KOZIER & ERB'S

FUNDAMENTALS OF NURSING

Concepts, Process, and Practice

TENTH EDITION

Audrey **Berman**

Shirlee **Snyder**

Geralyn **Frandsen**

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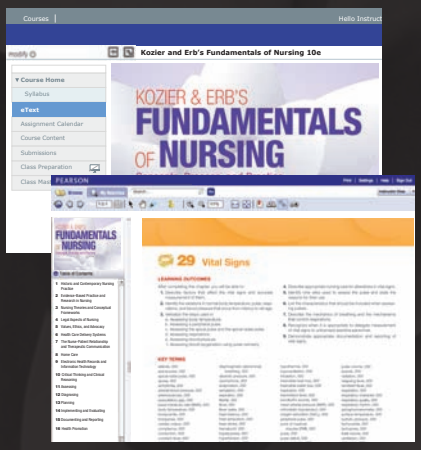

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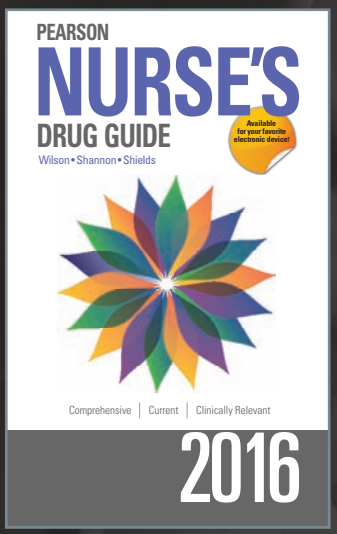

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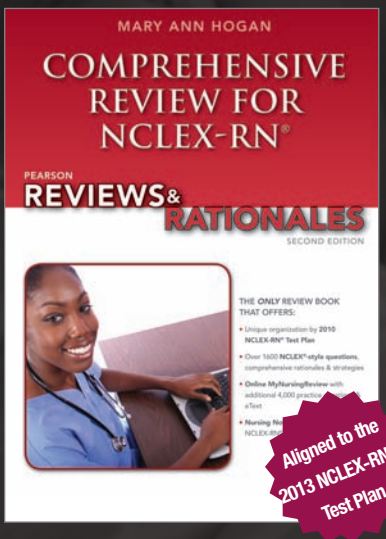

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Brief Contents

KOZIER & ERB'S

FUNDAMENTALS OF NURSING

Concepts, Process, and Practice

TENTH EDITION

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Composition: S4Carlisle Publishing Services
Printer/Binder: Courier Kendalville
Cover Printer: Phoenix Color/Hagerstown
Cover Image: Shutterstock, ISebyl

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Library of Congress Cataloging-in-Publication Data
Berman, Audrey, author.
Kozier & Erb's fundamentals of nursing : concepts, practice, and process / Audrey Berman, Shirlee Snyder, and Geralyn Frandsen.—Tenth edition.
p. ; cm.
Kozier and Erb's fundamentals of nursing
Fundamentals of nursing
Includes bibliographical references and index.
ISBN 978-0-13-397436-2—ISBN 0-13-397436-7
I. Snyder, Shirlee, author. II. Frandsen, Geralyn, author. III. Title. IV. Title: Kozier and Erb's fundamentals of nursing. V. Title: Fundamentals of nursing.
[DNLM: 1. Nursing Process. 2. Nursing Care. 3. Nursing Theory. WY 100]
RT41
610.73—dc23

2014018545

10 9 8 7 6 5 4 3 2 1

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ISBN-13: 978-0-13-397436-2
ISBN-10: 0-13-397436-7

Dedication

Audrey Berman dedicates this tenth edition to everyone who ever played a part in its creation: to Barbara Kozier and Glenora Erb who started it all and taught me the ropes; to the publishers, editors, faculty authors, contributors, reviewers, and adopters who improved every edition; to the students and their clients who made all the hard work worthwhile; and to all my family and colleagues who allowed me the time and space to make these books my scholarly contribution to the profession.

Shirlee Snyder dedicates this edition to her husband, Terry J. Schnitter, for his unconditional love and support; and to all of the nursing students and nurse educators she has worked with and learned from during her nursing career.

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

About the Authors

Audrey Berman, PhD, RN

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

Dr. Berman has traveled extensively, visiting nursing and health care institutions in Australia, Botswana, Brazil, Germany, Israel, Japan, Korea, the Philippines, the Soviet Union, and Spain. She serves on the board of directors for the Bay Area Tumor Institute and the East Bay American Heart Association. She is a member of the American Nurses Association and Sigma Theta Tau and is a site visitor for the Commission on Collegiate Nursing Education. She has twice participated as an NCLEX-RN item writer for the National Council of State Boards of Nursing. She has presented locally, nationally, and internationally on topics related to nursing education, breast cancer, and technology in health care.

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

Shirlee J. Snyder, EdD, RN

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

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

Another career opportunity in 1998 led her to the Community College of Southern Nevada in Las Vegas, Nevada, where Dr. Snyder was the nursing program director with responsibilities for the associate degree and practical nursing programs for 5 years. During this time she coauthored the fifth edition of *Kozier & Erb's Techniques in Clinical Nursing* with Audrey Berman.

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

Dr. Snyder enjoyed traveling to the Philippines (Manila and Cebu) in 2009 to present all-day seminars to approximately 5,000 nursing students and 200 nursing faculty. She is a member of the American Nurses Association and Sigma Theta Tau. She has been a site visitor for the National League for Nursing Accrediting Commission and the Northwest Association of Schools and Colleges.

Geralyn Frandsen, EdD, RN

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

In service to the university, she has been a member and chair of the promotion and tenure committee for the past 10 years. She is a tenured full professor and currently serves as assistant director

of the Catherine McCauley School of Nursing at Maryville. When educating undergraduate and graduate students, she utilizes a variety of teaching strategies to engage her students. When teaching undergraduate pharmacology she utilizes a team teaching approach, placing students in groups to review content. Each student is also required to bring a completed ticket to class covering the content to be taught. The practice of bringing a ticket to class was introduced to her by Dr. Em Bevis, who is famous for the *Toward a Caring Curriculum*.

Dr. Frandsen has authored textbooks in pharmacology and nursing fundamentals. In the ninth edition of *Kozier & Erb's Fundamentals of Nursing* she contributed the chapters on *Safety, Diagnostic Testing, Medications, Perioperative Nursing,* and *Fecal Elimination*. In 2013 she was the fundamentals contributor for *Ready Point* and *My Nursing Lab.* This is an online resource to assist students in reviewing content in their nursing fundamentals course. She has authored both the *Nursing Fundamentals: Pearson Reviews and Rationales* and, in 2007, *Pharmacology Reviews and Rationales.*

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

Acknowledgments

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

We would like to thank the editorial team, especially Kelly Trakalo, executive acquisitions editor, for her continual support, Melissa Bashe, Program Manager, Pearson Nursing, and most of all Teri Zak, development editor, for keeping our noses to the grindstone and especially for her dedication and attention to detail that promoted an excellent outcome once again. Many thanks to the production team of Michael Giaccobe, production liaison, and Roxanne Klaas, production editor, for producing this book with precision, and to the design team led by Maria Siener and Maria Guglielmo, art directors, for providing a truly beautiful design for this textbook.

Audrey Berman
Shirlee Snyder
Geralyn Frandsen

Thank You

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

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Preface

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

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

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

ORGANIZATION

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

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

In Unit 2, *Contemporary Health Care*, four chapters cover contemporary health care topics such as health care delivery systems, community-based care, home care, and informatics.

In Unit 3, *The Nursing Process*, six chapters introduce students to this important framework with each chapter dedicated to a specific step of the nursing process. Chapter 10 applies critical thinking, clinical reasoning, and the nursing process. A Nursing in Action case study is used as the frame of reference for applying content in all phases of the nursing process in Chapter 11, *Assessing*; Chapter 12, *Diagnosing*; Chapter 13, *Planning*; and Chapter 14, *Implementing and Evaluating*. Chapter 15 covers documenting and reporting. Starting in this unit and incorporated throughout the book, we refer to the NANDA International diagnoses.

In Unit 4, *Health Beliefs and Practices*, four chapters cover health-related beliefs and practices for individuals and families from a variety of cultural backgrounds.

Unit 5, *Lifespan Development*, consists of five chapters that discuss life span and development from conception to older adults.

Unit 6, *Integral Aspects of Nursing*, discusses topics such as caring; communicating; teaching; and leading, managing, and delegating. These topics are all crucial elements for providing safe, competent nursing care.

