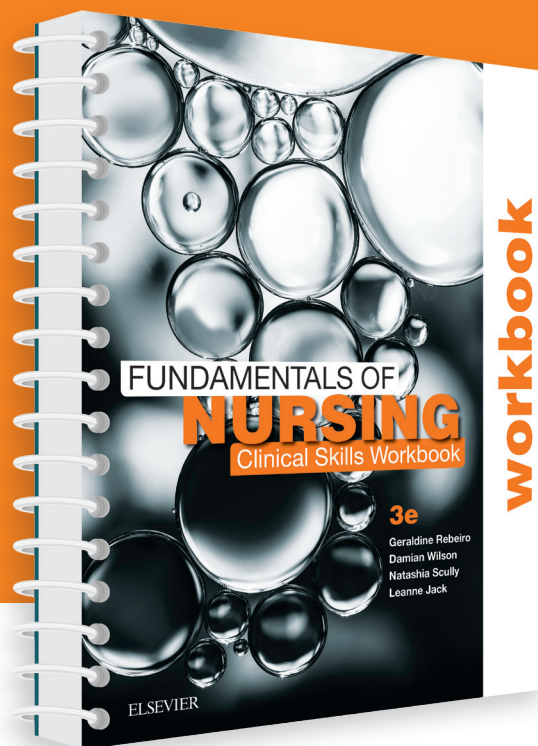
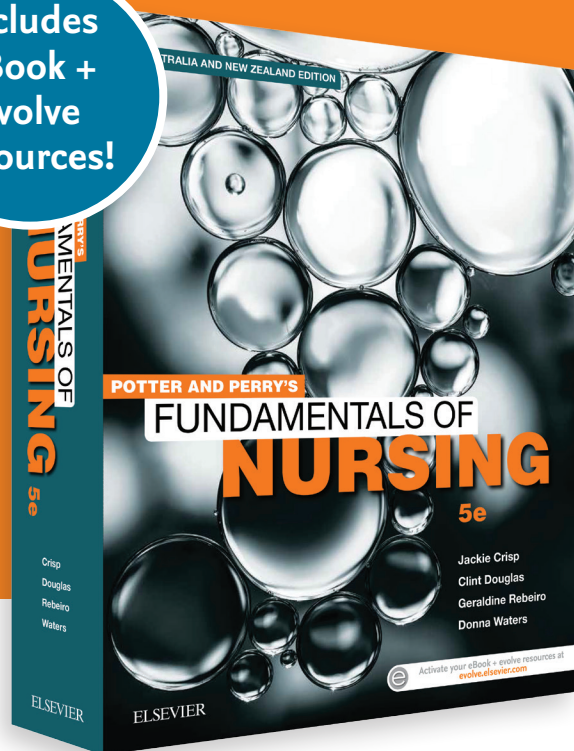


Setting the standard as the
leading fundamentals texts
for Australian and
New Zealand nursing students

