KOZIER ERB BERMAN SNYDER FRANDSEN
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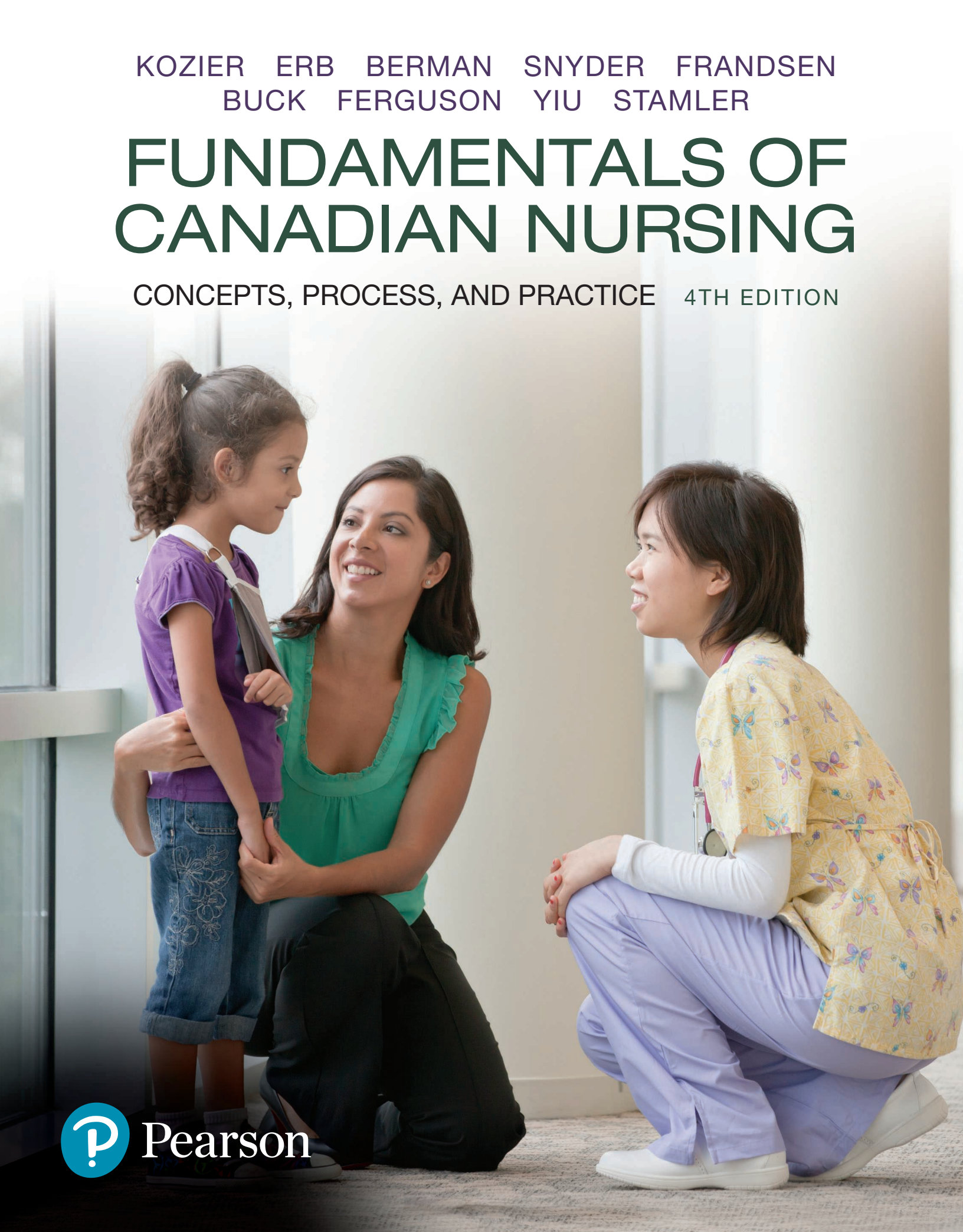
FUNDAMENTALS OF CANADIAN NURSING

CONCEPTS, PROCESS, AND PRACTICE 4TH EDITION



Pearson

Fundamentals of Canadian Nursing

Concepts, Process, and Practice

Fourth Canadian Edition

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About the Canadian Editors

Madeleine Buck

Madeleine Buck is an Assistant Professor and Director of the Bachelor of Science (Nursing) program at the McGill University Ingram School of Nursing. She is also a clinical associate at the McGill University Health Centre and consultant at the TANWAT Hospital in Njombe, Tanzania. Her 38-year career in nursing has provided her with opportunities to work in acute and critical care, community health, and educational settings. She teaches in the undergraduate and graduate nursing programs at McGill, principally in the areas of acute care and illness management. She is involved in international work and leads McGill Nurses for Highlands Hope, which works with a group of Tanzanian nurses and peer health educators in dealing with the HIV/AIDS pandemic in the Highlands of Tanzania. With her nursing students in the McGill Global Health Masters stream, she works to foster collaboration and development of nursing education and practice relationships, including implementing nursing best practices in low-resourced settings in Tanzania. As with previous editions, half of her royalties from the publication of this book will go toward supporting sustainable nursing projects originating from the Tanzanian Highlands Hope Nurse network.

Linda Ferguson

Linda Ferguson, RN, BSN, MN, PhD (Alberta), is Full Professor at the College of Nursing, University of Saskatchewan. Her undergraduate, master's, and PhD studies were in the field of nursing, and she has a postgraduate diploma in Continuing Education. She has worked extensively in the field of faculty development in the College of Nursing and the University of Saskatchewan. At the University of Saskatchewan, she has taught educational methods courses at the undergraduate (nursing and physical therapy), post-registration, and master's levels for the past 25 years, and nursing theory and philosophy in the master's and PhD programs. Her research expertise is in the area of qualitative research, with a particular focus on nursing education and workplace learning in professional practice. Her research has focused on mentorship and preceptorship, continuing education needs of precepting nurses, teaching excellence, interprofessional education, and the process of developing clinical judgment in nursing practice and mentorship. She is past president of the Canadian Association of Schools of Nursing and currently serves as a member of the Board of Governors of the University of Saskatchewan.

Lucia Yiu

Lucia Yiu, RN, BScN, BA (Psychology, Windsor), BSc (Physiology, Toronto), MScN (Administration, Western Ontario), is an Associate Professor in the Faculty of Nursing, University of Windsor, and an Educational and Training Consultant in community nursing. She has authored various publications on family and public health nursing. Her practice and research interests include multicultural health, international health, experiential learning, community development, breast health, and program planning and evaluation. She has worked overseas and served on various community and social services committees involving local and district health planning. Lucia was a board member for various community boards related to children's mental health; community health centres; quality assurance; status of women, equity, and diversity; occupational health, employment equity, and breast cancer. She is currently a board member with CARE working with international educated nurses.