Unit 7, *Assessing Health*, addresses vital signs and health assessment skills in two separate chapters, so beginning students can understand normal assessment techniques and findings. Chapter 29, *Vital Signs*, begins to introduce students to the clinical procedures that they need to learn to perform.

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

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

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

WHAT'S NEW TO THE TENTH EDITION

- **QSEN linkages.** The delivery of high-quality and safe nursing practice is imperative for every nurse. The QSEN competencies were developed to address the gap between nursing education and practice. There are expectations for each of the six QSEN competencies and these expectations relate to knowledge, skills, and attitudes. Nursing students are expected to achieve these competencies during nursing school and use them in their professional role as RNs. This edition has incorporated QSEN competencies and specified expectations in QSEN features. The content in these QSEN features will guide students to learn and maintain safety and quality in their provision of nursing care.
- **Culturally Responsive Care** highlights diversity and special considerations in nursing care.
- **Evidence-Based Practice** focuses on evidence-informed practice to highlight relevant research and its implications for nursing care.
- **Home Care Assessment** focuses on educating the client, family, and community to recognize what is needed for care in the home.
- **Home Care Considerations** focus on teaching the client and caregiver the proper care at home.
- **Safety Alerts** correlate to the National Patient Safety Goals and identify other crucial safety issues.
- Updated photo program with more than 150 new photos

- **Clinical reasoning.** The practice of nursing requires critical thought and clinical reasoning. Clinical reasoning is the cognitive processes a nurse utilizes to gather and analyze client data, evaluate the relevance of the information, and implement nursing interventions to improve the client's well being.
- **Interprofessional practice.** The concept of interprofessional practice is identified in specific skills. It reinforces to the student that other members of the health care team may also be performing the specified skill.
- **Men in nursing.** This edition has increased information about men in nursing from a historical and current perspective in Chapter 1.
- **Standards of care.** This edition continues to value and update standards of care as evidenced by the latest National Patient Safety Goals, Infusion Nursing Society *Standards of Practice, ANA Scope and Standa*rds of Practice, 2014 Hypertension Guidelines; IHI Pressure Ulcer Prevention Guidelines, ANA Safe Patient Handling and Mobility Interprofessional National Standards, OSHA/CDC BBP and Infection Prevention Standards, and Cancer Screening Guidelines.

FEATURES

For years, *Kozier & Erb's Fundamentals of Nursing* has been a gold standard that helps students embark on their careers in nursing. This new edition retains many of the features that have made this textbook the number-one choice of nursing students and faculty. The walk-through at the beginning of the textbook illustrates these features. A significant addition to this edition is the inclusion of QSEN features that address the competencies and expectations for quality nursing care. Another important feature is the inclusion of a section on Interprofessional Practice within specific skills. In addition, Evidence-Based Practices boxes replace the Research Notes in recognition that research is not the only way in which nurses determine best practices.

Supplements That Inspire Success for the Student and the Instructor

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

- TestGen Test Bank
- Lecture Note PowerPoints
- Classroom Response System PowerPoints
- New! Annotated Instructor's eText—This version of the eText is designed to help instructors maximize their time and resources in preparing for class. The AIE contains suggestions for classroom and clinical activities and key concepts to integrate into the classroom in any way imaginable. Additionally, each chapter has recommendations for integrating other digital Pearson Nursing resources, including The Neighborhood 2.0, Skills videos, and MyNursingLab.

Features of the Tenth Edition

NEW AND ENHANCED FEATURES

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

Evidence-Based Practice **Are Pulse Oximeter Readings Accurate If Measured on a Restrained Arm?**

EVIDENCE-BASED PRACTICE

The aim of this study by Korhan, Yönt, and Khorshid (2011) was to compare the pulse oximetry values obtained from a finger on restrained or unrestrained sides of the body. In clinical settings such as intensive care, physical restraints may be indicated to lessen the chances that clients will displace tubes and monitors. However, the most important complication in using physical restraints is impaired circulation. Thus, oxygen saturation from body parts in which circulation is impaired can be inaccurate. The research sample consisted of 30 hospitalized clients. A significant difference was found between the oxygen saturation values obtained from a finger of an arm that had been physically restrained and a finger of an arm that had not been physically restrained. The mean oxygen saturation value measured from a finger of an arm that had been physically restrained was found to be 93.40 and the mean oxygen saturation value measured from a finger of an arm that had not been physically restrained was found to be 95.53.

IMPLICATIONS

The results of this study indicate that nurses should use a finger of an arm that is not physically restrained when evaluating oxygen saturation values. The use of physical restraints is carefully evaluated because there are many possible adverse effects of their use. This study provides one additional physiological consideration: that assessment data gathered from a restrained limb may not be accurate.

Culturally Responsive Care

PATIENT-CENTERED CARE

Cultural Aspects of Social Support

It is important to understand how various subgroups of U.S. society may define social support.

- In the African American community, the family and church have been major providers of social support.
- Hispanic/Latino Americans and Asian Americans view the family as being a major social support system.
- Asian Americans respect older adults and use shame and harmony in giving and receiving support.
- Native Americans live in social networks that foster mutual assistance and support.

From *Health Promotion in Nursing Practice*, 6th ed. (p. 220), by N. J. Pender, C. L. Murdaugh, and M. A. Parsons, 2011, Upper Saddle River, NJ: Prentice Hall.

SAFETY ALERT!

SAFETY

Take safety measures before faxing confidential information. A fax cover sheet should contain instructions that the faxed material is to be given only to the named recipient. Consent is needed from the client to fax information. Make sure that personally identifiable information (e.g., client name, Social Security number) has been removed. Finally, check that the fax number is correct, check the number on the display of the machine after dialing, and check the number a third time before pressing the "send" button.

Home Care Considerations **Temperature**

PATIENT-CENTERED CARE

- Teach the client accurate use and reading of the type of thermometer to be used. Examine the thermometer used by the client in the home for safety and proper functioning. Facilitate the replacement of mercury thermometers with nonmercury ones. See page 482 for instructions regarding management of a broken mercury thermometer.
- Observe the client/caregiver taking and reading a temperature. Reinforce the importance of reporting the site and type of thermometer used and the value of using the same site and thermometer consistently.
- Discuss means of keeping the thermometer clean, such as warm water and soap, and avoiding cross contamination.
- Ensure that the client has water-soluble lubricant if using a rectal thermometer.
- Instruct the client or family member to notify the health care provider if the temperature is 38.5°C (101.3°F) or higher.
- When making a home visit, take a thermometer with you in case the clients do not have a functional thermometer of their own.
- Check that the client knows how to record the temperature. Provide a recording chart/table if indicated.
- Discuss environmental control modifications that should be made during illness or extreme climate conditions (e.g., heating, air conditioning, appropriate clothing and bedding).
- Pacifier thermometers (Figure 29–12 ■) may be used in the home setting for children under 2 years old. The manufacturer's instructions must be followed carefully since many require adding 0.5°F in order to estimate rectal temperature.

Figure 29–12 ■ A pacifier thermometer.

ENHANCED PHOTO PROGRAM shows procedural steps and the latest equipment.

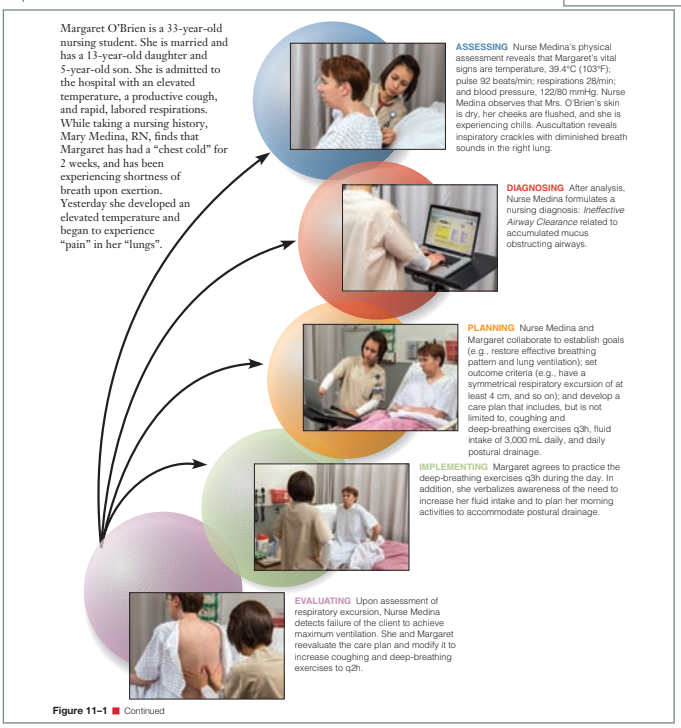


Figure 11–1 ■ Continued

INTERPROFESSIONAL PRACTICE

Assessing an apical pulse may be within the scope of practice for many health care providers. For example, in addition to nurses, respiratory therapists may check the client's apical pulse before, during, and after treatment, and physicians often check the apical pulse when assessing the chest during examinations. Although these providers may verbally communicate their findings and plan to other health care team members, the nurse must also know where to locate their documentation in the client's medical record.

