



Pearson

Kozier & Erb's
Fundamentals of Nursing, 11e
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Kozier & Erb's

Eleventh Edition

Fundamentals of Nursing

Concepts, Process, and Practice

Audrey Berman • Shirlee Snyder • GERALYN FRANDSEN

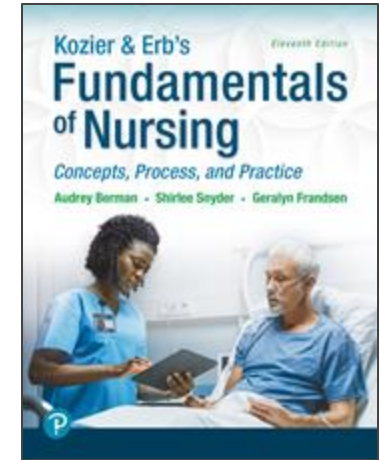


Preparing students to succeed in modern nursing careers

Nurses today must grow and evolve to meet the demands of a dramatically changing healthcare system. ***Kozier & Erb's Fundamentals of Nursing*** provides a core foundation of contemporary professional nursing so students can succeed in today's environment. From the integral aspects of nursing, such as managing and communicating, to assessing health and client care, the text sets the foundation for nursing excellence. To help students develop their clinical-reasoning abilities, QSEN features throughout the 11th Edition draw connections to actual nursing practice. Students will learn to think like nurses as they see how the material they are reading is applied in nursing practice. Other updates include new examples, additional photos, and the latest standards of care.

MyLab™ is the teaching and learning platform that empowers you to reach every student. By combining trusted author content with digital tools and a flexible platform, MyLab personalizes the learning experience and improves results for each student. MyLab Nursing helps students master key concepts, prepare for success on the NCLEX-RN® exam, and develop clinical reasoning skills. Learn more about MyLab Nursing.

Top Reasons to Adopt *Kozier & Erb's Fundamentals of Nursing, 11e*



1

The MyLab

*This MyLab Nursing course has moved from the MMND Foundations platform to the MMND XL Platform. **New functionality and new features!***

Demo these features:

- Dynamic Study Modules
- Decision-Making Case Studies
- NCLEX Review Questions
- Pearson eText

2

Develops Clinical Reasoning

- EXPANDED - QSEN competencies and specified expectations appear throughout the text.
- UPDATED - Evidence-Based Practice boxes highlight relevant research and implications for nursing care.
- Critical-Thinking Checkpoints present brief case studies about issues challenging nurses today.
- Meeting The Standards end-of-unit activities.

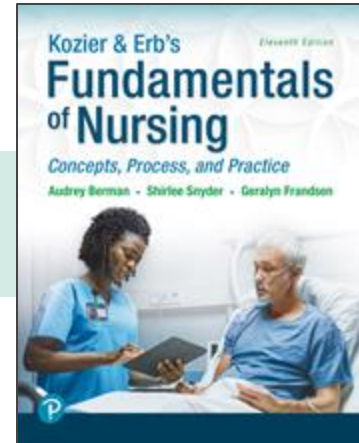
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Current Content & Issues

- The most up to date information on nursing today, including: legal considerations, standards of care, evidence-based practice, cultural considerations and electronic health records.
- Culturally Responsive Care feature
- Evidence-Based Practice

Features

Features that Link to QSEN Competencies



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 Boxes
- Safety Alerts
- Lifespan Considerations
- Client Teaching

EVIDENCE-BASED PRACTICE

Evidence-Based Practice
What is the impact of Chlorhexidine Bathing on Healthcare-Associated Infections?
According to Dany and Murro (2017), approximately 4% of hospitalized clients contract a healthcare-associated infection (HAI) during their hospitalizations. These infections frequently result in increased morbidity, mortality, and length of hospital stay. Skin bacterial colonization aids in the transmission and development of HAIs. Nurses frequently use bathing with chlorhexidine gluconate (CHG) to reduce bacterial colonization on the client's skin. Studies have shown that bathing with CHG products has had mixed results in the prevention of HAIs. As a result, the authors performed a literature review to examine the current evidence on the impact of CHG bathing on HAIs. The literature search identified peer-reviewed studies and meta-analyses that examined the impact of CHG bathing in preventing HAIs, specifically surgical site infections (SSIs), central line-associated bloodstream infections (CLABSI), ventilator-associated pneumonia (VAP), catheter-associated urinary tract infections (CAUTI), and Clostridium difficile-associated disease. The search resulted in 23 articles for review.
The findings concluded that there was good evidence to support using a CHG bathing regimen to reduce the incidence of CLABSI, SSI, vancomycin-resistant enterococci (VRE), and methicillin-resistant Staphylococcus aureus (MRSA) HAIs.
The authors, based on the literature search, raised questions for further research, including the value of using CHG liquid soap versus CHG-impregnated washcloths. Research has shown that application of CHG on the client's body without rinsing has greater impact than applying CHG followed by rinsing the body. Do CHG-impregnated washcloths have an advantage because the CHG in the wipes is not rinsed from the skin? Another issue raised by the authors was that most studies were conducted in targeted populations (e.g., intensive care units). They suggest that more research is needed on the benefits of bathing all clients versus a targeted (bathing only at-risk clients) approach.