Lynnette Leeseberg Stamler

Lynnette Leeseberg Stamler began her nursing career with a BSN from St. Olaf College, Northfield, Minnesota, USA. Her interest in patient teaching began within that program and inspired her to complete an MEd degree from the University of Manitoba. Although she has worked in many areas of nursing, she has always gravitated toward clinical areas where the relationship with patients and families is essential—such as rehabilitation, long-term care, dialysis, and VON (visiting nursing). After teaching in a diploma program at Red River College in Winnipeg, she completed her PhD in nursing from the University of Cincinnati, where she was their third graduate. She has since taught at the University of Windsor, Nipissing University/Canadore College Collaborative BSN program, the University of Saskatchewan, South Dakota State University, and, currently, the University of Nebraska Medical Center. She has been very active in the Canadian Association of Schools of Nursing (CASN), serving as Treasurer and the first elected President who was not a Dean or Director. She is also active in Sigma Theta Tau International. Her research and international work have focused on aspects of education, from patient to health to nursing. In this spirit, she began work on Canadian nursing textbooks, recognizing that this is one way to influence the next generation of nurses. She has served as an accreditation site visitor. In 2011, her work was recognized when she was inducted as an International Fellow in the American Academy of Nursing, one of eight Canadian nurses to hold that distinction at that time.

Dedication

Madeleine Buck dedicates this edition to the Highlands Hope Umbrella, an organization that brings together community, professional, and volunteer networks to address the challenge of HIV-AIDS and related social problems in the Njombe region of the Southern Highlands of Tanzania. The knowledge, skill, creativity, and dedication of nurses, nursing students, and other members within the "umbrella" are truly commendable.

Linda Ferguson dedicates this edition to those nurses in professional practice who contribute their knowledge and expertise to nursing students in teacher-led groups and preceptored relationships across Canada. Their substantive and tacit knowledge of nursing and their enthusiasm for the profession are inspiring to students, faculty, clients, and their nursing colleagues.

Lucia Yiu dedicates this edition to her daughters, Tamara, Camillia, and Tiffany; and especially to her students and nursing colleagues who have inspired her to strive for excellence in nursing.

Lynnette Leeseberg Stamler dedicates this edition to the many nurses who have taught and inspired her throughout her life to "pay it forward" to the nurses of tomorrow. Together, we daily move mountains.

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.

Preface

As the scope and pace of nursing and allied health knowledge continue to grow exponentially, one must ask what is truly "*fundamental*" for a nurse to know and understand in order to practice knowledgeably, morally, ethically, accurately, sensitively, and compassionately in both today's and tomorrow's health care delivery system. Within the context of the current and future health care system, the fourth edition of *Fundamentals of Canadian Nursing: Concept, Process, and Practice* provides undergraduate nursing students with the *fundamentals* they will require as they embark on their nursing careers. This textbook aims to provide students with a broad and solid foundation of knowledge about the health of individuals, families, communities, and populations. Also included are the issues that client populations face at varying points in time, as well as the nursing care that is possible in health and illness situations, whether clients are situated at home, in the community, at a clinic, at an extended or palliative care facility, or in an acute care setting. We hope that this text will serve as a "go to" resource for students and practising nurses working in a wide range of settings.

With the goal of providing a fundamental understanding of what is required for contemporary professional nursing practice in Canada, we built on the first three editions to ensure that we thoroughly addressed needed *skills*, such as communication, critical thinking, clinical reasoning, decision making, use of the nursing process, development of interpersonal and interprofessional relationships, teaching, leading and managing change, use of technology, and application of primary health care principles. We placed high importance on such concepts as caring, wellness, health promotion, disease prevention, complementary and alternative health modalities, rural health, environmental and global health, multiculturalism, growth and development, nursing theories, nursing informatics, nursing research and education, ethics, accountability, and advocacy. Furthermore, we highlighted basic nursing care for clients across the lifespan from hospital to community settings in the culturally diverse Canadian health care system throughout. In all areas, we integrated the most recent literature and clinical best-practice guidelines.

To ensure that our text reflects "pan-Canadian" issues and practices, we enlisted reviewers and contributors from across the country, representing different geographical perspectives. We expended every effort to ensure that the level of specificity and readability is appropriate for beginning nursing students. We believe that this text will also provide a strong foundation for advanced nursing studies. Enjoy!

Organization

For this fourth edition, we present seven units containing in total 48 chapters—one less than our last edition, as we have merged the chapter on "Self-Concept" (Chapter 45 in the 3rd edition) with "Individual Care" (Chapter 12 in this edition). The material presented in this publication addresses foundational and fundamental knowledge and skills required for a person entering the nursing profession. Building on the strengths of our previous editions, we enhanced many features to ensure that our textbook is relevant and informative to nurses across the country.

UNIT 1—THE FOUNDATION OF NURSING IN CANADA (Chapters 1–6) introduces the nature of the nursing profession, from the history of nursing to its current practice, education, and research. Each chapter has been updated since our previous edition to reflect evolving trends and emerging issues, such as changes to nursing practice standards, the increasing role of nurses as research consumers, the influx of internationally educated nurses, moral distress in the work of nurses, and the role of social media in nursing and health care, among many other topics.

UNIT 2—CONTEMPORARY HEALTH CARE IN CANADA (Chapters 7–16) includes discussions on health care practice in today's multicultural environments. Concepts of health, illness, and wellness are addressed as well as the role nurses can play in health promotion from an individual, family, community and global perspective. This unit addresses foundational concepts related to Canada's health care system and specific issues related to rural and remote health care, including Northern nursing.

UNIT 3—LIFESPAN AND DEVELOPMENTAL STAGES (Chapters 17–20) describes concepts of growth and development and outlines the various developmental stages and their specific health needs throughout the lifespan. Particular attention has been given to the issues facing the very young and older adults.

UNIT 4—INTEGRAL ASPECTS OF NURSING (Chapters 21–27) describes the fundamental nursing tools required for practice, including critical thinking, clinical reasoning and decision making, caring and communicating, the nursing process, documenting and reporting, teaching and learning, and leading and managing change. These tools provide a foundation for competent nursing care.

UNIT 5—NURSING ASSESSMENT AND CLINICAL STUDIES (Chapters 28–36) provides fundamental knowledge

to guide comprehensive health assessment, including vital signs, and addresses integral components of care in relation to pain assessment and management, hygiene, safety, medications, infection prevention and control, skin integrity and wound care, and caring for perioperative clients.

UNIT 6—PROMOTING PHYSIOLOGICAL HEALTH (Chapters 37–44) discusses such physiologic concepts as sensory perception; sleep; activity and exercise; nutrition; fecal elimination; urinary elimination; fluid, electrolytes, and acid–base balance; and oxygenation and circulation.