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POTTER & PERRY'S FUNDAMENTALS OF NURSING, 5E – ANZ EDITION

By Jackie Crisp, Clint Douglas,
Geraldine Rebeiro and Donna Waters

Publication date: 26th September, 2016

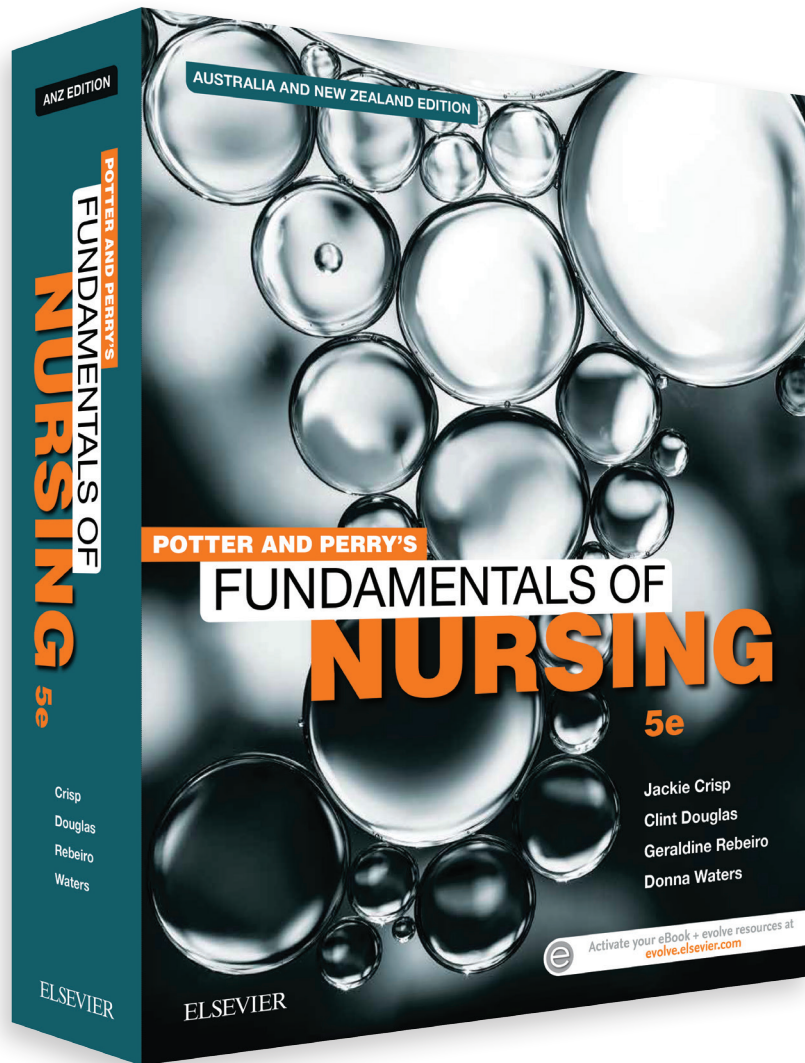
FUNDAMENTALS OF NURSING CLINICAL SKILLS WORKBOOK, 3E

By Geraldine Rebeiro, Damian Wilson,
Natasha Scully and Leanne Jack

Publication date: 26th September, 2016

A complete fundamentals of nursing suite that continues to set the standard as the leading fundamentals texts for Australian and New Zealand nursing students. *Potter & Perry's Fundamentals of Nursing, 5e – ANZ Edition* and *Fundamentals of Nursing Clinical Skills Workbook, 3e* focus on the very important basics – the fundamentals of care that are the building blocks on which professional nursing practice is built. These new editions will prepare students for the dynamic and evolving nature of nursing practice and will challenge them to become competent, engaged and agile nurses of today, leading the way to be effective nurses of the future.

Now aligned to the Registered Nurse Standards for Practice, 2016 (AUS) and Competencies for Registered Nurses, 2007 (NZ), both *Potter & Perry's Fundamentals of Nursing, 5e – ANZ Edition* and *Fundamentals of Nursing Clinical Skills Workbook, 3e* are the only fundamentals suite in the market that are aligned to the Registered Nurse Standards for Practice, 2016.



Potter & Perry's Fundamentals of Nursing, 5e – ANZ Edition

A bestselling title for over 15 years, the updated 5th edition of *Potter & Perry's Fundamentals of Nursing, 5e – ANZ Edition* is an essential resource for all nursing students.

The importance of safe and effective person-centred care continues to feature throughout, with a new emphasis on professional responsibility and accountability. *Clinical examples* and *Critical reflection* points highlight how the quality of nursing care, knowledge and skills can impact people's lives and mean the difference between recovery and ongoing illness and complications.

Words from Donna Waters, on behalf of the Editorial Team

“Nursing of the future will be situated in many contexts and we believe it is crucial for you to understand the dynamic and evolving nature of your practice.”

[View full list of Contributors + Reviewers](#)

“The editorial team sincerely want you to discover why seemingly routine activities, such as feeding, bathing, toileting, walking or turning patients, are so critically important to your nursing and nursing care.”

“In this edition, we welcome a number of academics and clinicians to the experienced writing team, and acknowledge their expert contemporary knowledge and contribution to perspectives on health and health care.”

“Everyone who has contributed to this text has done so because they want you to be the best nurse you can possibly be.”

