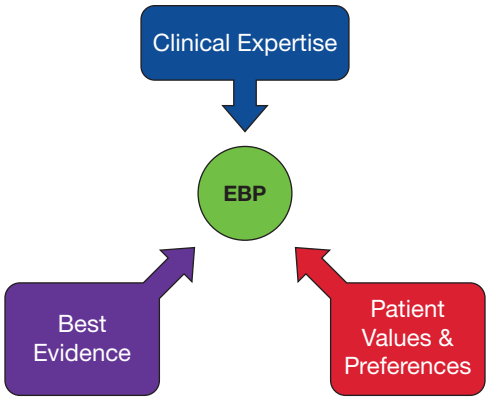

Figure 2.1 ■ Components of evidence-based practice.

the clinical condition of the client, available resources, institutional policies, and the client's wishes. Only then can an appropriate intervention be established.

- ***Implement and evaluate the outcomes of the intervention.*** The nurse gathers all relevant data that may indicate whether or not the intervention was successful. If the outcomes varied from those reported in the evidence, this evaluation can help determine the reasons for the variable responses and will contribute to improving the evidence available for future situations.
- ***Disseminate the outcomes.*** Nurses need to share the results of their work with others. This can be done locally with colleagues or more formally through publications, posters, or conference presentations.

See Chapter 18 for further description of the nurse's role in managing change.

Some scholars contend that, while evidence includes theories, opinions of recognized experts, clinical expertise, clinical experiences, and findings from client assessments, findings from research studies are often given the most weight in the decision-making process. This emphasis is because **research** entails using formal and systematic processes to solve problems and answer questions. The disciplined thinking and the careful planning and execution that characterize research mean that the resulting findings should be accurate, dependable, and free from bias.

Other scholars and practitioners express concerns about the current prominence and conception of EBP as primarily using research as the source of evidence. Some believe that the best evidence for EBP is theory rather than research. Reasons for concerns about reliance solely on research for EBP include the following:

1. Research is often done under controlled circumstances, which is very different from the real world of healthcare delivery.
2. Research evidence suggests that there is one best solution to a problem for all clients, and this limited perspective stifles creativity.
3. Research may ignore the significance of life events to the individual. Nursing care should consider feasibility, appropriateness, meaningfulness, and effectiveness of interventions and plans.
4. Not all published research is robust and flawless.
5. EBP should promote cost-effective care, but cost is often not included in traditional research studies.

A variety of models are available to assist nurses in using EBP. These include the ACE Star Model (Stevens, 2012), Iowa Model (Buckwalter et al., 2017), Johns Hopkins EBP Model (Dang & Dearholt, 2017), and Stetler Model (Stetler, 2010).

BOX 2.1 Sources of Synthesized Knowledge

Cochrane Library

Evidence-Based Nursing Journal
Joanna Briggs Institute
National Guidelines Clearinghouse
Essential Evidence Plus/Patient-Oriented Evidence That Matters (POEMS)
U.S. National Library of Medicine Health Information Databases
Worldviews on Evidence-Based Nursing

Nursing Research

Using research findings to guide decisions about client care is nothing new. As early as 1854, Florence Nightingale demonstrated how research findings could be used to improve nursing care. When Nightingale arrived in the Crimea in 1854, she found the military hospital barracks overcrowded, filthy, infested with fleas and rats, and lacking in food, drugs, and essential medical supplies. By systematically collecting, organizing, and reporting data, Nightingale was able to institute sanitary reforms and significantly reduce mortality rates from contagious diseases and infection. Although the Nightingale tradition influenced the establishment of American nursing schools, her ideas about the importance of research did not take hold in nursing until early in the 20th century.

Currently, accrediting organizations require all baccalaureate and higher degree programs to include coursework in research and EBP. Many associate degree and diploma programs also include content in these important areas. Research-related role expectations for nurses with different levels of educational preparation were reaffirmed by the American Association of Colleges of Nursing (AACN) in 2006 and are presented in Table 2.1. All nurses, however, have a responsibility to identify nursing issues that require research and to participate in research studies to the extent they are able.

The journal *Nursing Research* was first published in 1952 to serve as a vehicle for communicating nurses' research findings. The publication of many other nursing research journals followed, some dedicated to research and others combining clinical and research articles. The breadth and diversity of nursing research is reflected in the examples of recent nursing studies shown in Box 2.2.