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

LIFESPAN CONSIDERATIONS Diagnosing

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

OLDER ADULTS
Older adults tend to have multiple problems with complex physical and psychosocial needs when they are ill. If the nurse has done a thorough and accurate assessment, nursing diagnoses can be selected to cover all problems and, at the same time, prioritize the special needs. For example, if a client is admitted with severe congestive heart failure, cardiac status is to improve the other nursing knowledge rate attention. They try heart failure outcomes and be an essential

CLIENT TEACHING Developing Written Teaching Aids

- Keep language level at a fifth- to sixth-grade level.
- Use active, not passive, voice (e.g., "take your medicine before breakfast" [active] versus "medicine should be taken before breakfast" [passive]).
- Use plain language that is, easy, common words of one or two syllables (e.g., use instead of utilize, or give instead of administer).
- Use the second person (you) rather than the third person (the client).
- Use a large type size (14 to 18 point).
- Write short sentences.
- Avoid using all capital letters.
- Place priority information first and repeat it more than once.
- Use bold for emphasis.
- Use simple pictures, drawings, or cartoons, if appropriate.
- Leave plenty of white space.
- Focus material on desired behavior rather than on medical facts.
- Make it look easy to read.

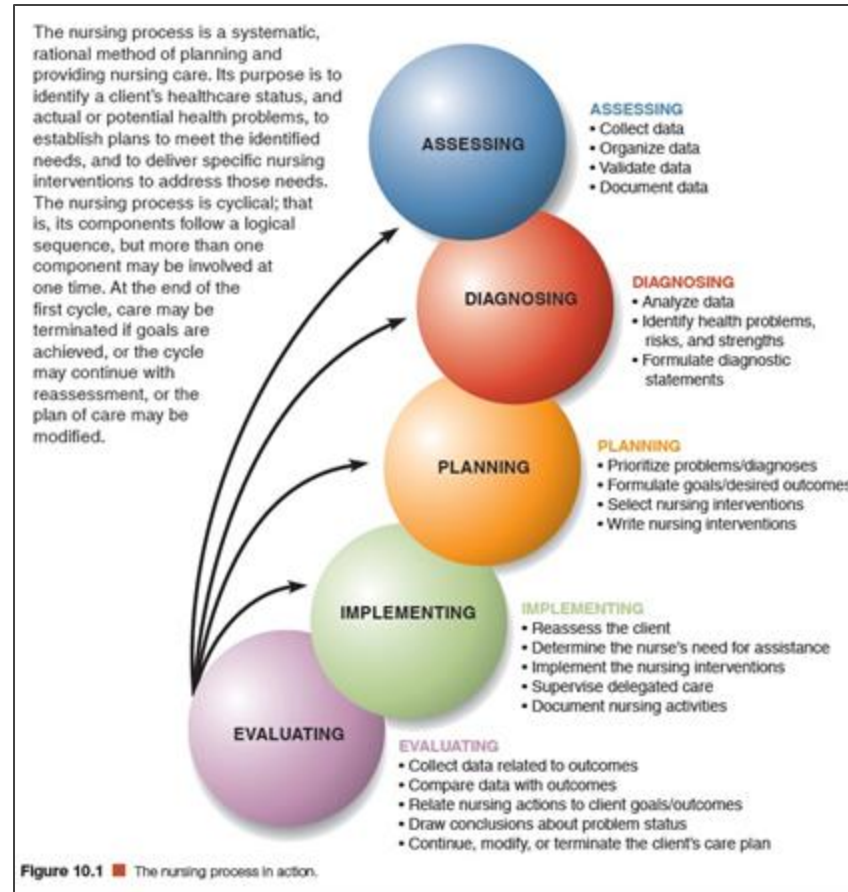
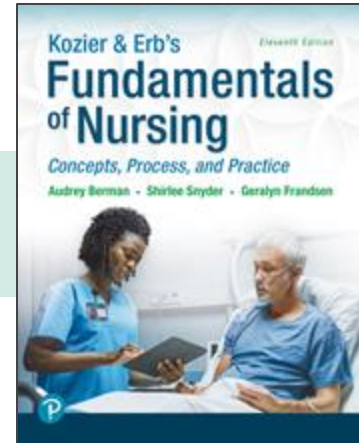
Safety Alert! SAFETY

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

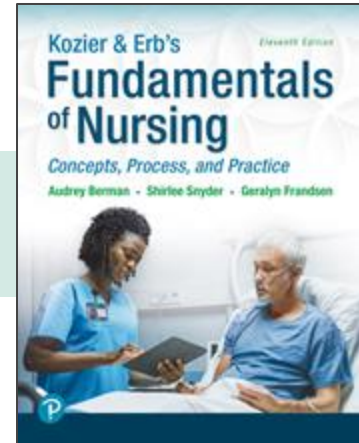
Features

Enhanced Photo Program

ENHANCED PHOTO PROGRAM:
shows procedural steps and the
latest equipment



Hallmark Features



Critical Thinking and Clinical Reasoning **9**

LEARNING OUTCOMES

After completing this chapter, you will be able to:

1. Describe the significance of developing critical thinking abilities in order to practice safe, effective, and professional nursing care.
2. Describe the actions of clinical reasoning in the implementation of the nursing process.
3. Discuss the attitudes and skills needed to develop critical thinking and clinical reasoning.
4. Describe the components of clinical reasoning.
5. Integrate strategies to enhance critical thinking and clinical reasoning as the provider of nursing care.
6. Integrate strategies to implement clinical reasoning while caring for clients during clinical.
7. Describe the process of concept mapping to enhance critical thinking and clinical reasoning for the provision of nursing care.