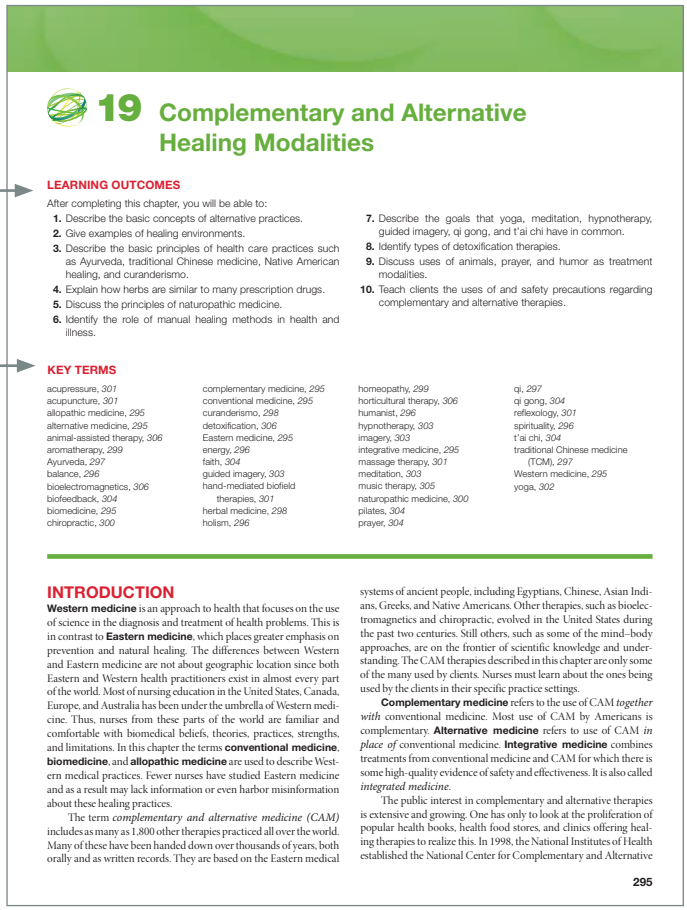
INTERPROFESSIONAL PRACTICE reinforces interactions with other members of the health care team.

HALLMARK FEATURES

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

LEARNING OUTCOMES help identify critical concepts.

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



19 Complementary and Alternative Healing Modalities

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe the basic concepts of alternative practices.
2. Give examples of healing environments.
3. Describe the basic principles of health care practices such as Ayurveda, traditional Chinese medicine, Native American healing, and curanderismo.
4. Explain how herbs are similar to many prescription drugs.
5. Discuss the principles of naturopathic medicine.
6. Identify the role of manual healing methods in health and illness.
7. Describe the goals that yoga, meditation, hypnotherapy, guided imagery, qi gong, and t'ai chi have in common.
8. Identify types of detoxification therapies.
9. Discuss uses of animals, prayer, and humor as treatment modalities.
10. Teach clients the uses of and safety precautions regarding complementary and alternative therapies.

KEY TERMS

acupressure, *301*
acupuncture, *301*
allopathic medicine, *295*
alternative medicine, *295*
animal-assisted therapy, *306*
aromatherapy, *299*
Ayurveda, *297*
balance, *296*
bioelectromagnetics, *306*
biofeedback, *304*
biomedicine, *295*
chiropractic, *300*
complementary medicine, *295*
conventional medicine, *295*
curanderismo, *298*
detoxification, *306*
Eastern medicine, *295*
energy, *296*
faith, *304*
guided imagery, *303*
hand-mediated biofield therapies, *301*
herbal medicine, *298*
holism, *296*
homeopathy, *299*
horticultural therapy, *306*
humanist, *296*
hypnotherapy, *303*
imagery, *303*
integrative medicine, *295*
massage therapy, *301*
meditation, *303*
music therapy, *305*
naturopathic medicine, *300*
pilates, *304*
prayer, *304*
qi, *297*
qi gong, *304*
reflexology, *301*
spirituality, *296*
t'ai chi, *304*
traditional Chinese medicine (TCM), *297*
Western medicine, *295*
yoga, *302*

INTRODUCTION

Western medicine is an approach to health that focuses on the use of science in the diagnosis and treatment of health problems. This is in contrast to **Eastern medicine**, which places greater emphasis on prevention and natural healing. The differences between Western and Eastern medicine are not about geographic location since both Eastern and Western health practitioners exist in almost every part of the world. Most of nursing education in the United States, Canada, Europe, and Australia has been under the umbrella of Western medicine. Thus, nurses from these parts of the world are familiar and comfortable with biomedical beliefs, theories, practices, strengths, and limitations. In this chapter the terms **conventional medicine**, **biomedicine**, and **allopathic medicine** are used to describe Western medical practices. Fewer nurses have studied Eastern medicine and as a result may lack information or even harbor misinformation about these healing practices.

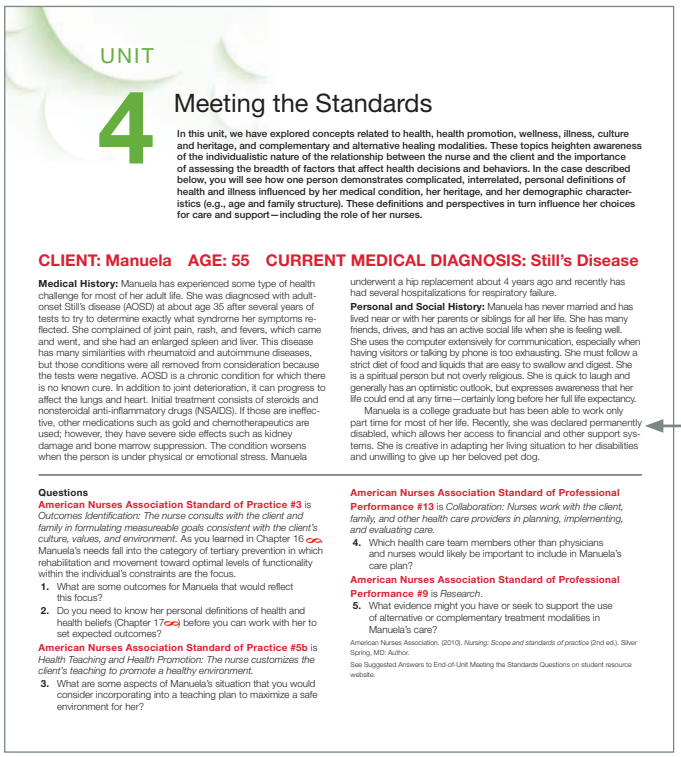
The term *complementary and alternative medicine (CAM)* includes as many as 1,800 other therapies practiced all over the world. Many of these have been handed down over thousands of years, both orally and as written records. They are based on the Eastern medical systems of ancient people, including Egyptians, Chinese, Asian Indians, Greeks, and Native Americans. Other therapies, such as bioelectromagnetics and chiropractic, evolved in the United States during the past two centuries. Still others, such as some of the mind–body approaches, are on the frontier of scientific knowledge and understanding. The CAM therapies described in this chapter are only some of the many used by clients. Nurses must learn about the ones being used by the clients in their specific practice settings.

Complementary medicine refers to the use of CAM *together with* conventional medicine. Most use of CAM by Americans is complementary. **Alternative medicine** refers to use of CAM *in place of* conventional medicine. **Integrative medicine** combines treatments from conventional medicine and CAM for which there is some high-quality evidence of safety and effectiveness. It is also called *integrated medicine*.

The public interest in complementary and alternative therapies is extensive and growing. One has only to look at the proliferation of popular health books, health food stores, and clinics offering healing therapies to realize this. In 1998, the National Institutes of Health established the National Center for Complementary and Alternative

295

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



UNIT 4 Meeting the Standards

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

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

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

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

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

Questions

American Nurses Association Standard of Practice #3 is *Outcomes Identification: The nurse consults with the client and family in formulating measureable goals consistent with the client's culture, values, and environment.* As you learned in Chapter 16 (p.), Manuela's needs fall into the category of tertiary prevention in which rehabilitation and movement toward optimal levels of functionality within the individual's constraints are the focus.