UNIT 7—PROMOTING PSYCHOSOCIAL HEALTH (Chapters 45–48) covers a wide range of areas that affect one's health. Sexuality, spirituality, stress and coping, and loss, grieving, and death are all areas that a nurse should consider to care effectively for a client.

Following the book chapters is a **Glossary** in which key terms are defined. Two **Appendices** are provided near the end of the book. They summarize important information about laboratory values, formulae, and vital signs.

What's New in the 4th Edition

- NEW approach with adoption of a broader, less prescriptive approach to nursing diagnoses. This new edition encourages students and nurses to use their knowledge, experience, and critical thinking skills to generate diagnoses or analyses.
- Inclusion of the Canadian Association of Schools of Nursing Competencies Domains from the Nursing Education Competencies Framework (CASN, 2014).
- A stronger focus on the roles of nurses in interprofessional collaboration in patient care.
- A focus on "Environmental and Global Health Nursing"—A whole chapter is devoted to this important and fascinating topic.
- All national patient safety consensus recommendations from Safer HealthCare NOW!, the Canadian Patient Safety Institute, and Accreditation Canada have been integrated into relevant chapters.
- Emphasis on continuity of care—To ensure that continuity of care and home care considerations are addressed we have featured "Continuity of Care" segments in relevant chapters.
- Inclusion of Strength-Based Nursing model (Gottlieb, 2013) as a way to address patient care as well as nursing leadership.
- An emphasis on Clinical Reasoning—A discussion about the importance of clinical reasoning and the similarities and differences between clinical reasoning and critical thinking now appear. "Clinical Reasoning" questions appear in several chapters to encourage readers to consider the clinical context as a major factor in determining the specific priorities and approach to nursing care.
- REINSTATED Glossary of Key Terms—Previously, our glossary of key terms was available online; based on feedback from users, we have reinstated the glossary as part of the text so that users have ready access to such an important feature.
- The latest evidence in the "Evidence-Informed Practice" (EIP) boxes—A thorough review of the literature was conducted for each chapter. Emphasis was placed on including the results of systematic reviews and meta-analyses to ensure the highest level of evidence is contained in the chapters. The EIP boxes highlight Canadian studies.
- A focus on the role of all Registered Nurses in clinical leadership as a means of providing high-quality and safe patient care.
- A focus on changes in the regulation of nurses in Canada, including reference to the NCLEX-RN examinations for licensure.
- UPDATED all relevant national consensus guidelines related to nursing care are included in the relevant chapters.
- ENHANCED Rationales for Nursing Care—All Skill instructions and Clinical Guidelines were reviewed and revised to ensure that a rationale is provided for each recommendation to promote clarity and understanding.
- ENHANCED Pan-Canadian Perspective—Reviewers and contributors were selected from across Canada to ensure that the textbook provides a relevant and comprehensive perspective on nursing care and issues facing nurses across the country.
- ENHANCED Level of foundational knowledge—We took care to sustain the broad knowledge base provided by this foundational "fundamentals" text; however, the depth and specificity of certain topics were updated and augmented where required throughout the text.
- ENHANCED images and photos—Over 50 new colour photos have been added, mostly in the Skill boxes, to enhance clarity and ensure that the most up-to-date equipment appears.

Resources and Supplements

Student Resources

Clinical Reference Cards

Each copy of the book is accompanied by a series of Clinical Reference Cards, which are intended to serve as a handy reference when engaged in clinical work. The contents include brief summaries of such topics as the normal ranges of vital signs for various age groups, common laboratory values, the Glasgow Coma Scale, and the "10 Rights" of medication administration.

Online Resources

MyNursingLab

A revised **MyNursingLab** accompanies the new edition of the text. MyNursingLab features a wealth of self-study material and practice questions, including NCLEX-style quizzes. Additional resources, such as Procedure Reviews and Skills Checklists, have been thoroughly reviewed and updated for the new edition.

Instructor Resources

The following instructor supplements are available for download from a password protected section of Pearson's online catalogue: catalogue.pearsoned.ca. Navigate to your book's catalogue page to view the complete list of available supplements. See your local sales representative for details and access.

The **Instructor's Manual** includes lecture outlines and additional material to help instructors design effective classes for their students. The Instructor's Manual includes unique Classroom and Clinical Activities geared towards students in both degree (BScN) and diploma (PN) programs.

A Testbank is available in both Word and TestGen formats. Pearson's TestGen computerized Testbank is a powerful program that enables instructors to view and edit existing questions, create new questions, and generate quizzes, tests, examinations, or homework by searching and selecting questions in each chapter by a number of attributes including CPRNE and NCLEX style. TestGen also allows for the administration of tests on a local area network, to have the tests graded electronically, and to have the results prepared in electronic or printed form.

PowerPoint Slides illuminate and build upon key concepts in the text.

An **Image Library** provides electronic files of all the figures, photos, and tables in the book.

Learning Catalytics

Learning Catalytics is a "bring your own device" assessment and classroom activity system that expands the possibilities for student engagement. Using Learning Catalytics, you can deliver a wide range of auto-gradable or open-ended questions that test content knowledge and build critical thinking skills.

You can also manage student interactions by using Learning Catalytics to automatically group students for discussion, teamwork, and peer-to-peer learning. Throughout the course, Learning Catalytics complements your instruction by capturing student feedback and offering a range of data to assess student understanding.

Over 200 Canadian NCLEX-style questions are currently available through Learning Catalytics, including selected end-of-chapter questions from the new edition of *Fundamentals of Canadian Nursing*.

Learning Solutions Managers

Pearson's Learning Solutions Managers work with faculty and campus course designers to ensure that Pearson technology products, assessment tools, and online course materials are tailored to meet your specific needs. This highly qualified team is dedicated to helping schools take full advantage of a wide range of educational resources, by assisting in the integration of a variety of instructional materials and media formats. Your local Pearson Education sales representative can provide you with more details on this service program.

Acknowledgments

We wish to extend our sincere thanks to the many talented and committed people involved in the development of this fourth edition. We are especially grateful to:

- The students and colleagues who provided valuable suggestions for developing this edition, in particular users who alerted us to new practices or region-specific variations in practice.
- The Canadian contributors, who worked diligently to provide content in their areas of expertise.
- The Canadian reviewers, who provided critical appraisal to strengthen this text (listed on pages xviii).
- The editors and contributors of the U.S. tenth edition for setting high standards for the book.
- The two people who revised the end-of-chapter test questions to make them NCLEX compliant: Joanne Jones, Thompson Rivers University; and Elizabeth Brownlee, Northern College of Applied Arts and Technology.
- The expert guidance and ongoing support from the editorial and production teams at Pearson Canada: Kimberley Veevers, Daniella Balabuk, John Polanszky, Jessica Mifsud, Avinash Chandra, Rohini Herbert, and many others who worked scrupulously behind the scenes to help realize this project.