KEY TERMS

clinical judgment, 155
clinical reasoning, 151
cognitive processes, 157
concept mapping, 160

creativity, 152
critical analysis, 153
critical thinking, 151
deductive reasoning, 154

inductive reasoning, 153
intuition, 155
metacognitive processes, 157
nursing process, 154

problem-solving, 155
Socratic questioning, 153
trial and error, 155

UNIT

5

Meeting the Standards

In this unit, we have selected concepts related to health, health promotion, wellness, stress, culture and heritage, and complementary and alternative healing modalities. These topics highlight 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 descriptions, you will see how one client demonstrates complex, fragmented, complex patterns 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 inform influential choices for care and support—including the role of the nurse.

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

Medical History: *Manuela has experienced some type of health change for most of her adult life. She was diagnosed with adult-onset (SUIT) disease (SUIT) at about age 38 after several years of health issues. She has a long history of hypertension, which she managed with medication, but she had an enlarged aorta and heart. This disease shows many similarities with myocardial and autoimmune diseases, but those conditions were not removed from consideration because the tests were negative. ASO is a chronic condition for which there is no exact cure. In addition to joint inflammation, 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 the methotrexate are used. However, they have severe side effects, such as kidney damage and bone marrow suppression. The sign often worsens when the individual is under physical or emotional stress. Manuela underwent a hip replacement about a year ago and recently had several hospitalizations for respiratory issues.*

Pastor and Social History: *Manuela has never married and has been married or with her parents or siblings for all her life. She has many friends, shares, and has an active social life when she is feeling well. She uses the computer extensively for communication, especially when using video or social media. She must force a slow pace of food and fluids that are easy to swallow and digest. She is a spiritual individual but not using religion. She is quick to laugh and generally has an optimistic outlook, but she expresses awareness that for the acute and all any those things are long battles for her to be happy.*

Manuela is a college graduate but has been able to work only part time for most of her life. Recently, she was diagnosed permanently disabled, which allows her access to financial and other support systems. She is creative in adapting her living situation to her abilities and wanting to pick up her beloved past job.

Questions

American Nurses Association Standard of Practice III: C— *Client Identification:* The nurse collaborates with the healthcare consumer to define expected outcomes integrating the healthcare consumer's culture, values, and unique considerations. (As you learned in Chapter 10, you, Manuela needs help in the category of safety, prevention, and health promotion and assessment based on the level of knowledge, skills, and individual conditions and the focus.)

1. What are some outcomes for Manuela that would reflect the goal?

2. Do you need to know her personal definition of health and health beliefs (Chapter 2) in order to work with her to her expected outcome?

American Nurses Association Standard of Practice III: A— *Health Teaching and Health Promotion:* The nurse employs strategies to promote health and a safe environment.

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

American Nurses Association Standard of Professional Performance III: C— *Collaboration:* Nurses partner with others to create, implement, and evaluate a comprehensive plan.

4. What healthcare team members other than the nurse and nurse would best be prepared to include Manuela's care plan?

American Nurses Association Standard of Professional Performance III: D— *Education:* Nurses Practice and Research.

5. What evidence might you have or seek to support the use of a complementary treatment modality in Manuela's case? (Chapter 10, you learned about the importance of evidence-based practice.)

6. How might you use the evidence to support the use of the complementary treatment modality in Manuela's case? (Chapter 10, you learned about the importance of evidence-based practice.)

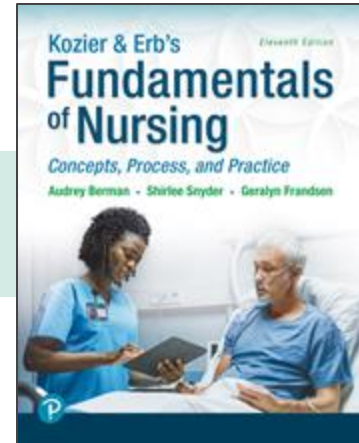
Learning Outcomes

Key Terms

Meeting the Standards

Features

Hallmark Features



NURSING CARE PLAN Margaret O'Brien

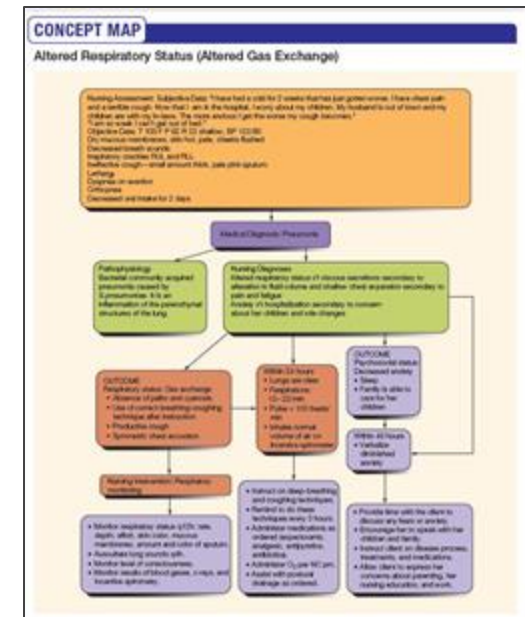
Nursing Diagnosis: Altered respiratory status related to viscous secretions secondary to alteration in fluid volume and shallow chest expansion secondary to pain and fatigue