1. What are some outcomes for Manuela that would reflect this focus?
2. Do you need to know her personal definitions of health and health beliefs (Chapter 17 (p.)) before you can work with her to set expected outcomes?

American Nurses Association Standard of Practice #5b is *Health Teaching and Health Promotion: The nurse customizes the client's teaching to promote a healthy environment.*

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

American Nurses Association Standard of Professional Performance #13 is *Collaboration: Nurses work with the client, family, and other health care providers in planning, implementing, and evaluating care.*

4. Which health care team members other than physicians and nurses would likely be important to include in Manuela's care plan?

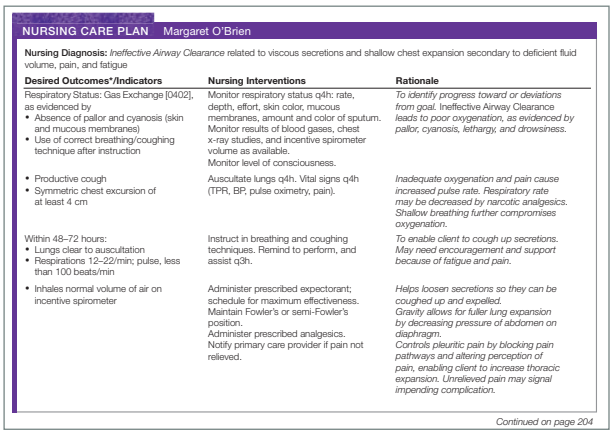
American Nurses Association Standard of Professional Performance #9 is *Research.*

5. What evidence might you have or seek to support the use of alternative or complementary treatment modalities in Manuela's care?

American Nurses Association. (2010). *Nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: Author.

See Suggested Answers to End-of-Unit Meeting the Standards Questions on student resource website.

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



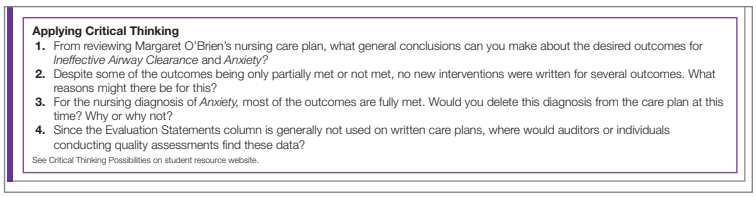
NURSING CARE PLAN Margaret O'Brien

Nursing Diagnosis: *Ineffective Airway Clearance* related to viscous secretions and shallow chest expansion secondary to deficient fluid volume, pain, and fatigue

Desired Outcomes*/Indicators	Nursing Interventions	Rationale
Respiratory Status: Gas Exchange [0402], as evidenced by • Absence of pallor and cyanosis (skin and mucous membranes) • Use of correct breathing/coughing technique after instruction	Monitor respiratory status q4h: rate, depth, effort, skin color, mucous membranes, amount and color of sputum. Monitor results of blood gases, chest x-ray studies, and incentive spirometer volume as available. Monitor level of consciousness.	*To identify progress toward or deviations from goal. Ineffective Airway Clearance leads to poor oxygenation, as evidenced by pallor, cyanosis, lethargy, and drowsiness.*
• Productive cough • Symmetric chest excursion of at least 4 cm	Auscultate lungs q4h. Vital signs q4h (TPR, BP, pulse oximetry, pain).	*Inadequate oxygenation and pain cause increased pulse rate. Respiratory rate may be decreased by narcotic analgesics. Shallow breathing further compromises oxygenation.*
Within 48–72 hours: • Lungs clear to auscultation • Respirations 12–22/min; pulse, less than 100 beats/min	Instruct in breathing and coughing techniques. Remind to perform, and assist q3h.	*To enable client to cough up secretions. May need encouragement and support because of fatigue and pain.*
• Inhales normal volume of air on incentive spirometer	Administer prescribed expectorant; schedule for maximum effectiveness. Maintain Fowler's or semi-Fowler's position. Administer prescribed analgesics. Notify primary care provider if pain not relieved.	*Helps loosen secretions so they can be coughed up and expelled. Gravity allows for fuller lung expansion by decreasing pressure of abdomen on diaphragm. Controls pleuritic pain by blocking pain pathways and altering perception of pain, enabling client to increase thoracic expansion. Unrelieved pain may signal impending complication.*

Continued on page 204

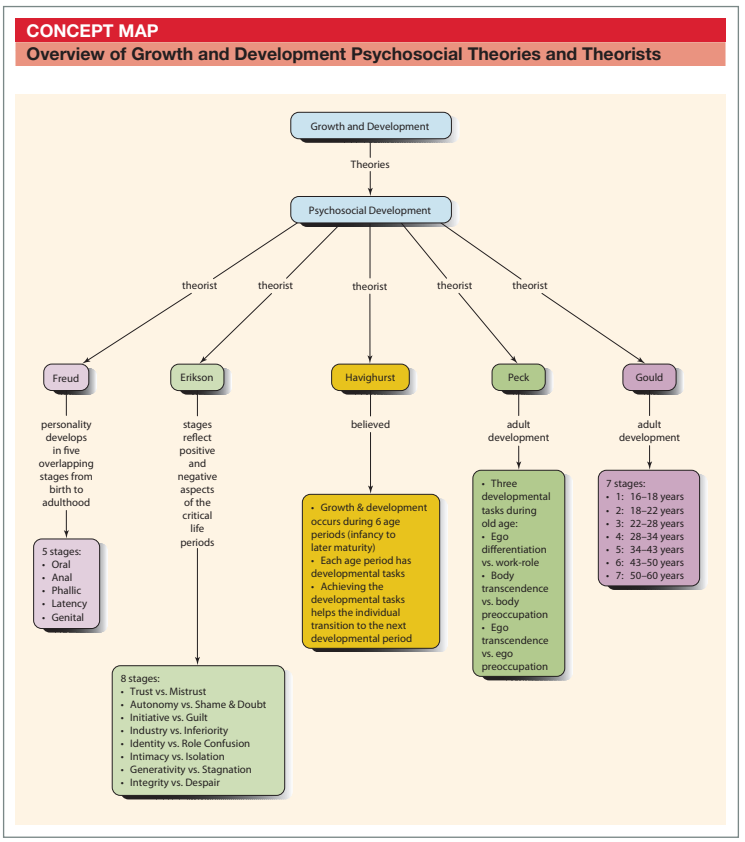
APPLYING CRITICAL THINKING questions come at the end of select sample Nursing Care Plans to encourage further reflection and analysis.



Applying Critical Thinking

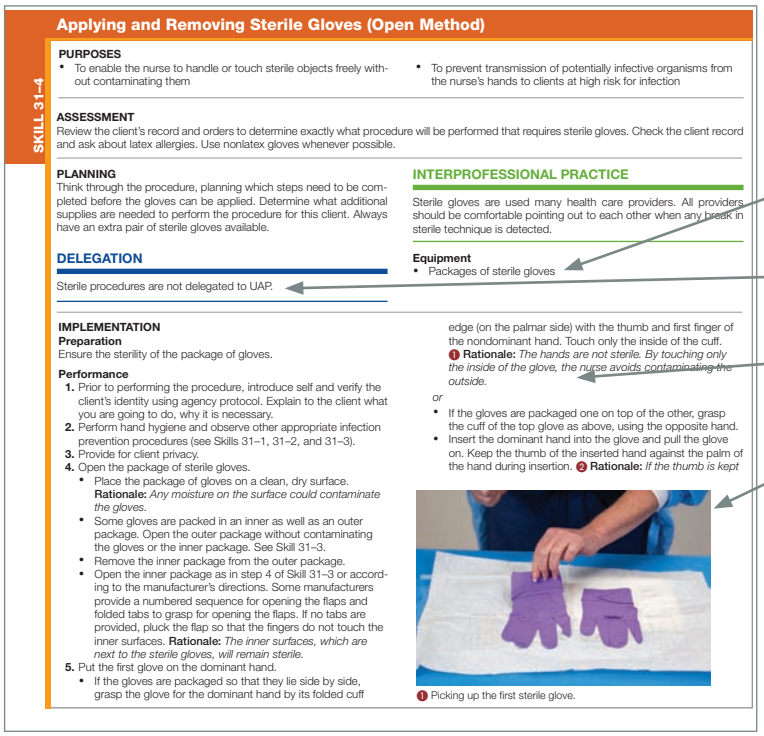
1. From reviewing Margaret O'Brien's nursing care plan, what general conclusions can you make about the desired outcomes for *Ineffective Airway Clearance* and *Anxiety*?
2. Despite some of the outcomes being only partially met or not met, no new interventions were written for several outcomes. What reasons might there be for this?
3. For the nursing diagnosis of *Anxiety,* most of the outcomes are fully met. Would you delete this diagnosis from the care plan at this time? Why or why not?
4. Since the Evaluation Statements column is generally not used on written care plans, where would auditors or individuals conducting quality assessments find these data?