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- Chapter 2** Building nursing practice: the Fundamentals of Care Framework **NEW!**
- Chapter 3** Engaging patients and keeping them safe **NEW!**

PART 2

Framing nursing: critical processes in nursing practice

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- Chapter 6** Setting priorities, taking action and evaluating outcomes
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- Chapter 12** Placing communication at the centre of person-centred care
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KEY FEATURES

- **Fundamentals of Care Framework for nursing practice** enables students to recognise and understand their perceptions of nursing and use concepts, hypotheses, frameworks, theories and everyday clinical experiences to think creatively about nursing and provide holistic person-centred care
- **Generic approach to clinical reasoning** enables students to work with any of the Clinical Reasoning models they may encounter across their undergraduate or postgraduate studies
- **Increased focus on the concept of 'self-care'** to encourage student nurses to put strategies in place to ensure their own emotional, cognitive and physical health
- **An enhanced focus on family involvement in patient care** as part of the person-centred care approach to creating caring and therapeutic relationships with patients
- **Directly aligned to *Fundamentals of Nursing Clinical Skills Workbook, 3e***
- **75 Clinical Skills** link applied nursing skills to effective clinical practice

CHAPTER 2

Building nursing practice: the Fundamentals of Care Framework

Tiffany Conroy, Rebecca Feo, Jan Alderman and Alison Kitson

KEY TERMS

Biomedical model, p. 35
Biopsychosocial model, p. 27
Concepts, p. 16
Conceptual framework, p. 16
Context of care, p. 20
Fundamentals of Care Framework, p. 17
Fundamentals of Care Practice Process, p. 17
Relationship, p. 19
Tacit knowledge, p. 16
Theories, p. 17
Working hypothesis, p. 17

Learning outcomes

- Mastery of the content will enable you to:
- use the Fundamentals of Care Practice Process to deliver person-centred nursing care
 - recognise and understand perceptions of nursing held by you and others
 - identify and use concepts, working hypotheses, frameworks and theories to inform the delivery of your nursing care
 - think creatively about nursing and providing person-centred care
 - access a range of theories.

CHAPTER 3

Engaging patients and keeping them safe

Rebecca Feo, Tiffany Conroy, Jan Alderman and Alison Kitson

KEY TERMS

Engagement, p. 31
Environmental safety, p. 38
Fundamentals of Care Framework, p. 31
Personal safety, p. 33
Physical safety, p. 34
Professional boundaries, p. 41
Psychosocial safety, p. 35
Risks, p. 33
Safety, p. 31
Therapeutic relationship, p. 31

Learning outcomes

- Mastery of the content will enable you to:
- address patient safety using the Fundamentals of Care Framework
 - identify potential negative consequences of your actions and how to minimise these
 - engage with patients and their families to establish a therapeutic relationship
 - assess all elements of a patient's personal safety, including physical, psychosocial and environmental safety
 - identify and address possible risks to your personal safety as a nurse
 - assess when your relationship with a patient has moved from therapeutic to non-therapeutic
 - be aware of appropriate work health safety and occupational health and safety regulations and codes of practice.

NEW TO THE FIFTH EDITION

- **4 new chapters:**
 - Creating a proactive and dynamic nursing profession
 - Building nursing practice: the Fundamentals of Care Framework
 - Engaging patients and keeping them safe
 - Documenting, retrieving and using information to inform practice
- **A new clinical reasoning framework** to support systematic and critical reflection on approaches to practice
- **Emphasis on the importance of self-reflection and awareness** for delivering quality care across diverse populations
- **Aligned to the Registered Nurse Standards for Practice, 2016 (AUS) and Competencies for Registered Nurses, 2007 (NZ)**
- **10 new Clinical Skills** including: patient handover, preparing a post-operative bed, assessment of fluid status, management of central venous access devices and management and assessment of the deteriorating patient

CHAPTER
1

Creating a proactive and dynamic nursing profession

Frances Hughes, David Stewart and Amanda Davies

KEY TERMS

Ageing population, p. 8
Chronic disease, p. 6
Health expenditure, p. 5
Healthcare reform, p. 8
Nursing workforce, p. 4
Person-centred care, p. 5

Practice pathway, p. 10
Professional development, p. 10
Professional regulation, p. 8
Scope of practice, p. 9

Learning outcomes

Mastery of content will enable you to:

- reflect on personal capabilities needed for a successful nursing career, in a future healthcare system characterised by rapid change
- discuss the broad aims and factors that are driving health reform in Australia and New Zealand
- understand the key elements of the nursing profession's regulatory framework in Australia and New Zealand
- discuss factors influencing nursing scope of practice
- appreciate the importance of nursing leadership at all levels for a proactive and dynamic profession.