DESIRED OUTCOMES*/INDICATORS	NURSING INTERVENTIONS	RATIONALE
<p>Respiratory Status: Gas Exchange [0402], as evidenced by</p> <ul style="list-style-type: none"> Absence of pallor and cyanosis (skin and mucous membranes) Use of correct breathing/coughing technique after instruction 	<p>Monitor respiratory status q4h: rate, depth, effort, skin color, mucous membranes, amount and color of sputum.</p> <p>Monitor results of blood gases, chest x-ray studies, and incentive spirometer volume as available.</p> <p>Monitor level of consciousness.</p>	<p>To identify progress toward or deviations from goal. Altered respiratory status leads to poor oxygenation, as evidenced by pallor, cyanosis, lethargy, and drowsiness.</p>
<ul style="list-style-type: none"> Productive cough Symmetric chest excursion of at least 4 cm 	<p>Auscultate lungs q4h. Vital signs q4h (TPR, BP, pulse oximetry, pain).</p>	<p>Inadequate oxygenation and pain cause increased pulse rate. Respiratory rate may be decreased by narcotic analgesics. Shallow breathing further compromises oxygenation.</p>

APPLYING CRITICAL THINKING

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

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



Nursing Care Plans

Applying Critical Thinking

Concept Maps

Features

Step by Step Skills

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

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

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

PURPOSE

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

ASSESSMENT

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

PLANNING

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

Assignment

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

Equipment

As indicated according to which activities will be performed, ensure that extra supplies are easily available.

- Gown
- Mask
- Eyewear
- Clean gloves


IMPLEMENTATION

Preparation


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

Performance

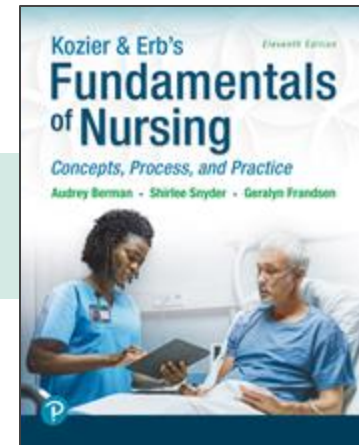
1. Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how to participate.
2. Perform hand hygiene.
3. Apply a clean gown.
 - Pick up a clean gown, and allow it to unfold in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



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

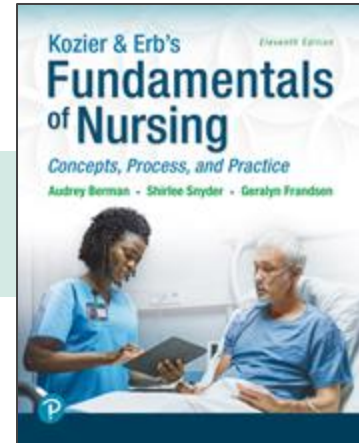


4 A face mask tucked under eye protection.



Features

Clinical Competence



Clinical Alert!

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

PRACTICE GUIDELINES Long-Term Care Documentation

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

DRUG CAPSULE

Benzodiazepine: midazolam hydrochloride (Versed)

THE CLIENT UNDERGOING ANESTHESIA

IV anesthetic agent used to induce general anesthesia.

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

NURSING RESPONSIBILITIES

- Obtain baseline vital signs and level of consciousness before administration.
- Monitor vital signs, level of consciousness, and oxygen saturation q3–5min intraoperatively and postoperatively. Notify primary care provider or CRNA if there are any changes.

- Have resuscitative equipment readily available.
- A too rapid IV administration or excessive dose increases the risk of respiratory depression or arrest.
- Dosage must be individualized based on age, underlying disease, and desired effect. Too much or too little a dosage or improper administration may result in cerebral hypoxia, agitation, involuntary movement, hyperactivity, and combativeness.

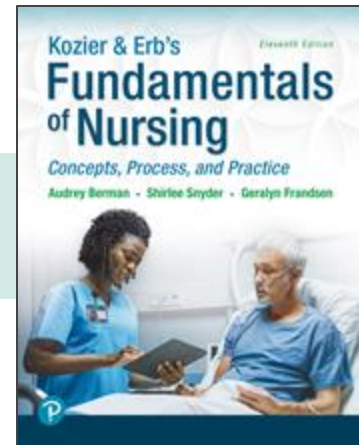
Note: Prior to administering any medication, review all aspects with a current drug handbook or other reliable source.

Clinical Alerts

Practice Guidelines

Drug Capsule

Anatomy & Physiology Review

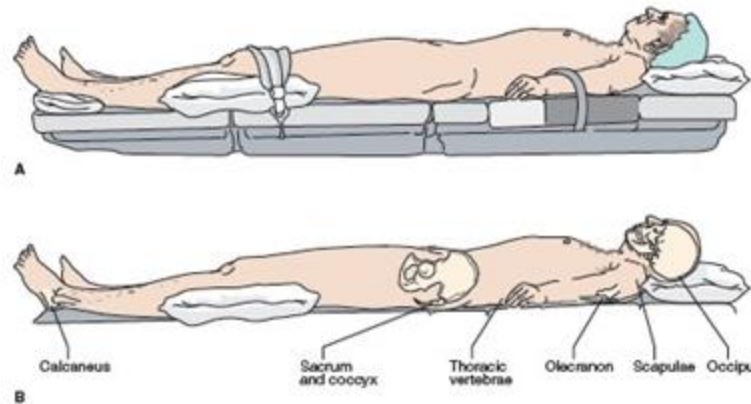


ANATOMY & PHYSIOLOGY REVIEW

Client Positioning

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

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



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

QUESTIONS

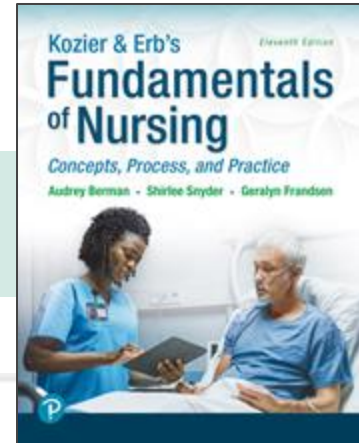
A 78-year-old male client scheduled for a colon resection is brought to the operating room. He weighs 82 kg (180 lb), has type 2 diabetes, and has a history of arthritis in his hips and shoulders.