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Chapter 1

UNIT 1
The Foundation of Nursing in Canada

Historical and Contemporary Nursing Practice*

Updated by
Lynnette Leeseberg Stamler, PhD, RN, FAAN
Professor and Associate Dean for Academic Programs
College of Nursing, University of Nebraska Medical Center

LEARNING OUTCOMES

After studying this chapter, you will be able to

1. Discuss the range of people who provided nursing care in different periods in Canadian history.
2. Compare different settings in which nursing care has been provided by Canadian nurses.
3. Explain the usefulness of nursing history for understanding current practice issues.
4. Analyze the influence of changing social, political, and economic conditions over time.
5. Describe the scope and standards of nursing practice.
6. Outline the expanded nursing career goals and their functions.
7. Examine the criteria of a profession and the professionalization of nursing.
8. Explain the functions of national and international nurses' associations.

Nurses have traditionally composed the largest portion of health care workers in Canada. As such, they have enabled and participated in shaping the Canadian health care system and have made a significant impact on the health of individuals, families, and communities. Although public surveys identify nurses as the most trusted of health care providers, gloomy forecasts of massive nursing shortfalls persist. Nurses perceive their work as being undervalued, while others deem it too expensive in the face of persistent cost-cutting measures and concerns over the viability of government-supported health care and medical care. At the same time, nurses struggle to articulate what they actually do (Nelson & Gordon, 2006). Nursing policymakers, educators, and union leaders are challenged with defining and defending a unique role for nurses among other health care professionals and within a rapidly changing health care system (Villeneuve & MacDonald, 2006).

*The author acknowledges the work of Drs. Jayne Elliott and Cynthia Toman in the historical section.

Historical Nursing Practice

In the past, Canadian nurses were on the front lines during cholera, influenza, and polio epidemics, as they were for more recent outbreaks of contagious diseases, such as the severe acute respiratory syndrome (SARS) outbreak in 2003 (MacDougall, 2007). They served in military medical units during the South African War, World Wars I and II, the Korean War, and the Gulf War, leaving a rich heritage for Canadian nurses who continue to play important roles in international conflicts. Nurses and their work were critical to the rapid expansion in the number and size of hospitals, and nurses continue to facilitate the spread and acceptance of medical technology both within and outside hospitals. Since the late nineteenth century, public health nurses have provided essential health and medical care to isolated populations in both rural and urban centres, a legacy taken up by street nurses caring for people on new frontiers.

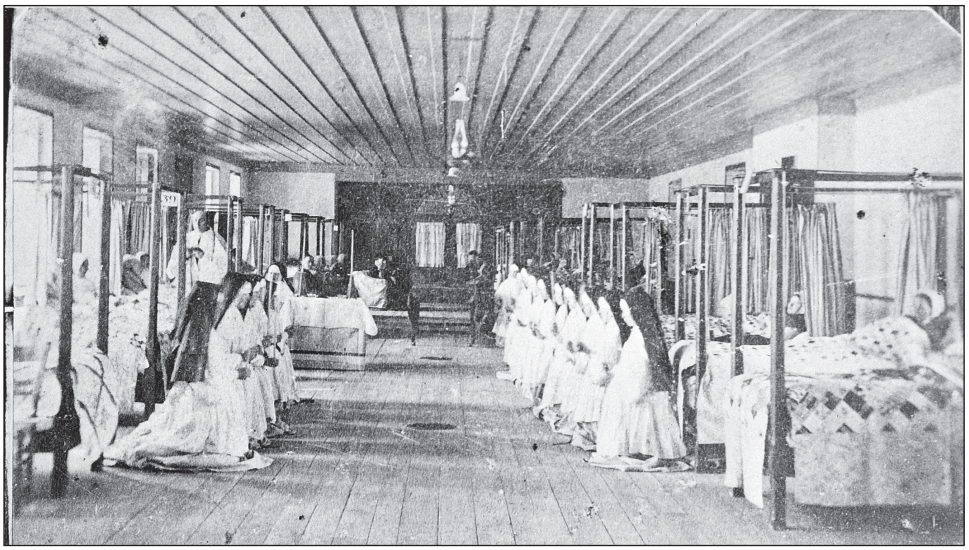
As these situations suggest, nursing takes place within broad cultural, sociopolitical, and economic contexts that also influence both its practitioners and its practice. Nursing evolved similarly in most Western nations, partially shaped by societal events and such changes as industrialization, urbanization, wars, cycles of economic depression and expansion, and the women's movement. Developments in scientific and technological knowledge and the consolidation of Western medicine have changed conceptualizations of health and illness, as well as the meanings associated with them. Historical research contributes to nursing knowledge in two main ways: (a) It develops in-depth analyses of these complex relationships, and (b) it creates enhanced understandings of the past that inform both present and future situations.

Early historians of nursing focused primarily on questions about professionalization, education, and leadership, tending to see their history as a steady march of progress through time. Although indebted to these writers who have preserved vast amounts of source material, historians since the 1980s have examined the profession more critically—paying closer attention to issues that complicate and add greater complexity to their analyses. It is important, for example, to understand who was considered a "nurse" and what nursing work encompassed in a particular historical period. Answers to these questions are contingent on who was available to work as a nurse, what status or value society attributed to nurses' (and women's) work, and how nurses were compensated for that work within a specific timeframe. Inclusion of gender, race, ethnicity, and class in historical analyses raises important questions about the social arrangements and relationships of power that shaped who was included or excluded as a nurse. Although, for the most part, nurses have worked as subordinates within health care systems, they often held positions of privilege, increased social status, and respect in comparison with other female workers. Analyzing nurses as agents of the state allows us to ask in what ways they did (and do) enable and influence larger social, political, and economic agendas through their participation in systems of health care. Knowledge of how nursing developed in specific contexts or sets of circumstances permits nurses to better understand their present situation and, particularly, to see how contemporary concerns might relate to larger social-structural conditions.

Before the establishment of training schools in Canada, women provided most of the nursing care either for family members and acquaintances or for strangers in their communities. Some took on these roles as charitable acts of kindness; others, self-identifying as nurses in the pretraining era, developed midwifery practices or hired themselves out as "monthly" nurses to care for women in their homes for a month after childbirth (Young, 2004). First Nations women provided much-needed help to new, white settler societies as they spread across the frontier—a history too long ignored because the skilled medical care provided by these women, particularly in midwifery and childhood diseases, was critical to the very survival of these new communities. Women who were members of religious groups were also early skilled caregivers, dating back to the first group of European nuns who arrived in 1639 in what is now Quebec, with a mission to provide care for the bodies and souls of both settlers and native inhabitants. These women cared for the sick and destitute where they landed (see figure 1.1) but many soon followed the new immigrants west and founded hospitals, some of which have survived into the present.

Hôtel Dieu, Quebec. From Gibbon, J., Mathewson, M. (1947). Three Centuries of Canadian Nursing. Toronto: Macmillan Co. of Canada

FIGURE 1.1 Arrival of the first three Augustinian sisters in Quebec, 1639.



