UNIT I

Foundations of Nursing Practice

Nursing is both an art and a science. It is a profession that uses specialized knowledge and skills to promote wellness and to provide care for people in both health and illness in a variety of practice settings. Unit I introduces concepts that provide the foundation for professional nursing practice. Chapters in this unit introduce the profession of nursing; theory, research, and evidence-based nursing practice; health, illness and disparities, cultural diversity; basic needs and health of people, their families, and the community; ethical and legal dimensions of nursing practice; communication; teaching and counseling; and leadership, managing, and delegating.

Historical perspectives, educational preparation, professional organizations, and guidelines for professional nursing practice serve as a base for understanding what nursing is and how it is organized. Nursing theories and nursing research provide a foundation for evidence-based nursing practice, defining the rationale for nursing actions and offering a focus for nursing care. The diverse society in which nurses care for others mandates the ability to provide culturally competent care. An understanding of basic human needs and the individualized definitions of wellness and illness prepare the nurse to integrate the human dimensions—the physical, intellectual, emotional, sociocultural, spiritual, and environmental aspects of each person—into nursing care to promote wellness, prevent illness, restore health, and facilitate coping with altered function or death. An understanding of the influence of values on human behavior and of the ethical dimensions of nursing practice is essential to responsible and accountable patient care. Sensitivity to the legal implications of professional nursing practice is imperative in today's culture. Finally, this unit describes competencies that are essential to every professional nurse: professional communication, teaching and counseling, and leadership, management and delegation.

Unit I explores the foundations for nursing practice from both the perspective of the nurse and a person-centered holistic understanding of the patient. You will be introduced to a challenging and rewarding profession, and be provided with a knowledge base to ground the development of caregiving skills and professional relationships and behaviors.

Basic to any philosophy of nursing seems to be these three concepts: (1) reverence for the gift of life; (2) respect for the dignity, worth, autonomy, and individuality of each human being; (3) resolution to act dynamically in relation to one's beliefs."

Ernestine Wiedenbach (1900–1996), *a faculty member at Yale University School of Nursing, where she developed her model of nursing from years of experience in various nursing positions*

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Introduction to Nursing

Roberto Pecorini

Roberto is a 38-year-old man diagnosed with metastatic colon cancer. Having undergone radiation treatments and chemotherapy, he is extremely weak and malnourished. He is receiving intravenous fluids via a central venous catheter. He has two pressure injuries on his sacrum, each approximately 2 cm in diameter, requiring wound care. He also has a colostomy that he cannot care for independently.

Michelle Fine

Michelle, a 19-year-old first-time mother who was discharged with her healthy 7-lb 8-oz baby girl 2 days ago, calls the nursery. She reports, "My baby isn't taking to my breast and she hasn't had any real feeding for 24 hours."

Ahmad Basshir

Ahmad, a 62-year-old man who is at risk for heart disease, is being taught about lifestyle modifications, such as diet and exercise. He states, "Just save your breath. Why should I bother about all that? I'd be better off dead than living like I am now, anyway!"

Learning Objectives

After completing the chapter, you will be able to accomplish the following:

1. Describe the historical background of nursing, definitions of nursing, and the status of nursing as a profession and as a discipline.
2. Explain the aims of nursing as they interrelate to facilitate maximal health and quality of life for patients.
3. Explain how nursing qualifies as a profession.
4. Describe the various levels of educational preparation in nursing.
5. Discuss the effects on nursing practice of nursing organizations, standards of nursing practice, nurse practice acts, and the nursing process.
6. Identify current trends in nursing.
7. Discuss the importance of self-care in relation to the demands of the nursing profession.

Key Terms

burnout
compassion fatigue
health
licensure
mindfulness
nurse practice act
nursing
nursing process
profession
reciprocity
secondary traumatic stress
standards

What is nursing? Consider the following examples of who nurses are and what they do:

- Delton Nix, RN, graduated from an associate degree nursing program 3 years ago. He is now working full-time as a staff nurse in a hospital medical unit while attending school part-time toward a baccalaureate degree in nursing; his goal is to become a nurse anesthetist.
- Jeiping Wu, RN, MSN, FNP, specializes as an advanced practice family nurse practitioner. She has an independent practice in a rural primary health clinic.
- Samuel Cohen, LPN, decided to follow his life's dream to become a nurse after 20 years as a postal worker. After examining all his options and goals, he completed a practical nursing program and is now a member of an emergency ambulance crew in a large city.
- Amy Orlando, RN, BSN, graduated 2 years ago and recently began a new job in an urban community health service.
- Ed Neill, RN, DNP, is the Chief Nursing Informatics Officer at a large health system.
- Roxanne McDaniel, RN, PhD, with a doctorate in nursing, teaches and conducts research on moral distress at a large university.

These examples show how difficult it is to describe nursing simply. If everyone in your class were asked to complete the sentence, "Nursing is…," there would be many different responses, because each person would answer based on his or her own personal experience and knowledge of nursing. As you progress toward graduation and as you practice nursing after graduation, your own definition will reflect changes as you learn about and experience nursing.

Nursing is a profession focused on assisting people, families, and communities to attain, recover, and maintain optimum health and function from birth to old age. Nurses act as a bridge between an often extremely vulnerable public and the health care resources that can literally make the difference between life and death, health and disease or disability, and well-being and discomfort. Yale School of Nursing faculty member and philosopher Mark Lazenby, PhD, APRN, FAAN, describes nursing as a "profoundly radical profession that calls society to equality and justice, to trustworthiness, and to openness. The profession is also radically political: it imagines a world in which the conditions necessary for health are enjoyed by all people" (Lazenby, 2017). According to an annual Gallup survey, the public has rated nursing as the most honest and ethical profession in America for 14 years straight. The only exception was 2001 when firefighters following the attacks on September 11 were named the most honest and ethical.

Nursing care involves a wide range of activities, from carrying out complicated technical procedures to something as seemingly simple as holding a hand. Nursing is a blend of science and art. The science of nursing is the knowledge base for the care that is given, and the art of nursing is the skilled application of that knowledge to help others achieve maximum health and quality of life. Today, 3.6 million nurses in the United States practice in over 200 different specialties, such as anesthesia, mental health, school nursing, cardiac care, pediatrics, surgery, oncology, obstetrics, and geriatrics. They are caregivers, administrators, innovators, and policy makers. Nursing is the largest of the health professions and the foundation of the nation's health care workforce (www.nursingworld.org).

This chapter introduces you to nursing, including a brief history of nursing from its beginnings to the present, and provides the definitions and aims of nursing. The educational preparation for professional nursing, professional nursing organizations, and guidelines for professional nursing practice are discussed to help you better understand what nursing as a profession is and how it is organized. (For an example demonstrating the importance of licensure to nursing practice and responsibilities, see the Reflective Practice box on the next page.) Because nursing is a part of an ever-changing society, current trends in nursing also are discussed.

HISTORICAL PERSPECTIVES ON NURSING

Caregivers for the ill and injured have always been a part of history. The roles, settings, and responsibilities, however, have changed over time, as is summarized in the following section.

QSEN Reflective Practice: Cultivating QSEN Competencies

CHALLENGE TO ETHICAL AND LEGAL SKILLS

During nursing school, I was working as a nurse's aide on a busy oncology unit. It was here that I met Roberto Pecorini, a 38-year-old man diagnosed with metastatic colon cancer. He had undergone radiation treatments and chemotherapy, and was extremely weak and malnourished. He was receiving numerous intravenous fluids via a central venous catheter. In addition, he had developed two pressure injuries on his sacrum, each approximately 1½ inches in diameter, that required wound care. He also had a colostomy that he could not care for independently.

Although the staff was very helpful, the orientation I received to the unit was brief because they were very short staffed. During one occasion, shortly after I had been oriented to the floor, I was working a night shift and was the only nurse's aide on the unit. The nurses I was working with asked me to care for Mr. Pecorini, including performing several tasks and skills with which I was unfamiliar. In addition to my lack of familiarity with skills such as changing central line dressings and performing blood draws and wound care, I was not licensed to perform these tasks. I felt uncomfortable performing these skills on my own. However, the nurses were extremely busy and I wanted to help them as much as possible. If I performed these skills on my own, I could be putting the patient at risk. Moreover, I could be threatening the license of the nurses.

Thinking Outside the Box: Possible Courses of Action

- Perform the tasks requested despite the fact that I had little experience with them.
- Inform the nurses that I did not feel comfortable completing these skills on my own and ask that they assign me other tasks within my scope of duty.
- Ask the nurses to be present when I performed these tasks so that they could observe my skills and intervene if necessary.
- Refrain from performing these tasks and alert the nurse manager the following day that I was assigned to tasks outside my scope of duty.

Evaluating a Good Outcome: How Do I Define Success?

- The patient received safe, comprehensive care without being placed at risk.
- I performed tasks and skills within my scope of practice.
- The nurses understood my job duties and properly delegated the necessary tasks.
- The nurses' licensure was not put in jeopardy.
- I felt comfortable and competent in my job performance.

Personal Learning: Here's to the Future!

Since I felt uncomfortable in performing the duties assigned to me by the nurses, I confronted them and told them that I had recently been oriented to the floor and did not have experience with these skills. Although somewhat surprised that I didn't have the experience, they understood and did not want me to do anything I felt uncomfortable with. The nurses were used to having an LPN as a night aide, and the LPN's scope of practice was broader than mine. Throughout the night, I observed the nurses performing the skills and tasks, with the nurses walking me through several of the skills that I was allowed to perform but in which I did not feel proficient. In the morning, we spoke with the nurse manager, who realized the need for clarifying the job duties of the nurse's aides and the appropriate delegation of tasks. I feel that I made the right decision in speaking to the nurses because patient safety could have been compromised by my inexperience. The nurses' licensure also could have been put at risk. As a result of our conversation with the nurse manager, the orientation for new nurse's aides was reorganized, helping greatly to define the scope of duties for the aides.

Colleen Kilcullen, Georgetown University

QSEN SELF-REFLECTION ON QUALITY AND SAFETY COMPETENCIES DEVELOPING KNOWLEDGE, SKILLS, AND ATTITUDES FOR CONTINUOUS IMPROVEMENT

How do you think you would respond in a similar situation? Why? What does this tell you about yourself and about the adequacy of your skills for professional practice? How was the nursing student's action ethical? Legal? Please explain. What other *knowledge, attitudes,* and *skills* do you need to develop to continuously improve the quality and safety of care for patients like Mr. Pecorini?

Patient-Centered Care: What role did the different members of the nursing team play in creating a partnership with Mr. Pecorini to best coordinate his care? What special talents do you bring to creating this partnership?

Teamwork and Collaboration/Quality Improvement: What communication skills do you need to improve to ensure that you function as a competent, caring, and responsible member of the patient-care team and ensure that you obtain assistance when needed? How would you have responded if nursing leadership did not address your concerns? What special talents do you bring to promoting a well-functioning interdisciplinary team?

Safety/Evidence-Based Practice: What priority did Mr. Pecorini's care team accord to his health, well-being, and safety? What evidence in the nursing literature supports adhering to the scope of practice and roles?

Informatics: Can you identify the essential information that must be available in Mr. Pecorini's electronic record to support safe patient care and coordination of care? Can you think of other ways to respond to or approach the situation?

Development of Nursing from Early Civilizations to the 16th Century

Most early civilizations believed that illness had supernatural causes. The theory of animism attempted to explain the cause of mysterious changes in bodily functions. This theory was based on the belief that everything in nature was alive with invisible forces and endowed with power. Good spirits brought health; evil spirits brought sickness and death. In providing treatment, the roles of the health care provider and the nurse were separate and distinct. The health care provider was the medicine man who treated disease by chanting, inspiring fear, or opening the skull to release evil spirits (Dolan, Fitzpatrick, & Herrmann, 1983). The nurse usually was the mother who cared for her family during sickness by providing physical care and herbal remedies. This nurturing and caring role of the nurse has continued to the present.

As ancient Greek civilizations grew, temples became the centers of medical care because of the belief that illness was caused by sin and the gods' displeasure (*disease* literally means "dis-ease"). During the same period, the ancient Hebrews developed rules through the Ten Commandments and the Mosaic Health Code for ethical human relationships, mental health, and disease control. Nurses cared for sick people in the home and the community and also practiced as nurse–midwives (Dolan et al., 1983).

In the early Christian period, nursing began to have a formal and more clearly defined role in society. Led by the idea that love and caring for others were important, women called "deaconesses" made the first organized visits to sick people, and members of male religious orders gave nursing care and buried the dead. Both male and female nursing orders were founded during the Crusades (11th to 13th centuries). Hospitals were built for the enormous number of pilgrims needing health care, and nursing became a respected vocation. Although the early Middle Ages ended in chaos, nursing had developed purpose, direction, and leadership.

At the beginning of the 16th century, many Western societies shifted from a religious orientation to an emphasis on warfare, exploration, and expansion of knowledge. Many monasteries and convents closed, leading to a tremendous shortage of people to care for the sick. To meet this need, women who were convicted of crimes were recruited into nursing in lieu of serving jail sentences. In addition to having a poor reputation, these nurses received low pay and worked long hours in unfavorable conditions.

Florence Nightingale and the Birth of Modern Nursing

From the middle of the 19th century to the 20th century, social reforms changed the roles of nurses and of women in general. It was during this time that nursing as we now know it began, based on many of the beliefs of Florence Nightingale. Born in 1820 to a wealthy family, she grew up in England, was well-educated, and traveled extensively. Despite strong opposition from her family, Nightingale began training as a nurse at the age of 31. The outbreak of the Crimean War and a request by the British to organize nursing care for a military hospital in Turkey gave Nightingale an opportunity for achievement (Kalisch & Kalisch, 2004). As she successfully overcame enormous difficulties, Nightingale challenged prejudices against women and elevated the status of all nurses. After the war, she returned to England, where she established the first training school for nurses and wrote books about health care and nursing education. Florence Nightingale's contributions include:

- Identifying the personal needs of the patient and the role of the nurse in meeting those needs
- Establishing standards for hospital management
- Establishing a respected occupation for women
- Establishing nursing education
- Recognizing the two components of nursing: health and illness
- Believing that nursing is separate and distinct from medicine
- Recognizing that nutrition is important to health
- Instituting occupational and recreational therapy for sick people
- Stressing the need for continuing education for nurses
- Maintaining accurate records, recognized as the beginnings of nursing research

Florence Nightingale, other historically important nurses, and images of early nursing can be seen in Figure 1-1 (on page 8). People important to the development of nursing are listed in Table 1-1 (on page 9). A historical overview of the foundational documents for nursing is presented in Box 1-1 on page 10.

Development of Nursing from the 19th to 21st Centuries

Both the work of Florence Nightingale and the care provided for battle casualties during the Civil War focused attention on the need for educated nurses in the United States. Schools of nursing, founded in connection with hospitals, were established on the beliefs of Nightingale, but the training they provided was based more on apprenticeship than on educational principles. Hospitals saw an economic advantage in having their own schools, and most hospital schools were organized to provide more easily controlled and less expensive staff for the hospital. This resulted in a lack of clear guidelines separating nursing service and nursing education. As students and as graduates, female nurses were under the control of male hospital administrators and health care providers. The lack of educational standards, the male dominance in health care, and the pervading Victorian belief that women were subordinate to men combined to contribute to several decades of slow progress toward professionalism in nursing (Kalisch & Kalisch, 2004).

World War II had an enormous effect on nursing. For the first time, as large numbers of women worked outside the home, they became more independent and assertive. These changes in women and in society led to an increased emphasis on education. The war itself had created a need for more

FIGURE 1-1. Images of nurses spanning more than 100 years of service. (Courtesy of the Center for the Study of the History of Nursing, University of Pennsylvania.)

nurses and resulted in a knowledge explosion in medicine and technology, which broadened the role of nurses. After World War II, efforts were directed at upgrading nursing education. Schools of nursing were based on educational objectives and were increasingly developed in university and college settings, leading to degrees in nursing for men, women, and minorities.

Nursing achievement has broadened in all areas, including practice in a wide variety of health care settings, the development of a specific body of knowledge, the conduct and publication of nursing research, and the recognition of the role of nursing in promoting access to affordable quality health care. Increased emphasis on nursing knowledge as the foundation for evidence-based practice (EBP) has led to the growth of nursing as a professional discipline.

To learn more about the history of nursing, be sure to visit the Penn Nursing Science Nursing, History, and Health Care website (https://www.nursing.upenn.edu/nhhc).

DEFINITIONS OF NURSING

The word *nurse* originated from the Latin word *nutrix,* meaning "to nourish." Most definitions of **nursing** describe the nurse as a person who nourishes, fosters, and protects and who is prepared to take care of sick, injured, aged, and dying people. With the expanding roles and functions of the nurse in today's society, however, any one definition may be too limited.

The International Council of Nurses (ICN) captures much of what nursing means in its definition:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Table 1-1 People Important to the Early Development of Nursing in North America

PERSON	CONTRIBUTION
19th Century	
Florence Nightingale	Defined nursing as both an art and a science, differentiated nursing from medicine, created freestanding nursing education; published books about nursing and health care; is regarded as the founder of modern nursing (see text for further information)
Clara Barton	Volunteered to care for wounds and feed Union soldiers during the Civil War; served as the supervisor of nurses for the Army of the James, organizing hospitals and nurses; established the Red Cross in the United States in 1882
Dorothea Dix	Served as superintendent of the Female Nurses of the Army during the Civil War; was given the authority and the responsibility for recruiting and equipping a corps of army nurses; was a pioneering crusader for the reform of the treatment of the mentally ill
Mary Ann Bickerdyke	Organized diet kitchens, laundries, and an ambulance service, and supervised nursing staff during the Civil War
Louise Schuyler	A nurse during the Civil War; returned to New York and organized the New York Charities Aid Association to improve care of the sick in Bellevue Hospital; recommended standards for nursing education
Linda Richards	Graduated in 1873 from the New England Hospital for Women and Children in Boston, Massachusetts, as the first trained nurse in the United States; became the night superintendent of Bellevue Hospital in 1874 and began the practice of keeping records and writing orders
Jane Addams	Provided social services within a neighborhood setting; a leader for women's rights; recipient of the 1931 Nobel Peace prize
Lillian Wald	Established a neighborhood nursing service for the sick poor of the Lower East Side in New York City; the founder of public health nursing
Mary Elizabeth Mahoney	Graduated from the New England Hospital for Women and Children in 1879 as America's first African American nurse
Harriet Tubman	A nurse and an abolitionist; active in the underground railroad movement before joining the Union Army during the Civil War
Nora Gertrude Livingston	Established a training program for nurses at the Montreal General Hospital (the first 3-year program in North America)
Mary Agnes Snively	Director of the nursing school at Toronto General Hospital and one of the founders of the Canadian Nurses Association
Sojourner Truth	Provided nursing care to soldiers during the Civil War and worked for the women's movement
Isabel Hampton Robb	A leader in nursing and nursing education; organized the nursing school at Johns Hopkins Hospital; initiated policies that included limiting the number of hours in a day's work and wrote a textbook to help student learning; the first president of the Nurses Associated Alumnae of the United States and Canada (which later became the American Nurses Association)
20th Century	
Mary Adelaide Nutting	Became the first professor of nursing in the world as a faculty member of Teachers' College, Columbia University; with Lavinia Dock, published the four-volume *History of Nursing*
Elizabeth Smellie	A member of the original Victorian Order of Nurses for Canada (a group that provided public health nursing); organized the Canadian Women's Army Corps during World War II
Lavinia Dock	A nursing leader and women's rights activist; instrumental in the Constitutional amendment giving women the right to vote
Mary Breckenridge	Established the Frontier Nursing Service and one of the first midwifery schools in the United States
Margaret Sanger	Opened the first birth control clinic in the United States; founder of Planned Parenthood Federation

Box 1-1 Timeline of the Development of Foundational Nursing Documents

1859	Florence Nightingale publishes Notes on Nursing: What It Is and What It Is Not.
1896	The Nurses' Associated Alumnae of the United States and Canada is founded. Later to become the American Nurses Association (ANA), its first purpose is to establish and maintain a code of ethics.
1940	A "Tentative Code" is published in the *American Journal of Nursing,* although never formally adopted.
1950	*Code for Professional Nurses,* in the form of 17 provisions that are a substantive revision of the "Tentative Code" of 1940, is unanimously accepted by the ANA House of Delegates.
1952	*Nursing Research* publishes its premiere issue.
1956	*Code for Professional Nurses* is amended.
1960	*Code for Professional Nurses* is revised.
1968	*Code for Professional Nurses* is substantively revised, condensing the 17 provisions of the code into 10 provisions.
1973	ANA publishes its first *Standards of Nursing Practice*.
1976	*Code for Nurses With Interpretive Statements,* a modification of the provision and interpretive statements, is published as 11 provisions.
1980	ANA publishes *Nursing: A Social Policy Statement*.
1985	The National Institutes of Health organizes the Center for Nursing Research.
	ANA publishes *Titling for Licensure*.
	Code for Nurses With Interpretive Statements retains the provisions of the 1976 version and includes revised interpretive statements.
	The ANA House of Delegates forms a task force to formally document the scope of practice for nursing.
1987	ANA publishes *The Scope of Nursing Practice*.
1990	The ANA House of Delegates forms a task force to revise the 1973 *Standards of Nursing Practice*.
1991	ANA publishes *Standards of Clinical Nursing Practice*.
1995	ANA publishes *Nursing's Social Policy Statement*.
	The Congress of Nursing Practice directs the Committee on Nursing Practice Standards and Guidelines to establish a process for periodic review and revision of nursing standards.
1996	ANA publishes *Scope and Standards of Advanced Practice Registered Nursing*.
1998	ANA publishes *Standards of Clinical Nursing Practice*, 2nd edition (also known as *Clinical Standards*).
2001	*Code of Ethics With Interpretive Statements* is accepted by the ANA House of Delegates.
	ANA publishes *Bill of Rights for Registered Nurses*.
2002	ANA publishes *Nursing's Agenda for the Future: A Call to the Nation*.
2003	ANA publishes *Nursing's Social Policy Statement*, 2nd edition.
2004	ANA publishes *Nursing: Scope and Standards of Practice*.
2008	*APRN Consensus Model* is published by the APRN Consensus Work Group and APRN Joint Dialogue Group.
	ANA publishes *Professional Role Competence Position Statement*.
	ANA publishes *Specialization and Credentialing in Nursing Revisited: Understanding the Issues, Advancing the Profession*.
2010	ANA publishes *Nursing's Social Policy Statement: The Essence of the Profession*
	ANA publishes *Nursing: Scope and Standards of Practice*, 2nd edition.
2015	ANA publishes *Code of Ethics for Nurses with Interpretive Statements.*
	ANA publishes *Nursing: Scope and Standards of Practice*, 3rd edition.

Source: From American Nurses Association (ANA). (2015). *Nursing: Scope and standards of practice* (3rd ed.). Silver Spring, MD: Author.