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

3. What is the priority nursing diagnosis and outcome for this client?

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

Critical Thinking Checkpoint



Critical Thinking Checkpoint

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

1. What factors place Mr. Teng at increased risk for the development of complications during and after surgery?
2. Speculate about why Mr. Teng's surgeon and anesthesiologist decided to perform Mr. Teng's surgery under regional anesthesia as opposed to general anesthesia.

3. What preparations were taken during the preoperative period to protect Mr. Teng from possible complications during and after his surgery?
4. How will Mr. Teng's postoperative assessments differ from those of a client who received general anesthesia?
5. What postoperative precautions are especially important to Mr. Teng in view of his chronic lung condition?

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

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

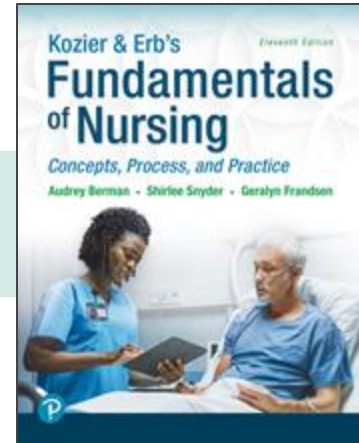
Features

End of Chapter Review

CHAPTER HIGHLIGHTS:
Focus attention and address key concepts.

TEST YOUR KNOWLEDGE:
Helps prepare for the NCLEX exam.

READINGS & REFERENCE:
Provides evidence-based materials.



162 Unit 3 • The Nursing Process

Critical Thinking Checkpoint

M. W. is a 55-year-old recently retired engineer with a history of infarcts from a stroke that causes frequent dizziness and vertigo. He is a schoolteacher, and his 12-year-old son comes to the acute care clinic complaining about "not feeling good." You conclude he is having a recurrence of his medical problem.

1. What questions would you ask yourself to check the assumption?
2. How would you demonstrate that you are using the critical thinking attitude of "suspension of reasoning"?

3. Scores might ask you about the consequences of your action by posing the question "What are the implications of your action?" How would you answer? Consider the following: How would you answer if you are correct and if you are incorrect? If your answer is correct, how would you answer if your answer is incorrect?

Answers to Critical Thinking Checkpoint questions are available in the Student Manual with your textbook.

Chapter 9 Review

CHAPTER HIGHLIGHTS

- Nurses need critical thinking skills and attitudes to be safe, competent, and effective.
- Nurses use critical reasoning skills to assess each client's condition and identify interventions that improve clients' physiologic and psychosocial outcomes.
- Carefully enhances critical thinking. Creative nurses generate many ideas, test them, and evaluate them. Creative nurses generate many ideas, test them, and evaluate them.
- Critical thinking skills include the ability to do critical analysis, perform inductive and deductive reasoning, make valid inferences, differentiate facts and opinions, evaluate the credibility of information sources, clarify concepts, and recognize assumptions.
- Critical thinkers have certain attitudes: independentness, insight, intellectual humility, intellectual courage, the status quo and risk, integrity, perseverance, curiosity.
- Nurses utilize cognitive processes in clinical reasoning: thinking is based on the knowledge of the aspects of the client's condition.
- Nurses also utilize metacognitive processes in clinical reasoning: the knowledge they gain in the care of the client.
- Clinical reasoning in question is the ability to recognize changes in a client's condition over time.
- Reflection is the identification of factors that influence the client's condition.

TEST YOUR KNOWLEDGE

1. A client with diabetes also has a primary care provider's order for a bulk laxative daily. The nurse, not wanting that bulk laxative can help satisfy certain types of diabetes, concludes, "The primary care provider does not know the client has diabetes." What type of statement is this?
 1. A fact
 2. An inference
 3. A judgment
 4. An opinion
2. A client reports feeling hungry but does not eat when food is served. Using critical reasoning skills, the nurse should perform which of the following?
 1. Assess why the client is not ingesting the food provided.
 2. Continue to leave the food at the bedside until the client is hungry enough to eat.
 3. Notify the primary care provider that tube feeding may be indicated soon.
 4. Believe the client is not truly hungry.
3. A client complains of shortness of breath. During the nurse observes that the client has edema of the feet. The nurse reviews evidence-based practice research on a previous client with the same clinical signs. What do these actions represent?
 1. Clinical judgment
 2. Clinical reasoning
 3. Reflection
 4. Intuition
4. The client who is short of breath benefits from the bed being elevated. Because this position can not be maintained in the second area, the nurse decides to attempt to raise pressure occurring in other parts of the client's body. The nurse implements which of the following?
 1. The research method
 2. The based-on-error method
 3. Intuition
 4. The nursing process

Chapter 9 • Critical Thinking and Clinical Reasoning 163

6. In the clinical reasoning process, the nurse sets and weighs the criteria, examines alternatives, and performs which of the following before implementing a plan?