CHAPTER
13

Documenting, retrieving and using information to inform practice

Elizabeth Cummings and Bryan Macdonald

KEY TERMS

Acuity charting, p. 249
Case management, p. 247
Change-of-shift report, p. 252
Charting by exception, p. 247
Clinical information systems, p. 236
Critical pathways, p. 247
DAR, p. 245
Diagnosis-related group (DRG), p. 236
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myHealth Record, p. 238
Nursing informatics, p. 237
PCHIE (personally controlled electronic health record), p. 238
PIE, p. 245
Problem-oriented medical record (POMR), p. 244
Record, p. 238
Report, p. 252
Resident, p. 252
SCAPE, p. 245
Source record, p. 246
Standardised care plans, p. 249
Transfer report, p. 255
Verbalos, p. 247

Learning outcomes

Mastery of content will enable you to:

- discuss the importance of documentation and reporting to patients and nurses
- discuss the difference between paper-based records and electronic records
- describe the relationship between documentation and healthcare financial reimbursement
- identify the purposes of a healthcare record
- describe and apply guidelines for effective documentation and reporting
- discuss legal guidelines for recording client care
- describe different methods of record-keeping
- discuss the advantages of standardised documentation forms
- identify critical elements of a client's discharge plan
- describe the role of critical pathways in multidisciplinary documentation
- identify the important aspects of long-term care documentation
- discuss issues related to computerisation in documentation
- describe the purpose and content of a change-of-shift report (handover) and other forms of reporting
- describe handover reporting tools
- explain the process of verifying telephone orders.

Discover More

Request an inspection copy

TEXT FEATURES

Each chapter is structured with:

Key terms

- Anticipating
- Interdisciplinary
- CHSE
- Clinical reasoning
- CHSE
- Learning outcomes
- CHSE
- Learning outcomes
- CHSE
- Learning outcomes
- CHSE
- Learning outcomes
- CHSE

Learning outcomes

- Identify the value of a reflective and systematic approach to clinical reasoning
- Describe the ways in which a systematic approach to clinical reasoning can enhance professional knowledge and development
- Apply the ways in which professional knowledge and development enhance the process of clinical reasoning
- Explain how using a systematic approach to clinical reasoning contributes to the safety of a nursing practice
- Describe the ways in which a systematic approach to clinical reasoning contributes to the safety of a nursing practice
- Use critical questioning when each of the six domains of the clinical reasoning model

Clinical examples

- Scenario 1: A patient with a broken arm who is unable to move it.
- Scenario 2: A patient with a broken arm who is unable to move it.
- Scenario 3: A patient with a broken arm who is unable to move it.

Clinical reasoning process

Cultural safety

Cultural safety is the concept that individuals are developed within the context of their culture. It is an important concept in nursing practice as it allows nurses to provide care that is respectful of the patient's beliefs, values and customs. Cultural safety is a process that involves working with patients to ensure that their beliefs, values and customs are respected and that they are able to participate in their care. Cultural safety is a process that involves working with patients to ensure that their beliefs, values and customs are respected and that they are able to participate in their care.

Clinical example

An example of being culturally safe in nursing practice is when a nurse works with a patient from a different culture. The nurse uses their knowledge of the patient's culture to provide care that is respectful of the patient's beliefs, values and customs. The nurse works with the patient to ensure that their beliefs, values and customs are respected and that they are able to participate in their care.

Clinical Reasoning Process

Clinical reasoning is the process of using critical thinking to make decisions about patient care. It is a complex process that involves a range of factors, including the patient's history, physical examination, and laboratory tests. Clinical reasoning is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.

Research highlights

- Research has shown that clinical reasoning is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.
- Research has shown that clinical reasoning is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.

Learning outcomes

Clinical examples

Cross-cultural ethics

Cross-cultural ethics is the study of ethical issues that arise in a global context. It is a complex field that involves a range of factors, including the patient's history, physical examination, and laboratory tests. Cross-cultural ethics is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.

Working with diversity

Working with diversity is the process of working with people from different backgrounds and cultures. It is a complex process that involves a range of factors, including the patient's history, physical examination, and laboratory tests. Working with diversity is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.

Research highlights

Research highlights are key findings from research that are of interest to the nursing profession. They provide a summary of the research and its implications for practice. Research highlights are key findings from research that are of interest to the nursing profession.

Reflection points

Reflection points are questions or statements that encourage the reader to think about their own practice and how it might be improved. They are a useful tool for professional development. Reflection points are questions or statements that encourage the reader to think about their own practice and how it might be improved.

Safety as one of the fundamentals of care

Safety is a fundamental aspect of nursing practice. It is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests. Safety is a process that involves a range of factors, including the patient's history, physical examination, and laboratory tests.