See Critical Thinking Possibilities on student resource website.



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

SETTING THE FOUNDATION FOR CLINICAL COMPETENCE!



STEP-BY-STEP SKILLS An easy-to-follow format helps students understand techniques and practice sequences.

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

CLINICAL ALERT!

Avoid writing the word *error* when a recording mistake has been made. Some believe that the word *error* is a "red flag" for juries and can lead to the assumption that a clinical error has caused a client injury.

CLINICAL ALERTS highlight special information useful for clinical settings.

SELF-CARE ALERT

Knowledge of health behaviors does not always translate into action. The nurse should be self-reflective and consider both the personal and professional advantages of examining and minimizing one's own barriers to ways of becoming a positive role model.

SELF-CARE ALERTS focus on actions nurses can perform to take care of themselves and serve as effective role models for clients and colleagues.

PRACTICE GUIDELINES

Home Health Care Documentation

- Complete a comprehensive nursing assessment and develop a plan of care to meet Medicare and other third-party payer requirements. Some agencies use the certification and plan of treatment form as the client's official plan of care.
- Write a progress note at each client visit, noting any changes in the client's condition, nursing interventions performed (including education and instructional brochures and materials provided to the client and home caregiver), client responses to nursing care, and vital signs as indicated.
- Provide a monthly progress nursing summary to the attending primary care provider and to the reimburser to confirm the need to continue services.
- Keep a copy of the care plan in the client's home and update it as the client's condition changes.
- Report changes in the plan of care to the primary care provider and document that these were reported. Medicare and Medicaid will reimburse only for the skilled services provided that are reported to the primary care provider.
- Encourage the client or home caregiver to record data when appropriate.
- Write a discharge summary for the primary care provider to approve the discharge and to notify the reimbursers that services have been discontinued. Include all services provided, the client's health status at discharge, outcomes achieved, and recommendations for further care.

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

CLINICAL MANIFESTATIONS boxes are a quick resource to learn key signs and symptoms of illness.

CLINICAL MANIFESTATIONS

Hypothermia

- Decreased body temperature, pulse, and respirations
- Severe shivering (initially)
- Feelings of cold and chills
- Pale, cool, waxy skin
- Frostbite (discolored, blistered nose, fingers, toes)
- Hypotension
- Decreased urinary output
- Lack of muscle coordination
- Disorientation
- Drowsiness progressing to coma

DRUG CAPSULE

Cardiac Glycoside or Digitalis Glycoside Digoxin (Lanoxin)

CLIENT WITH CARDIAC MEDICATIONS THAT AFFECT HEART RATE

Cardiac glycosides increase cardiac contractility, which increases cardiac output. As a result, perfusion to the kidneys is increased, which increases the production of urine. Cardiac glycosides also decrease heart rate by prolonging cardiac conduction, especially at the AV node.

Digoxin is commonly used for the clinical management of heart failure, atrial fibrillation, atrial flutter, and paroxysmal atrial tachycardia.

NURSING RESPONSIBILITIES

- Take the apical pulse for 1 minute before administering the dose. If the apical pulse is < 60 beats/min or another specific parameter set by the health care provider, do not administer the dose and retake the pulse in 1 hour. If pulse remains < 60, call the prescriber. *Note:* If the initial resting pulse is significantly < 60 or the client has symptoms of bradycardia such as dizziness, notify the primary care provider without waiting to retake.
- Monitor electrolyte levels: Low potassium and low magnesium and high levels of calcium place the client at risk for digitalis toxicity. Check the client's most recent electrolyte laboratory work for safe levels before administering the dose.
- Avoid giving with meals because this will delay absorption.
- Monitor for therapeutic drug levels: 0.5–2 ng/mL. Digoxin has a narrow therapeutic index, which means that there is not much difference between a therapeutic effect and a toxic effect.
- Assess for signs of digoxin toxicity: anorexia, nausea, vomiting, diarrhea, blurred or "yellow" vision, unusual tiredness and weakness.

CLIENT AND FAMILY TEACHING

- Explain the reason for taking digoxin and the importance of medical checkups that may include laboratory work to evaluate the effects and dosage of the drug.
- Teach the client and/or family how to check the radial or carotid pulse for a full minute. Inform them to take the pulse at the same time each day and to write it on the calendar. Provide pulse parameters and tell them when it is appropriate to call the health care provider.
- Caution the client not to stop taking the digoxin without approval of the health care provider.
- Caution the client to avoid over-the-counter drugs, except on the advice of the health care provider, because many can interact with digoxin.
- Explain the signs and symptoms of digoxin toxicity and the importance of calling the health care provider.

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

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

Critical Thinking Checkpoint

Mark Jones, a 22-year-old construction worker, comes into the health center for a "physical." He states that the last time he saw a health care provider was during high school, and he is only here today because his employer required that he be examined prior to returning to work. Mr. Jones has been off the job for 2 weeks following an accident in which he fell off a ladder, sustaining multiple contusions and a concussion. He mentions that he and "his buddies" have enjoyed his 2 weeks off from work, and have used the time to "drink beer and chase women."

1. What questions would you ask Mr. Jones about his usual health promotion activities?
2. How would you ask Mr. Jones about his risk for sexually transmitted infections?
3. What health conditions are young adults at risk for, and how would you explain these to Mr. Jones?
4. What health screening activities would you suggest to Mr. Jones? How would you explain the rationale to him?
5. How would you assess Mr. Jones's psychosocial development?

See Critical Thinking Possibilities on student resource website.

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

EXTENSIVE END OF CHAPTER REVIEW

CHAPTER HIGHLIGHTS focus your attention and review critical concepts.

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

Chapter 21 Review

CHAPTER HIGHLIGHTS

- Prenatal or intrauterine development lasts approximately 9 calendar months.
- The embryonic phase is the 8-week period during which the fertilized ovum develops into an organism with most of the features of the human.
- The infant's weight, length, head and chest circumferences, fontanel size and status, vision, hearing, smell and taste, touch, reflexes, and motor development are important indicators of the newborn's growth and health.
- Infants from birth to 12 months reveal marked growth in size and stature with appropriate nutrition and care: Birth weight doubles by about 5 months and triples by 12 months.
- Rapid weight gain in the first 5 to 6 months of life appears to be related to overweight and obesity in childhood and as an adult.
- During infancy, motor development is notable: At 1 month infants can lift their heads momentarily when prone; at 6 months they can sit unsupported; and at 12 months they can walk with help.
- Fulfillment of the infant's physiological and psychological needs is required to develop a basic sense of trust. Parents can enhance this sense of trust by being sensitive to the infant's needs and meeting those needs skillfully, promptly, and consistently, and providing a predictable environment in which routines are established.
- For the infant, cognitive development is a result of interaction between an individual and the environment. The infant needs a variety of sensory and motor stimuli.
- The toddler group, ages 12 months to 3 years, is, according to Erikson, developing a sense of autonomy. Voluntary control increases and these children learn to walk and speak. They also learn to control their bladders and bowels, and they acquire all kinds of information about their environment.
- During the preschool years, ages 4 to 5, physical growth slows, but control of the body and coordination increase greatly. The preschooler's world gets larger as they meet relatives, friends, and neighbors. They are engaged in Erikson's task of initiative versus guilt.
- The school-age period starts when children are about 6 years of age. In general, this period from 6 to 12 years is one of significant change. Skills learned during this stage are particularly important in relation to work later in life and willingness to try new tasks.
- During psychosocial development, school-age children face Erikson's conflict of industry versus inferiority.
- School-age children change from being egocentric to having cooperative interactions, and begin to understand cause-and-effect relationships. According to Piaget, they are in the concrete operations phase of cognitive development.
- Most school-age children progress to the conventional level of moral development and to the mythic-literal stage of spiritual development.
- Rapid growth in height, development of secondary sexual characteristics, sexual maturity, and increasing independence from the family are major landmarks of adolescence.
- Peer groups assume great importance during adolescence; they provide a sense of belonging, pride, social learning, and sexual roles.
- Adolescents between the ages of 11 and 15 begin the formal operations stage of cognitive development; they are able to think logically, rationally, and futuristically and can conceptualize things as they could be rather than as they are.
- The adolescent is at Kohlberg's conventional level of moral development, and some proceed to the postconventional or principled level.
- Adolescents are at Fowler's synthetic-conventional stage of spiritual development.
- The four leading causes of adolescent death are motor vehicle crashes, other unintentional injuries, homicide, and suicide.