1. Reassesses the purpose for making the decision.
2. Consults the client and family members to determine their view of the options.
3. Identifies and considers various means for reaching the outcomes.
4. Determines the logical course of action about intervening problems areas.

6. The nurse is concerned about a client who begins to breathe very rapidly. Which action by the nurse reflects critical reasoning?

1. Notify the primary care provider.
2. Obtain vital signs and oxygen saturation.
3. Reassess a chest x-ray.
4. Call the rapid response team.

7. The nurse is teaching a client about wound care during a follow-up visit in the client's home. Which critical thinking attitude causes the nurse to reconsider the plan and supports evidence-based practice when the client states, "I just don't know how I can afford these dressings?"

1. Integrity
2. Intellectual humility
3. Confidence
4. Independence

8. When the nurse suspects that a client is from a developing country and may have a positive tuberculosis test due to a prior infection, which critical thinking attitude and skill is the nurse practicing?

1. Creating environments that support critical thinking.
2. Suspending assumptions and ambiguity.
3. Self-assessment.
4. Seeking situations where good thinking is practiced.

8. A client in a cardiac rehabilitation program says to the nurse, "I have to eat a low sodium diet for the rest of my life, and I hate it!" Which is the most appropriate response by the nurse?

1. "I will get a dietary consult to talk to you before next week."
2. "What do you think is so difficult about following a low-sodium diet?"
3. "No need to exercise heart attack and we will be able to return to work."
4. "You may not need to follow a low-sodium diet for so long as you think."

10. Which reasoning process describes the nursing actions when the nurse evaluates possible solutions for care of an infected wound for optimal client outcomes?

1. Intuition
2. Research process
3. Trial and error
4. Problem solving

See Answers to Test Your Knowledge in Appendix B.

READINGS AND REFERENCES

Suggested Reading

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Wong, J., & Hargrett-Anderson, N. (2018). Nursing process: A review. *Nursing Clinics of North America*, 13(4), 589-600.

Related Research

Wong, J., & Hargrett-Anderson, N. (2018). Nursing process: A review. *Nursing Clinics of North America*, 13(4), 589-600.

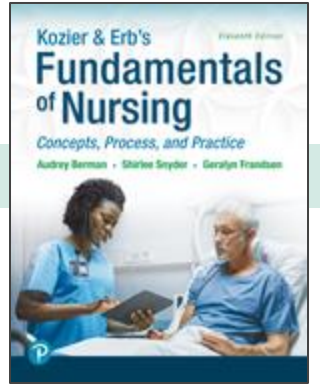
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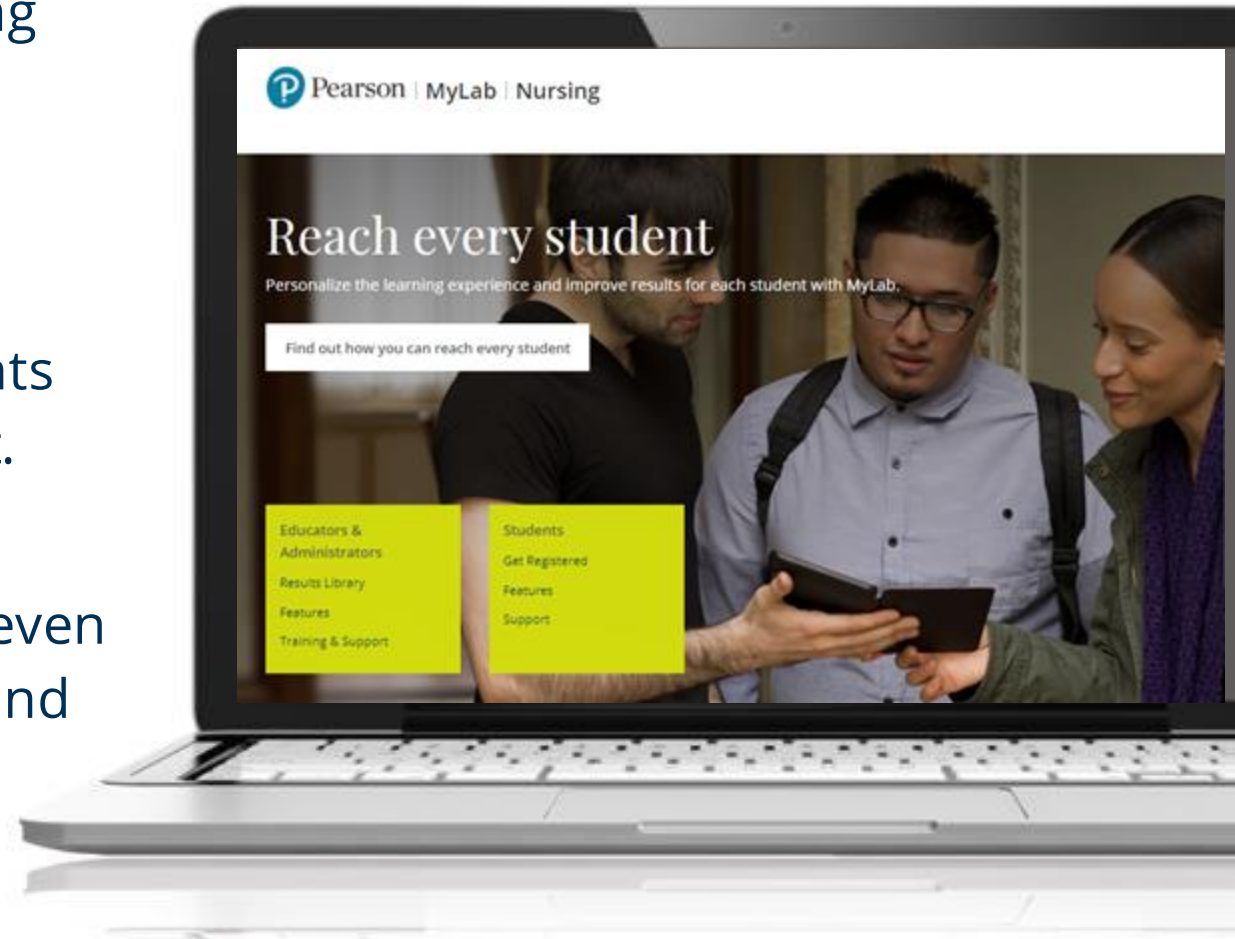
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Features: MyLab Nursing