Critical reflection points

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Working with diversity

Critical reflection points

SAMPLE STUDENT NURSING CARE PLAN

Gathering relevant information and data

James is 83 years old and has recently been diagnosed with Alzheimer's disease. He has been taking his medicine for the past 3 days. During the last 3 days, James expresses a fear of going and anger with God. The nurses want to learn more about James' faith and sources of spiritual support, as well as his beliefs and values that he finds very important. I just don't know what to do.

Expected outcomes

Client will express a sense of purpose.
Client will express a sense of confidence in treatments administered.
Client will express a sense of hope.
Client will be able to take care of himself.

Priority problem(s)

Client's spiritual needs related to fear and uncertainty of advanced illness.

Interventions

1. Provide a safe and secure environment for James to express his fears and concerns.
2. Encourage James to express his feelings through journaling and drawing.

Evaluating impacts and outcomes

1. Ask client to discuss what meaning he has gained from journaling.

Sample student nursing care plans

Skills

Administering rectal suppositories

Delegation considerations

Administering medications is the most appropriate skill for the problem-solving and knowledge-pertaining activities of professional nurses. In specific situations and under the direct supervision of a registered nurse or a licensed practical nurse, client assistance personnel may administer rectal suppositories if they are trained and supervised.

Equipment

- Rectal suppository
- Lubricating jelly (water soluble)
- Disposable gloves
- Tissues
- Drain
- Medication administration record (MAR)

Steps

- Review medication order, including client's name, medication name, form, route and rate of administration.
- Review medication order for relevant contraindications such as rectal surgery or bleeding.
- Perform hand hygiene.
- Put on disposable gloves.
- Identify client, check MAR with client's identification bracelet and ask client's name.
- Explain procedure to the client and gain their consent. Do not proceed if client refuses to self-administer medication.
- Arrange suppository to be inserted.
- Close room curtain or door.
- Wash hands with liquid (soap) and water. Keep client draped with only anal area exposed.
- Ensure condition of anal insertion and obtain rectal meatus as needed (Chapter 50). If gloves become soiled, dispose of them by tying them together and putting them in appropriate receptacle.

Rationale

Ensures safety and correct administration of medication.

Conditions contraindications use of suppository.

Reduces transfer of microorganisms.

Prevents contact with infected faecal material.

Ensures that correct client receives medication.

Enables understanding and cooperation. Will enable client to self-administer medication if physically able.

Ensures accurate procedure.

Maintains privacy and ensures embarrassment.

Prevents client and visitor contact with feces. Reduces risk of infection. Maintains privacy and facilitates relation.

Reduces risk of active rectal bleeding. Patient discomfort, whether rectal or abdominal, indicates health, however with appropriate placement.

Reduces transportation of insects.

Therapeutic relationship and patient considerations

Critical decision points

Steps and rationale

Critical decision points

Steps

1. Perform hand hygiene.
2. Put on disposable gloves.
3. Identify client, check MAR with client's identification bracelet and ask client's name.
4. Explain procedure to the client and gain their consent. Do not proceed if client refuses to self-administer medication.
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Reduces transportation of insects.

Images

Key concepts

Conclusion

In this chapter, we explore the role of the nurse in the delivery of care to patients with chronic conditions. We discuss the importance of patient education and self-management in the management of chronic conditions. We also discuss the role of the nurse in the management of chronic conditions in the home setting.

Key concepts

- Chronic conditions are long-lasting health conditions that often persist for the rest of a person's life.
- Chronic conditions can be managed through a combination of medication, lifestyle changes, and patient education.
- The nurse plays a key role in the management of chronic conditions by providing patient education, monitoring symptoms, and providing emotional support.
- Self-management is a key component of chronic disease management, and the nurse plays a key role in teaching patients how to manage their condition.
- The nurse also plays a key role in the management of chronic conditions in the home setting, including monitoring symptoms, providing emotional support, and coordinating care with other healthcare providers.

Key concepts

Conclusion

Online resources

References

1. Australian Bureau of Statistics (ABS) (2015) *Chronic Diseases in Australia*. Canberra: ABS.

2. Australian Bureau of Statistics (ABS) (2016) *Chronic Diseases in Australia: A Profile of the Burden of Disease*. Canberra: ABS.

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1. Australian Bureau of Statistics (ABS) (2015) *Chronic Diseases in Australia*. Canberra: ABS.