The American Nurses Association (ANA) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations" (ANA, 2015c). In addition to a definition of nursing, the ANA describes the social context of nursing, the knowledge base for nursing practice, the scope of nursing practice, standards of professional nursing practice, and the regulation of professional nursing in its *Nursing's Social Policy Statement* (2010). Within today's definitions of nursing we find all the elements of professional nursing. Nurses focus on human experiences and responses to birth, health, illness, and death

Table 1-2 Nursing Roles in All Settings

ROLE	FUNCTION
Caregiver	The provision of care to patients that combines both the art and the science of nursing in meeting physical, emotional, intellectual, sociocultural, and spiritual needs. As a caregiver, the nurse integrates the roles of communicator, teacher, counselor, leader, researcher, advocate, and collaborator to promote wellness through activities that prevent illness, restore health, and facilitate coping with disability or death. The role of caregiver is the primary role of the nurse.
Communicator	The use of effective interpersonal and therapeutic communication skills to establish and maintain helping relationships with patients of all ages in a wide variety of health care settings
Teacher/educator	The use of communication skills to assess, implement, and evaluate individualized teaching plans to meet learning needs of patients and their families
Counselor	The use of therapeutic interpersonal communication skills to provide information, make appropriate referrals, and facilitate the patient's problem-solving and decision-making skills
Leader	The assertive, self-confident practice of nursing when providing care, effecting change, and functioning with groups
Researcher	The participation in or conduct of research to increase knowledge in nursing and improve patient care
Advocate	The protection of human or legal rights and the securing of care for all patients based on the belief that patients have the right to make informed decisions about their own health and lives
Collaborator	The effective use of skills in organization, communication, and advocacy to facilitate the functions of all members of the health care team as they provide patient care

within the context of people, families, groups, and communities. The knowledge base for nursing practice includes diagnosis, interventions, and evaluation of outcomes from an established care plan. In addition, the nurse integrates objective data with knowledge gained from an understanding of the patient's or group's subjective experience, applies scientific knowledge in the nursing process, and provides a caring relationship that facilitates health and healing.

The central focus in all definitions of nursing is the patient (the person receiving care), which includes the physical, emotional, social, and spiritual dimensions of that person. Nursing is no longer considered to be concerned primarily with illness care. Nursing's concepts and definitions have expanded to include the prevention of illness and the promotion and maintenance of health for people, families, groups, and communities.

NURSING'S AIMS AND COMPETENCIES

Four broad aims of nursing practice can be identified in the definitions of nursing:

1. To promote health
2. To prevent illness
3. To restore health
4. To facilitate coping with disability or death

To meet these aims, the nurse uses four blended competencies: cognitive, technical, interpersonal, and ethical/legal. More recently these competencies have been further specified as the Quality and Safety Education for Nurses (QSEN) project competencies: patient-centered care, teamwork and collaboration, quality improvement, safety, EBP, and informatics (Sherwood & Barnsteiner, 2012). These competencies are described in Chapter 13. The Reflective Practice Boxes that begin each chapter of this book offer examples of practical challenges to these competencies that actual nursing students have encountered.

The primary role of the nurse as caregiver is given shape and substance by the interrelated roles of communicator, teacher, counselor, leader, researcher, advocate, and collaborator. These roles are described in Table 1-2 and throughout the text. The nurse carries out these roles in many different settings, with care increasingly provided in the home and in the community. Examples of settings for care are fully described in Unit II.

Recall ***Roberto Pecorini***, the 38-year-old patient with metastatic cancer. When providing care for Mr. Pecorini, the nurse assumes the role of competent, caring, and responsible caregiver, creates a respectful partnership while identifying best practices, maintains the patient's safety throughout, and appropriately educates the patient and advocates for the patient's rights.

Promoting Health

Health is a state of optimal functioning or well-being. As defined by the World Health Organization (WHO), a person's health includes physical, social, and mental components, and is not merely the absence of disease or infirmity. Health is often a subjective state: people medically diagnosed with an illness may still consider themselves healthy. Wellness, a term that is often associated with health, is an active state of being healthy by living a lifestyle that promotes good physical, mental, emotional, and spiritual health. Models of health and wellness are described in Chapter 3.

Health is an essential part of each of the other aims of nursing. Nurses promote health by identifying, analyzing,

and maximizing each patient's own individual strengths as components of preventing illness, restoring health, and facilitating coping with disability or death.

When teaching ***Mr. Basshir***, the patient described at the beginning of the chapter with risk factors for heart disease, the nurse would focus the teaching plan to rely on the patient's strengths. Although his statements reflect a reluctance to learn and change, emphasizing the patient's strengths would help the patient feel more in control of his health, and thus, hopefully, spur him to make the necessary changes.

Health promotion is motivated by the desire to increase a person's well-being and health potential. A person's level of health is affected by many different interrelated factors that either promote health or increase the risk for illness. These factors include genetic inheritance, cognitive abilities, educational level, race and ethnicity, culture, age and biological sex, developmental level, lifestyle, environment, and socioeconomic status. A level of health or wellness is also strongly influenced by what is termed "health literacy." Health literacy, defined by the U.S. Department of Health and Human Services in the document *Healthy People 2020,* is the ability of people to obtain, process, and understand the basic information needed to make appropriate decisions about health. Examples of ways that nurses can promote health literacy are included throughout this text.

Healthy People 2020 also establishes health promotion guidelines for the nation as a whole. The guidelines are focused on meeting four overarching goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

The guidelines also contain 12 Leading Health Indicators, which are used to measure the health of the nation over a 10-year period. The Healthy People 2020 Leading Health Indicators listed in Box 1-2 reflect the major health concerns in the United States at the beginning of the 21st century. They were selected on the basis of their ability to motivate action, availability to measure progress, and importance as public health issues.

Patient-centered health promotion is the framework for nursing activities. The nurse considers the patient's self-awareness, health awareness, and use of resources while providing care. Through knowledge and skill, the nurse:

- Facilitates patients' decisions about lifestyle that enhance the quality of life and encourage acceptance of responsibility for their own health
- Increases patients' health awareness by assisting in the understanding that health is more than just not being ill, and by teaching that certain behaviors and factors can contribute to or diminish health
- Teaches self-care activities to maximize achievement of goals that are realistic and attainable
- Serves as a role model
- Encourages health promotion by providing information and referrals

Box 1-2 Healthy People 2020: Leading Health Indicators

Access to health services
Clinical preventive services
Environmental quality
Injury and violence
Maternal, infant, and child health
Mental health
Nutrition, physical activity and obesity
Oral health
Reproductive and sexual health
Social determinants
Substance abuse
Tobacco

Source: From U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020.* Washington, DC. Retrieved http://www.healthypeople.gov/2020.

Recall ***Michelle Fine***, the young mother with a new baby who calls the nursery for help with breastfeeding. Making a referral for home care follow-up before Michelle's discharge from the hospital would have been an appropriate intervention to offer support, guidance, and additional teaching.

Preventing Illness

The U.S. Department of Health and Human Service's Office of Disease Prevention and Health Promotion leads efforts to improve the health of all Americans. The objectives of disease prevention activities are to reduce the risk of illness, to promote good health habits, and to maintain optimal functioning. Nurses prevent illness primarily by teaching and by personal example. Examples include:

- Educational programs in areas such as prenatal care for pregnant women, smoking-cessation programs, and stress-reduction seminars
- Community programs and resources that encourage healthy lifestyles, such as aerobic exercise classes, "swimnastics," and physical fitness programs
- Literature, television, radio, or Internet information on a healthy diet, regular exercise, and the importance of good health habits

- Health assessments in institutions, clinics, and community settings that identify areas of strength and risks for illness

Take time to check out Health.gov, the Office of Disease Prevention and Health Promotion's website, at https://health.gov, to familiarize yourself with many helpful resources that you can use for yourself, your family, and your patients.

Think back to ***Ahmad Basshir***, the 62-year-old man at risk for heart disease who was described at the beginning of the chapter. By addressing Mr. Basshir's resistance to change and teaching him the lifestyle modifications necessary to reduce his risk for developing heart disease, the nurse contributes to illness prevention by promoting healthier behavior.

Restoring Health

Activities to restore health encompass those traditionally considered to be the nurse's responsibility. These focus on the person with an illness, and range from early detection of a disease to rehabilitation and teaching during recovery. Such activities include:

- Performing assessments that detect an illness (e.g., taking blood pressure, measuring blood sugars)
- Referring questions and abnormal findings to other health care providers as appropriate
- Providing direct care of the person who is ill by such measures as giving physical care, administering medications, and carrying out procedures and treatments
- Collaborating with other health care providers in providing care
- Planning, teaching, and carrying out rehabilitation for illnesses such as heart attacks, arthritis, and strokes
- Working in mental health and chemical-dependency programs

Facilitating Coping With Disability and Death

Although the major goals of health care are promoting, maintaining, and restoring health, these goals cannot always be met. Nurses also facilitate patient and family coping with altered function, life crisis, and death. Altered function decreases a person's ability to carry out activities of daily living (ADLs) and expected roles. Nurses facilitate an optimal level of function through maximizing the person's strengths and potentials, through teaching, and through referral to community support systems. Nurses provide care to both patients and families at the end of life, and they do so in hospitals, long-term care facilities, hospices, and homes. Nurses are active in hospice programs, which assist patients and their families in multiple settings in preparing for death and in living as comfortably as possible until death occurs.

NURSING AS A PROFESSIONAL DISCIPLINE

As definitions of nursing have expanded to describe more clearly the roles and actions of nurses, increased attention has been given to nursing as a professional discipline. Nursing uses existing and new knowledge to solve problems creatively and meet human needs within ever-changing boundaries. Nursing is recognized as a **profession** based on the following defining criteria:

- Well-defined body of specific and unique knowledge
- Strong service orientation
- Recognized authority by a professional group
- Code of ethics
- Professional organization that sets standards
- Ongoing research
- Autonomy and self-regulation

Nursing involves specialized skills and application of knowledge based on an education that has both theoretical and clinical practice components. Nursing is guided by standards set by professional organizations and an established code of ethics. Nursing focuses on human responses to actual or potential health problems and is increasingly focused on wellness, an area of caring that encompasses nursing's unique knowledge and abilities. Nursing is increasingly recognized as scholarly, with academic qualifications, research, and publications specific to the profession that are widely accepted and respected. In addition, nursing interventions are focused on EBP, which is practice based on research and not intuition.

Nursing has evolved through history from a technical service to a person-centered process that maximizes potential in all human dimensions. This has been an active development process, using lessons from the past to gain knowledge for practice in the present and in the future.

EDUCATIONAL PREPARATION FOR NURSING PRACTICE

Educational preparation for nursing practice involves several different types of programs that lead to **licensure**, or the legal authority to practice as a nursing professional. Students may choose to enter a practical nursing program and become a licensed practical nurse (LPN) or they may enter a diploma, an associate degree, or a baccalaureate program to be licensed as a registered nurse (RN). State laws in the United States recognize both the LPN and the RN as credentials to practice nursing. Increasingly, various levels of nursing education are providing programs for educational advancement. For example, the LPN can complete an associate degree and become an RN, and the RN prepared at the diploma or associate degree level can attain a bachelor of science in nursing (BSN) degree. There are also programs that provide RN-to-master's degrees, as well as BSN-to-DNP or PhD, and master's degree-to-DNP or PhD. Graduate programs in nursing provide master's and doctoral degrees.

Educational preparation for the nurse has become a major issue in nursing; the multiple methods of preparation are

confusing to employers, consumers of health care services, and nurses themselves. Nursing organizations are working hard to answer questions such as "What is technical nursing?" and "What is professional nursing?" as well as "Should graduates of different programs take the same licensing examination and have the same title?" These questions are likely to be resolved during your nursing career. The American Association of Colleges of Nursing (AACN) believes that baccalaureate education should be the minimum level required for entry into professional nursing practice in today's complex health care environment. The AACN's *Essentials of Baccalaureate Education for Professional Nursing Practice* notes that "nursing has been identified as having the potential for making the biggest impact on a transformation of health care delivery to a safer, higher quality, and more cost-effective system" (AACN, 2008). The *Essentials* document describes the outcomes expected of graduates of baccalaureate programs and emphasizes concepts such as patient-centered care, interprofessional teams, EBP, quality improvement, patient safety, informatics, clinical reasoning/critical thinking, genetics and genomics, cultural sensitivity, professionalism, and practice across the lifespan in an ever-changing and complex health care environment.

The following sections discuss current education for LPNs and RNs, as well as graduate nursing education, continuing education for nurses, and in-service education.

Practical and Vocational Nursing Education

Practical (also labeled vocational) nursing programs were established to teach graduates to give bedside nursing care to patients. Schools for practical nursing programs are located in varied settings, such as high schools, technical or vocational schools, community colleges, and independent facilities. Most programs are 1 year in length, divided into one third classroom hours and two thirds clinical laboratory hours. On completion of the program, graduates can take the National Council Licensure Examination–Practical Nurse (NCLEX–PN) for licensure as an LPN. LPNs work under the direction of a health care provider or RN to give direct care to patients, focusing on meeting health care needs in hospitals, long-term care facilities, and home health facilities.

Registered Nursing Education

Three types of educational programs traditionally lead to licensure as an RN: (1) diploma, (2) associate degree, and (3) baccalaureate programs. Graduates of all three programs take the NCLEX–RN examination. Although it is a national examination, it is administered by—and the nurse is licensed in—the state in which the examination is taken and passed. *It is illegal to practice nursing unless one has a license verifying completion of an accredited (by state) program in nursing and has passed the licensing examination.* Nurses gain legal rights to practice nursing in another state by applying to that state's board of nursing and receiving reciprocal licensure.

The U.S. Department of Labor, Bureau of Labor Statistics (BLS), annually collects and publishes data on employment and earnings for more than 800 occupations. As of June 2017, the BLS estimates that there were 2,751,000 RNs employed in various settings in the United States. See Figure 1-2 for a breakdown of where nurses are employed.

Diploma in Nursing

Many nurses practicing in the United States today received their basic nursing education in a 3-year, hospital-based diploma school of nursing. The first schools of nursing established to educate nurses were diploma programs; until the 1960s, they were the major source of graduates. In recent years, the number of diploma programs has decreased greatly.

Graduates of diploma programs have a sound foundation in the biologic and social sciences, with a strong emphasis on clinical experience in direct patient care. Graduates work in acute, long-term, and ambulatory health care facilities.

Associate Degree in Nursing

Most associate degree in nursing (ADN) programs are offered by community or junior colleges. These 2-year educational programs attract more men, more minorities, and more nontraditional students than do the other types of programs. Associate degree education prepares nurses to give care to patients in various settings, including hospitals, long-term care facilities, and home health care and other community settings. Graduates are technically skilled and well prepared to carry out nursing roles and functions. As defined by the National League for Nursing (NLN), competencies of the ADN on entry into practice encompass the roles of provider of care, manager of care, and member of the discipline of nursing.

Baccalaureate in Nursing

The first baccalaureate nursing programs were established in the United States in the early 1900s. The number of programs and the number of enrolling students, however, did not increase markedly until the 1960s. Most graduates receive a BSN.

Recommendations by national nursing organizations that the entry level for professional practice be at the baccalaureate level have resulted in increased numbers of these programs. Although BSN nurses practice in a wide variety of settings, the 4-year degree is required for many administrative, managerial, and community health positions.

In BSN programs, the major in nursing is built on a general education base, with concentration on nursing at the upper level. Students acquire knowledge of theory and practice related to nursing and other disciplines, provide nursing care to individuals and groups, work with members of the health care team, use research to improve practice, and have a foundation for graduate study. Nurses who graduate from a diploma or associate degree program and wish to complete requirements for a BSN may choose to enroll in an on-campus, online, or external degree RN-to-BSN program. In addition, there are accelerated BSN programs for people who already have a degree in another area.

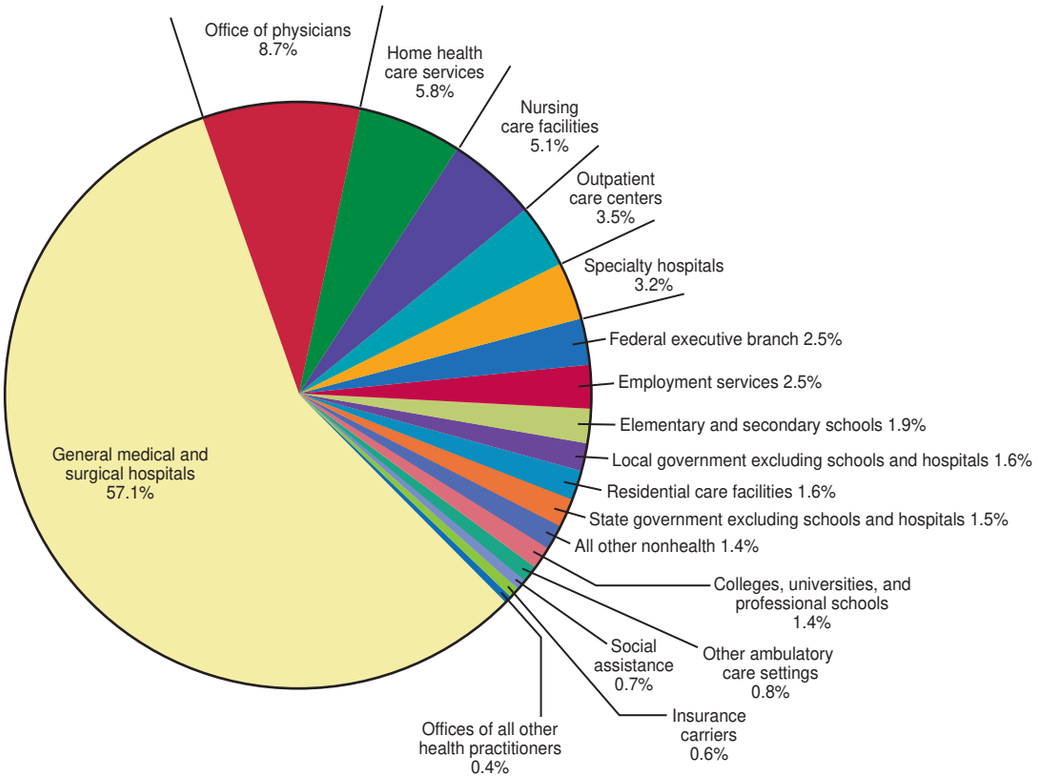

FIGURE 1-2. Employment settings of registered nurses in the United States, as of May 2011. (McMenamin, P. [2012]. Compensation and employment of registered nurses: Part 1. Registered nurse jobs by industry. Retrieved http://www.ananursespace.org/browse/blogs/blogviewer?BlogKey=e36976cc-ade3-480f-8fe0-ccbebdaf5506&ssopc=1. Reprinted with permission from Peter McMenamin, PhD., Senior Policy Fellow-ANA Health Economist, American Nursing Association.)

Emerging Entry Points

Beyond the traditional entry routes to a career as an RN, a number of additional pathways are emerging and proving effective at attracting new audiences into the nursing profession. These alternative routes include entry-level master's programs, accelerated programs for graduates of nonnursing disciplines, community college–based baccalaureate programs, and RN completion programs for LPNs and other allied health providers.

Graduate Education in Nursing

The two levels of graduate education in nursing are the master's and doctoral degrees. A master's degree prepares advanced practice nurses (APRNs) to function in educational settings, in managerial roles, as clinical specialists, and in various advanced practice areas, such as nurse–midwives and nurse practitioners (Table 1-3 on page 16). Many master's graduates gain national certification in their specialty area—for example, as family nurse practitioners (FNPs) or nurse midwives. The clinical nurse leader (CNL) is an emerging nursing role developed by the American Association of Colleges in Nursing (AACN, 2012) in collaboration with an array of leaders from the practice environment. The CNL, an advanced clinician with education at the master's degree level, puts EBP in to action to ensure that patients benefit from the latest innovations in care delivery. The CNL role is not one of administration or management. Nurses with doctoral degrees meet requirements for academic advancement and organizational management. They also are prepared to carry out research necessary to advance nursing theory and practice.

The newest graduate nursing degree is the doctor of nursing practice (DNP). In 2004, the AACN, in consultation with a variety of stakeholder groups, called for moving the current level of preparation necessary for advanced practice from the master's degree to the DNP by the year 2015. According to their position statement, the DNP is designed for nurses seeking a terminal degree in nursing practice and offers an alternative approach to research-focused doctoral programs. DNP-prepared nurses are well equipped to fully implement the science developed by nurse researchers prepared in PhD, DNSc, and other research-focused doctorates. For more information on the AACN's position, refer to the AACN Fact Sheet on the DNP, available at http://www.aacn.nche.edu/media-relations/fact-sheets/dnp. It is a good idea as you begin clinical practice to talk with as many nurses with graduate degrees as you can to see if one of their roles might become your next goal.

Continuing Education

The ANA defines continuing education as those professional development experiences designed to enrich the nurse's contribution to health. Colleges, hospitals, voluntary

Table 1-3 Expanded Educational and Career Roles of Nurses

TITLE	DESCRIPTION
Clinical nurse specialist Examples: enterostomal therapist, geriatrics, infection control, medical–surgical, maternal–child, oncology, quality assurance, nursing process	A nurse with an advanced degree, education, or experience who is considered to be an expert in a specialized area of nursing; carries out direct patient care; consultation; teaching of patients, families, and staff; and research
Nurse practitioner	A nurse with an advanced degree, certified for a special area or age of patient care; works in a variety of health care settings or in independent practice to make health assessments and deliver primary care
Nurse anesthetist	A nurse who completes a course of study in an anesthesia school; carries out preoperative visits and assessments; administers and monitors anesthesia during surgery; and evaluates postoperative status of patients
Nurse–midwife	A nurse who completes a program in midwifery; provides prenatal and postnatal care; and delivers babies for women with uncomplicated pregnancies
Clinical nurse leader	A nurse prepared at the graduate level who oversees the lateral integration of care for a distinct group of patients and who may actively provide direct patient care in complex situations. The CNL role is not one of administration or management.
Nurse educator	A nurse, usually with an advanced degree, who teaches in educational or clinical settings; teaches theoretical knowledge and clinical skills; conducts research
Nurse administrator	A nurse who functions at various levels of management in health care settings; is responsible for the management and administration of resources and personnel involved in giving patient care
Nurse researcher	A nurse with an advanced degree who conducts research relevant to the definition and improvement of nursing practice and education
Nurse entrepreneur	A nurse, usually with an advanced degree, who may manage a clinic or health-related business, conduct research, provide education, or serve as an adviser or consultant to institutions, political facilities, or businesses

facilities, and private groups offer formal continuing education through courses, seminars, and workshops. In many states, continuing education is required for an RN to maintain licensure. You will quickly learn that successful nurses are lifelong learners!

In-Service Education

Many hospitals and health care facilities provide education and training for employees of their institution or organization, called in-service education. This is designed to increase the knowledge and skills of the nursing staff. Programs may involve learning, for example, a specific nursing skill or how to use new equipment.

PROFESSIONAL NURSING ORGANIZATIONS

One of the criteria of a profession is having a professional organization that sets standards for practice and education. Nursing's professional organizations are concerned with current issues in nursing and health care, and influence health care policy and legislation. The benefits of belonging to a professional nursing organization include networking with colleagues, having a voice in legislation affecting nursing, and keeping current with trends and issues in nursing.

International Nursing Organization

The ICN, founded in 1899, was the first international organization of professional women. By sharing a commitment to maintaining high standards of nursing service and nursing education and by promoting ethics, the ICN provides a way for national nursing organizations to work together.

National Nursing Organizations

Professional nursing organizations in the United States include the ANA, the NLN, the AACN, and many other specialty organizations such as the Association of Critical Care Nurses. The National Student Nurses' Association (NSNA) prepares students to participate in professional nursing organizations.