Library and Archives Canada

FIGURE 1.2 Nuns at prayer, along with their patients, at an early Hotel Dieu hospital.

By the late nineteenth century, immigration, growing urbanization, and changing concepts around the transmission and treatment of diseases contributed to the push for formally trained nurses. Early Canadian towns and cities were plagued by inadequate sanitation and sewage systems. Waves of infectious diseases, such as typhus, influenza, and smallpox, regularly devastated both immigrant and native populations (Cassel, 1994). Wealthy patrons initially established hospitals during the late nineteenth century as philanthropic institutions that served the increasingly visible "sick poor." Measures to improve and protect the delivery of food and water supplies, a gradual acceptance of germ theory in disease transmission, and the availability of anesthesia all helped to increase confidence in the idea of scientific medicine. Although cures for many illnesses often lagged far behind identification of causes, perceptions of increased therapeutic efficacy predisposed the better-off classes to choose care in medical institutions over treatments (including surgeries) in their homes. Hospital administrators increasingly relied on these paying patients to offset the costs of caring for the poor (Gagan & Gagan, 2002). Significantly, the advent of trained nurses lent both efficiency and respectability to this shift toward hospital care.

Two main influences have shaped formally prepared nursing in Canada. The British system, associated primarily with Florence Nightingale during the mid-nineteenth century, has attracted the most historical attention, even if her vision for an independent nursing force complementary to, and not dependent on, hospital administration was never fully realized. French-Canadian religious communities, which also contributed significantly to the development of trained nurses, blended religious and work life to own and manage hospitals and training schools across the country. The Quiet Revolution in Quebec during the 1960s, in reaction to the hegemony of the church over French-Canadian society, brought in a period of rapid secularization with closer government control over institutions, eroding the nuns' authority within their institutions and shifting nursing education into the public sphere (Charles, 2003; Paul, 2005; Violette, 2005) (Figure 1.2). Both systems built on religious and cultural ideals of respectable femininity that integrated contemporary ideas about scientific thinking with womanly, selfless devotion to duty and service.

The first official training school was established in St. Catharines, Ontario, in 1874 by Dr. Theophilus Mack. Over the next decades, the number of nurses rose dramatically from only 300 at the turn of the twentieth century to 20 000 by the end of World War I (McPherson, 1996). Student nurses formed the major portion of the hospital workforce until the 1940s, with the expectation that they would become self-employed as private duty nurses outside the hospital on graduation. The apprenticeship training system was the predominant model of nursing education in both large and small hospitals across the country until the 1970s. Several universities did offer combined programs whereby it was possible to earn a degree in nursing, such as the first degree program established at the University of British Columbia in 1919.The focus of these programs was often on preparing nurses to be supervisors, educators, and public health nurses.

Nursing became one of the few respectable opportunities for paid work available to women in the first half of the twentieth century. The vast majority of student placements in nursing schools were reserved for young, white women whose families could afford to do without their financial contribution, at least for the duration of their training. Two men appear in the 1899 graduating class of Victoria

Library and Archives Canada/Canadian Nurses Association fonds

FIGURE 1.3 Ottawa General Hospital graduation 1912.

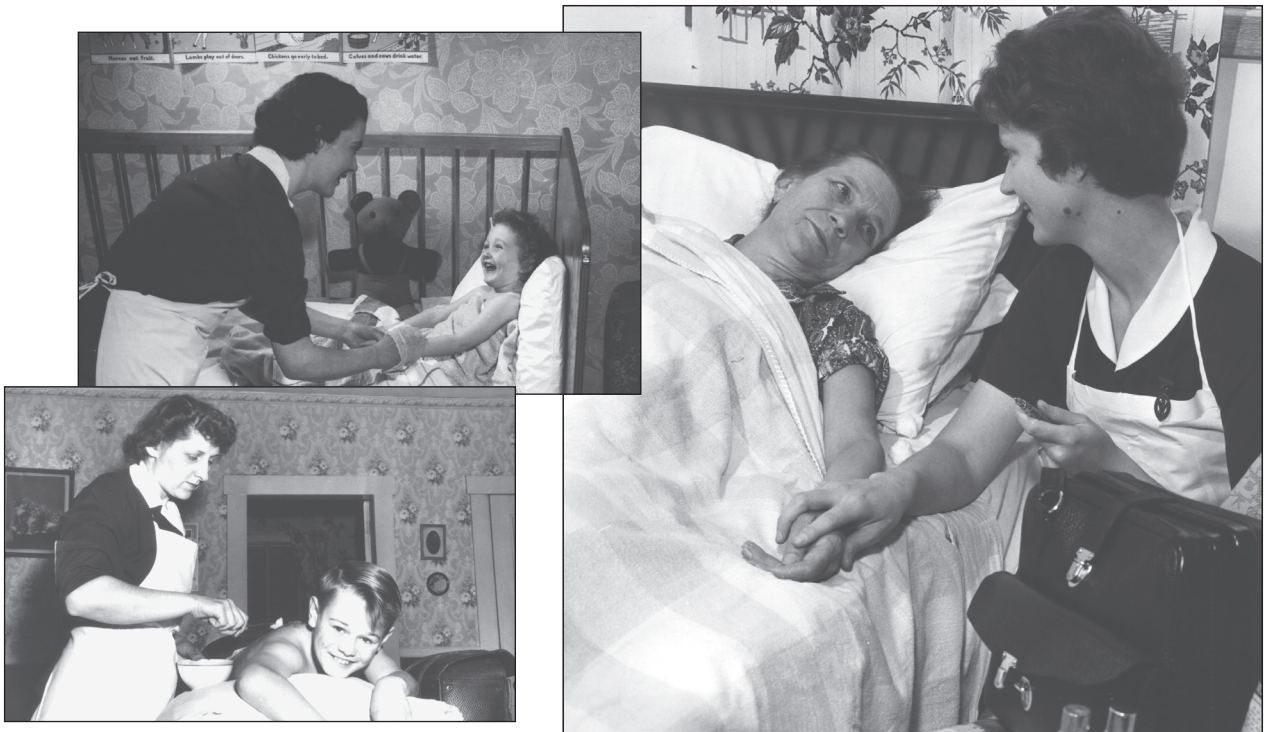
FIGURE 1.4 Aboriginal nurse with a patient at Blood Hospital, Cardston, Alberta.