TEST YOUR KNOWLEDGE

1. The parent of an 8-month-old girl who has been admitted to the hospital with pneumonia is worried about the infant having sudden infant death syndrome (SIDS). The parent stated that "My sister's baby died at the age of 2 months and all he had was a little cold." Which is the nurse's best response?
   1. "You don't need to worry. Your daughter is too old for SIDS."
   2. "Girls are less likely to have SIDS than boys are."
   3. "We don't know what causes SIDS, so I would try not to worry about it."
   4. "You must be very anxious; let's talk about SIDS and what you are thinking."
2. Four-year-old Angie, whose grandmother recently died, tells the nurse, "My grandma has wings just like angels. She flew to heaven yesterday and tomorrow she'll be back." Which is the nurse's best response?
   1. "She's not coming back, honey."
   2. "It is normal for a little one to make believe."
   3. "You must miss your grandma a lot."
   4. "When people get old they die."
3. Because near-drowning is one of the leading causes of vegetative state in young children, which is the best instruction for the nurse to teach parents?
   1. Supervise children at all times when near any source of water.
   2. Enroll children in swimming classes at an early age to ensure water safety.
   3. Make bathroom doors and toilets easily accessible and appropriate for a toddler's size.
   4. Allow unsupervised play only in "kiddy pools" designated for young children.
4. Which statement most accurately describes physical development during the school-age years?
   1. Child's weight almost triples.
   2. Child acquires stereognosis.
   3. Few physical changes occur during middle childhood.
   4. Fat gradually increases, which contributes to the child's heavier appearance.

READINGS AND REFERENCES

Suggested Reading

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Nurses have an important task in developing teaching materials for parents to educate them on health promotion strategies to be implemented while raising their children. The key to successful education is the development of these resources in all languages.

Related Research

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

Contents

UNIT

1

The Nature of Nursing

1 Historical and Contemporary Nursing Practice

LEARNING OUTCOMES

After completing this chapter, you will be able to:

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

KEY TERMS

Alexian Brothers, *3*
caregiver, *15*
case manager, *16*
change agent, *15*
Clara Barton, *6*
client, *13*
client advocate, *15*
communicator, *15*
consumer, *13*
continuing education (CE), *12*
counseling, *15*
demography, *20*
Dorothea Dix, *4*
Fabiola, *2*
Florence Nightingale, *6*
governance, *17*
Harriet Tubman, *3*
in-service education, *13*
Knights of Saint Lazarus, *3*
Lavinia L. Dock, *7*
leader, *15*
Lillian Wald, *7*
Linda Richards, *6*
Luther Christman, *8*
manager, *15*
Margaret Higgins Sanger, *7*
Mary Breckinridge, *8*
Mary Mahoney, *7*
patient, *13*
Patient Self-Determination Act (PSDA), *20*
profession, *16*
professionalism, *17*
professionalization, *17*
Sairy Gamp, *5*
socialization, *17*
Sojourner Truth, *3*
Standards of Practice, *15*
Standards of Professional Performance, *15*
teacher, *15*
telehealth, *20*
telenursing, *20*

INTRODUCTION

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

HISTORICAL PERSPECTIVES

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

Women's Roles

Traditional female roles of wife, mother, daughter, and sister have always included the care and nurturing of other family members. From the beginning of time, women have cared for infants and children; thus, nursing could be said to have its roots in "the home." Additionally, women, who in general occupied a subservient and dependent role, were called on to care for others in the community who were ill. Generally, the care provided was related to physical maintenance and comfort. Thus, the traditional nursing role has always entailed humanistic caring, nurturing, comforting, and supporting.

Religion

Religion has also played a significant role in the development of nursing. Although many of the world's religions encourage benevolence, it was the Christian value of "love thy neighbor as thyself" and Christ's parable of the Good Samaritan that had a significant impact on the development of Western nursing. During the third and fourth centuries, several wealthy matrons of the Roman Empire, such as **Fabiola**, converted to Christianity and used their wealth to provide houses of

Figure 1–1 ■ The Knights of Saint Lazarus (established circa 1200) dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions. From the time of Christ to the mid-13th century, leprosy was viewed as an incurable and terminal disease.
Battman/Corbis.

Figure 1–2 ■ Harriet Tubman (1820–1913) was known as "The Moses of Her People" for her work with the Underground Railroad. During the Civil War she nursed the sick and suffering of her own race.
Universal Images Group/Getty Images.

care and healing (the forerunner of hospitals) for the poor, the sick, and the homeless. Women were not, however, the sole providers of nursing services.

The Crusades saw the formation of several orders of knights, including the Knights of Saint John of Jerusalem (also known as the Knights Hospitalers), the Teutonic Knights, and the Knights of Saint Lazarus (Figure 1–1 ■). These brothers in arms provided nursing care to their sick and injured comrades. These orders also built hospitals, the organization and management of which set a standard for the administration of hospitals throughout Europe at that time. The **Knights of Saint Lazarus** dedicated themselves to the care of people with leprosy, syphilis, and chronic skin conditions.

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

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

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

War

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

During the American Civil War (1861–1865), several nurses emerged who were notable for their contributions to a country torn by internal strife. **Harriet Tubman** and **Sojourner Truth** (Figures 1–2 and 1–3 ■) provided care and safety to slaves fleeing to the North on the Underground Railroad. Mother Biekerdyke and Clara Barton searched the battlefields and gave care to injured and dying soldiers. Noted

Figure 1–3 ■ Sojourner Truth (1797–1883), abolitionist, Underground Railroad agent, preacher, and women's rights advocate, was a nurse for more than 4 years during the Civil War and worked as a nurse and counselor for the Freedmen's Relief Association after the war.
National Portrait Gallery, Smithsonian Institution/Art Resources, NY.

Figure 1–4 ■ Dorothea Dix (1802–1887) was the Union's superintendent of female nurses during the Civil War.
Bettman/Corbis.

authors Walt Whitman and Louisa May Alcott volunteered as nurses to give care to injured soldiers in military hospitals. Another female leader who provided nursing care during the Civil War was **Dorothea Dix** (Figure 1–4 ■). She became the Union's superintendent of female nurses responsible for recruiting nurses and supervising the nursing care of all women nurses working in the army hospitals.

The arrival of World War I resulted in American, British, and French women rushing to volunteer their nursing services. These nurses endured harsh environments and treated injuries not seen before. A monument entitled "The Spirit of Nursing" stands in Arlington National Cemetery (Figure 1–5 ■). It honors the nurses who served in the U.S. armed services in World War I, many of whom are buried in Section 21, which is also called the "Nurses Section" (Arlington National Cemetery, n.d.). Progress in health care occurred during World War I, particularly in the field of surgery. For example, advancements were made in the use of anesthetic agents, infection control, blood typing, and prosthetics.

World War II casualties created an acute shortage of caregivers, and the Cadet Nurse Corps was established in response to a marked shortage of nurses (Figure 1–6 ■). Also at that time, auxiliary health care workers became prominent. "Practical" nurses, aides, and technicians provided much of the actual nursing care under the instruction and supervision of better prepared nurses. Medical specialties also arose at that time to meet the needs of hospitalized clients.

During the Vietnam War, approximately 11,000 American military women stationed in Vietnam were nurses. Most of them volunteered to go to Vietnam right after they graduated from nursing school, making them the youngest group of medical personnel ever to serve in wartime (Vietnam Women's Memorial Foundation, n.d.). Near the Vietnam Veterans Memorial ("The Wall") stands the Vietnam Women's Memorial (Figure 1–7 ■).

Societal Attitudes

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

A

B

C

Figure 1–5 ■ *A,* Section 21 in Arlington National Cemetery honors the nurses who served in the Armed Services in World War I. *B,* The "Spirit of Nursing" monument that stands in Section 21. *C,* Monument plaque.
Photo by Sherrilyn Coffman, RN, PhD.

Figure 1–6 ■ Recruiting poster for the Cadet Nurse Corps during World War II.
Stocktrek Images, Inc./Alamy.