American Nurses Association

The ANA is the professional organization for RNs in the United States. Founded in the late 1800s, its membership is comprised of the state nurses' associations to which individual nurses belong. Its primary mission is to advance the profession of nursing to improve health for all. It is the premier organization representing the interests of the 3.6 million RNs in the United States. It advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. Publications of the ANA include the *Code of Ethics for Nurses, American Nurse Today, The American Nurse,* and *OJIN: The Online Journal of Issues in Nursing.* The website NurseBooks.org provides access to the publishing program of the ANA. ANA electronic newsletters include *ANA SmartBrief, Nursing Insider, ANA ImmuNews,* and *Capitol Update.*

National League for Nurses

The NLN is an organization open to all people interested in nursing, including nurses, nonnurses, and facilities. Established in 1952, its objective is to foster the development and improvement of all nursing services and nursing education. The NLN conducts one of the largest professional testing services in the United States, including pre-entrance testing for potential students and achievement testing to measure student progress. It also serves as the primary source of research data about nursing education, conducting annual surveys of schools and new RNs. The organization also provides voluntary accreditation for educational programs in nursing.

American Association of Colleges of Nursing

The AACN is the national voice for baccalaureate and higher-degree nursing education programs. The organization's goals focus on establishing quality educational standards, influencing the nursing profession to improve health care, and promoting public support of baccalaureate and graduate education, research, and nursing practice. National accreditation for collegiate nursing programs is provided (based on meeting standards) through the AACN by the Commission on Collegiate Nursing Education (CCNE).

National Student Nurses Association

Established in 1952 with the assistance of the ANA and the NLN, the NSNA is the national organization for students enrolled in nursing education programs. Through voluntary participation, students practice self-governance, advocate for student and patient rights, and take collective, responsible action on social and political issues.

Specialty Practice and Special-Interest Nursing Organizations

A wide variety of specialty practice and special-interest nursing organizations are available to nurses. These organizations provide information on specific areas of nursing, often have publications in the specialty area, and may be involved in certification activities. Examples of these organizations are listed in Box 1-3.

Box 1-3 Examples of U.S. Specialty Practice and Special Interest Nursing Organizations

American Academy of Nurse Practitioners
American Assembly for Men in Nursing
American Association for the History of Nursing
American Association of Nurse Attorneys
American Holistic Nurses Association
Association of Nurses in AIDS Care
American Association of Critical Care Nurses
Dermatology Nurses Association
Hospice Nurses Association
Oncology Nurses Society
Sigma Theta Tau International
Transcultural Nursing Society

GUIDELINES FOR NURSING PRACTICE

Nursing controls and guarantees its practice through standards of practice, nurse practice acts and licensure, the ANA's *Code of Ethics for Nurses*, professional values, and the use of the nursing process. Each of these will guide your nursing education as a student and how you practice after graduation.

Standards of Nursing Practice

The ANA's 2015 *Nursing: Scope and Standards of Practice* defines activities that are specific and unique to nursing. **Standards** allow nurses to carry out professional roles, serving as protection for the nurse, the patient, and the institution where health care is provided. Each nurse is accountable for his or her own quality of practice and is responsible for the use of these standards to ensure knowledgeable, safe, and comprehensive nursing care. The 2015 ANA standards outlined in Box 1-4 (on page 18) apply to the practice of professional nursing for all RNs, in all settings.

Concept Mastery Alert

Standards of Practice address the key steps involved in caring for patients; Standards of Professional Performance address the key concepts that the nurse integrates into his or her role as a professional nurse.

Nurse Practice Acts and Licensure

Nurse practice acts are laws established in each state in the United States to regulate the practice of nursing. They are

Box 1-4 ANA Standards of Nursing Practice and Professional Performance

Standards of Practice

Standard 1. Assessment
The registered nurse collects pertinent data and information relative to the health care consumer's health or the situation.

Standard 2. Diagnosis
The registered nurse analyzes the assessment data to determine the actual or potential diagnoses, problems, and issues.

Standard 3. Outcomes Identification
The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation.

Standard 4. Planning
The registered nurse develops a plan that prescribes strategies and alternatives to attain expected, measurable outcomes.

Standard 5. Implementation
The registered nurse implements the identified plan.

Standard 5a. Coordination of Care
The registered nurse coordinates care delivery.

Standard 5b. Health Teaching and Health Promotion
The registered nurse employs strategies to promote health and a safe environment.

Standard 6. Evaluation
The registered nurse evaluates progress toward attainment of goals and outcomes.

Standards of Professional Performance

Standard 7. Ethics
The registered nurse practices ethically.

Standard 8. Culturally Congruent Practice
The registered nurse practices in a manner that is congruent with cultural diversity and inclusion principles.

Standard 9. Communication
The registered nurse communicates effectively in all areas of practice.

Standard 10. Collaboration
The registered nurse collaborates with health care consumer and other key stakeholders in the conduct of nursing practice.

Standard 11. Leadership
The registered nurse leads within the professional practice setting and the profession.

Standard 12. Education
The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.

Standard 13. Evidence-Based Practice and Research
The registered nurse integrates evidence and research findings into practice.

Standard 14. Quality of Practice
The registered nurse contributes to quality nursing practice.

Standard 15. Professional Practice Evaluation
The registered nurse evaluates one's own and others' nursing practice.

Standard 16. Resource Utilization
The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible.

Standard 17. Environmental Health
The registered nurse practices in an environmentally safe and healthy manner.

Source: American Nurses Association (ANA). (2015). *Nursing: Scope and standards of practice* (3rd ed., pp. 4–6). Silver Spring, MD: Author.

broadly worded and vary among states, but all of them have certain elements in common, such as the following:

- Protect the public by defining the legal scope of nursing practice, excluding untrained or unlicensed people from practicing nursing.
- Create a state board of nursing or regulatory body having the authority to make and enforce rules and regulations concerning the nursing profession.
- Define important terms and activities in nursing, including legal requirements and titles for RNs and LPNs.
- Establish criteria for the education and licensure of nurses.

The board of nursing for each state has the legal authority to allow graduates of approved schools of nursing to take the licensing examination. Those who successfully meet the requirements for licensure are then given a license to practice nursing in the state. The license, which must be renewed at specified intervals, is valid during the life of the holder and is registered in the state. Many states have a requirement for a specified number of continuing education units to renew and maintain licensure. The license and the right to practice nursing can be denied, revoked, or suspended for professional misconduct (e.g., incompetence, negligence, chemical impairment, or criminal actions).

There are two ways in which nurses can practice in a state other than in the one they were originally licensed. One is by **reciprocity**, which allows a nurse to apply for and be endorsed as an RN by another state. Some states are members of the Nurse Licensure Compact (NLC), allowing a nurse who is licensed and permanently lives in one of the member states to practice in the other member states without additional licensure. The Enhanced Nurse Licensure Compact (eNLC) increases access to care while maintaining public protection at the state level. Nurses with an original NLC multistate license will be grandfathered into the new eNLC. New applicants residing in compact states will need to meet 11 uniform licensure requirements (National Council of State Boards of Nursing, 2017).

As nursing roles continue to expand and issues in nursing are resolved, revised nurse practice acts will reflect those changes. All nurses must be knowledgeable about the specific nurse practice act for the state in which they practice. Check out the National Council of State Boards of Nursing Nurse Practice Act Toolkit, available at https://www.ncsbn.org/npa-toolkit.htm, to:

- Learn about the law and regulations that guide and govern nursing practice
- Locate your state nurse practice act and regulations
- Access nurse practice act educational resources

Code of Ethics and Professional Values

Professional values provide the foundation for nursing practice and will guide your interactions with patients, colleagues and the public. In 1998, the AACN (2008) identified five values that epitomize the caring, professional nurse: altruism, autonomy, human dignity, integrity, and social justice. These values are further specified in the ANA Code of Ethics for Nurses (ANA, 2015a). Both are described in Chapter 6.

It is never too early for students to be intentional about cultivating the character that comports with professional nursing. Begin by asking yourself:

- Am I able to commit myself wholeheartedly to securing the interest of my patients—even when this entails self-sacrifice?
- Recognizing that we live in a society with great diversity, am I committed to respecting my patients' right to make their own decisions about health care?
- Am I able to respect the inherent worth and uniqueness of each individual and population, even when this is difficult?
- Do I value my own integrity sufficiently to challenge workplace cultures that expect me to be less than my personal best?
- Am I committed to making health care work for everyone, especially the most vulnerable?

Nursing Process

The **nursing process** is another of the major guidelines for nursing practice. The essential activities involved in the nursing process are assessing, diagnosing, planning, implementing, and evaluating (see Unit III). Nurses implement their roles through the nursing process, which integrates both the art and the science of nursing—that is, the nursing process is nursing made visible.

The nursing process is used by the nurse to identify the patient's health care needs and strengths, to establish and carry out a care plan to meet those needs, and to evaluate the effectiveness of the plan to meet established outcomes. The nursing process allows nurses to use critical thinking and clinical reasoning when providing care that is individualized and holistic, and to define those areas of care that are within the domain of nursing. Clinical reasoning and the nursing process are fully described in Unit III.

CURRENT TRENDS IN HEALTH CARE AND NURSING

The National Advisory Council on Nurse Education and Practice (NACNEP) identifies critical challenges to nursing practice in the 21st century: a growing population of hospitalized patients who are older and more acutely ill, increasing health care costs, and the need to stay current with rapid advances in medical knowledge and technology. You are sure to experience all of these as you begin your clinical practice. Complicating these challenges are an existing shortage of nurses (more acute in some regions than others), an aging nurse workforce, and prospects of a worsening nurse shortage (NACNEP, 2010, p. 1). The American Nurses Association (2015b) identified four health care trends that will affect American nurses:

- Nursing shortages will offer unique opportunities.
- Job opportunities are expanding outside the hospital, and nurses will play a much bigger role in communities.
- Technology will play a larger role in nursing practice.
- Nurses will collaborate more with other health care providers.

According to the Association of American Medical Colleges (AAMC), many Americans are "medically homeless" and find it difficult to navigate the health care system when they need care or advice. In addition, the existing health care system financially rewards "patchwork" care provided by assorted clinicians instead of encouraging continuity and care coordination. These problems are compounded by a lack of shared health information systems that could make critical health information available to both patients and providers (AAMC, 2008, p. 2). You will learn more about these realities in Unit II. This much is clear: the public needs professional nurses who are "prepared to work when they are hired, willing to continue to learn, and ready to adapt their skills to the needs of the working environment" (NACNEP, 2010). The most recent NACNEP report (2016) emphasizes needed changes in policy, legislation, and research to strengthen nursing's ability to lead and to practice population health management initiatives and more health care transitions out of hospitals into the community (Fig. 1-3 on page 20).

The NLN has identified 10 trends to watch for in nursing education (Heller, Oros, & Durneey-Crowley, 2000):

- Changing demographics and increasing diversity
- The technologic explosion
- Globalization of the world's economy and society
- The era of the educated consumer, alternative therapies, and genomic and palliative care
- The shift to population-based care and the increasing complexity of patient care
- The cost of health care and the challenge of managed care
- The impact of health policy and regulation
- The growing need for interdisciplinary education and for collaborative practice
- The current nursing shortage, and opportunities for lifelong learning and workforce development
- Significant advances in nursing science and research

FIGURE 1-3. Faculty and student lobby on the hill. From left to right: Jennifer Jagger, CNM, MSN, FACNM, Georgetown University faculty and Midwives-PAC chair (OR); Pamela Jellen, SNM (IL); and Mandy Walters, SWHNP (WI) pose in front of the Capitol on their way to visit legislators.

Each of these trends continues to influence what and how you are taught and the challenges you will daily encounter in practice.

In 2011, the Institute of Medicine (IOM) released the results of a groundbreaking study on the role of nurses in realizing a transformed health care system. The report, *The Future of Nursing: Leading Change, Advancing Health*, is "a thorough examination of how nurses' roles, responsibilities and education should change to meet the needs of an aging, increasingly diverse population and to respond to a complex, evolving health care system." The four key messages underlying the IOM's recommendations for transforming the nursing profession (IOM, 2011, p. 4) are as follows:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with health care providers and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

To read more about these recommendations for the future of nursing, visit the IOM website: http://www.nationalacademies.org/hmd.

An exciting follow-up to the *Future of Nursing* report is the Campaign for Action, which aims to ensure that everyone in America can live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health. Campaign for Action is working in every state to mobilize nurses, health providers, consumers, educators, and businesses to strengthen nursing on multiple fronts, using the recommendations from the IOM's *Future of Nursing* report. The Campaign for Action works on seven major interrelated issues that together contribute to a healthier America through nursing: improving access to care, fostering interprofessional collaboration, promoting nursing leadership, transforming nursing education, increasing diversity in nursing, collecting workforce data, and building healthier communities. Visit the Campaign for Action website, https://campaignforaction.org. See also Figure 1-4.

The January 2017 issue of the *American Journal of Nursing* identified the top health care policy news stories of 2016. Gun violence topped the list. There were over 14,000 deaths and almost 29,000 injuries related to gun violence in the United States in 2016. Access to care was the second theme. In 2016, sexual and biological sex minorities, including lesbian, gay, bisexual, and transgender people, were officially designated by the National Institutes of Health as a "health disparity population," allowing for more research on improving health and health care access for this population. Other access-to-care stories involved mental health care (one in five Americans experience mental health challenges, and resources are frequently unavailable), the rising costs of prescription drugs, and rural health care access (Sofer, 2017). Identified as stories to watch in 2017 were new cancer initiatives and precision medicine, climate change and health, changing trends in the use, abuse, and cost of drugs, and obesity (Potera, 2017).

To address these challenges, employers will seek nurses who have knowledge, skills, and attitudes that are aligned with the requirements of their practice environments, those who can work effectively in interprofessional teams across a variety of health care settings, and those who can provide traditional nursing services, as well as other needed services such as case and practice leadership, case management, health promotion, and disease prevention.

SELF-CARE

Hopefully this chapter has made you excited about your chosen profession and eager to begin professional practice. There are so many rewards that nursing offers each of us. You will, however, quickly learn that nursing is also a demanding profession, one the U.S. Department of Labor identifies as a hazardous occupation because of the numbers of nurses who miss work days owing to occupational injuries or illness. As you begin clinical practice, remember that while the ANA Code of Ethics for Nurses reminds us that our primary duty is to the patient, it also reminds us (ANA, 2015a) that "the nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth." ANA designated 2017 the year of the Healthy Nurse, Healthy Nation, and invited us to reflect on how well we are executing our ethical duty to care for ourselves. ANA defines a healthy nurse as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional well-being.

FIGURE 1-4. Campaign for Action. Building a healthier America through nursing. (From Campaign for Action. Retrieved https://campaignforaction.org/issues. Used with permission.)

Healthy nurses live life to the fullest capacity, across the wellness/illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities and work environments, and ultimately for their patients.

It is easy to identify the challenges to nurses' living life to the full: understaffing and unrealistic nurse—patient ratios, night rotation, increased patient acuity, needing to come in early or leave late to complete work, regulatory demands, mandatory overtime, an increasing number of abusive patients, families, and staff, not to mention the fact that many nurses are older and caring for children or aging parents. A study by Thacker and colleagues (2016) revealed that many nurses may not practice adequate self-care, especially when they feel they have too many competing priorities.

As a nurse, you must be alert to early signs of fatigue, as well as:

- **Compassion fatigue**: Loss of satisfaction from providing good patient care
- **Burnout**: Cumulative state of frustration with the work environment that develops over a long time
- **Secondary traumatic stress**: A feeling of despair caused by the transfer of emotion distress from a victim to a caregiver, which often develops suddenly

Healthy self-care practices include stress reduction training, the use of relaxation techniques, time management, assertiveness training, work–life balance measures, and meditation or mindfulness-based practices. Many health care professionals are learning how to use mindfulness practices as daily elements of their self-care. Howland and Bauer-Wu (2015, p. 12) describe **mindfulness** as the "capacity to intentionally bring awareness to present-moment experience with an attitude of openness and curiosity." Mindfulness promotes healing as you pause, focus on the present, and listen. Stopping to focus on your breathing before walking into a patient encounter helps you to focus your mind and allows you to then be more centered and more fully present with the patient.

Ponte and Koppel (2015) recommend using the STOP technique to reduce stress and be able to respond more skillfully during challenging times.

S—Stop and take a step back

T—Take a few breaths

O—Observe inside yourself

P—Proceed after you pause.

Nurse Sharon Tucker advocates a "Vital Signs Selfie Campaign" (Tucker, 2016). She urges nurses everywhere to take

evidence-based action on an important set of vital signs for nurses using the BP–T–P–R technique:

- BP = Being Present (Have I cultivated the art of being truly present in each human encounter? Does my lifestyle support this?)
- T = Tracking (Am I tracking the numbers most important to my health: blood pressure, weight, blood sugar, lipid levels?)
- P = Practicing health and wellness behaviors (Am I a model of healthy behaviors?)
- R = Refueling (Do I get adequate sleep and find meaning, energy, and joy in many aspects of my life? When I am running on empty, how do I refuel?)

What do *your* vital signs say about *your* health and your ability to practice the art and science of person-centered care?

DEVELOPING CLINICAL REASONING

1. Consider the roles and functions of professional nursing (see Table 1-2). Interview several nurses in different settings to see how much value they attach to these roles and how much time they are able to devote to them. Two great questions to ask practicing nurses: What breaks your heart? What makes you come alive?
2. Describe how a nurse would meet the aims of nursing as described in this chapter—promoting health, preventing illness, restoring health, and facilitating coping with death or disability—when caring for the following patients:
   - A single mother who has just delivered her first child and is scheduled to be discharged 12 hours after delivery
   - An 82-year-old woman who wants to begin an exercise program
   - A 32-year-old man dying of AIDS at home

   As you consider these situations, try to identify factors that either promote or inhibit the fulfilling of these aims.
3. How would you rate the adequacy of your self-care? On any given day would you describe yourself as "energized to heal" or "just about making it"? Ask nurses to talk about how they balance their duty to make patients their primary commitment with the duty to self-care.

PRACTICING FOR NCLEX

1. A nurse is caring for a patient in the ICU who is being monitored for a possible cerebral aneurysm following a loss of consciousness in the emergency department (ED). The nurse anticipates preparing the patient for ordered diagnostic tests. What aspect of nursing does this nurse's knowledge of the diagnostic procedures reflect?
   a. The art of nursing
   b. The science of nursing
   c. The caring aspect of nursing
   d. The holistic approach to nursing
2. Nurses today complete a nursing education program, and practice nursing that identifies the personal needs of the patient and the role of the nurse in meeting those needs. Which nursing pioneer is MOST instrumental in this birth of modern nursing?
   a. Clara Barton
   b. Lilian Wald
   c. Lavinia Dock
   d. Florence Nightingale
3. The role of nurses in today's society was influenced by the nurse's role in early civilization. Which statement best portrays this earlier role?
   a. Women who committed crimes were recruited into nursing the sick in lieu of serving jail sentences.
   b. Nurses identified the personal needs of the patient and their role in meeting those needs.
   c. Women called deaconesses made the first visits to the sick, and male religious orders cared for the sick and buried the dead.
   d. The nurse was the mother who cared for her family during sickness by using herbal remedies.
4. Nurses today work in a wide variety of health care settings. What trend occurred during World War II that had a tremendous effect on this development in the nursing profession?
   a. There was a shortage of nurses and an increased emphasis on education.
   b. Emphasis on the war slowed development of knowledge in medicine and technology
   c. The role of the nurse focused on acute technical skills used in hospital settings.
   d. Nursing was dependent on the medical profession to define its priorities.
5. A nurse practicing in a primary care center uses the ANA's Nursing's Social Policy Statement as a guideline for practice. Which purposes of nursing are outlined in this document? Select all that apply.
   a. A description of the nurse as a dependent caregiver
   b. The provision of standards for nursing educational programs
   c. A definition of the scope of nursing practice
   d. The establishment of a knowledge base for nursing practice
   e. A description of nursing's social responsibility
   f. The regulation of nursing research
6. A nurse working in a rehabilitation facility focuses on the goal of restoring health for patients. Which examples of nursing interventions reflect this goal? Select all that apply.
   a. A nurse counsels adolescents in a drug rehabilitation program
   b. A nurse performs range-of-motion exercises for a patient on bedrest

c. A nurse shows a diabetic patient how to inject insulin
d. A nurse recommends a yoga class for a busy executive
e. A nurse provides hospice care for a patient with end-stage cancer
f. A nurse teaches a nutrition class at a local high school

7. A nurse instructor outlines the criteria establishing nursing as a profession. What teaching point correctly describes this criteria? Select all that apply.
   a. Nursing is composed of a well-defined body of general knowledge
   b. Nursing interventions are dependent upon medical practice
   c. Nursing is a recognized authority by a professional group
   d. Nursing is regulated by the medical industry
   e. Nursing has a code of ethics
   f. Nursing is influenced by ongoing research
8. A nurse is practicing as a nurse-midwife in a busy OB-GYN office. Which degree in nursing is necessary to practice at this level?
   a. LPN
   b. ADN
   c. BSN
   d. MSN
9. Nursing in the United States is regulated by the state nurse practice act. What is a common element of each state's nurse practice act?
   a. Defining the legal scope of nursing practice
   b. Providing continuing education programs
   c. Determining the content covered in the NCLEX examination
   d. Creating institutional policies for health care practices
10. According to the National Advisory Council on Nurse Education and Practice, what is a current health care trend contributing to 21st century challenges to nursing practice?
    a. Decreased numbers of hospitalized patients
    b. Older and more acutely ill patients
    c. Decreasing health care costs owing to managed care
    d. Slowed advances in medical knowledge and technology

ANSWERS WITH RATIONALES

1. **b.** The science of nursing is the knowledge base for care that is provided. In contrast, the skilled application of that knowledge is the art of nursing. Providing holistic care to patients based on the science of nursing is considered the art of nursing.
2. **d.** Florence Nightingale elevated the status of nursing to a respected occupation, improved the quality of nursing care, and founded modern nursing education. Clara Barton established the Red Cross in the United States in 1882. Lillian Wald was the founder of public health nursing. Lavinia Dock was a nursing leader and women's rights activist instrumental in establishing women's right to vote.
3. **d.** In early civilizations, the nurse usually was the mother who cared for her family during sickness by providing physical care and herbal remedies. This nurturing and caring role of the nurse has continued to the present. At the beginning of the 16th century, the shortage of nurses led to the recruitment of women who had committed crimes to provide nursing care instead of going to jail. In the early Christian period, women called deaconesses made the first organized visits to sick people, and members of male religious orders gave nursing care and buried the dead. The influences of Florence Nightingale were apparent from the middle of the 19th century to the 20th century; one of her accomplishments was identifying the personal needs of the patient and the nurse's role in meeting those needs.
4. **a.** During World War II, large numbers of women worked outside the home. They became more independent and assertive, which led to an increased emphasis on education. The war itself created a need for more nurses and resulted in a knowledge explosion in medicine and technology. This trend broadened the role of nurses to include practicing in a wide variety of health care settings.
5. **c, d, e**. The ANA Social Policy Statement (2010) describes the social context of nursing, a definition of nursing, the knowledge base for nursing practice, the scope of nursing practice, standards of professional nursing practice, and the regulation of professional nursing.
6. **a, b, c.** Activities to restore health focus on the person with an illness and range from early detection of a disease to rehabilitation and teaching during recovery. These activities include drug counseling, teaching patients how to administer their medications, and performing range-of-motion exercises for bedridden patients. Recommending a yoga class for stress reduction is a goal of preventing illness, and teaching a nutrition class is a goal of promoting health. A hospice care nurse helps to facilitate coping with disability and death.
7. **c, e, f.** Nursing is recognized increasingly as a profession based on the following defining criteria: well-defined body of specific and unique knowledge, strong service orientation, recognized authority by a professional group, code of ethics, professional organization that sets standards, ongoing research, and autonomy and self-regulation.
8. **d.** A master's degree (MSN) prepares advanced practice nurses. Many master's graduates gain national certification in their specialty area, for example, as family nurse practitioners (FNPs) or nurse midwives.
9. **a.** Nurse practice acts are established in each state to regulate the practice of nursing by defining the legal scope of nursing practice, creating a state board of nursing to make and enforce rules and regulations, define important terms and activities in nursing, and establish criteria for the education and licensure of nurses. The acts do not determine the content covered on the NCLEX, but they do have the legal authority to allow graduates of approved schools of nursing to take the licensing examination. The acts also may determine

educational requirements for licensure, but do not provide the education. Institutional policies are created by the institutions themselves.