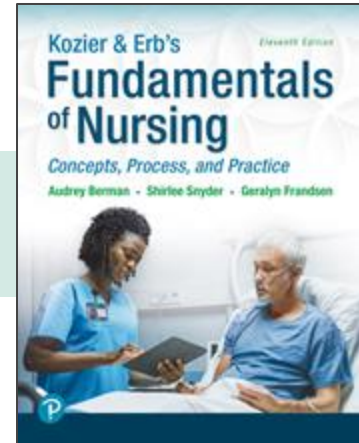


- **NCLEX Review Questions:** Practice NCLEX®-style questions build students' comfort and familiarity with the exam format, while letting them go at their own pace.
- **Dynamic Study Modules** - personalized, adaptive learning.
- **Decision-Making Case Studies** help students develop and improve their clinical judgment.
- **Pearson eText** includes highlighting, note taking and vocab review all in one place — even when offline. Seamlessly integrated videos and other rich media.




Features: MyLab Nursing

Dynamic Study Modules



QUESTION



Fetal heart tones may be audible with a Doppler as early as _____ weeks gestation.

ANSWER


16

14

I AM SURE

LEARN

QUESTION REVIEWING 1 OF 6



ANSWER INCORRECT

YOU WERE SURE AND INCORRECT
Nothing; this is a normal finding.

Additional prenatal education

THE CORRECT ANSWER
Rh sensitization

Blood transfusions

I DON'T KNOW YET

During the initial prenatal assessment, you discuss blood type with Shelley and Harold. Shelley thinks she is Rh negative based

WHAT YOU NEED TO KNOW

If the woman has Rh-negative blood type and her partner has Rh-positive blood type, this may cause Rh sensitization, which can result in fetal anemia, hydrops fetalis, kernicterus, or erythroblastosis fetalis in the fetus.

Rh sensitization can lead to a poor fetal outcome. Therefore, testing is necessary. While you explain the need to test for Rh sensitization, the additional need for prenatal education will be based on the results of the test.

The Rh sensitization results do not indicate a need for blood transfusion.

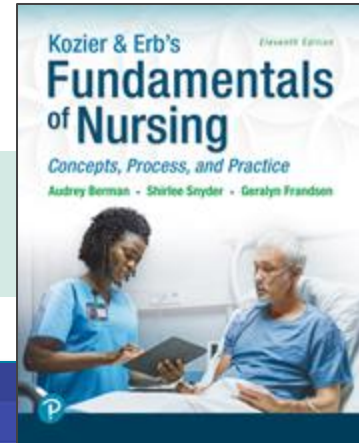
[▶ Additional Learning](#)

Obstetric risk factors affecting pregnancy can include but are not limited to:

- Maternal anxiety and psychological distress resulting from a previous fetal or neonatal death, or a history of early pregnancy loss.
- Grandmultiparity is associated with postpartum hemorrhage.
- Maternal Rh negative blood type:
 - Rh sensitization can result in fetal anemia, hydrops fetalis, kernicterus, or erythroblastosis fetalis.

Features: MyLab Nursing

Decision Making Case Studies



PEARSON
PATHOPHYSIOLOGY DECISION MAKING CASE 1


CASE

YOUR DECISIONS

SBAR

ELECTRONIC HEALTH RECORD

Case Introduction



Yashika Devon

Case Environment

- You are a registered nurse
- Your interdisciplinary care team consists of a physician, three registered nurses, and a physical therapist.

PEARSON
PATHOPHYSIOLOGY DECISION MAKING CASE 1

CASE

YOUR DECISIONS

SBAR

ELECTRONIC HEALTH RECORD

Assessment Data

ACTION DECISION

Which objective assessment data would be needed to evaluate Yashika's response to her plan of care?

Please select all that apply.

Eating habits

Please select all that apply.

Eating habits ✘ Incorrect

Yashika tells you she has "not been very focused on nutrition" since her last visit to the clinic.

Although reported eating habits are relevant to the physical assessment, this information is subjective data.

BMI calculation ✔ Correct

You calculate Yashika's BMI at 31.2 kg/m². You enter this data into the EHR.

Obesity, which refers to an excess of body fat, is clinically defined by the body mass index (BMI). BMI is calculated by dividing the weight in kilograms by the square of height in meters. When using measured height and weight, BMI calculation provides objective assessment data.

INCORRECT

Not all of the choice(s) selected were correct.