Figure 1–7 ■ Vietnam Women's Memorial. Four figures include a nurse tending to the chest wound of a soldier, another woman looking for a helicopter for assistance, and a third woman (behind the other figures) kneeling while staring at an empty helmet in grief.
Radius Images/Alamy.

Figure 1–8 ■ Sairy Gamp, a character in Dickens' book *Martin Chuzzlewit,* represented the negative image of nurses in the early 1800s.
Stapleton Collection/Corbis.

Before the mid-1800s, nursing was without organization, education, or social status; the prevailing attitude was that a woman's place was in the home and that no respectable woman should have a career. The role for the Victorian middle-class woman was that of wife and mother, and any education she obtained was for the purpose of making her a pleasant companion to her husband and a responsible mother to her children. Nurses in hospitals during this period were poorly educated; some were even incarcerated criminals. Society's attitudes about nursing during this period are reflected in the writings of Charles Dickens. In his book *Martin Chuzzlewit* (1896), Dickens reflected his attitude toward nurses through his character **Sairy Gamp** (Figure 1–8 ■). She "cared" for the sick by neglecting them, stealing from them, and physically abusing them (Donahue, 2011, p. 112). This literary portrayal of nurses greatly influenced the negative image and attitude toward nurses up to contemporary times.

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

Another image arising in the early 19th century that has affected subsequent generations of nurses and the public and other professionals working with nurses is the image of *doctor's handmaiden.* This image evolved when women had yet to obtain the right to vote, when family structures were largely paternalistic, and when the medical profession portrayed increasing use of scientific knowledge that, at that time, was viewed as a male domain. Since that time, several images of nursing have been portrayed. The *heroine* portrayal evolved from nurses' acts of bravery in World War II and their contributions in fighting poliomyelitis—in particular, the work of the Australian nurse Elizabeth Kenney. Other images in the late 1900s include the nurse as sex object, surrogate mother, and tyrannical mother.

During the past few decades, the nursing profession has taken steps to improve the image of the nurse. In the early 1990s, the Tri-Council for Nursing (the American Association of Colleges of Nursing, the American Nurses Association [ANA], the American Organization of Nurse Executives, and the National

League for Nursing [NLN]) initiated a national effort, titled "Nurses of America," to improve the image of nursing. Launched in 2002, the Johnson & Johnson corporation continues their "Campaign for Nursing's Future" to promote nursing as a positive career choice. Through various outreach programs, this campaign increases exposure to the nursing profession, raises awareness about its challenges (e.g., nursing shortage), and encourages people of all ages to consider a career in nursing.

Nursing Leaders

Florence Nightingale, Clara Barton, Linda Richards, Mary Mahoney, Lillian Wald, Lavinia Dock, Margaret Sanger, and Mary Breckinridge are among the leaders who have made notable contributions both to nursing's history and to women's history. These women were all politically astute pioneers. Their skills at influencing others and bringing about change remain models for political nurse activists today. Contemporary nursing leaders, such as Virginia Henderson, who created a modern worldwide definition of nursing, and Martha Rogers, a catalyst for theory development, are discussed in Chapter 3 ∞.

NIGHTINGALE (1820–1910)

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

Nightingale (Figure 1–9 ■) was born to a wealthy and intellectual family. She believed she was "called by God to help others . . . [and] to improve the well-being of mankind" (Schuyler, 1992, p. 4). She was determined to become a nurse in spite of opposition from her family and the restrictive societal code for affluent young English women. As a well-traveled young woman of the day, she visited Kaiserswerth in 1847, where she received 3 months' training in nursing. In 1853 she studied in Paris with the Sisters of Charity, after which she returned to England to assume the position of superintendent of a charity hospital for ill governesses.

When she returned to England from the Crimea, a grateful English public gave Nightingale an honorarium of £4,500. She later used this money to develop the Nightingale Training School for Nurses, which opened in 1860. The school served as a model for other training schools. Its graduates traveled to other countries to manage hospitals and institute nurse-training programs.

Despite poor health that left her an invalid, Florence Nightingale worked tirelessly until her death at age 90. As a passionate statistician, she conducted extensive research and analysis (Florence Nightingale International Foundation, 2014). Nightingale is often referred to as the first nurse researcher. For example, her record keeping proved that her interventions dramatically reduced mortality rates among soldiers during the Crimean War.

Nightingale's vision of nursing changed society's view of nursing. She believed in personalized and holistic client care. Her vision also included public health and health promotion roles for nurses. It is easy to see how Florence Nightingale still serves as a model for nurses today.

BARTON (1821–1912)

Clara Barton (Figure 1–10 ■) was a schoolteacher who volunteered as a nurse during the American Civil War. Her responsibility was to organize the nursing services. Barton is noted for her role in establishing the American Red Cross, which linked with the International Red Cross when the U.S. Congress ratified the Treaty of Geneva (Geneva Convention). It was Barton who persuaded Congress in 1882 to ratify this treaty so that the Red Cross could perform humanitarian efforts in time of peace.

RICHARDS (1841–1930)

Linda Richards (Figure 1–11 ■) was America's first trained nurse. She graduated from the New England Hospital for Women and Children in 1873. Richards is known for introducing nurse's notes and doctor's orders. She also initiated the practice of nurses wearing uniforms (ANA, 2013b). She is credited for her pioneering work in psychiatric and industrial nursing.

Figure 1–9 ■ Considered the founder of modern nursing, Florence Nightingale (1820–1910) was influential in developing nursing education, practice, and administration. Her publication, *Notes on Nursing: What It Is, and What It Is Not*, first published in England in 1859 and in the United States in 1860, was intended for all women.
Classic Clock/Corbis.

Figure 1–10 ■ Clara Barton (1821–1912) organized the American Red Cross, which linked with the International Red Cross when the U.S. Congress ratified the Geneva Convention in 1882.
© Bettman/CORBIS.

Figure 1–11 ■ Linda Richards (1841–1930) was America's first trained nurse.
National League for Nursing. National League for Nursing Records. 1894–1952. Located in: Archives and Modern Manuscripts Collection, History of Medicine Division, National Library of Medicine, Bethesda, MD; MS C 274.

Figure 1–12 ■ Mary Mahoney (1845–1926) was the first African American trained nurse.
Schomberg Center for Research in Black Culture/NYPL/Art Resource.

MAHONEY (1845–1926)

Mary Mahoney (Figure 1–12 ■) was the first African American professional nurse. She graduated from the New England Hospital for Women and Children in 1879. She constantly worked for the acceptance of African Americans in nursing and for the promotion of equal opportunities (Donahue, 2011, p. 144). The ANA (2013c) gives a Mary Mahoney Award biennially in recognition of significant contributions in interracial relationships.

WALD (1867–1940)

Lillian Wald (Figure 1–13 ■) is considered the founder of public health nursing. Wald and Mary Brewster were the first to offer trained nursing services to the poor in the New York slums. Their home among the poor on the upper floor of a tenement, called the Henry Street Settlement and Visiting Nurse Service, provided nursing services, social services, and organized educational and cultural activities. Soon after the founding of the Henry Street Settlement, school nursing was established as an adjunct to visiting nursing.

DOCK (1858–1956)

Lavinia L. Dock (Figure 1–14 ■) was a feminist, prolific writer, political activist, suffragette, and friend of Wald. She participated

Figure 1–13 ■ Lillian Wald (1867–1940) founded the Henry Street Settlement and Visiting Nurse Service (circa 1893), which provided nursing and social services and organized educational and cultural activities. She is considered the founder of public health nursing.
National Portrait Gallery, Smithsonian Institution/Art Resources, NY.

Figure 1–14 ■ Nursing leader and suffragist Lavinia L. Dock (1858–1956) was active in the protest movement for women's rights that resulted in the constitutional amendment in 1920 that allowed women to vote.
Courtesy of The Gottesman Libraries at Teachers College, Columbia University.

in protest movements for women's rights that resulted in the 1920 passage of the 19th Amendment to the U.S. Constitution, which granted women the right to vote. In addition, Dock campaigned for legislation to allow nurses rather than physicians to control their profession. In 1893, Dock, with the assistance of Mary Adelaide Nutting and Isabel Hampton Robb, founded the American Society of Superintendents of Training Schools for Nurses of the United States, a precursor to the current National League for Nursing.

SANGER (1879–1966)

Margaret Higgins Sanger (Figure 1–15 ■), a public health nurse in New York, has had a lasting impact on women's health care. Imprisoned for opening the first birth control information clinic in America, she is considered the founder of Planned Parenthood. Her experience with the large number of unwanted pregnancies among the working poor was instrumental in addressing this problem.