10. **b.** The National Advisory Council on Nurse Education and Practice identifies the following critical challenges to nursing practice in the 21st century: A growing population of hospitalized patients who are older and more acutely ill, increasing health care costs, and the need to stay current with rapid advances in medical knowledge and technology.

TAYLOR SUITE RESOURCES

Explore these additional resources to enhance learning for this chapter:

- NCLEX-Style Questions and other resources on thePoint®, http://thePoint.lww.com/Taylor9e
- *Study Guide for Fundamentals of Nursing*, 9th edition
- Adaptive Learning | Powered by PrepU, http://thepoint.lww.com/prepu

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2

Theory, Research, and Evidence-Based Practice

Joe Wimmer

Joe, a first-time father of a healthy 8-lb baby girl delivered several hours ago, is visiting with his wife and new daughter. He asks, "Why is my daughter wearing that funny little cap on her head?"

Charlotte Horn

Charlotte, the daughter of a 57-year-old patient being discharged with an order for intermittent nasogastric tube feedings, is being taught how to perform the procedure. During one of the teaching sessions, Charlotte asks, "How will I know that the tube is in the right place?"

Maribella Santos

Maribella, who had just arrived back on the unit after undergoing abdominal surgery, is complaining of nausea. A while later she states, "My nausea is gone. The nurse did something with her hands and the feeling just went away."

Learning Objectives

After completing the chapter, you will be able to accomplish the following:

1. Explain the sources of nursing knowledge and historical influences on nursing knowledge.
2. Compare and contrast systems theory, adaptation theory, and developmental theory.
3. Explain the significance of the four concepts common to all nursing theories.
4. Discuss the evolution of nursing research.
5. Compare and contrast quantitative and qualitative research methods.
6. Describe evidence-based practice in nursing, including the rationale for its use.
7. Outline the steps in implementing evidence-based practice.
8. Read and understand, on a beginning level, a published research article.
9. Use a framework to evaluate the salience of a research study.

Key Terms

applied research
basic research
concept
conceptual framework or model
data
deductive reasoning
evidence-based practice (EBP)
evidence-based practice guideline
inductive reasoning
informed consent
nursing research
nursing theory
qualitative research
quality improvement (QI)
quantitative research
research
systematic review
theory

Nursing is a unique health care discipline in which nurses provide a service based on knowledge and skill. Nursing has two essential elements: a body of knowledge and the application of that knowledge in nursing care interventions. The body of knowledge provides the rationale for nursing interventions. There is a growing knowledge base developed specifically for nursing through theory development and research (see the accompanying Reflective Practice display for an example). Rationales for nursing interventions also come from many different disciplines, including anatomy, physiology, chemistry, nutrition, psychology, and sociology. This chapter discusses the concepts of nursing knowledge, nursing theory, nursing research, and evidence-based practice (EBP) as separate entities, but in fact, they are often intertwined in clinical practice.

NURSING KNOWLEDGE

Knowledge is an awareness of reality acquired through learning or investigation. Every person collects, organizes, and arranges facts to build a knowledge base relevant to one's personal reality. The knowledge base for professional nursing practice includes nursing science, philosophy, and ethics; biology and psychology; and the social, physical, economic, organizational, and technologic sciences. Nursing's Social Policy Statement (American Nurses Association [ANA], 2010, pp. 13–14; Fowler, 2015) lists the following as issues that nurses address in partnership with individuals, families, communities, and populations:

- Promotion of health and wellness
- Promotion of safety and quality of care
- Care, self-care processes, and care coordination
- Physical, emotional, and spiritual comfort, discomfort, and pain
- Adaptation to physiologic and pathophysiologic processes
- Emotions related to the experience of birth, growth and development, health, illness, disease, and death
- Meanings ascribed to health, illness, and other concepts
- Linguistic and cultural sensitivity
- Health literacy
- Decision making and the ability to make choices
- Relationships, role performance, and change processes within relationships
- Social policies and their effects on health
- Health care systems and their relationships to access, cost, and quality of health care
- The environment and the prevention of disease and injury

As you reflect on this list, you can see why your nursing education is so important and why professional nurses are lifelong learners.

Sources of Knowledge

Knowledge comes from a variety of sources and may be traditional, authoritative, or scientific.

Traditional Knowledge

Traditional knowledge is that part of nursing practice passed down from generation to generation. When questioned about the origin of such nursing practices, nurses might reply, "We've always done it this way." Changing bedclothes is an example of how traditional knowledge has affected nursing practice. It is customary in acute care settings to change a patient's bedclothes daily, whether soiled or not. There are no research data to support this, yet virtually millions of hospital beds are changed daily because this practice is accepted as a necessary component of quality patient care. Until this practice is challenged scientifically and its assumed value disproved, it will remain a traditional part of patient care.

Authoritative Knowledge

Authoritative knowledge comes from an expert and is accepted as truth based on the person's perceived

QSEN Reflective Practice: Cultivating QSEN Competencies

CHALLENGE TO COGNITIVE SKILLS

One of the nurses, Danielle, on a surgical floor where I was assigned, took a course in therapeutic touch. When she returned to work, she was eager to use her new "intervention." My patient, Maribella Santos, had come back to the unit after undergoing abdominal surgery. Upon her return, she complained of nausea. Danielle used her "unruffling" technique to calm the patient, whose nausea then "disappeared." Excited, I reported this in postconference, only to learn from my instructor that therapeutic touch was "a lot of bunk" without scientific support.

Thinking Outside the Box: Possible Courses of Action

- Accept my instructor's dismissal of therapeutic touch.
- Learn more about therapeutic touch from my colleague Danielle and professional literature.
- Become an advocate for therapeutic touch if it *does* work!

Evaluating a Good Outcome: How Do I Define Success?

- Patient is not harmed by anyone using an unproven therapy.
- Patient benefits from my openness to new (potentially beneficial) therapies.
- I rely on research and EBP, not hearsay, as a basis for my clinical judgments and actions.

Personal Learning: Here's to the Future!

I was surprised to find the literature so inconclusive about the benefits of therapeutic touch. Obviously, its adherents claim that they can measure its efficacy. Others find these claims unsupported. Since this event happened at the beginning of my clinical rotation, I decided to observe Danielle throughout my rotation. What I saw made me a believer in this technique. Danielle was using therapeutic touch as an adjuvant to other therapies and it seemed to be working. I want to learn more about this technique. My goal is to attend a workshop on therapeutic touch to see if it is something I can incorporate into my practice.

Katherine Figliala, Georgetown University

QSEN SELF-REFLECTION ON QUALITY AND SAFETY COMPETENCIES DEVELOPING KNOWLEDGE, SKILLS, AND ATTITUDES FOR CONTINUOUS IMPROVEMENT

How do you think you would respond in a similar situation? Why? What does this tell you about yourself and about the adequacy of your competencies for professional practice? Can you think of other ways to respond? Do you agree with the criteria that the nursing student used to evaluate a successful outcome? Why or why not? What *knowledge, skills*, and *attitudes* do you need to develop to continuously improve the quality and safety of care?

Patient-Centered Care: What information should be communicated to Maribella Santos and other patients about the use of therapeutic touch to involve them as partners in the use of this technique?

Teamwork and Collaboration/Quality Improvement: Other members of the professional caregiving team can have positive and negative effects on us. In what ways do you practice so as to remain open to learning new interventions from colleagues and not allow negativity to inhibit your creativity?

Safety/Evidence-Based Practice: What sources of knowledge did the nursing student use? Did the nursing student use theory and research? If so, please explain how. Would you consider therapeutic touch to be EBP? Why or why not? How might the patient's culture have affected the response? Might patients be harmed through the use of a new intervention such as therapeutic touch? What safeguards exist in practice sites to prevent reckless experimentation on patients? When a review of the literature proves inconclusive, on what should we base our judgment about the efficacy of therapeutic touch or other interventions?

Informatics: What research strategy is likely to yield the best evidence about the efficacy of therapeutic touch? Can you identify the essential information that must be available in a patient's record about the use of therapeutic touch?

expertise—for example, when a senior staff nurse teaches a new graduate nurse a more efficient method of doing a technical procedure, such as inserting an intravenous catheter. The senior nurse has gained knowledge through experience, and the new graduate nurse accepts it as truth based on the perceived authority of the experienced nurse. Authoritative knowledge generally remains unchallenged as long as presumed authorities maintain their perceived expertise.

Scientific Knowledge

Scientific knowledge is knowledge obtained through the scientific method (implying thorough research). New ideas are tested and measured systematically using objective criteria.

Think back to ***Maribella Santos***, the woman complaining of nausea after undergoing abdominal surgery. The nurse would integrate scientific knowledge about the effects of surgery and anesthesia on the body and the side effects of pain medication to develop the postoperative care plan.

Significance of Knowledge Sources

All sources of knowledge are useful in the collective body of knowledge that constitutes the nursing profession. Although these three sources provide nursing with important contributions, each has inherent strengths and limitations. Both traditional and authoritative knowledge are practical to implement but are often based on subjective data, limiting their usefulness in a wide variety of practice settings. For this reason, nurses increasingly focus on scientific knowledge to provide care, commonly called EBP, a topic that will be thoroughly discussed later in this chapter. See Table 2-1 for an illustration of the importance of scientific knowledge.

Historical Influences on Nursing Knowledge

The development of nursing knowledge has been influenced by the early work of Florence Nightingale, later nurse researchers and theorists, and societal changes.

Nightingale's Contributions

Nightingale influenced nursing knowledge and practice by demonstrating efficient and knowledgeable nursing care, defining nursing practice as separate and distinct from medical practice, and differentiating between health nursing and illness nursing (see Chapter 1 for further information).

The training of nurses was initially carried out under the direction and control of the medical profession. Because the conceptual and theoretical basis for nursing practice came from outside the profession, nursing struggled for years to establish its own identity and to receive recognition for its significant contributions to health care.

Societal Influences on Nursing Knowledge

Most early schools of nursing established in the United States were adapted from Nightingale's model. There was no planned educational curriculum; instead, knowledge was acquired from lectures by physicians and through practical experience by caring for sick people in hospitals. This service orientation for nursing education remained the strongest influence on nursing practice until the 1950s. Nursing care was carried out under the control and direction of the hospital administration and physicians practicing in that hospital. Nursing care was based on traditional ideas about following orders, as well as on common wisdom about caring for others based on either "common sense" or widely accepted scientific principles (Chinn & Kramer, 2015). As a result, nursing knowledge remained undeveloped and fragmented.

During the first half of the 20th century, a change in the structure of society resulted in changed roles for women and, in turn, for nursing. As a result of World Wars I and II, women increasingly entered the workforce, became more independent, and sought higher education. At the same time, nursing education began to focus more on education than hands-on training, and nursing research was conducted and published. As women became more independent and assertive, nursing's need for a clearly defined identity based on unique contributions to the health care system emerged. In the mid-20th century, the idea of nursing as a science became more generally accepted, and philosophic beliefs and a knowledge base for nursing practice began to evolve. Today the proliferation of graduate nursing programs, including the PhD in nursing, demonstrate society's acceptance of nursing science.

Table 2-1 Moving From Traditions to Evidence-Based Practice Interventions

CATEGORY	TRADITION	EVIDENCE-BASED INTERVENTION
Respiratory	Saline instillation for secretion removal	Normal saline should not be instilled as a routine step with endotracheal suctioning; instilling saline will not enhance removal of secretions.
	Excessive sedation; avoiding sedation and daily awakening practice	Interrupt sedation daily to assess patients' neurologic status and/or readiness for reduced ventilator support or extubation.
Psychosocial	Restricting intensive care unit visitation	Open visitation 24/7 enhances patient/family engagement and does not have adverse physiologic impact on patients' outcomes.
Hospital-acquired conditions	Early removal of urinary catheters to reduce catheter-associated urinary tract infections is not possible in the intensive care unit	Nurse-driven interventions to reduce catheter-associated infections focus on addressing the need for the catheter, sterile/aseptic catheter insertion, keeping drainage bag below the level of the bladder at all times, daily catheter care, and prompt removal of catheter.

Source: Select Examples used with permission of American Association of Critical Care Nurses, from Select examples from Makic, M. B. F., & Rauen, C. (2016). Maintaining your momentum: Moving evidence into practice. *Critical Care Nurse, 36*(2), 13–18; permission conveyed through Copyright Clearance Center, Inc.

In the 21st century, the Institute of Medicine (IOM) issued its seminal report, *The Future of Nursing* (IOM, 2011), which identifies research priorities for transforming nursing practice, nursing education, and nursing leadership. "Taken together, the recommendations are meant to provide a strong foundation for the development of a nursing workforce whose members are well educated and well prepared to practice to the full extent of their education, to meet the current and future health needs of patients, and to act as full partners in leading change and advancing health" (IOM, 2011, p. 271). The IOM report and the 2015 update on progress are available on their website: www.iom.edu.

NURSING THEORY

A **theory** is composed of a group of concepts that describe a pattern of reality. **Concepts**, like ideas, are abstract impressions organized into symbols of reality. Concepts describe objects, properties, and events and relationships among them. A group of concepts that follows an understandable pattern makes up a **conceptual framework or model**. Concepts can be thought of as the individual bricks and boards used to build a house, with the conceptual framework being the blueprint that specifies where each brick and board should go. Theories can be tested, changed, or used to guide research or to provide a base for evaluation. They are derived through two principal methods: **deductive reasoning**, in which one examines a general idea and then considers specific actions or ideas, and **inductive reasoning**, in which the reverse process is used—one builds from specific ideas or actions to conclusions about general ideas.

Nursing theory is developed to describe nursing. Nursing theory differentiates nursing from other disciplines and activities in that it serves the purposes of describing, explaining, predicting, and controlling desired outcomes of nursing care practices. Thus, theories provide a means of testing knowledge through research and for expanding nursing's knowledge base to meet the health care needs of patients in an ever-changing society.

Interdisciplinary Base for Nursing Theories

Nursing theories are often based on, and influenced by, other broadly applicable processes and theories. The ideas and principles of the theories described briefly in the following sections are basic to many nursing concepts and are a part of the nursing literature. Nurses need to understand these theories and terminologies as they develop their own knowledge base in nursing.

General Systems Theory

General systems theory has been used in a wide range of disciplines since it emerged in the 1920s. Its primary theorist, Ludwig von Bertalanffy, developed the theory for universal application. This theory describes how to break whole things into parts and then to learn how the parts work together in "systems." It emphasizes relationships between the whole and the parts and describes how parts function and behave. These concepts may be applied to different kinds of systems, for example, molecules in chemistry, cultures in sociology, organs in anatomy, and health in nursing. The key points in general systems theory are outlined in Box 2-1.

Box 2-1 Key Points in General Systems Theory

- A system is a set of interacting elements, all contributing to the overall goal of the system. The whole system is always greater than the sum of its parts.
- Systems are hierarchical in nature and are composed of interrelated subsystems that work together in such a way that a change in one element could affect other subsystems, as well as the whole.
- Boundaries separate systems both from each other and from their environments.
- A system communicates with and reacts to its environment through factors that enter the system (input) or are transferred to the environment (output).
- An open system allows energy, matter, and information to move freely between systems and boundaries, whereas a closed system does not allow input from or output to the environment (no totally closed systems are known to exist in reality).
- To survive, open systems maintain balance through feedback.

Recall ***Maribella Santos***, the woman described in the Reflective Practice box who received therapeutic touch? The nurse would need to integrate knowledge of systems theory, including system communication, open systems, and energy transfer to better understand the goal of this technique.

Adaptation Theory

Adaptation theory defines adaptation as the adjustment of living matter to other living things and to environmental conditions. Adaptation is a continuously occurring process that effects change and involves interaction and response. Human adaptation occurs on three levels: the internal (self), the social (others), and the physical (biochemical reactions). Chapter 42 describes adaptation in relation to stress.

Developmental Theory

Developmental theory outlines the process of growth and development of humans as orderly and predictable, beginning with conception and ending with death. Although the pattern has definite stages, the progress and behaviors of a person within each stage are unique. Heredity, temperament, emotional and physical environment, life experiences, and health status influence the growth and development of a person.

Several theorists have made important contributions to developmental theory, but only two are mentioned here because their work is often used to develop nursing theory and to organize nursing practice. Erik Erikson based his theory of psychosocial development on the process of socialization, emphasizing how people learn to interact with the world. Erikson recognized the role of social, biologic, and environmental factors in development, and defined specific tasks or conflicts that people accomplish or overcome during what he defined as the eight stages of life. Chapters 21 to 23 present more information on developmental theory.

Abraham Maslow developed his theory of human needs in terms of physical and psychosocial needs considered essential to human life, rather than by chronologic age as Erikson did. As described in Chapter 4, Maslow defined five levels of need in a hierarchy, with different needs existing simultaneously.

Think back to ***Joe Wimmer***, the new father of a baby girl. When explaining about the use of the cap on the baby's head, the nurse would incorporate knowledge of Maslow's hierarchy of needs, specifically physiologic needs, and the need to minimize heat loss as a priority.

As you continue in your nursing education and practice, you will learn how systems, adaptation, and developmental theories are used in planning and giving holistic care to patients. The following sections on specific nursing theories will help you better understand the knowledge base used to develop the concepts unique to nursing.

Nursing Theories

Even though nurses have difficulty agreeing on precise definitions of nursing, theory-based nursing directs nurses toward a common goal, with the ultimate outcome being improved patient-centered care. Nursing theory provides rational and knowledgeable reasons for nursing interventions, based on descriptions of what nursing is and what nurses do. Additionally, nursing theory gives nurses the knowledge base necessary for acting and responding appropriately in nursing care situations, provides a base for discussion, and, ideally, helps resolve current nursing issues. Theory gives nurses who know and practice theory better problem-solving skills, so that nursing interventions are better organized, considered, and purposeful. Nursing theory also prepares nurses to question assumptions and values in nursing, thus further defining nursing and increasing the knowledge base.

Nursing theories identify and define interrelated concepts important in nursing and clearly state the relationships between and among these concepts. Nursing theories should be simple and general; simple terminology and broadly applicable concepts ensure their usefulness in a wide variety of nursing practice situations. Nursing theories should also increase the nursing profession's body of knowledge by generating research to guide and improve practice. Overall, nursing theory guides nursing practice by providing a knowledge base, organizing concepts, providing guidelines for practice, and identifying nursing care goals.

Nursing theories may be descriptive or prescriptive (Meleis, 2018). Descriptive theories describe a phenomenon, an event, a situation, or a relationship. They further identify the properties and components of each of these as well as the circumstances in which it occurs. Prescriptive theories address nursing interventions and the consequences of those interventions; they are designed to control, promote, and change clinical nursing practice.

The aims of nursing, described in Chapter 1, are the same for all nursing theorists, but the values, assumptions, and beliefs individualize each theory when it is applied to nursing care. Theoretical frameworks of nursing provide a focus for nursing care activities. The person receiving care is the central theme, but the way each theorist defines that person, the environment, health, and nursing gives a unique focus specific to a particular theory. The ultimate goal of each framework is holistic patient care, individualized to meet needs, promote health, and prevent or treat illness. Selected theories of nursing are outlined in Table 2-2.

Common Concepts in Nursing Theories

Four concepts common in nursing theory that influence and determine nursing practice are (1) the person (patient), (2) the environment, (3) health, and (4) nursing. Each of these concepts is usually defined and described by a nursing theorist, and although these concepts are common to all nursing theories, both the definitions and the relations among them may differ from one theory to another. Of the four concepts, the most important is that of the person. The focus of nursing, regardless of definition or theory, is the person (Fig. 2-1).

Nursing Theory in Clinical Practice

As a discipline, nursing is increasingly defining its own independent functions and contributions to health care. The development and use of nursing theory provide autonomy (independence and self-governance) in the practice of nursing

FIGURE 2-1. Four concepts common to all nursing theories are person, environment, health, and nursing. The most important concept, and the focus of nursing, is the person. (*Photo by Rick Brady.* From Eliopoulos, C. [2013]. *Gerontological Nursing* [8th ed.]. Philadelphia: Wolters Kluwer.)

Table 2-2 Selected Theorists and Theories of Nursing

NURSING THEORIST AND DATE OF THEORY	CENTRAL THEME	APPLICATION TO CLINICAL PRACTICE
Florence Nightingale (1860)	Meeting the personal needs of the patient within the environment.	Concern for the environment of the patient, including cleanliness, ventilation, temperature, light, diet, and noise.
Hildegard Peplau (1952)	Nursing is a therapeutic, interpersonal, and goal-oriented process.	Nursing interventions are directed toward developing the patient's personality for productive personal and community living.
Virginia Henderson (1955)	The patient is a person who requires help to reach independence.	Nursing practice is independent; autonomous nursing functions are identified, and self-help concepts are described.
Faye Abdullah (1960)	Nursing is a problem-solving art and science used to identify the nursing problems of patients as they move toward health and cope with illness-related health needs.	The 21 nursing-care problems identified were based on research and can be used to determine patient needs and formulate nursing-focused care.
Ida Jean Orlando (1961)	The nurse reacts to the patient's verbal and nonverbal expression of needs both to understand the meaning of the distress and to know what is needed to alleviate it.	Uses the nursing process to provide solutions to problems as well as to prevent problems.
Ernestine Wiedenbach (1964)	Nursing as an art; nursing is providing nurturing care to patients.	Clinical nursing includes a philosophy, a purpose, the practice, and the art. Care is directed toward a specific purpose to meet the patient's perceived health care needs.
Lydia E. Hall (1966)	Focus is on rehabilitation, encompassing nursing's autonomy, the therapeutic use of self, treatment within the health care team (cure), and nurturing (care).	The major outcome of nursing care is rehabilitation and feelings of self-actualization by the patient.
Myra E. Levine (1967)	Emphasis is on the ill person in the health care setting; describes detailed nursing skills and actions.	The patient is the center of nursing activities, with nursing care provided based on four conservation principles to help patients adapt to their environment.
Martha Rogers (1970)	Emphasis is on the science and art of nursing, with the unitary human being central to the discipline of nursing.	Nursing interventions are directed toward repatterning human environment fields or assisting in mobilizing inner resources.
Dorothea Orem (1971)	Self-care is a human need; self-care deficits require nursing actions.	Nursing is a human service, and nurses design interventions to provide or to manage self-care actions for sustaining health or recovering from illness or injury.
Imogene King (1971)	The patient is a personal system within a social system; the nurse and the patient experience each other and the situation, act and react, and transact.	Nursing is a process of human interactions as nurses and patients communicate to mutually set goals, and explore and agree on the means to reach those goals.
Betty Newman (1972)	Humans are in constant relationship with stressors in the environment.	The major concern for nursing is keeping the patient's system stable through accurately assessing the effects of environmental stressors and assisting the patient with adjustments required for optimal wellness.
Sister Callista Roy (1974)	Humans are biopsychosocial beings existing within an environment. Needs are created within interrelated adaptive modes: physiologic self-concept, role function, and interdependence.	Nursing interventions are required when people demonstrate ineffective adaptive responses.
Madeleine Leininger (1978)	Caring is the central theme of nursing care, knowledge, and practice.	This provides the foundation of transcultural nursing care. Caring improves human conditions and life processes.