General Hospital in Halifax (Nursing Education in Nova Scotia, n.d.), but men, in general, have remained vastly underrepresented in the ranks of an occupation strongly tied to the concept, promoted sometimes by nurses themselves, that nursing is women's work (McPherson, 1996). Despite the Canadian Nurses Association's official policy of nondiscrimination, in place since the 1940s, few black nurses gained entrance to training programs until the 1970s (McPherson, 1996). In British Columbia, a few nursing students of Asian background were admitted during the late 1930s for the explicit purpose of nursing among their own ethnic communities. And in 1954, Jean Cuthand Goodwill became the first Aboriginal woman in Saskatchewan to graduate from nursing school, but again, not until the 1970s was a concerted effort made to recruit First Nations and Inuit students into nursing (McBain, 2005) (see Figures 1.3 and 1.4).

Various professionalization movements throughout the twentieth century also intensified debates over who was, or could become, a nurse. In the early decades, nursing leaders attempted to distance skilled nursing work from domestic caregiving and midwifery. Following a successful campaign by physicians to gain control over medical practice, nurses sought to establish control over nursing through the standardization of educational curricula and the legal authority to credential graduates of recognized hospital-based training programs. Most provinces brought in nurse registration between 1910 and 1922, thus separating trained nurses from others who used the title *nurse* (Mansell, 2003). Newfoundland and Labrador nurses obtained registration in 1954, Northwest Territories nurses in 1975, and Yukon nurses in 1992.

During the first half of the twentieth century, most nurses worked in private duty after graduation, but changing concepts in public health provided other opportunities. Women's groups were instrumental in pushing for reform, particularly in maternal and child health, and initiated many services that provincial health authorities later took over. Poor health status (and subsequent rejection) of wartime recruits because of preventable and treatable illnesses contracted in childhood, the devastating impact of the influenza epidemic (1917–1918), and a high rate of tuberculosis and venereal diseases among returning World War I soldiers in 1918 fuelled demands for increased government responsibility in matters of health. Specially trained nurses were dispersed into schools and homes across Canada, in both urban and rural districts. Nurses, as women, met gendered expectations that they were the ideal people to bring the new "gospel of good health" to mothers and their families. By helping to spread new scientific theories of health, including those on social and mental hygiene, nurses were responsible for Canadianizing new immigrants through the promotion of white, middle-class, urban-based ideals of health, which they found that their clients sometimes could not, or would not, meet.

The Victorian Order of Nurses was founded in 1897, but other organizations, such as the Margaret Scott Nursing Mission in Winnipeg, the Alberta District Nursing Service, the Newfoundland Outport Nursing and Industrial Association (NONIA), and the Medical Service to Settlers in Quebec, emerged to meet these public health needs. Several provincial divisions of the Canadian Red Cross Society began outpost programs in isolated parts of their territories (Elliott, 2004; McKay, 2007; Penney, 1996; Richardson, 1998; Rousseau & Daigle, 2000). The federal health department did not regularly supply nursing stations

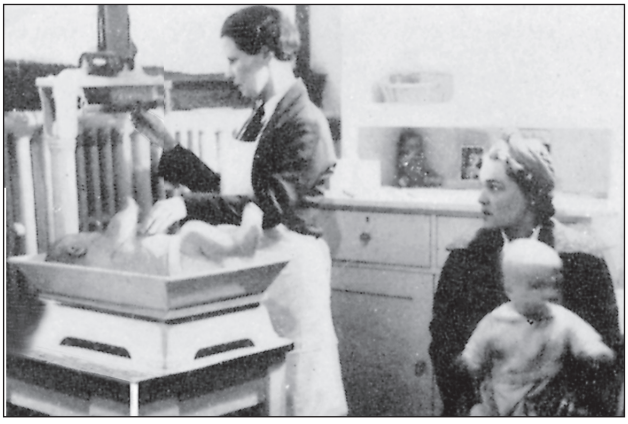


Victorian Order of Nurses Canada

FIGURE 1.5 Three patients of Victorian Order of Nurses (VON) cared for in their own homes. The VON still provides community and home care services across Canada.

and nurses to First Nations and Inuit populations in the sub-Arctic and Arctic regions of the country until after World War II (McPherson, 2003; Meijer-Drees & McBain, 2001). Together, these nurses brought much-needed health care to areas underserved by physicians, and they often found they needed to undertake such tasks as midwifery, stitching of wounds, or teeth pulling, for which they had received little training (see Figures 1.5, 1.6, 1.7, and 1.8).

Several small groups of civilian nurses volunteered with the Canadian militia during the Northwest Rebellion (1885), with the Northwest Mounted Police during the Klondike Gold Rush (1898), and with the British Expeditionary Force during the South African War (1899–1902), but they were not officially part of the Canadian military. With the formation of the first permanent nursing service as part of the Canadian Army Medical Corps (CAMC) in 1904, civilian nurses became fully integrated into the Canadian armed forces as soldiers, enlisting as lieutenants with the specially created officer's rank and title of *nursing sister,* serving under the supervision of higher-ranked matrons. During 1944, Matron-in-Chief Elizabeth Smellie became the first woman in the world to rise to the rank of a full

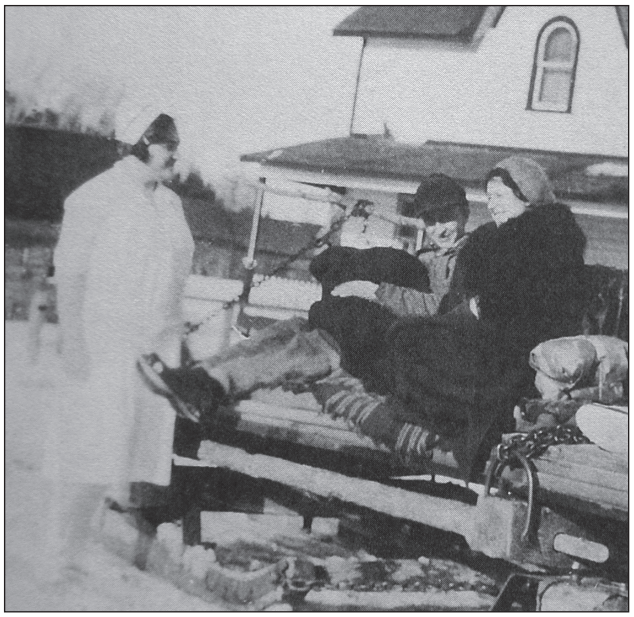


Gibson, J., Mathewson, M. (1947). *Three Centuries of Canadian Nursing.* Toronto: MacMillan

FIGURE 1.6 Well-baby clinic in Manitoba.

Gibson, J., Mathewson, M. (1947). *Three Centuries of Canadian Nursing.* Toronto: MacMillan

FIGURE 1.7 District nurse at Old Pendryl Cottage, Alberta.



Wilberforce Red Cross Outpost & Historic House

FIGURE 1.8 Red Cross Nurse Gertrude Leroy Miller discharging a patient from the nursing outpost at Wilberforce, Ontario, in the 1930s.

colonel. Initially, nursing sisters were the only women to serve in the military, and they readily filled every available position in the Canadian armed forces throughout both World Wars—even creating long waiting lists to get into the military. Canadian military nurses served with the North Atlantic Treaty Organization (NATO) forces in Europe during the 1950s and with the Allied Forces during the Korean War (1950–1953), as well as with peacekeeping forces during the 1990s and beyond.