Figure 1–15 ■ Nurse activist Margaret Sanger (1879–1966), considered the founder of Planned Parenthood, was imprisoned for opening the first birth control information clinic in Baltimore in 1916.
© Bettman/CORBIS.

Figure 1–16 ■ Mary Breckinridge (1881–1965), a nurse who practiced midwifery in England, Australia, and New Zealand, founded the Frontier Nursing Service in Kentucky in 1925 to provide family-centered primary health care to rural populations.
Newscom.

BRECKINRIDGE (1881–1965)

After World War I, **Mary Breckinridge** (Figure 1–16 ■), a notable pioneer nurse, established the Frontier Nursing Service (FNS). In 1918, she worked with the American Committee for Devastated France, distributing food, clothing, and supplies to rural villages and taking care of sick children. In 1921, Breckinridge returned to the United States with plans to provide health care to the people of rural America. In 1925, Breckinridge and two other nurses began the FNS in Leslie County, Kentucky. Within this organization, Breckinridge started one of the first midwifery training schools in the United States.

Men in Nursing

Men have worked as nurses as far back as before the Crusades. Although the history of nursing primarily focuses on the female figures in nursing, schools of nursing for men existed in the United States from the late 1880s until 1969. Male nurses were denied admission to the Military Nurse Corps during World War II based on gender. It was believed at that time that nursing was women's work and combat was men's work. During the 20th century, men were denied admission to most nursing programs. The ANA denied membership to male nurses until 1930 and many state nursing associations did not allow men to join until the 1950s (O'Lynn & Tranbarger, 2007, p. 68).

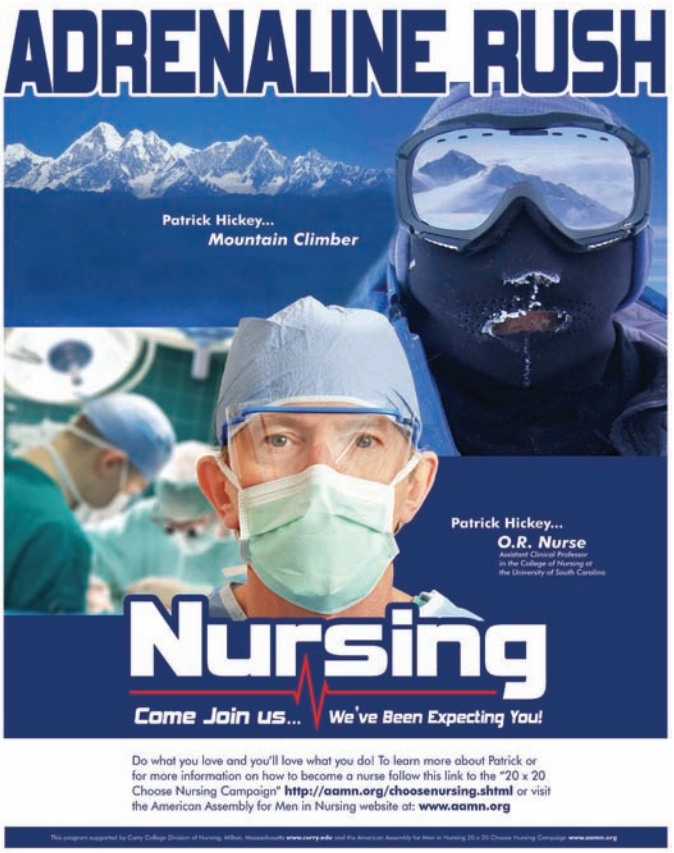

Figure 1–17 ■ Poster for American Assembly for Men in Nursing "20 × 20 Choose Nursing Campaign."
Courtesy American Association for Men in Nursing.

In 1971, a nurse who practiced in Michigan, Steve Miller, formed an organization called Men in Nursing. In 1974, Luther Christman organized a group of male nurses in Chicago. The two groups reorganized into the National Male Nurses Association with the primary focus of recruiting more men into nursing. In 1981, the organization was renamed the American Assembly for Men in Nursing (AAMN) (2011). The purpose of the AAMN is to provide a framework for nurses, as a group, to meet to discuss and influence factors that affect men as nurses. In 2009 and 2010, members of the AAMN discussed ways to change the image of men in nursing in both recruitment and retention. They subsequently introduced the theme "Do what you love and you'll love what you do" (Figure 1–17 ■). This idea led to the AAMN initiative "20 × 20 Choose Nursing," which has the goal of increasing the enrollment of men in nursing programs nationally from the current 10% to 20% by 2020 (Anderson, 2011).

Luther Christman (1915–2011), one of the founders of the AAMN, graduated from the Pennsylvania Hospital School of Nursing for Men in 1939 and did experience discrimination while in nursing school. For example, he was not allowed a maternity clinical experience, yet was expected to know the information related

to that clinical experience for the licensing exam. After becoming licensed, he wanted to earn a baccalaureate degree in nursing, but was denied access to two universities because of gender. After receiving his doctorate he accepted the position as dean of nursing at Vanderbilt University. He was the first man to be a dean at a university school of nursing. He accomplished many firsts: the first man nominated for president of the ANA, the first man elected to the American Academy of Nursing (he was named a "Living Legend" by this organization), and the first man inducted into ANA's Hall of Fame for his extraordinary contributions to nursing (O'Lynn & Tranbarger, 2007).

Men comprised 9.6% of the nation's nursing workforce in 2011 (U.S. Census Bureau, 2013). Men do experience barriers to becoming nurses. For example, the nursing image is one of femininity, and nursing has been slow to neuter this image. As a result, many people may believe that only homosexual men enter nursing, which is not true. Other barriers and challenges for male nursing students include the lack of male role models in nursing and caring (e.g., differences in caring styles between men and women) and suspicion surrounding intimate touch (MacWilliams, Schmidt, & Bleich, 2013). The nursing profession and nursing education need to address these issues. Improved recruitment and retention of men and other minorities into nursing will strengthen the profession.

NURSING EDUCATION

The practice of nursing is controlled from within the profession through state boards of nursing and professional nursing organizations. These groups also determine the content and type of education that is required for different levels or scopes of nursing practice. Originally, the focus of nursing education was to teach the knowledge and skills that would enable a nurse to practice in a hospital setting. However, as nursing roles have evolved in response to new scientific knowledge; advances in technology; and cultural, political, and socioeconomic changes in society; nursing education curricula have been revised to enable nurses to work in more diverse settings and assume more diverse roles. Nursing programs are increasingly based on a broad knowledge of biologic, social, and physical sciences as well as the liberal arts and humanities. Current nursing curricula emphasize critical thinking and the application of nursing and supporting knowledge to health promotion, health maintenance, and health restoration as provided in both community and hospital settings (Figure 1–18 ■).

There are two types of entry-level generalist nurses: the registered nurse (RN) and the licensed practical or vocational nurse (LPN or LVN). Responsibilities and licensure requirements differ for these two levels. The majority of new RNs graduate from associate degree or baccalaureate degree nursing programs. In some states, a person can be eligible to take the licensure exam through other qualifications such as completing a diploma nursing program or challenging the exam as a military corps person or LVN after completing specified coursework. There also are "generic" master's and doctoral programs that lead to eligibility for RN licensure. These latter programs are for students who already have a baccalaureate degree in a discipline other than nursing. On completion of the program, which may be from 1 to 3 years in length, graduates obtain their initial professional degree in nursing. Graduates of these

Figure 1–18 ■ Nursing students learn to care for clients in community settings.
Jim West/Alamy.

programs are eligible to take the licensure examination to become an RN and also may continue into specialty roles such as nurse practitioner or nurse educator.

Although educational preparation varies considerably, all RNs in the United States take the same licensure examination, the National Council Licensure Examination (NCLEX-RN). This examination is administered in each state and the successful candidate becomes licensed in that particular state, even though the examination is of national origin. To practice nursing in another state, the nurse must receive reciprocal licensure by applying to that state's board of nursing. Some state legislatures have created a regulatory model called *mutual recognition* that allows for multistate licensure under one license. States that enter into these recognition agreements are referred to as *compact states*. Nurses who have received their training in other countries may be granted registration after successfully completing the NCLEX. Both licensure and registration must be renewed regularly in order to remain valid. For additional information about licensure and registration, see Chapter 4 ∞.

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

Types of Education Programs

Education programs available for nurses include practical or vocational nursing, registered nursing, graduate nursing, and continuing education. All levels of nursing are needed in health care today.