(*continued*)

Table 2-2 Selected Theorists and Theories of Nursing *(continued)*

NURSING THEORIST AND DATE OF THEORY	CENTRAL THEME	APPLICATION TO CLINICAL PRACTICE
Jean Watson (1979)	Nursing is concerned with promoting and restoring health, preventing illness, and caring for the sick.	Clinical nursing care is holistic to promote humanism, health, and quality of living. Caring is universal and is practiced through interpersonal relationships.
Margaret A. Newman (1979)	Nursing interventions are purposeful, using a total-person approach to patient care to help people, families, and groups attain and maintain wellness.	Nursing care is directed toward reducing stress factors and adverse conditions that increase the risk for or actually affect optimal patient functions.
Dorothy E. Johnson (1980)	Nursing problems arise when there are disturbances in the system or subsystem, or the level of behavioral functioning is below an optimal level.	Nursing interventions are designed to support/maintain health, educate, counsel, and modify behavior.
Rosemarie Parse (1981)	The person continually interacts with the environment and participates in maintaining health.	Health is a continual, open process (rather than an absence of illness), with nursing care planned based on the patient's perspective of health and care.
Nola Pender (1982)	The goal of nursing is the optimal health of the person, with a focus on how people make health care decisions.	Factors significant to health-promoting behaviors include a person's beliefs about the importance of health and the perceived benefits of, and perceived barriers to, those behaviors. Participation in health-promoting behaviors is modified by one's demographic and biologic characteristics, interpersonal influences, and situational and behavioral factors.
Patricia Benner and Judith Wrubel (1989)	Nursing practice occurs within a context of caring and skill development. Caring is a common bond of people situated in a state of being that is essential to nursing.	They presented a systematic description of stages of nursing practice: novice, advanced beginner, competent, proficient, and expert.
Katherine Kolcaba (2003)	Patient comfort exists in three forms: relief, ease, and transcendence. If a patient is comfortable, he or she will feel emotionally and mentally better which will aid in recovery.	The role of the nurse is to assess a patient's comfort needs and create a nursing care plan to meet those needs.

in many ways. As nurses demonstrate that nursing care does indeed make a difference and that nursing services are valuable, the discipline becomes more independent. Having a body of knowledge specific to the discipline allows members to be viewed by others as experts; this, in turn, gives nurses authority to carry out actions. In addition, interventions carried out and based on sound rationales are trusted and respected.

Today, it has become even more necessary and important for nurses to demonstrate efficient, cost-effective, high-quality care within organized health care delivery systems. By practicing theory-based nursing combined with clinical reasoning skills, nurses are able not only to deliver care that meets those criteria but also to describe and document what it is they do. Professional nurses use theories from nursing and from the behavioral sciences to collect, organize, and classify patient data and to understand, analyze, and interpret patients' health situations. Theoretical concepts and theories guide all phases of the nursing process, including planning, implementing, and evaluating nursing care, while also describing and explaining desired responses to and outcomes of care.

The major concepts of a chosen model or theory guide each step of the nursing process. The concepts serve as categories to guide the nurse in determining what information is relevant and should be collected to make assessments and to formulate nursing diagnoses. The concepts also suggest the appropriate types of nursing interventions and patient outcomes to be included in the care plan (see Table 2-2 for the purpose and clinical application of selected nursing theories). It is important to realize that as the focus of nursing changes, so does the applicability of the concepts within a specific theory.

NURSING RESEARCH

Research most simply defined means to examine carefully or to search again. Research as scientific inquiry is a process that uses observable and verifiable information (**data**),

collected in a systematic manner, to describe, explain, or predict events. Research is conducted to validate and refine current knowledge or to develop new knowledge. The goals of research are to develop explanations (in theories) and to find solutions to problems.

Consider ***Charlotte Horn***, the daughter who is being taught how to give tube feedings and is asking about ensuring proper tube placement. The nurse would recommend the best method to use based on scientific evidence from research.

Nursing research, broadly defined, encompasses research to improve the care of people in the clinical setting as well as the broader study of people and the nursing profession, including studies of education, policy development, ethics, and nursing history. Research is included as an essential component of nursing by the ANA, by the International Council of Nurses, and by nursing specialty organizations (Box 2-2). One of the many ways to promote nursing's development of greater autonomy and strength is nursing research. Nurses, depending on their level of education, conduct or participate in research to improve their efforts to deliver high-quality, cost-efficient care. Nurses also increasingly use the findings of research to provide evidence-based nursing practice (discussed in the next section).

Nursing research is fundamental to the recognition of nursing as a profession. As an occupation, nursing has existed since the beginning of human history. One of the essential elements that differentiate a profession from an occupation is the existence of a unique and distinct knowledge base. The ultimate goal of expanding nursing's body of knowledge is to learn improved ways to promote and maintain health. As health care and illness patterns change, nursing interventions must change. Ongoing practice-based research reflects the nursing profession's commitment to meet the ever-changing demands of health care consumers.

Remember ***Joe Wimmer***, the new father described at the beginning of the chapter. Before responding to Mr. Wimmer, the nurse would need knowledge of newborn heat loss and methods to minimize it. A review of the literature would provide theoretical information necessary to explain the scientific rationale for using caps on the heads of newborns to reduce heat loss.

Box 2-2 ANA Standards of Professional Nursing Practice

Standard 13. Evidence-Based Practice and Research

The registered nurse integrates evidence and research findings into practice.

Competencies

The registered nurse:

- Articulates the values of research and its application relative to the health care setting and practice.
- Identifies questions in the health care setting and practice that can be answered by nursing research.
- Uses current evidence-based knowledge, including research findings, to guide practice.
- Incorporates evidence when initiating changes in nursing practice.
- Participates in the formulation of evidence-based practice through research.
- Promotes ethical principles of research in practice and the health care setting.
- Appraises nursing research for optimal application in practice and the health care setting.
- Shares peer-reviewed research findings with colleagues to integrate knowledge into nursing practice.

Source: American Nurses Association (ANA). (2015). *Nursing: Scope and standards of practice* (3rd ed., p. 77). Silver Spring, MD: Author.

The Evolution of Nursing Research

While caring for victims of the Crimean War, Florence Nightingale kept careful and objective records. These records provided baseline data that she later used to determine which nursing interventions were most effective in treating her patients.

Although nurses have always provided care through nursing interventions and have evaluated the response of the patient, for a long time those interventions were primarily based on a philosophy of "It's always been done that way." As advances were made in technology and medical research during the 20th century, nursing leaders realized that research about the practice of nursing was necessary to meet the health needs of modern society. Increasing numbers of nurses began to conduct research and publish articles telling other nurses how to conduct nursing research.

During the 1950s and 1960s, nursing research was increasingly recognized as important. Early studies provided the basis for the development of nursing practice standards and the most effective educational preparation for registered nurses. The ANA sponsored a series of nursing research conferences. A focus on clinical studies to examine quality of care and the development of outcomes of care grew out of the newly developed intensive care units (ICUs).

The 1970s and 1980s focused on clinical research, with published studies of clinical interventions, such as vital signs and treatment procedures. Primary patient care was a popular method of nursing care, with research investigating outcomes and quality of care. The nursing process also was studied, with research into assessment and effective nursing diagnosis of patient responses to the effects of illness. Studies of nursing education were concerned with student learning experiences and clinical evaluation methods, as well as differentiation of practice by educational preparation. In addition, models, conceptual frameworks, and theories were developed to guide nursing practice. More nurses were prepared at the master's and doctoral levels, and federal

funding for nursing research increased. Journals specific to nursing research (both generally and in specialty areas) were published.

Of major importance was the ANA's 1985 creation of the National Center for Nursing Research, which was subsequently promoted to the National Institute of Nursing Research (NINR) in 1993, thereby gaining equal status with the other 27 National Institutes of Health. The NINR website funds research that establishes the scientific basis for quality patient care. According to the NINR, the goals of nursing research are to:

- Build the scientific foundation for clinical practice
- Prevent disease and disability
- Manage and eliminate symptoms caused by illness
- Enhance end-of-life and palliative care

In September 2016, NINR released its new Strategic Plan: Advancing science, improving lives: A vision for nursing science. The new Strategic Plan describes four areas of scientific focus:

1. Symptom science: promoting personalized health strategies
2. Wellness: promoting health and preventing illness
3. Self-management: improving quality of life for people with chronic conditions
4. End-of-life and palliative care: the science of compassion

An additional two areas were deemed of high priority across all of NINR's scientific programs: (1) Promoting innovation: technology to improve health and (2) 21st-century nurse scientists: innovative strategies for research careers (Grady, 2017).

The NINR website offers a series of Featured Research Highlights, which summarize the recent work of NINR-supported researchers across the country. Box 2-3 provides an example of one of these Research Highlights.

Methods of Conducting Nursing Research

Nursing research is conducted by quantitative and qualitative methodology. Each method is summarized here to facilitate understanding published research so that findings may be used in clinical practice.

Quantitative Research Methods

Quantitative research involves the concepts of basic and applied research. Box 2-4 provides definitions of important terms for quantitative research. **Basic research**, sometimes called pure or laboratory research, is designed to generate and refine theory, and the findings are often not directly useful in practice. **Applied research**, also called practical research, is designed to directly influence or improve clinical practice.

The types of quantitative research depend on the level of current knowledge about a research problem (Table 2-3). The steps of quantitative research are followed carefully, although they may be designed in different ways. Table 2-4 presents an overview of the basic steps of the quantitative research process.

Qualitative Research Methods

Qualitative research is a method of research conducted to gain insight by discovering meanings. At its core is the idea

Box 2-3 National Institute of Nursing Research (NINR): Featured Research Highlight

Program that Can Provide Long-Term Physical and Mental Health Improvement Among Adolescents

- Being overweight or obese or having depressive symptoms can interfere with health and academic performance among young people, yet the number of overweight and obese young people has increased in recent years.
- To help find the best way to address weight and depression among teens, scientists tested the long-term effectiveness of the COPE (Creating Opportunities for Personal Empowerment) Healthy Lifestyles TEEN (Thinking, Emotions, Exercise, Nutrition) program.
- The COPE Healthy Lifestyles TEEN program, which involves teacher-led physical activity and positive behavioral skills training, was compared with an attention control program, Healthy Teens. The interventions were presented as part of required health classes in 11 high schools. In all, 779 students aged 14–16 participated in the study.

Researchers measured the two programs' effects on overweight and obesity, as well as depressive symptoms, at 12 months following the interventions. After these 12 months, students participating in the COPE Healthy Lifestyles TEEN program had lower body mass index than those participating in the Healthy Teens program. None of those in the COPE Healthy Lifestyles TEEN intervention became obese, and only about 5% moved from a healthy weight to overweight, whereas 10% of those in the Healthy Teens control group moved into overweight or obesity. Among the subgroup of participants with severely elevated depressive symptoms, participants in the COPE Healthy Lifestyles TEEN group improved after 12 months, while depressive symptoms in the Healthy Teens group remained elevated. The researchers concluded that the COPE Healthy Lifestyles TEEN program may help at-risk youth improve their physical and mental health. They also note that the program was delivered by teachers as part of their curriculum, making it easily available to students who may need it the most.

Citation

Melnyk, B. M. ; Jacobson, D.; Kelly, S. A.; et al. Twelve-Month Effects of the COPE Healthy Lifestyles TEEN Program on Overweight and Depressive Symptoms in High School Adolescents. *Journal of School Health*. 2015;85(12):861–870.

Source: From National Institute of Nursing Research. Retrieved https://www.ninr.nih.gov/researchandfunding/researchhighlights#cope-teen. Used with permission.

Box 2-4 Important Terms in Quantitative Research

- **Variable:** Something that varies and has different values that can be measured
- **Dependent variable:** The variable being studied, determined as a result of a study
- **Independent variable:** Causes or conditions that are manipulated or identified to determine the effects on the dependent variable
- **Hypothesis:** Statement of relationships between the independent and dependent variables that the researcher expects to find
- **Data:** Information the researcher collects from subjects in the study (expressed in numbers)
- **Instruments:** Devices used to collect and record the data, such as rating scales, pencil-and-paper tests, and biologic measurements. Instruments should be both reliable (produce the same results [data] on repeated use) and valid (test what they are supposed to test).

that reality is based on perceptions, which differ for each person and change over time. The research design follows many of the same steps as quantitative research, but differs in that the researcher primarily analyzes words or narratives rather than numbers. Table 2-5 (on page 36) outlines and briefly describes the methods of qualitative research.

Table 2-3 Types of Quantitative Research

TYPE	PURPOSE
Descriptive Research	To explore and describe events in real-life situations, describing concepts and identifying relationships between and among events; often used to generate new knowledge about topics with little or no prior research
Correlational Research	To examine the type and degree of relationships between two or more variables; the strength of the relationship varies from a –1 (perfect negative correlation, in which one increases as the other decreases) to a +1 (perfect positive correlation, with both variables increasing or decreasing together)
Quasi-experimental Research	To examine cause-and-effect relationships between selected variables; often conducted in clinical settings to examine the effects of nursing interventions on patient outcomes
Experimental Research	To examine cause-and-effect relationships between variables under highly controlled conditions; often conducted in a laboratory setting

Table 2-4 Steps of the Quantitative Research Process

STEP	DESCRIPTION
1. State the research problem.	This is often stated as a question, which should be focused narrowly on the problem being studied. For example: "What is the optimal time for taking a rectal temperature with a digital thermometer?"
2. Define the purpose of the study.	The purpose explains "why" the problem is important and what use the findings will be.
3. Review-related literature.	The literature review provides information about what is already known, as well as providing information about concepts and how the concepts have been measured. It also identifies gaps in knowledge that will be studied.
4. Formulate hypotheses and variables.	Hypotheses are statements about two or more variables. Scientific hypotheses must be testable using variables that can be measured, manipulated, or controlled in a study.
5. Select the research design.	The design is a carefully determined, systematic, and controlled plan for finding answers to the question of the study. This provides a "road map" for all aspects of the study, including how to collect and analyze the data.
6. Select the population and sample.	The population is the group to be studied. The sample refers to specific people or events in the population from which data will be collected.
7. Collect the data.	Sources of data may include people, literature, documents, and findings (e.g., from sources such as laboratory data or measurements of vital signs). Data may be collected from interviews, questionnaires, direct measurement, or examinations (such as physical or psychological tests).
8. Analyze the data.	Statistical procedures are used to analyze the data and provide answers to the research question.
9. Communicate findings and conclusions.	Through publications and presentations, the researcher explains the results of the study and links them to the existing body of knowledge in the literature. The researcher also describes the implications of the study and suggests directions for further research.

Table 2-5 Qualitative Research Methods

METHOD	DESCRIPTION
Phenomenology	The purpose of phenomenology (both a philosophy and a research method) is to describe experiences as they are lived by the subjects being studied. Analysis of data provides information about the meaning of the experience within each person's own reality (e.g., the experience of health or of having a heart attack).
Grounded Theory	The basis of grounded theory methodology is the discovery of how people describe their own reality and how their beliefs are related to their actions in a social scene. The findings are grounded in the data from subjects and are used to formulate concepts and to generate a theory of the experience, supported by examples from the data (e.g., coping with a seriously ill child).
Ethnography	Developed by the discipline of anthropology, ethnographic research is used to examine issues of a culture that are of interest to nursing.
Historical	Historical research examines events of the past to increase understanding of the nursing profession today. Many historical studies focus on nursing leaders, but there is increasing interest in the historical patterns of nursing practice.

Protection of the Rights of Human Subjects

Many nurses work in health care institutions in which patients are invited to participate in clinical research. With their focus on the overall well-being of the patient, nurses play an important role in ensuring that patient interests are not sacrificed to research interests. Nursing priorities include determining that the studies have met appropriate scientific and ethical criteria before their implementation, and protecting patient rights. Specific patient rights include **informed consent**, the patient's right to consent knowledgeably to participate in a study without coercion (knowing that this consent may be withdrawn at any time) or to refuse to participate without jeopardizing the care that he or she will receive, the right to confidentiality, and the right to be protected from harm. Nurse ethicist Christine Grady and her colleagues propose seven requirements that provide a coherent framework for evaluating the ethics of clinical research studies (Emmanuel, Wendler, & Grady, 2000):

- Value: Enhancements of health or knowledge must be derived from the research.
- Scientific validity: The research must be methodologically rigorous.
- Fair subject selection: Scientific objectives, not vulnerability or privilege, and the potential for and distribution of risks and benefits, should determine communities selected as study sites and the inclusion criteria for individual subjects.
- Favorable risk–benefit ratio: Within the context of standard clinical practice and the research protocol, risks must be minimized and potential benefits enhanced, and the potential benefits to people and knowledge gained for society must outweigh the risks.
- Independent review: Unaffiliated people must review the research and approve, amend, or terminate it.
- Informed consent: People should be informed about the research and provide their voluntary consent.
- Respect for enrolled subjects: Subjects should have their privacy protected, the opportunity to withdraw, and their well-being monitored.

Federal regulations require that institutions receiving federal funding or conducting studies of drugs or medical devices regulated by the Food and Drug Administration establish institutional review boards (IRBs). The IRBs review all studies conducted in the institution to determine the risk status of all studies and to ensure that ethical principles are followed (see Chapter 6 for a full discussion of values and ethics in nursing).

The National Cancer Institute (NCI) offers an online training tutorial (with a certificate) titled, "Protecting Human Research Participants." You can access the tutorial on NCI's website, https://phrp.nihtraining.com/users/login.php. You will also find helpful resources on the Office for Human Research Protections (OHRP) website, http://www.hhs.gov/ohrp.

Application of Research to Practice

The most common impediments to nursing research include restricted access to resources, limited time to participate in research-related activities, and lack of educational preparation needed by nurses for research. Research about nursing education, administration, and practice all affect patient care directly or indirectly. Too often, practicing nurses mistakenly think research is far removed from caring for patients at the bedside. This false impression has slowed the progress of practice-based nursing research. Yet much of what bedside nurses routinely do constitutes research. The nursing process (i.e., assessing, diagnosing, planning, implementing, and evaluating) represents the basic framework of the research process.

QSEN EVIDENCE-BASED PRACTICE (EBP)

Nurses who value the concept of EBP as integral to determining best clinical practice regularly read relevant professional journals to keep their practice up to date. They similarly value the need for continuous improvement in clinical practice based on new knowledge.

Unless the research findings of nurse researchers are used by practicing nurses to improve the quality of patient care, clinical nursing research is useless. Nursing students developing clinical skills must understand the scientific

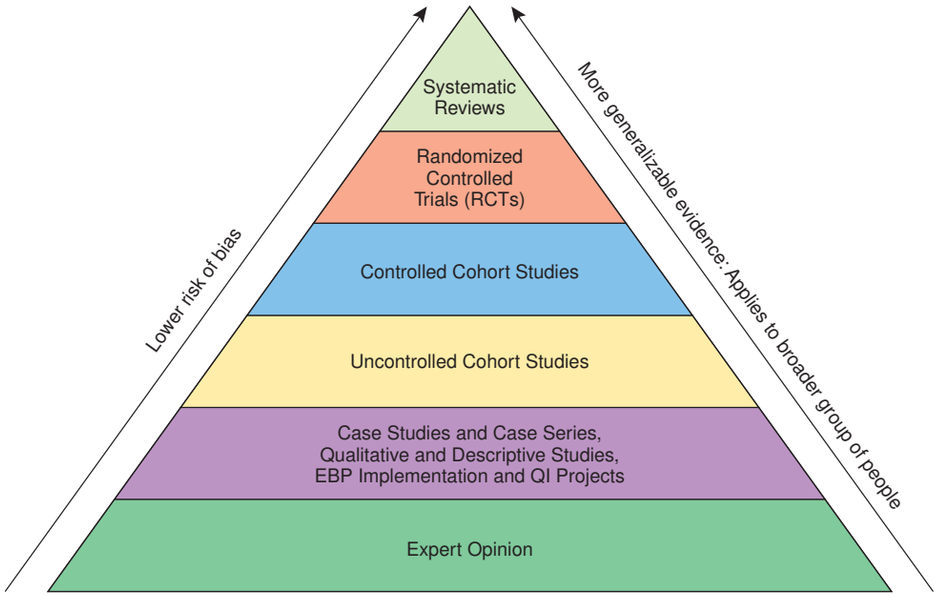

FIGURE 2-2. Hierarchy of evidence for intervention questions. (Adapted from Melnyk, B. M., & Fineout-Overholt, E. [2015]. *Evidence-based practice in nursing: A guide to best practice* [3rd ed., p. 92]. Philadelphia, PA: Wolters Kluwer Health. Used with permission.)

rationale that makes one course of action preferable to another. Throughout this text, Research in Nursing boxes highlight current studies that have the potential to make a positive difference in nursing practice and patient outcomes.

EVIDENCE-BASED PRACTICE

Nurses make decisions about many different aspects of patient care each day. For example, questions for consideration range from "What site should I use to take an infant's temperature?" to "How can I move my patient in bed to decrease complications and promote safety?" Patient safety and health may be adversely affected unless the most current best evidence is used to answer questions and make clinical decisions.

Evidence-based practice (EBP) in nursing is a problem-solving approach to making clinical decisions, using the best evidence available (considered "best" because it is collected from sources such as published research, national standards and guidelines, and reviews of targeted literature). See Figure 2-2 for a hierarchy of evidence.

Makic & Rauen (2016) identify essential elements of EBP as (1) the integration of best research and other forms of evidence to guide practice; (2) viewing clinical expertise as a component in care effectiveness; and (3) considering patients' preferences, values, and engagement in care decisions as essential to providing optimal evidence-based care to patient and their families (Fig. 2-3).