At least 3141 nursing sisters served during World War I and 4079 during World War II. They called themselves soldiers and understood their work as winning the war through the salvage of damaged men. They actively sought opportunities to move closer to the front lines, readily accepting increased risk and danger as part of the job. In both wars, some died as a result of enemy action and military-related illnesses and accidents; two were prisoners of war under the Japanese army in Hong Kong for almost 2 years during World War II; others were torpedoed, bombed, or strafed—and survived to talk about the experiences. Some of them left personal accounts of these experiences; some questioned the contradictory values of caring and saving lives while working in organizations designed for the destruction of lives. The armed forces placed high value on the knowledge and skills of nurses, reluctantly moving them forward as they demonstrated better outcomes for the soldiers under their care than less-trained personnel could achieve. The military was adamant, however, that nurses were temporary—only for the duration of the war, regardless of what nurses preferred with regard to their military careers (Toman, 2007) (see Figures 1.9, 1.10, and 1.11).

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FIGURE 1.9 Canadian civilian nurses with the British Expeditionary Force in South Africa (1899–1902).

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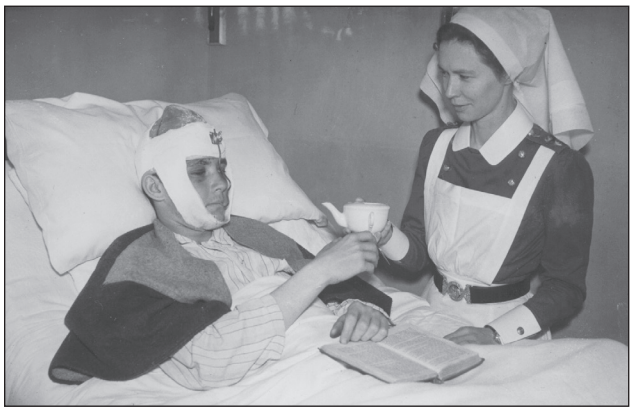
FIGURE 1.10 World War I Nursing Sister Mabel Lucas Rutherford (*left*) and three colleagues in their dress uniforms.



University of Ottawa

FIGURE 1.11 World War II Nursing Sister Dorothy Macham attending to a wounded soldier.

During the 1930s, the private duty market for nurses shrank because of both an oversupply of graduate nurses and the widespread economic depression that left at least 30% of the Canadian population unemployed. A boom in hospital construction and the growing use of medical technologies, among other factors, increased the need for nurses again, precipitating a nursing shortage that continued into the 1970s. The nursing leadership campaigned to move nurses' training into educational institutions and gradually weaned hospital administrators from depending on student labour, opening up further employment opportunities for graduate nurses within hospitals. Although hospitals soon became the preferred employer for nurses, the shortage was so great that hospitals had to make substantial changes in the workplace to attract new students for training and married nurses back into the workforce. Due to nursing shortages, Nursing Assistants (CNAs) were created to assist RNs in hospitals.

Changes in medical and surgical therapeutics were central forces in defining the nature and scope of nursing practices. By accepting delegated medical tasks, nurses have been instrumental in facilitating the spread and acceptance of many technologies that range from thermometers in the early twentieth century, through routine blood tests in the 1940s and 1950s, to the complex systems of medical monitoring in place today (Sandelowski, 2000; Toman, 2001). An increasingly specialized nursing workforce has resulted in a hierarchical relationship among nurses and between nurses and lesser-skilled auxiliary workers, whose positions emerged initially to help address the shortage of trained nurses.

Each of these issues lies within a body of historical research that offers alternative perspectives through which we can question who and what is determining today's nursing practice. On the one hand, the wider socioeconomic and political milieu has shaped nurses and their work; on the other hand, nurses have participated in shaping the health care system and the role of nursing within it. Curiosity about the roots of the nursing profession has merit in itself, but many would argue that the value of nursing history lies in its relevance to current issues in professional practice. Much more research is needed, for example, on the history of registered psychiatric nursing programs and how the baccalaureate degree as entry to practice has affected perceptions of nursing work among nurses themselves and the wider society. Hospital-based training and work environments tried to standardize nurses, nurses' knowledge, and nursing care, creating the illusion of a homogeneous nursing workforce while devaluing the vast diversity among people performing nursing work. A more critical analysis of the roles of gender, class, race, and ethnicity, and the way these factors have worked to include or exclude those wanting to enter the profession, is necessary to understand who became nurses in Canada and how these influences still shape who become nurses in today's multicultural health care context.

Contemporary Nursing Practice

An in-depth study of contemporary nursing practice includes a look at selected definitions of nursing, a framework for the Canadian health system, the goals of the nurse within this system, the acts that legislate health care and nursing practice, and the scope and standards of practice. This chapter will concentrate on definitions and the goals and roles of nursing. Currently, four legislated categories of nursing exist in Canada: (a) Licensed (Registered) Practical Nurses, (b) Registered Nurses, (c) Registered Psychiatric Nurses, and (d) Nurse Practitioners (Extended Class). Each has a scope of practice legislated within a province or territory. For the Canadian health care system, see Chapter 9, and for legal issues, see Chapter 6.

Definitions of Nursing

To understand what nursing is, we must first define the word. Many definitions exist, some of which misrepresent the complex knowledge and skill of professional nursing. Common dictionary definitions, for example, still refer to the nurse as "a person, usually a woman, trained to care for the sick" (Cayne, 1988). Today, however, many men are choosing to become nurses, and nurses also provide preventive and health-promoting care to well clients. This section provides several definitions of nursing, and Chapter 4 provides other definitions created by nursing theorists.

In 1860, Florence Nightingale described nursing as the "use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet" (Nightingale, 1938, p. 8). She considered a clean, well-ventilated, and quiet environment essential for recovery from illnesses. Often considered the first nurse theorist, Nightingale raised the status of nursing through education. Nurses were no longer untrained housekeepers but persons educated in the care of the sick.

Virginia Henderson was one of the first modern nurses to define *nursing*. In 1960, she wrote: "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1966, p. 3). Like Nightingale, Henderson described nursing in relation to the client and the client's environment. Unlike Nightingale, Henderson saw the nurse as concerned with both well and ill individuals, acknowledged that nurses interact with clients even when recovery may not be feasible, and mentioned the teaching and advocacy roles of the nurse.

Professional nursing associations have also examined nursing and developed their definitions of it. In 1987, the Canadian Nurses Association (CNA) described nursing practice as a dynamic, caring, helping relationship in which the nurse helps the client to achieve and maintain optimal health (CNA, 1987). Many countries have chosen to use the International Council of Nurses (2015) definition:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2015b).