If you believe you made the correct choice for a patient, but your choice was marked incorrect, provide your reasoning in the **Difficult Decision Form**.

BEST CHOICES

BMI calculation

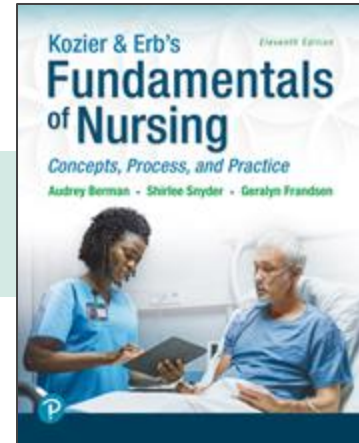
Obesity, which refers to an excess of body fat, is clinically defined by the body mass index (BMI). BMI is calculated by dividing the weight in kilograms by the square of height in meters. When using measured height and weight, BMI calculation provides objective assessment data.

Height measurement

Height measurement is necessary to calculate body mass index (BMI). While self-reported height is subjective data, current measured height

Features: MyLab Nursing


NCLEX Prep



PEARSON return Nursing DevSpider

Pregnancy Demo Progress bar with 15 segments, 10 are filled (green and red)

QUESTION



ANSWER

- "I respect your nutritional preferences, and we can work within those guidelines."
- "Let's talk about other foods that you can eat to ensure nutrition that will support the health..."
-
-
-

Study Plan Contents	MP Earned
<input type="checkbox"/> M. 16: The Concept of Perfusion	0/1
• 16.1 Answering NCLEX-RN style questions, demonstrate the ability to incorporate integrated proc...	0/1
<input type="checkbox"/> M. 16-1: Exemplar: Cardiomyopathy	0/1
• 16-1.1 Answering NCLEX-RN style questions, demonstrate the ability to incorporate integrated pro...	0/1
<input type="checkbox"/> M. 16-6: Exemplar: Heart Failure	0/1
• 16-6.1 Answering NCLEX-RN style questions, demonstrate the ability to incorporate integrated pro...	0/1
Total	0/3

Learn More Online.

The screenshot displays the Pearson MyLab Nursing website interface. At the top left is the Pearson logo followed by the text "Pearson | MyLab | Nursing". At the top right is a home icon and the text "MYLAB & MASTERING HOME". The main content area features a background image of three students looking at a tablet. Overlaid on the left is a white box with the text "Find out how you can reach every student". Below this are two yellow navigation boxes: one for "Educators & Administrators" (with links for Results Library, Features, and Training & Support) and one for "Students" (with links for Get Registered, Features, and Support). On the right, a dark grey overlay contains a "Sign In" section with a "Sign in" button and a "Forgot username or password?" link, and a "Register" section with "Student" and "Educator" buttons.

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MYLAB & MASTERING HOME

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 - Results Library
 - Features
 - Training & Support
- Students
 - Get Registered
 - Features
 - Support

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Sign in

Forgot username or password?

Register

Need access? Start here!

Student

Educator



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 Chemo-therapy: The Experience of Women with Breast Cancer*. She worked in oncology at Samuel Merritt Hospital prior to beginning her teaching career in the diploma program at Samuel Merritt Hospital School of Nursing in 1976. As a faculty member, she participated in the transition of that program into a baccalaureate degree and in the development of the master of science and doctor of nursing practice programs. Over the years, she has taught a variety of medical-surgical nursing courses in the prelicensure programs on three campuses. She served as the dean of nursing at Samuel Merritt University from 2004-2019 and was 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 is a senior director of the Bay Area Tumor Institute and served 3 years as director on the Council on Accreditation of Nurse Anesthesia Educational Programs. She is a member of the American Nurses Association and Sigma Theta Tau and is a site visitor for the Commission on Collegiate Nursing Education. She has twice participated as an NCLEX-RN item writer for the National Council of State Boards of Nursing. She has presented locally, nationally, and internationally on topics related to nursing education, breast cancer, and technology in healthcare.

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



Shirlee J. Snyder, EdD, RN

Shirlee J. Snyder graduated from Columbia Hospital School of Nursing in Milwaukee, Wisconsin, and subsequently received a bachelor of science in nursing from the University of Wisconsin–Milwaukee. Because of an interest in cardiac nursing and teaching, she earned a master of science in nursing with a minor in cardiovascular clinical specialist and teaching from the University of Alabama in Birmingham. A move to California resulted in becoming a faculty member at Samuel Merritt Hospital School of Nursing in Oakland, California. Shirlee was fortunate to be involved in the phasing out of the diploma and ADN programs and development of a baccalaureate intercollegiate nursing program. She held numerous positions during her 15-year tenure at Samuel Merritt College, including curriculum coordinator, assistant director–instruction, dean of instruction, and associate dean of the Intercollegiate Nursing Program. She is an associate professor alumnus at Samuel Merritt College. Her interest and experiences in nursing education resulted in Shirlee obtaining a doctorate of education focused on curriculum and instruction from the University of San Francisco. Dr. Snyder moved to Portland, Oregon, in 1990 and taught in the ADN program at Portland Community College for 8 years. During this teaching experience she presented locally and nationally on topics related to using multimedia in the classroom and promoting 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 5000 nursing students and 200 nursing faculty. She is a member of the American Nurses Association. She has been a site visitor for the National League for Nursing Accrediting Commission and the Northwest Association of Schools and Colleges.



Geralyn Frandsen, EdD, RN

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



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