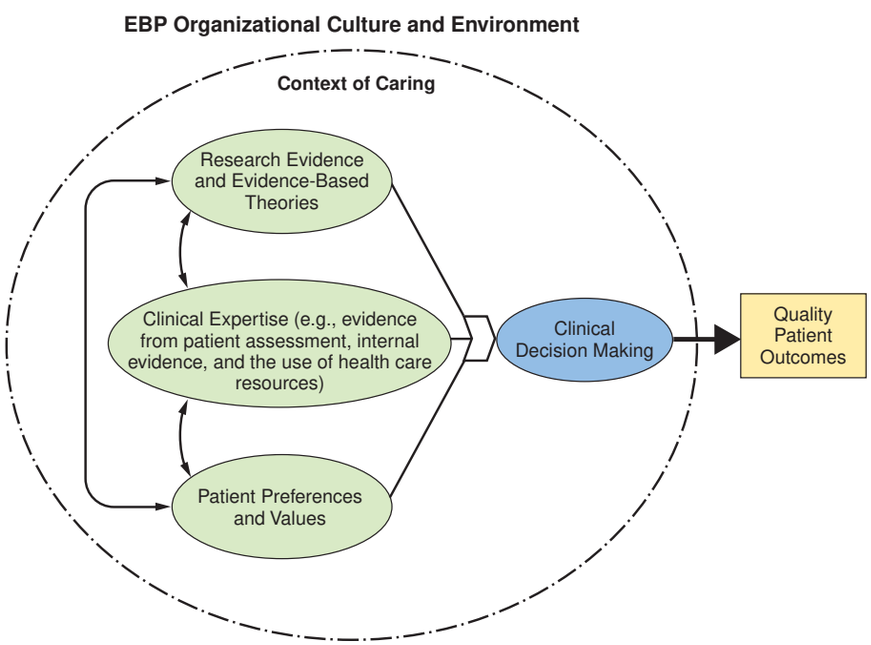

FIGURE 2-3. The merging of science and art: Evidence-based practice (EBP) within a context of caring and an EBP culture and environment results in the highest quality of health care and patient outcomes. (From Melnyk, B. M., & Fineout-Overholt, E. [2015]. *Evidence-based practice in nursing: A guide to best practice* [3rd ed., p. 5]. Philadelphia, PA: Wolters Kluwer Health. Used with permission.)

The steps of EBP are as follows (Melnyk & Fineout-Overholt, 2015, p. 2750):

- Cultivate a spirit of inquiry.
- Ask the burning clinical question in Population/Patient/Problem, Intervention, Comparison, Outcome, and Time (PICOT) format.
- Search for and collect the most relevant best evidence.
- Critically appraise the evidence (i.e., rapid critical appraisal, evaluation, and synthesis).
- Integrate the best evidence with one's clinical expertise and patient preferences and values in making a practice decision or change.
- Evaluate outcomes of the practice decision or change based on evidence.
- Disseminate the outcomes of the EBP decision or change.

EBP blends both the science and the art of nursing so that the best patient outcomes are achieved (Fig. 2-4).

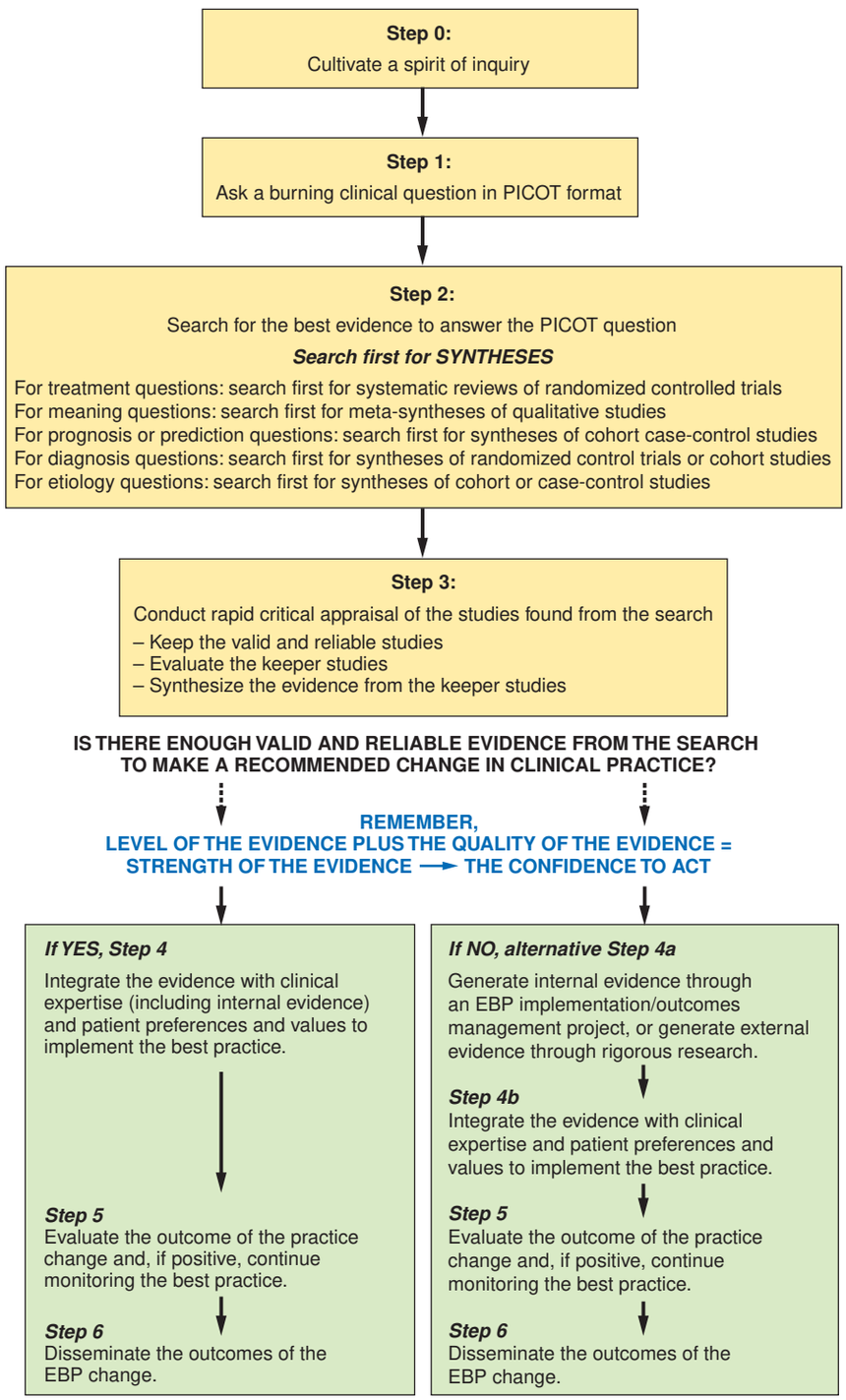

FIGURE 2-4. Steps of the evidence-based practice process leading to high-quality health care and best patient outcomes. (From Melnyk, B. M., & Fineout-Overholt, E. [2015]. *Evidence-based practice in nursing: A guide to best practice* [3rd ed., p. 15]. Philadelphia, PA: Wolters Kluwer Health. Used with permission.)

The information that is collected is analyzed and used to answer questions (the science of nursing), taking into consideration patient preferences and values, as well as the clinical experiences of the nurse (the art of nursing). EBP may consist of specific nursing interventions or may use guidelines established for the care of patients with certain illnesses, treatments, or surgical procedures.

Implementing EBP in clinical practice can present multiple challenges. Resistance to using EBP may arise in the current health care setting as a result of the nursing shortage, the acuity level of patients, nurses' skill in reading and evaluating published research, and an organizational culture that does not support change. Other factors include insufficient time to implement new ideas; insufficient time to read research; lack of authority to change patient care procedures; lack of support from physicians, managers, and other staff members; and inadequate infrastructure support, such as libraries and ethics committees (Yoder et al., 2014). However, to achieve desired outcomes for quality patient care and to demonstrate clinical nursing effectiveness, it is critical that nurses gain the necessary knowledge and skills to provide the best possible nursing care. The practice settings in which nurses work must support changes made based on EBP. The changes may be implemented by an individual nurse, by groups of nurses working together, or by interdisciplinary teams of health care providers.

Unfolding Patient Stories: Sara Lin • Part 1

Sara Lin, an 18-year-old female returned from the recovery room to the medical-surgical unit following an appendectomy. An intravenous (IV) line and indwelling urinary catheter were placed in the operating room. Sara is awake and can begin oral fluids and advance activity, as tolerated. The nurse reviews the provider orders and confirms the continuation of the IV for fluids and antibiotics. How does EBP support the nurse's clinical decision to contact the provider for an order to discontinue the urinary catheter? (Sara Lin's story continues in Chapter 18.)

Care for Sara and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimFunds). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

Johns Hopkins Nursing Evidence-Based Practice Model

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model is a powerful problem-solving approach to clinical decision making, and is accompanied by user-friendly tools to guide individual or group use. It is designed specifically to meet the needs of the practicing nurse and uses a three-step process called PET: practice question, evidence, and translation (Fig. 2-5). The goal of the model is to ensure

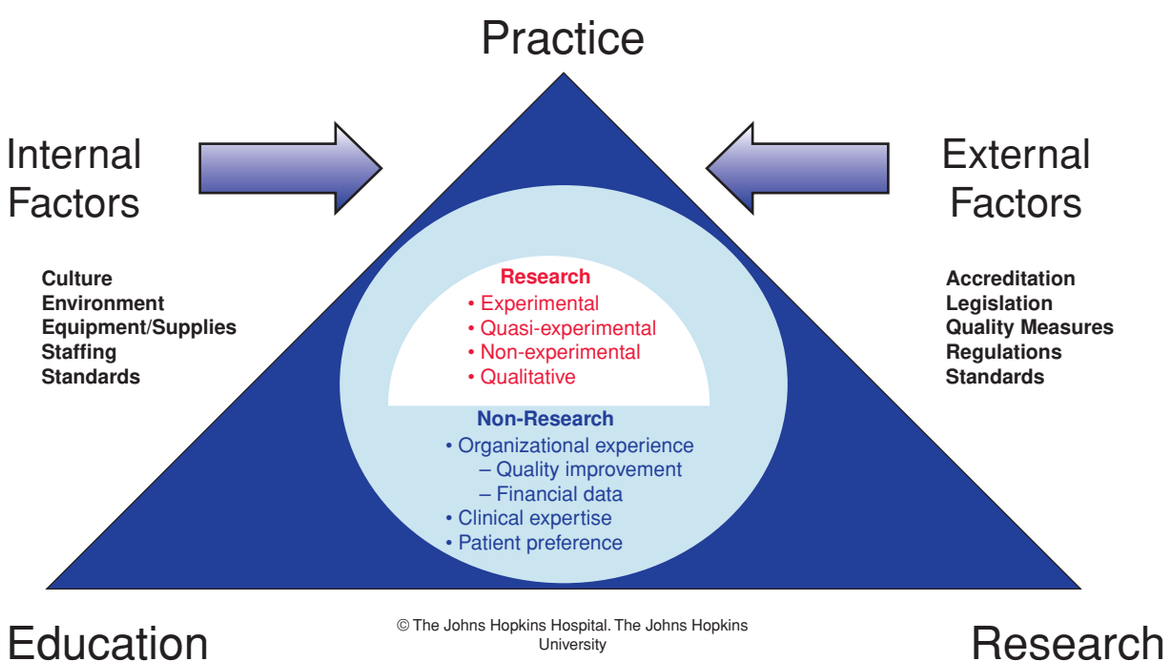

FIGURE 2-5. The Johns Hopkins Nursing Evidence-Based Practice model is a powerful problem-solving approach to clinical decision making and is accompanied by user-friendly tools to guide individual or group use. It is designed specifically to meet the needs of the practicing nurse and uses a three-step process called PET: practice question, evidence, and translation. The goal of the model is to ensure that the latest research findings and best practices are quickly and appropriately incorporated into patient care. (From John Hopkins Medicine Center for Evidence-Based Practice. Used with permission. ©The Johns Hopkins Hospital/The Johns Hopkins University.)

that the latest research findings and best practices are quickly and appropriately incorporated into patient care. Check the Johns Hopkins Medicine website for helpful tools: http://www.hopkinsmedicine.org/evidence-based-practice/jhn_ebp.html.

Rationale for Using Evidence-Based Practice

The impetus for EBP is based on the IOM report (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*, which challenged health care professionals to provide care based on scientific evidence. In addition, those interested in quality and cost control want evidence that the services and interventions being funded or reimbursed are effective in securing valued goals.

Until the mid-1990s, many large hospitals had research utilization departments directed by doctoral-prepared nurse scientists. These departments conducted research within the hospital to answer clinical practice questions, and used the research findings to dictate practice changes. Today, few hospitals use findings from their own research to direct clinical nursing practice. As a result of recent advances in information technology, findings from published literature can be found, analyzed, and applied to answer clinically relevant questions. Key databases and search engines may be easily accessed on most work computer stations as well as home computer systems. Many research articles in journals and guidelines developed by expert panels can be downloaded, read, evaluated, and shared with colleagues.

Therefore, the use of EBP mandates the analysis and systematic review of research findings. The first step for you as a student is to be able to read and understand a research article. To help you, the typical format of a research journal article with a description of each part is outlined in Table 2-6. See also Box 2-5 for a helpful checklist to use when reading and critiquing a research article.

Steps in Implementing EBP

To practice EBP, nurses carry out the following five steps (Melnyk & Fineout-Overholt, 2015).

Step 1: Ask a question about a clinical area of interest or an intervention. There are several different methods that can be used to ask clinical questions. The most common method is the PICOT format (Melnyk & Fineout-Overholt, 2015), described in Table 2-7. See the accompanying PICOT in Practice, for a sample of the development of a clinical question using PICOT and the EBP decision-making process; additional samples are found in selected chapters of this book.

Step 2: Collect the most relevant and best evidence. It is important to collect information that is regarded as the strongest level of evidence. The level for strength of evidence is numerical, with level 1 being the strongest and level 7 the lowest. The strongest ("best") evidence is provided by findings from systematic reviews, EBP guidelines, and meta-analyses. **Systematic reviews** summarize findings from multiple studies of a specific clinical practice question or topic, and recommend practice changes and future directions for research. **Evidence-based practice guidelines** synthesize information from multiple studies and recommend best practices to treat patients with a disease (e.g., hypertension), a symptom (e.g., chronic pain), or a disability (e.g., cognitive impairment). These guidelines are typically written by a panel of experts. A *meta-analysis* uses statistical analysis of the effect of a specific intervention across multiple studies, providing stronger evidence than results from a single study. If

Table 2-6 Parts of a Research Journal Article

SECTIONS (IN USUAL ORDER)	DESCRIPTION
Abstract	The abstract is at the beginning of the article. It summarizes the entire article and usually provides the purpose of the study; a description of the subjects, data collection, and data analysis; and a summary of important findings.
Introduction • Review of the literature • Statement of the purpose	The literature review discusses relevant studies that have been conducted in the area of this study. A statement of the specific goals or purpose of the study often follows the review.
Method • Subjects • Design • Data collection • Data analysis	The methods section describes in detail how the study was conducted, including the type and number of subjects, the research design used, what data were collected and how, and the types of analysis done. There should be enough information so that the study could be replicated (repeated).
Results	The results (findings) are often presented both in words and in charts, tables, or graphs. It is important to understand what the results were and whether they are meaningful.
Discussion (Conclusions)	The discussion section reports what the results mean in regard to the purpose of the study and the literature review. It may also include suggestions for further research and application to nursing education or practice, as appropriate.
References	The references are at the end of the article and include a list of articles and books used by the researcher.

Box 2-5 American Association of Critical Care Nurses' Resources for Online Searches

Systematic Reviews

A systematic review is a review of available research studies focusing on a single question. The systematic review summarizes, appraises, and synthesizes large bodies of evidence relevant to a focused research question.

- Cochrane Collaboration: www.cochrane.org
- Database of Abstracts of Reviews of Effectiveness (DARE): www.brad.ac.uk/library/elecinfo/dare.php
- Clinical Evidence: www.clinicalevidence.bmj.com
- The Joanna Briggs Institute (Library of Systematic Reviews): www.joannabriggs.edu.au/pubs/systematic_reviews.php
- PubMed: www.ncbi.nlm.nih.gov/entrez/query/static/clinical.shtml#reviews
- National Health Service (NHS) Evidence Health Information Resources—Specialist Collections: www.library.nhs.uk/specialistlibraries

Guideline Database

Guideline databases are searchable databases of evidence-based clinical practice guidelines.

- U.S. National Guideline Clearinghouse: www.guideline.gov
- U.S. Agency for Healthcare Research and Quality: www.ahrq.gov
- New Zealand Guidelines Group: www.nzgg.org.nz
- Trip Database: www.tripdatabase.com
- National Institute for Health Care Excellence (NICE): https://www.evidence.nhs.uk
- Institute for Healthcare Improvement: www.ihi.org/IHI/topics
- Centers for Disease Control: www.cdc.gov/hai
- Australian National Health and Medical Research Council: www.nhmrc.gov.au/guidelines/index.htm
- Michigan Quality Improvement Consortium Guidelines: www.mqic.org/guidelines.htm

Professional Organizations

Professional organizations often offer position statements, guidelines, protocols, and other documents to promote evidence-based practice.

- American Association of Critical Care Nurses: www.aacn.org
- Society of Critical Care Medicine: www.learnicu.org/Pages/Guidelines.aspx
- American College of Chest Physicians: www.chestnet.org

Online Clinical Databases

These databases allow literature searches for primary sources of evidence and research.

- The Cumulative Index of Nursing and Allied Health Literature (CINAHL) is a comprehensive resource for nursing and allied health literature; www.ebscohost.com/cinahl or access through www.aacn.org
- MEDLINE is the U.S. National Library of Medicine's (NLM) database that references journal articles focused on biomedicine. It can be searched for free through PubMed: www.ncbi.nlm.nih.gov/pubmed

Journals

Professional journals may contain abstracts with expert commentaries. Here are some suggestions; others exist beyond this listing.

- *Evidence-Based Nursing*: www.ebn.bmj.com
- *Evidence-Based Medicine*: www.ebm.bmj.com
- *British Medical Journal's Clinical Evidence*: www.clinicalevidence.com
- *American Journal of Critical Care,* Clinical Pearls Section: http://ajcc.aacnjournals.org
- *American College of Physicians Journal Club*: From AACN Searching for Evidence Toolkit. Resources for Online Search.

systematic reviews, EBP guidelines, and meta-analyses are not available, collect reviews of descriptive or qualitative studies or articles of original quantitative studies listed in databases such as MEDLINE and CINAHL (Cumulative Index to Nursing and Allied Health Literature). Box 2-6 (on page 42) provides a suggested list of resources for collecting evidence.

Step 3: Critically appraise the evidence. Ask three questions: (1) What were the results of the study? (2) Are the results valid (did the investigator measure what was intended to be measured) and reliable (were the measurements consistent across time)? (3) Will the results of the study improve patient care?

Table 2-7 Asking Clinical Questions in PICOT Format

COMPONENTS	CONSIDERATIONS
P = Patient, population, or problem of interest	Need for explicit description; may include setting, limiting to subgroups (such as by age)
I = Intervention of interest	The more defined, the more focused the search of the literature will be; may include exposure, treatment, patient perception, diagnostic test, or predicting factor
C = Comparison of interest	Usually a comparison to another treatment or the usual standard of care
O = Outcome of interest	Specifically identifying the outcome to enable a literature search to find evidence that examined the same outcome, perhaps in different ways
T = Time	The time when the comparison of interest is completed and the outcome can be evaluated

Box 2-6 Checklist for Reading and Critiquing a Research Article

1. Review the elements of the article.
   - Title describes the article.
   - Abstract summarizes the article.
   - Introduction makes the purpose clear.
   - Problem is properly introduced.
   - Purpose of the study is explained.
   - Research question(s) are clearly presented.
   - Theoretical framework informs the research.
   - Literature review is relevant and comprehensive and includes recent research.
   - Methods section details how the research questions were addressed or hypotheses were tested.
   - Analysis is consistent with the study questions and research design.
   - Results are clearly presented and statistics clearly explained.
   - Discussion explains the results in relation to the theoretical framework, research questions, and significance to nursing.
   - Limitations are presented and their implications discussed.
   - Conclusion includes recommendations for nursing practice, future research, and policymakers.
2. Determine the level and quality of the evidence using a scale (several can be found in ANA's Research Toolkit http://www.nursingworld.org/Research-Toolkit/Appraising-the-Evidence).
3. Decide if the study is applicable to your practice.

Source: From Kaplan, L. (2012). Reading and critiquing a research article. *American Nurse Today, 7*(10). Used with permission. Copyright ©2018, HealthCom Media. All rights reserved. American Nurse Today, October 2012.

PICOT in Practice

ASKING CLINICAL QUESTIONS: PRESSURE INJURY

Scenario: You are a staff nurse in a specialty long-term care facility for adult patients with spinal cord injuries. Patients admitted to your unit usually are young and have had injuries that resulted in quadriplegia. The patients are at risk for pressure injuries.

In a monthly staff meeting, you report that the incidence of pressure injuries on the unit in each of the most recent quarters was higher than it had been for any of the previous 12 quarters. The nurse manager notes that monies have been allocated in the current budget for purchase of new equipment as needs are identified. The nurse manager gives the staff information on a new type of low air loss alternating pressure mattress that is reported to be "more effective in preventing pressure injuries than the alternating pressure mattress overlays now being used." The nurse manager requests that the staff make a recommendation about purchase of the new pressure injury prevention mattress.

- **Problem:** Adults at risk for pressure injuries
- **Intervention:** Low air loss alternating pressure mattress
- **Comparison:** Alternating pressure mattress overlays
- **Outcome:** Incidence of pressure injuries
- **Time:** During admission to a long-term care facility

PICOT Question: Is the use of a low air loss alternating pressure mattress more effective than an alternating pressure mattress overlay in preventing pressure injuries among a population of patients with quadriplegia during admission to a long-term care facility?

Findings

1. Ratliff, C. R., & Droste, L. R. (2016). Guidelines for the prevention and treatment of pressure ulcers (injuries). Wound, Ostomy, and Continence Nurses Society. Retrieved https:// www. guideline.gov/summaries/summary/50473/guideline-for-prevention-and-management-of-pressure-ulcer

2. McNichol, L., Watts, C., Mackey, D., Beitz, J. M., & Gray, M. (2015). Identifying the right surface for the right patient at the right time: Generation and content validation of an algorithm for support surface selection. *Journal of Wound Ostomy Continence Nursing, 42*(1), 19–37.

Results of four high-quality systematic reviews reveal insufficient evidence to conclude superiority of one type of support surface over another. Guidelines across multiple organizations support that the use of support surfaces is not a stand-alone intervention for the prevention of pressure injuries. A pressure injury prevention program should include a routine assessment of skin, risk for pressure injuries, weight and mobility of patient, nutritional status, skin moisture, pressure redistribution when in bed and chair, repositioning, and patient and caregiver education.

Level of Evidence C: Two or more supporting case series of at least 10 humans with pressure injuries, or expert opinion.
Strength of Recommendation Class III: Intervention is indicated, recommended, and should be done.
Recommendations: Based on the staff's review of the literature, a recommendation NOT to buy the new pressure prevention mattress was made to the nurse manager.

In addition, the staff recommend that the current nursing protocol for prevention of pressure injuries be reviewed to assure that current evidence-based recommendations for assessment risk and non-support surface interventions were included. The decision about which support surface intervention to use should be based on development of the evidence-based algorithm for selection of the right surface for the right patient at the right time developed by the Wound, Ostomy, and Continence Nurse Society.

The staff also recommended that:

1. An analysis of type of patients presenting to the facility for long-term care who are at risk for pressure injuries be conducted to determine the most common types of support surface devices needed per the algorithm.
2. An inventory of support surfaces be recommended in the algorithm that is currently available in the facility.
3. An educational program be developed for staff regarding any revisions made in the revised pressure injury prevention program and use of the algorithm for selection of a support surface.