In the latter half of the twentieth century, a number of nurse theorists developed their own theoretical definitions of nursing. Theoretical definitions are important because they go beyond simplistic common definitions. They describe what nursing is and the interrelationship among nurses, nursing, the environment, the client, and the intended client outcome—health. See Chapters 4 and 23. Several themes are common to all the various definitions of nursing (see Box 1.1).

Caring is described as the "essence of nursing" (Leininger, 1984). It is a complex concept that has multiple aspects: affective, cognitive, and ethical. Research to explore the meaning of caring in nursing has been increasing because nursing, more than any other profession, has "the distinction of being responsible for the caring that clients receive in the health care system" (Miller, 1995, p. 29). Details about caring are discussed in Chapter 22. See also Watson's assumptions of caring in Box 4.2 in Chapter 4 (see page 59).

BOX 1.1 THEMES COMMON TO DEFINITIONS

Although several different definitions of nursing have been made over the years, they do share some common themes:

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

Recipients of Nursing

Nurses work with many and varied recipients of care. The recipients can be individuals, families, groups, communities, and populations. Even when planning and implementing care to various recipients, it is important for the nurse to recognize that these recipients live within a larger society—for instance, individuals are connected to families, groups live in the community, and multiple communities exist within a given population. Groups are collections of individuals with a shared goal or purpose, and communities may be defined by geography, culture, or other characteristics.

In this book, we have generally identified the recipient of care as the individual (see Chapter 12). We have, however, also provided some beginning information on families and working with families in providing nursing care (see Chapter 13). When referring to individuals who are receiving nursing care, the literature refers to them as consumers, patients, residents, or clients and by other terms. A **consumer** is an individual, a group of people, or a community that uses a service or commodity. People who use health care products or services are consumers of health care.

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

For the reasons mentioned above, nurses also refer to recipients of health care as *clients*. A **client** is a person who engages the advice or services of another who is qualified to provide this service. The term *client* presents the receivers of health care as collaborators in the care, that is, as people who are also responsible for their own health. Thus, the health status of a client is the responsibility of the individual that is met in collaboration with health care professionals. In this book, we have generally used the term *patient* to describe the individual admitted to an acute care facility or otherwise seeking care, the term *resident* for an individual cared for in a long-term care facility, and the term *client* to describe recipients of nursing care in other settings. The topics discussed in this book are often equally applicable to clients, patients, and residents. When this is the case, readers may see references to more than one recipient of care in the same paragraph.

EVIDENCE-INFORMED PRACTICE

Pain experienced by patients has long been studied, but no clear consensus has been reached on the results of the studies or the proposed strategies. In this study, all eligible patients in the clinical areas of cardiology, medicine, and surgery in 12 hospital units were visited within a 4-hour period to assess their pain experience. Of the 65% who responded, 70.4% indicated they had pain at that time. Although the duration, anatomic location, and severity of pain varied across the patients, almost all (92%) indicated that hospital staff had assessed their pain within the previous 8 hours. Gender and age differences were noted in the responses. The study patients also indicated that their pain interfered with their activities, to varying degrees. Although this study did not consider the problem of memory in that it only asked for the pain experience "right now," it is clear that pain remains a multifactorial experience that is difficult to describe and treat.

CLINICAL IMPLICATIONS: Health care organizations that desire to create a culture where pain assessment and treatment are expected and valued will need to first acknowledge that pain is a real issue for many patients.

Source: Jabusch, K. M., Lewthwaite, B. J., Mandzuk, L. L., Schnell-Hoehn, K. N., & Wheeler, B. J. (2015). The pain experience of inpatients in a teaching hospital: Revisiting a strategic priority. *Pain Management Nursing, 16*(1), 69–76.

Scope of Nursing

Nursing practice involves four areas: (a) promoting health and wellness, (b) preventing illness, (c) restoring health, and (d) caring for the dying. Within each of these areas, nurses seek to articulate and follow best practices in terms of the care they provide. Various chapters of this book relate to each of the areas of nursing practice. The Registered Nurses' Association of Ontario has led the way in developing a series of best practices documents (see the Weblinks section in this chapter). Reference to appropriate best practices documents can be found in the chapters throughout the book.

PROMOTING HEALTH AND WELLNESS "Wellness is a process that engages people in activities and behaviors that enhance quality of life and maximize personal potential" (Anspaugh, Hamrick, & Rosata, 2003, p. 490). Nurses promote wellness in clients who are healthy as well as those who are ill. This promotion may involve individual and community activities to enhance healthy lifestyles, such as improving nutrition and physical fitness, preventing problematic drug and alcohol use, smoking cessation, and preventing accidents and injury in the home and workplace. See Chapters 8 and 14 for further discussion.

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

RESTORING HEALTH Restoring health focuses on the ill client, and it extends from early detection of disease through helping the client during the recovery period. Examples of nursing activities focused on restoring health include the following:

- Providing direct care to the ill person, such as administering medications, baths, and specific procedures and treatments
- Performing diagnostic and assessment procedures, such as measuring blood pressure and examining feces for occult blood
- Consulting and working collaboratively with other health care professionals about client problems
- Teaching clients about recovery activities, such as exercises that will accelerate recovery after a cerebrovascular accident (stroke)
- Rehabilitating clients to their optimal functional level following physical or mental illness, injury, or chemical addiction

CARING FOR THE DYING This area of nursing practice involves comforting and caring for people of all ages who are dying. It includes helping clients be as comfortable as possible until death and helping the support people cope with death. Nurses carrying out these activities work in homes, hospitals, and extended care facilities. Some agencies, called *hospices,* are specifically designed for this purpose. See Chapter 48 for further discussion.

Nursing Numbers and Settings

Canada has four categories of regulated nurses: (a) registered nurses (RNs), (b) licensed (registered) practical nurses (LPNs/RPNs), (c) Nurse Practitioners (NPs), (d) registered psychiatric nurses (RPNs) (see Box 1.2 for definitions of each category of regulated nurses). The Canadian Institute for Health Information reported that Canada had a supply of 415 864 regulated nurses in 2015. Of these, RNs numbered 296 731 practical nurses 113 367 and psychiatric nurses 5766. The RN numbers include 4353 nurse practitioners (NPs) (Canadian Institute for Health Information [CIHI], 2016). The acute care hospital remains the primary practice setting. In 2014, approximately 63.3% of RNs, 47.2% of LPNs/RPNs, and 38.8% of NPs worked in hospitals. The remainder worked in clients' homes; community agencies, including long-term care facilities; ambulatory clinics; and nursing practice centres (CIHI, 2016). The CIHI also noted that the supply of RNs declined by 1% in 2014 but increased by 1.2% in 2015; the numbers of LPNs and RPNs had slower growth. In addition, perhaps as a function of the aging of the "baby boomer" generation, fewer (30 897) new nurses registered for the