Step 4: Integrate the evidence with clinical expertise, patient preferences, and values in making a decision to change. Patients want to be involved in decision making about their care; if evidence is found to support a change but the patient does not want it, the change should not occur. If the change that is proposed cannot be applied in a practical sense, or is too costly or too risky, then the change should also not occur. For example, the most reliable method to determine if a nasogastric tube is correctly placed is by x-ray examination. However, this method of verification is costlier and more risky to the patient (i.e., through exposure to radiation) than other methods; therefore, it is not considered the preferred method in many situations.

Step 5: Evaluate the practice decision or change. The evaluation step is essential to determining if the change is effective for a particular patient or setting and if the expected outcomes resulted from the change.

It is important for nurses and the patients they care for to implement EBP in their clinical practice. "In doing so, patients, health care professionals, and health care systems will be able to place more confidence in the care that is being delivered and know the best outcomes for patients and their families are being achieved" (Melnyk & Fineout-Overholt, 2015).

QUALITY IMPROVEMENT

In health care, we value research that generates new knowledge to improve the quality of the care patients experience. The Health Resources and Services Administration (HRSA) defines **quality improvement (QI)** as systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. Not surprisingly HRSA notes that an important measure of quality is the extent to which patients' needs and expectations are met. Services that are designed to meet the needs and expectations of patients and their communities include:

- Systems that affect patient access
- Care provision that is evidence based
- Patient safety
- Support for patient engagement
- Coordination of care with other parts of the larger health care system
- Cultural competence, including assessing health literacy of patients, patient-centered communication, and linguistically appropriate care

Nurses who are part of QI teams work collaboratively with their colleagues asking the questions:

- What are the desired improvements?
- How are changes and improvements measured?
- How is staff organized to accomplish the work?
- How can QI models be leveraged to accomplish improvements effectively and efficiently?
- How is change managed?

There are many QI models in use. Figure 2-6 illustrates how the popular Plan-Do-Study-Act (PDSA) model is used to test and implement changes in real-work settings. Read more about QI and performance improvement in everyday clinical practice in Chapter 18.

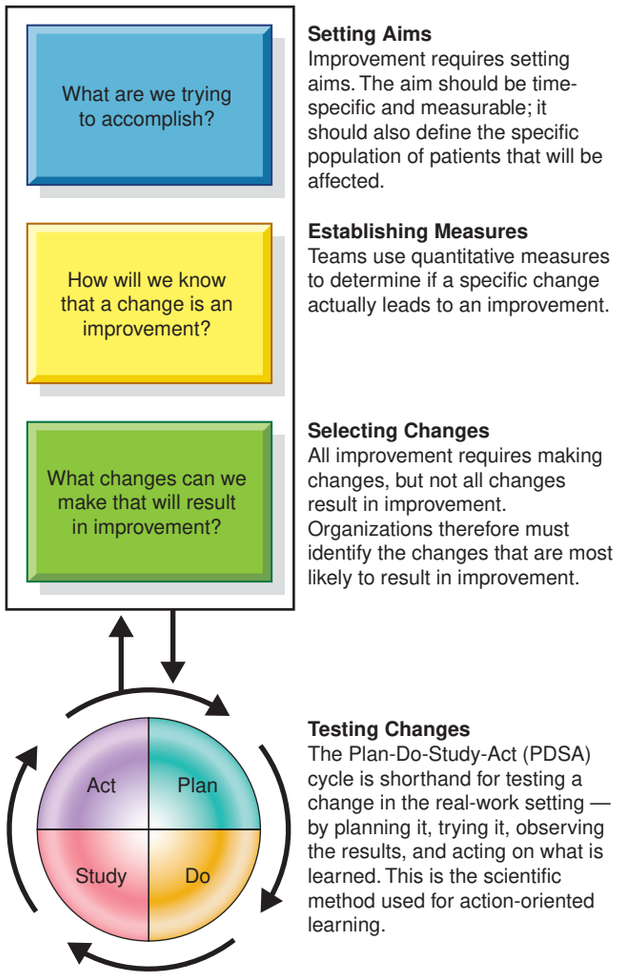

FIGURE 2-6. Model for improvement. Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real-work settings. The PDSA cycle guides the test of change to determine if the change is an improvement. (Adapted from Institute for Health Care Improvement. *Health system and services research*. Retrieved https://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/part3.html.)

DEVELOPING CLINICAL REASONING

1. Describe your own beliefs about the patient, the nurse, health, and what nursing is. Compare and contrast your answers with those of another student. How do they differ and how are they alike? How do you think such differences might influence nursing practice for each of you?
2. In preparation for your clinical assignment, you read three research articles about positioning and moving patients who are at risk for pressure injuries (bedsores). The staff nurse responsible for the patient tells you, "Oh, I don't pay any attention to that stuff." How should you respond?
3. Describe the research strategy you would use to identify evidence-based interventions to reduce sexual

misconduct and assault on your campus or to help people stop smoking.

PRACTICING FOR NCLEX

1. A student nurse asks an experienced nurse why it is necessary to change the patient's bed every day. The nurse answers: "I guess we have just always done it that way." This answer is an example of what type of knowledge?
   a. Instinctive knowledge
   b. Scientific knowledge
   c. Authoritative knowledge
   d. Traditional knowledge
2. A nurse is using the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model PET as a clinical decision-making tool when delivering care to patients. Which steps reflect the intended use of this tool? Select all that apply.
   a. A nurse recruits an interprofessional team to develop and refine an EBP question.
   b. A nurse draws from personal experiences of being a patient to establish a therapeutic relationship with a patient.
   c. A nurse searches the Internet to find the latest treatments for type 2 diabetes.
   d. A nurse uses spiritual training to draw strength when counseling a patient who is in hospice for an inoperable brain tumor.
   e. A nurse questions the protocol for assessing postoperative patients in the ICU.
   f. A nursing student studies anatomy and physiology of the body systems to understand the disease states of assigned patients.
3. A nurse is using general systems theory to describe the role of nursing to provide health promotion and patient teaching. Which statements reflect key points of this theory? Select all that apply.
   a. A system is a set of individual elements that rarely interact with each other.
   b. The whole system is always greater than the sum of its parts.
   c. Boundaries separate systems from each other and their environments.
   d. A change in one subsystem will not affect other subsystems.
   e. To survive, open systems maintain balance through feedback.
   f. A closed system allows input from or output to the environment.
4. A charge nurse meets with staff to outline a plan to provide transcultural nursing care for patients in their health care facility. Which theorist promoted this type of caring as the central theme of nursing care, knowledge, and practice?
   a. Madeline Leininger
   b. Jean Watson
   c. Dorothy E. Johnson
   d. Betty Newman
5. A student nurse interacting with patients on a cardiac unit recognizes the four concepts in nursing theory that determine nursing practice. Of these four, which is most important?
   a. Person
   b. Environment
   c. Health
   d. Nursing
6. A nurse manager schedules a clinic for the staff to address common nursing interventions used in the facility and to explore how they can be performed more efficiently and effectively. The nurse manager's actions to change clinical practice are an example of a situation described by which nursing theory?
   a. Prescriptive theory
   b. Descriptive theory
   c. Developmental theory
   d. General systems theory
7. When conducting quantitative research, the researcher collects information to support a hypothesis. This information would be identified as:
   a. The subject
   b. Variables
   c. Data
   d. The instrument
8. A nurse is conducting quantitative research to examine the effects of following nursing protocols in the emergency department (ED) on patient outcomes. This is also known as what type of research?
   a. Descriptive
   b. Correlational
   c. Quasi-experimental
   d. Experimental
9. A nurse studies the culture of Native Alaskans to determine how their diet affects their overall state of health. Which method of qualitative research is the nurse using?
   a. Historical
   b. Ethnography
   c. Grounded theory
   d. Phenomenology
10. A nurse is formulating a clinical question in PICOT format. What does the letter *P* represent?
    a. Comparison to another similar protocol
    b. Clearly defined, focused literature review of procedures
    c. Specific identification of the purpose of the study
    d. Explicit descriptions of the population of interest

ANSWERS WITH RATIONALES

1. d. Traditional knowledge is the part of nursing practice passed down from generation to generation, often without

research data to support it. Scientific knowledge is that knowledge obtained through the scientific method (implying thorough research). Authoritative knowledge comes from an expert and is accepted as truth based on the person's perceived expertise. Instinct is not a source of knowledge.

2. **a, c, e.** The JHNEBP model is a powerful problem-solving approach to clinical decision making, and is accompanied by user-friendly tools to guide individual or group use. It is designed specifically to meet the needs of the practicing nurse and uses a three-step process called PET: practice question, evidence, and translation. The goal of the model is to ensure that the latest research findings and best practices are quickly and appropriately incorporated into patient care. Steps in PET include, but are not limited to, recruiting an interprofessional team, developing and refining the EBP question, and conducting internal and external searches for evidence.
3. **b, c, e.** According to general systems theory, a system is a set of interacting elements contributing to the overall goal of the system. The whole system is always greater than its parts. Boundaries separate systems from each other and their environments. Systems are hierarchical in nature and are composed of interrelated subsystems that work together in such a way that a change in one element could affect other subsystems, as well as the whole. To survive, open systems maintain balance through feedback. An open system allows energy, matter, and information to move freely between systems and boundaries, whereas a closed system does not allow input from or output to the environment.
4. **a.** Madeline Leininger's theory provides the foundations of transcultural nursing care by making caring the central theme of nursing. Jean Watson stated that nursing is concerned with promoting and restoring health, preventing illness, and caring for the sick. The central theme of Dorothy E. Johnson's theory is that problems arise because of disturbances in the system or subsystem or functioning below optimal level. Betty Newman proposed that humans are in constant relationship with stressors in the environment and the major concern for nursing is keeping the patient system stable through accurate assessment of these stressors.
5. **a.** Of the four concepts, the most important is the person. The focus of nursing, regardless of definition or theory, is the person.
6. **a.** Prescriptive theories address nursing interventions and are designed to control, promote, and change clinical nursing practice. Descriptive theories describe a phenomenon, an event, a situation, or a relationship. Developmental theory outlines the process of growth and development of humans as orderly and predictable, beginning with conception and ending with death. General systems theory describes how to break whole things into parts and then to learn how the parts work together in "systems."
7. **c.** Data refer to information that the researcher collects from subjects in the study (expressed in numbers). A variable is something that varies and has different values that can be measured. Instruments are devices used to collect and record the data, such as rating scales, pencil-and-paper tests, and biologic measurements.
8. **c.** Quasi-experimental research is often conducted in clinical settings to examine the effects of nursing interventions on patient outcomes. Descriptive research is often used to generate new knowledge about topics with little or no prior research. Correlational research examines the type and degree of relationships between two or more variables. Experimental research examines cause-and-effect relationships between variables under highly controlled conditions.
9. **b.** Ethnographic research was developed by the discipline of anthropology and is used to examine issues of culture of interest to nursing. Historical research examines events of the past to increase understanding of the nursing profession today. The basis of grounded theory methodology is the discovery of how people describe their own reality and how their beliefs are related to their actions in a social scene. The purpose of phenomenology (both a philosophy and a research method) is to describe experiences as they are lived by the subjects being studied.
10. **d.** The *P* in the PICOT format represents an explicit description of the patient population of interest. *I* represents the intervention, *C* represents the comparison, *O* stands for the outcome, and *T* stands for the time.

TAYLOR SUITE RESOURCES

Explore these additional resources to enhance learning for this chapter:

- NCLEX-Style Questions and other resources on thePoint®, http://thePoint.lww.com/Taylor9e
- *Study Guide for Fundamentals of Nursing,* 9th edition
- Adaptive Learning | Powered by PrepU, http://thepoint.lww.com/prepu

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3

Health, Wellness, and Health Disparities

Ruth Jacobi

Ruth is a 62-year-old woman who was hospitalized after a "mini-stroke." She has now returned to her pre-event level of functioning and is being prepared for discharge. She states, "I know that I have an increased risk for a major stroke, so I want to do everything possible to stay as active and as healthy as I possibly can."

Sara Gelbart

Sara, a college freshman, is encouraged to visit the student health center by her roommate because she rarely visits the dining hall for meals, runs 5 to 8 miles a day, and has recently lost a significant amount of weight. She is very thin now, and when she does eat a meal, she just seems to move the food around on her plate. Sara states, "I'm plenty healthy, just a bit 'nuts' about being fit!"

Daniel Sternman

Daniel, a 27-year-old man with a history of schizophrenia, comes to the mental health clinic, loudly demanding relief from the voices that are telling him to hurt himself.
Mr. Sternman is well known by the clinic staff. His medical record reveals that he has had numerous visits to the clinic and that he has difficulty interacting and dealing with various staff members.

Learning Objectives

After completing the chapter, you will be able to accomplish the following:

1. Describe concepts and models of health, wellness, disease, and illness.
2. Compare and contrast acute illness and chronic illness.
3. Discuss the factors that play a role in health equity and health disparities
4. Explain how the human dimensions, basic human needs, and self-concept influence health and illness.
5. Summarize the role of the nurse in promoting health, preventing illness, and addressing disparities in health care.
6. Explain the levels of preventive care.

Key Terms

acute illness
chronic illness
disease
exacerbation
health
health disparity
health equity
health promotion
holistic health care
illness
morbidity
mortality
remission
risk factor
social determinants of health
vulnerable population
wellness

The primary objectives of the nurse as caregiver are to promote health, to prevent illness, to restore health, and to facilitate coping with illness, disability, or death. These objectives focus care on maximizing the health of patients of all ages and in all populations, in all settings, and in both health and illness.

Health is more than just the absence of illness; it is an active process in which a person moves toward his or her maximum potential. Each person has a different definition of health. (See the accompanying Reflective Practice box for an example.) To give person-centered **holistic health care**—care that addresses the many dimensions that comprise the whole person—the nurse must understand and respect each person's own definition of health and responses to illness, and should be familiar with models of health and illness. The nurse's knowledge of health and illness is even more important because of today's focus on health promotion and advocacy, the continuing trend toward care being provided in the home and community, the increasing numbers of older adults, the growing incidence of chronic illnesses, and the ongoing efforts to maximize health care outcomes for all populations.

The 2013 report by the Institute of Medicine and the National Research Council provides additional impetus to foster positive health behaviors. Compared to 16 other affluent countries, the United States has a serious health disadvantage despite the fact that the country spends twice as much per person on health care in comparison to the other nations in the survey. Americans fare worse in nine key health areas: infant mortality and low birth weight, injuries and homicides, teenage pregnancies and sexually transmitted infections, prevalence of HIV and AIDS, drug-related deaths, obesity and diabetes, heart disease, chronic lung disease, and disability. There is agreement that the United States must vigorously investigate potential explanations for this health disadvantage, as well as intensify efforts to strengthen systems responsible for health and social services, education and employment; promote healthy lifestyles; and design healthier environments. Some of these problems are long-standing concerns, and many evidence-based strategies have been implemented to address these challenges. The United States can no longer afford to ignore these compelling issues. Better health must be an achievable outcome for all Americans (Woolf & Aron, 2013). As this text goes to publication, Congress is again trying to decide how best to meet the health care needs of citizens. See Chapter 11.

CONCEPTS OF HEALTH AND WELLNESS

A classic definition of health is that **health** is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (World Health Organization, 1974). The health of the public is measured globally by **morbidity** (how frequently a disease occurs) and **mortality** (the numbers of deaths resulting from a disease). On a personal level, however, most people define health according to how they feel ("I feel really sick"), the absence or presence of symptoms of illness ("I have a terrible pain in my stomach"), or their ability to carry out activities of daily living ("I felt so much better that I got up and cooked supper"). The accompanying feature, Through the Eyes of a Student (on page 50), presents a personal viewpoint of the meaning of health.

Each person defines health in terms of his or her own values and beliefs. The person's family, culture, community, and society also influence this personal perception of health.

Think back to ***Sara Gelbart***, the college freshman who rarely eats and runs several miles almost daily. According to her statement, she considers herself to be healthy. However, her roommate is concerned because of what she views as excessive exercise and Sara's poor nutrition. The nurse needs to investigate Sara's views further to determine exactly what Sara believes to be healthy. Doing so provides a foundation on which to develop an appropriate care plan.

QSEN Reflective Practice: Cultivating QSEN Competencies

CHALLENGE TO ETHICAL AND LEGAL SKILLS

My first college roommate, Sara Gelbart, seemed the ideal roommate when I first met her. A good student, she was thoughtful, outgoing, and fun. By October, however, I was really worried about her. I noticed that she rarely wanted to come to the dining hall with our group of friends. When she did come, she just seemed to pick at her food. She also spent a lot of time at the athletic center, running 5 to 8 miles almost daily. I wasn't surprised when she started losing significant amounts of weight. What worried me was her lack of willingness to talk about her nutritional habits and health. She told me that she was plenty healthy, just a bit "nuts" about being fit! She also kidded that I'd be healthier if I worked out more often with her. While she was certainly right about that, I was worried that she had a serious eating disorder and wasn't sure what I could do to help. She politely told me to "mind my own business" when I asked her if she had ever spoken with anyone about her health and eating.

Thinking Outside the Box: Possible Courses of Action

- Respect Sara's wishes and simply try to be a good friend without continuing to confront her about her nutritional status.
- Tell Sara I am concerned that she has a serious eating disorder, and then plan the next steps with her, fully respecting her right to seek or refuse professional help.
- Tell Sara that if she fails to get professional help, I will contact her parents or a counselor at school.

Evaluating a Good Outcome: How Do I Define Success?

- Sara gets whatever help she needs to address her eating problems and regain health.
- Sara's right to make her own decisions is respected.
- My obligations as a friend are fulfilled.
- My beginning ability to identify and correctly respond to health problems affirms my choice for nursing.

Personal Learning: Here's to the Future!

Unfortunately, I did not intervene because (1) I failed to recognize how serious a problem this would become, and (2) I wasn't sure what I could do after Sara refused my initial offers of help. Sara dropped out of school at the end of our freshman year and she has not returned my calls, so I'm not sure how she is doing. I've read more about eating disorders, and I now know how important it is to get professional help early. I learned too late that Sara had been in treatment for anorexia during high school and that the pressures of college life had led to a relapse. I think I valued her friendship more than I valued getting her the help that she needed to address a serious health problem.

QSEN SELF-REFLECTION ON QUALITY AND SAFETY COMPETENCIES DEVELOPING KNOWLEDGE, SKILLS, AND ATTITUDES FOR CONTINUOUS IMPROVEMENT

How do you think you would respond in a similar situation? Why? What does this tell you about yourself and about the adequacy of your skills for professional practice? Can you think of other ways to respond? Do you agree with the criteria that the nursing student used to evaluate a successful outcome? Why or why not? What *knowledge, skills,* and *attitudes* do you need to develop to continuously improve quality and safety when caring for patients like Sara?

Patient-Centered Care: What is the best approach when Sara denies that she has an eating problem? If Sara refuses any help, is it better to focus on her positive attributes and avoid conflict regarding her current situation? How might the student's and Sara's developmental level have affected their responses? How should you, as her roommate and friend, proceed? What is the best way to communicate emotional support, concern, and caring to Sara?

Teamwork and Collaboration/Quality Improvement: What communication skills do you need in order to facilitate your role as a patient advocate for Sara? As a student nurse, what other skills do you need to respond appropriately in this situation? Should you offer to make an appointment for her with a professional (nutritionist, counselor, nurse) or offer to accompany her to an appointment?

Safety/Evidence-Based Practice: Can you secure any evidence in nursing literature that provides information related to eating disorders and the need for professional treatment? Should you share this information with Sara? What response best contributes to a safe environment for Sara?

Informatics: If you were completing a rotation in a clinical setting as a student nurse, what information should you document electronically regarding your assessment of a patient like Sara and her response to any interventions?

Through the Eyes of a Student

Carrie was a 17-year-old brunette who attended my high school, dated my best friend Ricky, and participated in many of the same clubs and activities as me. By looking at her, I never would have guessed anything was wrong. However, once I got to know her, I learned that she was diagnosed with cancer and that the disease had spread through her heart and lungs. The situation, as doctors continually told her, did not look promising. Yet, she never once let that slow her down, and she lived each day to the fullest. It was almost 1 year ago I watched this friend pass away from bone cancer. However, until the days before her last breath, in my eyes she was a happy and healthy girl. She never once let the disease get the best of her, and she fought for life every second of every day. Her constant optimism and determined smile touched and moved so many others. So you ask me, was Carrie healthy?

Health to me is a state of mind, not the physical condition of a person's body. Carrie, in my opinion, was the definition of healthy: she was happy, she lived her life to the fullest, and she continually inspired others to embrace life. The dictionary may state that health is the absence of a disease; however, for me it is the way a person thinks and reacts to life. A person's health consists of being able to work to the best of her capability, look out for herself, and her ability to respond to life enthusiastically. In my eyes, a person like Carrie can be physically unwell, but in terms of living, is healthy. Perhaps this is where health and wellness differ in that, to me, health means the person's entire state of being and is decided by the person, whereas wellness refers more to the physical condition of a person and is determined more readily by society. The words *illness* and *disease* also correspond with these words. I believe that illness, like health, is a matter of thinking, while disease is a medical term that relates to physical condition and wellness. All of these states are constantly changing, and I have probably experienced the best and worst of all of them. However, as I embark on this new and exciting journey of college, I consider myself extremely healthy. I am living each day to the fullest, trying to impact other people's lives, and am filled with optimism. This all may change shortly, but as I look back on Carrie's life and the effect she has had on me, I will always try to live my life in a healthy and grateful way.

—Molly Proskine, Georgetown University

Health integrates all the human dimensions—the physical, intellectual, emotional, sociocultural, spiritual, and environmental aspects of the whole person. The nurse giving holistic care must equally consider all these interrelated dimensions of the whole person (Fig. 3-1).

FIGURE 3-1. The human dimensions. All of these interdependent parts compose the whole person.

Unfolding Patient Stories: Kim Johnson • Part 1

Kim Johnson, a 26-year-old, single, African American police officer is hospitalized with a thoracic spinal cord injury from a gunshot wound and is now paraplegic. What factors influencing health status and recovery should the nurse consider for each human dimension when developing an individualized, holistic care plan for Kim? (Kim Johnson's story continues in Chapter 11.)

Care for Kim and other patients in a realistic virtual environment: ***vSim*** *for Nursing* (thepoint.lww.com/vSimFunds). Practice documenting these patients' care in DocuCare (thepoint.lww.com/DocuCareEHR).

Wellness—a term often used interchangeably with health—is an active state of being healthy, including living a lifestyle that promotes good physical, mental, and emotional health. Dunn (1977) described his model of high-level wellness as functioning to one's maximum potential while maintaining balance and a purposeful direction in the environment. Dunn differentiated "wellness" from "good health," believing that good health is a passive state simply denoting that the person is not ill at this time. Wellness is a more active state, regardless of one's level of health. Dunn also defined processes that help people know who and what they are. These processes, which are a part of each person's perception of his or her own wellness state, are *being* (recognizing oneself as separate and individual), *belonging* (being part of a whole), *becoming* (growing and developing), and *befitting* (making personal choices to befit oneself for the

future). Dunn's model encourages the nurse to care for the total person, with regard for all factors affecting the person's state of being while striving to reach maximum potential.

CONCEPTS OF ILLNESS AND DISEASE

Disease is a medical term, referring to pathologic changes in the structure or function of the body or mind. Box 3-1 lists common causes of disease. An **illness** is the response of the person to a disease; it is a process in which the person's level of functioning is changed when compared with a previous level. This response is unique for each person and is influenced by self-perceptions, others' perceptions, the effects of changes in body structure and function, the effects of those changes on roles and relationships, and cultural and spiritual values and beliefs. A disease is traditionally diagnosed and treatment is prescribed by a health care provider or advanced practice nurse, whereas nurses focus on the person with an illness. However, the terms *disease* and *illness* are often used interchangeably. It is important for nurses to remember that a person may have an illness or injury but still achieve maximum functioning and quality of life, and consider himself or herself to be healthy.

Classifications of Illness

Illnesses are classified as either acute or chronic. A person may have an acute illness, a chronic illness, or both at the same time; for example, an adult with diabetes (a chronic illness) may also have an acute episode of severely low blood sugar.

Acute Illness

An **acute illness** usually has a rapid onset of symptoms and lasts only a relatively short time. Although some acute illnesses are life threatening, simple acute illnesses, such as the common cold or diarrhea, do not usually require medical treatment. If medical care is required, a specific treatment with medication (e.g., an antibiotic for pneumonia), surgical procedures (e.g., an appendectomy for appendicitis), or another medical treatment usually return the person to normal functioning.

Box 3-1 Common Causes of Diseases

- Inherited genetic defects
- Developmental defects resulting from exposure to such factors as viruses or chemicals during pregnancy
- Biologic agents or toxins
- Physical agents such as temperature, chemicals, and radiation
- Generalized tissue responses to injury or irritation
- Physiologic and emotional reactions to stress
- Excessive or insufficient production of body secretions (hormones, enzymes, and so forth)

Chronic Illness

Chronic illness is a broad term that encompasses a number of different physical and mental alterations in health, each having one or more of the following characteristics:

- It is a permanent change.
- It causes, or is caused by, irreversible alterations in normal anatomy and physiology.
- It requires special patient education for rehabilitation.
- It requires a long period of care or support.

Chronic illnesses usually have a slow onset and many have periods of **remission** (the disease is present, but the person does not experience symptoms) and **exacerbation** (the symptoms of the disease reappear).

Recall ***Daniel Sternman***, the young man with schizophrenia. The nurse would integrate knowledge of this disorder, understanding that it is a chronic illness that can be treated. The patient's arrival at the clinic with reports of hearing voices would indicate to the nurse that symptoms of the disorder have reappeared, necessitating treatment.

The Centers for Disease Control and Prevention (CDC) reports that chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, disabling and preventable of all health problems (CDC, 2016a, 2016b). A 2014 CDC study found that each year, nearly 900,000 Americans die prematurely from the five leading causes of death (heart disease, cancer, chronic lower respiratory disease, stroke, and unintentional injury), yet 20% to 40% of the deaths from each cause could have been prevented.

The chronic disease burden in the United States largely results from a short list of risk factors that can be effectively addressed for individuals and populations. These risk factors include tobacco use, poor diet and physical inactivity (both strongly associated with obesity), excessive alcohol consumption, uncontrolled high blood pressure, and hyperlipidemia (Bauer, Briss, Goodman, & Bowman, 2014).

To help to meet the chronic disease burden, the CDC uses four cross-cutting strategies: (1) epidemiology and surveillance to monitor trends and inform programs; (2) environmental approaches that promote health and support healthy behaviors; (3) health system interventions to improve the effective use of clinical and other preventive services; and (4) community resources linked to clinical services that sustain improved management of chronic conditions. This approach is based on the assumption that establishment of community conditions to support healthy behaviors and promote effective management of chronic conditions will deliver healthier students to schools, healthier workers to employers and businesses, and a healthier population to the health care system (Bauer et al., 2014, p. 45).

Because chronic illnesses are the leading health problem in the world, the health promotion and illness prevention

activities discussed later in this chapter are vital to nursing care. Nurses will be caring for more patients with chronic illnesses in the future. Although not all people with a chronic illness require care, all who are chronically ill must accept certain conditions of life to be able to live with the illness on a day-to-day basis for the rest of their lives. People with a chronic illness often grieve over losses or changes in physical structure and function; worry about their finances, status, roles, and dignity; and face the possibility of an earlier death.

To successfully adapt to a chronic illness, the person must learn to live as normally as possible and maintain a positive self-concept and sense of hope, despite symptoms and treatments that may make the person feel different from others. Activities of daily living, relationships, and self-care activities must often be modified, and it is important that the person maintain a feeling of being in control of his or her own life and the prescribed treatments.

Nurses care for people of all ages with chronic illnesses, providing that care in all types of settings, including homes, hospitals, clinics, long-term care facilities, and other institutions. Regardless of the age of the patient or the effects and demands of the illness or the setting, the nurse must make every effort to promote health for patients with chronic illness, with a focus of care that emphasizes what is possible rather than what can no longer be.

Illness Behaviors

When a person becomes ill, certain illness behaviors may occur in identifiable stages (Suchman, 1965). These behaviors are how people cope with altered functioning caused by the disease. They are unique to the person and are influenced by age, biological sex, family values, economic status, culture, educational level, and mental status.

There is no specific timetable for the stages-of-illness behaviors, which may occur rapidly or slowly. Nursing roles throughout the stages remain constant. In all stages, the nurse accepts the patient as an individual, gives nursing care based on prioritized needs, and facilitates recovery through physical care, emotional support, and health education.

STAGE 1: EXPERIENCING SYMPTOMS

How do people define themselves as "sick"? The first indication of an illness usually is recognizing one or more symptoms that are incompatible with one's personal definition of health. Although pain is the most common symptom indicating illness, other common symptoms include a rash, fever, bleeding, or a cough. If the symptoms last for a short time or are relieved by self-care, the person usually takes no further action. If the symptoms continue, however, the person enters the next stage.

STAGE 2: ASSUMING THE SICK ROLE

The person now self-defines as being sick, seeks validation of this experience from others, gives up normal activities, and assumes a "sick role." At this stage, most people focus on their symptoms and bodily functions. Depending on individual health beliefs and practices, the person may choose to do nothing, may research symptoms on Internet sources, may buy over-the-counter medications, may try alternative remedies to relieve symptoms, or may seek out a health care provider for diagnosis and treatment. In our society, an illness becomes "legitimate" when a health care provider diagnoses it and prescribes treatment. After seeking help from the health care provider, the person becomes a patient and enters the next stage.

Recall ***Daniel Sternman***, the young man with schizophrenia. His arrival at the mental health clinic indicates that he is seeking help from a health care provider. The nurse would interpret this behavior as signaling his assumption of the sick role.

STAGE 3: ASSUMING A DEPENDENT ROLE

This stage is characterized by the patient's decision to accept the diagnosis and follow the prescribed treatment plan. The person may initially have difficulty conforming to the recommendations of the health care provider and may decide to seek a second opinion or deny the diagnosis. The lack of independence is more troubling for some people who, based on their diagnosis, often require assistance in carrying out activities of daily living, and need emotional support through acceptance, approval, physical closeness, and protection.

If the disease is serious (such as a heart attack or stroke), the patient may enter the hospital for treatment. If the symptoms can be managed by the patient or family alone or with the assistance of home care providers, the patient is cared for at home. To facilitate adherence to the treatment plan, the patient needs effective relationships with caregivers, knowledge about the illness, and an individualized care plan. The patient's responses to care depend on a variety of factors, including the seriousness of the illness, the patient's degree of fear about the disease, the loss of roles, the support of others, and previous experiences with illness care. The optimal outcome expected by both caregivers and family is to get well and resume normal roles.

STAGE 4: ACHIEVING RECOVERY AND REHABILITATION

Recovery and rehabilitation might begin in the hospital and conclude at home, or may be totally concluded at a rehabilitation center or at home. Most patients complete this final stage of illness behavior at home. In this stage, the person gives up the dependent role and resumes normal activities and responsibilities. If the care plan includes health education, the person may return to health at a higher level of functioning and health than before the illness.

Remember ***Ruth Jacobi***, the woman being prepared for discharge after a mini-stroke. The patient's stated desire to be as active and as healthy as she possibly can reflects her desire to give up the dependent role. The nurse would use this knowledge as a basis for the patient's teaching plan, thereby fostering a return to health, possibly at a level higher than before the patient's mini-stroke.

Effects of Illness on the Family

Most nursing care is given to patients with some form of support system, usually family members. When an illness occurs, daily life changes for both the patient and the family. For example, a chronic illness creates stress for the patient and family because of possible lifelong alterations in roles or lifestyle, frequent hospitalizations, economic problems, and decreased social interactions among family members. The responses of family members to an illness are also individualized. Some family members want to be with the patient all the time, while others might avoid visiting. Parents of a sick child often react with blame, overprotection, and severe anxiety, and family members of patients requiring intensive care often feel alone and frightened. In both cases, they might also feel guilty and imagine the worst possible outcome. See Chapter 4 for more information.

DISPARITIES IN HEALTH CARE

Healthy People 2020 defines **health equity** as the attainment of the highest level of health for all people. Although health care is increasingly focused on the promotion of health and the prevention of illness, there continue to be disparities that lead to different health outcomes among different populations of people. A **health disparity** is defined by Healthy People 2020 as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (Healthy People 2020, Disparities).

Health disparities are influenced by many different factors, including race and ethnicity, poverty, biological sex, age, mental health, educational level, disabilities, sexual orientation, health insurance, and access to health care. Healthy People 2020 defines **social determinants of health** as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks (Healthy People 2020). See Figure 3-2. See also the discussion of social determinants of health in Chapter 4 and Healthy People 2020's list of social determinants across the life stages in Box 3-2 on page 54.

Disparities in health outcomes are especially common in racial and ethnic minorities, in whom higher rates of obesity, cancer, diabetes mellitus, and AIDS are seen. See the U.S. Department of Health and Human Services Office of Minority Health for Specifics (USDHHS, 2016). The Health Equity Institute urges the following measures to eliminate avoidable health inequities and health disparities (Health Equity Institute):

- Attention to the root causes of health inequities and health disparities—specifically, health determinants, a principal focus of Healthy People 2020.
- Particular attention to groups that have experienced major obstacles to health associated with socioeconomic disadvantages and historical and contemporary injustices.
- Promotion of equal opportunities for all people to be healthy and to seek the highest level of health possible.
- Distribution of socioeconomic resources needed to be healthy in a manner that progressively reduces health disparities and improves health for all.
- Continuous efforts to maintain a desired state of equity after avoidable health inequities and health disparities are eliminated.

National trends in efforts to prevent health disparities focus on **vulnerable populations**, such as racial and ethnic minorities, those living in poverty, women, children, older adults, rural and inner-city residents, and people with disabilities and special health care needs. Emphasis is given to disparities in access to care, quality of care, health insurance status, specific sources of ongoing care, and quality and access to care for people with limited English proficiency. It is critical that nurses recognize that disparities exist and plan specific and individualized interventions for patients who are most at risk.

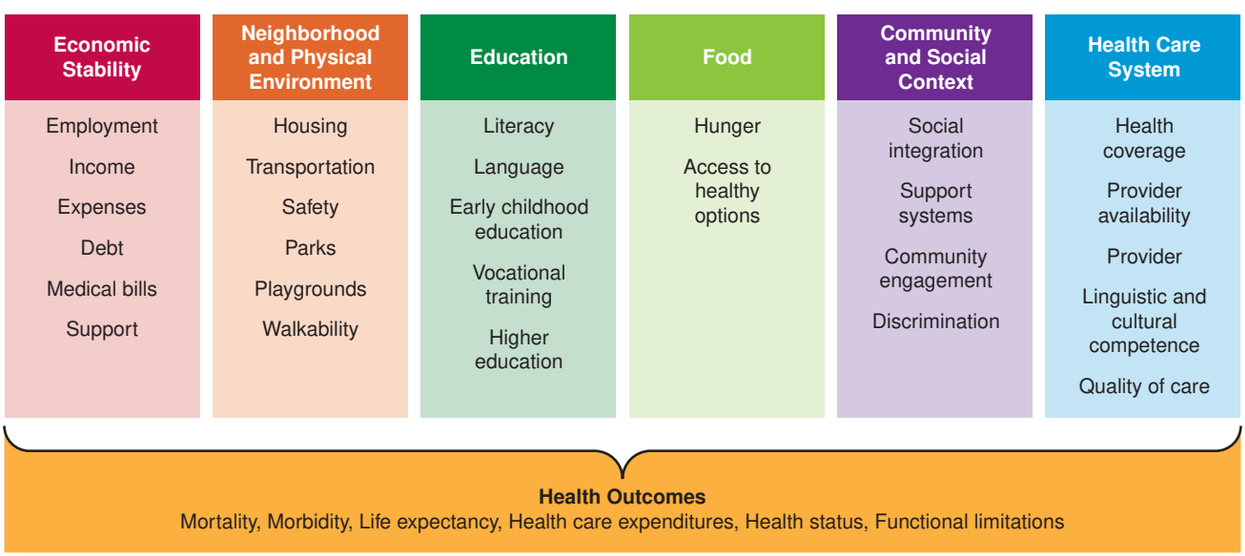

FIGURE 3-2. Social determinants of health. (Used with permission: The Henry J. Kaiser Family Foundation.)

Box 3-2 Social Determinants Across the Life Stages

From infancy through old age, the conditions in the social and physical environments in which people are born, live, work, and age can have a significant influence on health outcomes.

Children

- Early and middle childhood provide the physical, cognitive, and social-emotional foundation for lifelong health, learning, and well-being. A history of exposure to adverse experiences in childhood, including exposure to violence and maltreatment, is associated with health-risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as health problems such as obesity, diabetes, heart disease, sexually transmitted diseases, and attempted suicide.
- Features of the built environment, such as exposure to lead-based paint hazards and pests, negatively affect the health and development of young children.

Adolescents

- Because they are in developmental transition, adolescents and young adults are particularly sensitive to environmental influences. Environmental factors, including family, peer group, school, neighborhood, policies, and societal cues, can either support or challenge young people's health and well-being. Addressing young people's positive development facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population.
- Adolescents who grow up in neighborhoods characterized by poverty are more likely to be victims of violence; use tobacco, alcohol, and other substances; become obese; and engage in risky sexual behavior.

Adults

- Access to and availability of healthier foods can help adults follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet. These venues may be less available in low-income or rural neighborhoods.
- Longer hours, compressed work weeks, shift work, reduced job security, and part-time and temporary work are realities of the modern workplace and are increasingly affecting the health and lives of U.S. adults. Research has shown that workers experiencing these stressors are at higher risk of injuries, heart disease, and digestive disorders.

Older Adults

- Availability of community-based resources and transportation options for older adults can positively affect health status. Studies have shown that increased levels of social support are associated with a lower risk for physical disease, mental illness, and death.

Source: HealthyPeople.gov. Social determinants across the life stages. Retrieved https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Social-Determinants/determinants.

FACTORS AFFECTING HEALTH AND ILLNESS

Many factors influence a person's health status, health beliefs, and health practices. These factors may be internal or external and may or may not be under the person's conscious control. To plan and provide holistic care, the nurse must understand how these factors influence behavior in both healthy and ill patients.

Basic Human Needs

A basic human need is something essential that must be met for emotional and physiologic health and survival. A person whose needs are met may be considered to be healthy, and a person who has one or more unmet needs is at an increased risk for illness. (Basic human needs are discussed in detail in Chapter 4.)

The Human Dimensions

The factors influencing a person's health–illness status, health beliefs, and health practices relate to the person's human dimensions (see Fig. 3-1). Each dimension interrelates with each of the others and influences the person's behaviors in both health and illness. Nursing assessments of strengths and weaknesses in each dimension are used to develop a care plan that is individualized and holistic. The nursing process, used to plan, implement, and evaluate plans of care, is discussed in Unit III.

Physical Dimension

The physical dimension includes genetic inheritance, age, developmental level, race, and biological sex. These components strongly influence the person's health status and health practices. For example, inherited genetic disorders include Down syndrome, hemophilia, cystic fibrosis, and color blindness. Toddlers are at greater risk for drowning, and adolescents and young adult males are at greater risk for automobile crashes from excessive speed. There are specific racial traits for disease, including sickle cell anemia, hypertension, and stroke. A young woman whose mother and grandmother had breast cancer is more likely to have an annual clinical breast examination and mammogram.

Emotional Dimension

How the mind affects body functions and responds to body conditions also influences health. Long-term stress affects body systems, and anxiety affects health habits; conversely, calm acceptance and relaxation can actually change the body's responses to illness. As examples of the negative effects of emotions, a student may always have diarrhea before examinations and an adolescent with poor

self-esteem may begin to experiment with drugs. The positive effects of emotions include reducing surgical pain with relaxation techniques and reducing blood pressure with biofeedback skills.

Knowledge of the emotional dimension would be important when planning care for ***Sara Gelbart***, the college freshman described at the beginning of the chapter. The nurse needs to examine how she responds to stress and anxiety.

Intellectual Dimension

The intellectual dimension encompasses cognitive abilities, educational background, and past experiences. Whether or not someone can understand the causes of disease and the importance of healthy lifestyle behaviors can have a huge impact on health and wellness. These influence the person's responses to teaching about health and reactions to nursing care during illness. They also play a major role in health behaviors. Examples involving this dimension include a young college student with diabetes who follows a diabetic diet but drinks beer and eats pizza with friends several times a week, and a middle-aged man who quits taking his high blood pressure medication after developing unpleasant side effects.

Environmental Dimension

The environment has many influences on health and illness. Housing, sanitation, climate, and pollution of air, food, and water are elements in the environmental dimension. Examples of environmental causes of illness include deaths in older adults from inadequate heating and cooling, an increased incidence of asthma and respiratory problems in large cities with smog, and an increased incidence of skin cancer in people who live in hot, sunny areas of the world.

Sociocultural Dimension

Health practices and beliefs are strongly influenced by a person's economic level, lifestyle, family, and culture. In general, low-income groups, racial and ethnic minorities, and other underserved populations are less likely to seek medical care to prevent illness and have fewer treatment options, while high-income groups are more prone to stress-related habits and illness. The family and the culture to which a person belongs influence the person's patterns of living and values about health and illness; such patterns are often unalterable. All of these factors are involved in personal care, patterns of eating, lifestyle habits, and emotional stability. Examples of other sociocultural situations that influence health and illness are an adolescent who sees nothing wrong with smoking or drinking because her parents smoke and drink; parents of a sick infant who do not seek medical care because they have no health insurance; a single parent (abused as a child) who in turn physically abuses her own small son; and a person of Asian descent who uses herbal remedies and acupuncture to treat an illness.

Spiritual Dimension

Spiritual beliefs and values are important components of a person's health and illness behaviors (see Chapter 46). It is important that nurses respect these values and understand their importance for the individual patient. Examples of the influences of the spiritual dimension on health care include the Roman Catholic requirement of baptism for both live births and stillborn babies; kosher dietary laws, prohibiting the intake of pork and shellfish, practiced by Orthodox and Conservative Jews; and opposition to blood transfusion, common to Jehovah's Witnesses.

Self-Concept

Another variable influencing health and illness is people's self-concept (see Chapter 41), which incorporates both how they feel about themselves (self-esteem) and the way they perceive their physical self (body image). Self-concept has both physical and emotional aspects and is an important factor in the way a person reacts to stress and illness, follows self-care health practices, and relates to others.

Consider ***Sara Gelbart***, the college freshman with a suspected eating disorder. Although she has lost a significant amount of weight, she states that she is healthy but just "nuts" about being fit. Her self-concept is most likely one of being overweight. Subsequently, she rarely eats. In contrast, people who are overweight may feel that nothing will change the way they look and refuse to follow a diet and exercise program.

A person's self-concept results from a variety of past experiences, interpersonal interactions, physical and cultural influences, and education. It includes perceptions of one's own strengths and weaknesses. Illness can alter a person's self-concept as it affects roles, independence, and relationships with important others.

Risk Factors for Illness or Injury

A **risk factor** is something that increases a person's chances for illness or injury. Like other components of health and illness, risk factors are often interrelated. Risk factors may be further defined as modifiable (things a person can change, such as quitting smoking) or nonmodifiable (things that cannot be changed, such as a family history of cancer). As a person's number of risk factors increases, so does the possibility of illness. For example, an overweight executive under pressure to increase sales may smoke and drink alcohol in excess. These factors, combined with a family history of heart disease, place this person at higher risk for illness.

Remember ***Daniel Sternman***, the man with schizophrenia. The Mayo Clinic had identified the following as risk factors for developing mental problems: having a blood relative with a mental illness; stressful life situations, such as financial problems or a loved one's death or divorce; an ongoing chronic medical condition; brain damage as a result of serious injury; traumatic experiences; use of alcohol or recreational drugs; being abused or neglected as a child; having few friends or few healthy relationships; and a previous mental illness (Mayo Clinic, 2015).

The six general types of risk factors are described in Table 3-1. Risk factors for each developmental level across the lifespan are included in Unit IV, and cultural influences on risk factors are discussed in Chapter 5.

HEALTH PROMOTION AND ILLNESS PREVENTION

Health promotion is the behavior of a person who is motivated by a personal desire to increase well-being and health potential. In contrast, illness/disease prevention, also called health protection, is behavior motivated by a desire to avoid or detect disease or to maintain functioning within the constraints of an illness or disability (Pender, Murdaugh, & Parsons, 2014). Health promotion and illness prevention activities are traditionally described as occurring on primary, secondary, and tertiary levels (Leavell & Clark, 1965). Definitions and examples of nursing activities for each level are discussed in the next section and are illustrated in Table 3-2.

Table 3-1 Major Areas of Risk Factors

RISK FACTOR	EXAMPLES
Age	School-aged children are at high risk for communicable diseases. After menopause, women are more likely to develop cardiovascular disease.
Genetic factors	A family history of cancer or diabetes predisposes a person to developing the disease.
Physiologic factors	Obesity increases the possibility of heart disease. Pregnancy places increased risk on both the mother and the developing fetus.
Health habits	Smoking increases the probability of lung cancer. Poor nutrition can lead to a variety of health problems.
Lifestyle	Multiple sexual relationships increase the risk for sexually transmitted infections (e.g., gonorrhea or AIDS). Events that increase stress (e.g., divorce, retirement, work-related pressure) may precipitate accidents or illness.
Environment	Working and living environments (such as hazardous materials and poor sanitation) may contribute to disease.

Table 3-2 Examples of Nursing Activities by Level of Health Promotion and Preventive Care

LEVEL	TOPIC
Primary	Weight loss Diet Exercise Smoking cessation Reduced alcohol consumption Avoidance of illicit drugs Farm safety Seat belts and child safety seats Immunizations Water treatment Safer sex practices Effective parenting
Secondary	Screenings (blood pressure, cholesterol, glaucoma, HIV, skin cancer) Pap smears Mammograms Testicular examinations Family counseling
Tertiary	Medication Medical therapy Surgical treatment Rehabilitation Physical therapy Occupational therapy Job training

Primary Health Promotion and Illness Prevention

Primary health promotion and illness prevention are directed toward promoting health and preventing the development of disease processes or injury. Nursing activities at the primary level may focus on people or groups. Examples of primary-level activities are immunization clinics, family planning services, providing poison-control information, and accident-prevention education. Other nursing interventions include teaching about a healthy diet, the importance of regular exercise, safety in industry and farms, using seat belts, and safer sex practices.

Health-risk assessments are an important part of primary health promotion and preventive care. A health-risk assessment is an assessment of the total person. The resulting "picture" of the person indicates areas of risk for disease or injury as well as areas that support health. A variety of formats are used to perform this assessment, but all take a broad approach to health, focusing on lifestyle and behaviors. Box 3-3 contains