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References

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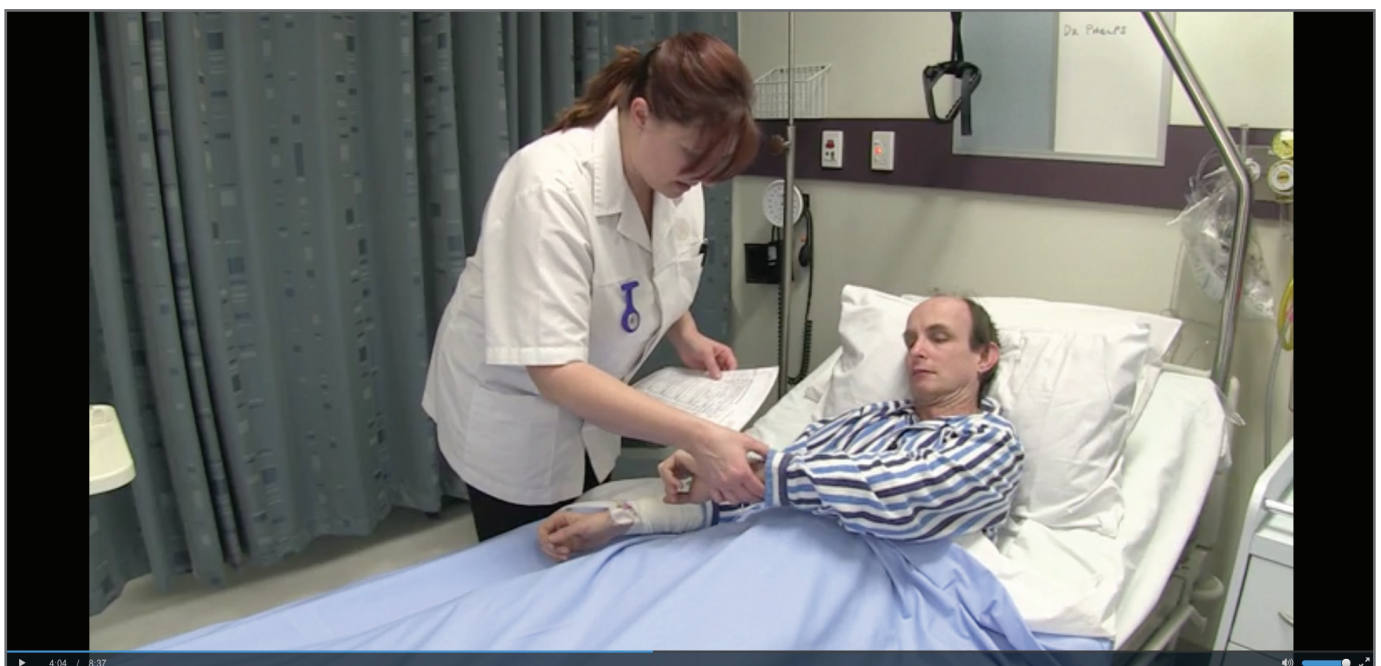
evolve is an online platform that provides additional teaching and learning resources to help you prepare your lectures and assessments, as well as student resources for revision. The 5th edition of *Potter & Perry's Fundamentals of Nursing* offers:

INSTRUCTOR RESOURCES

- **An eBook on VitalSource**
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 - Critical Reflection Points and answers
 - Image collection
 - Tables and boxes collection

STUDENT RESOURCES

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 - *Essentials of Care* chapter
 - 37 Clinical Skills Australian videos (including 10 NEW)
 - *Clinical Cases: Fundamentals of Nursing Case Studies*
 - Weblinks



[View example Clinical Skills video](#)

Words from your peers

Fiona Foxall

*Director - Undergraduate Nursing Studies, School of Nursing & Midwifery
Edith Cowan University*

“The content is well thought out, very comprehensive and appropriate, logically sequenced and appears to build on knowledge gained from earlier chapters.

This is the most comprehensive and accessible text I have seen to contextualise nursing for the beginning student nurse and for the consolidation of learning for the late student and qualified practitioner. It is an outstanding text.”

Thomas Mathew

*Lecturer in Acute and Critical Care
The University of Melbourne*

“The content discussed is relevant and contextualised with the extensive use of case studies, research examples and critical thinking activities to ensure students are engaged well.”

Michelle Maw

*Acute Care Lecturer,
Sydney Nursing School
The University of Sydney*

“The text is set out well. It is easy to read which is important for students new to nursing. It provides clear definitions and easy to read tables. The inclusion of pictures is always appreciated by students.”

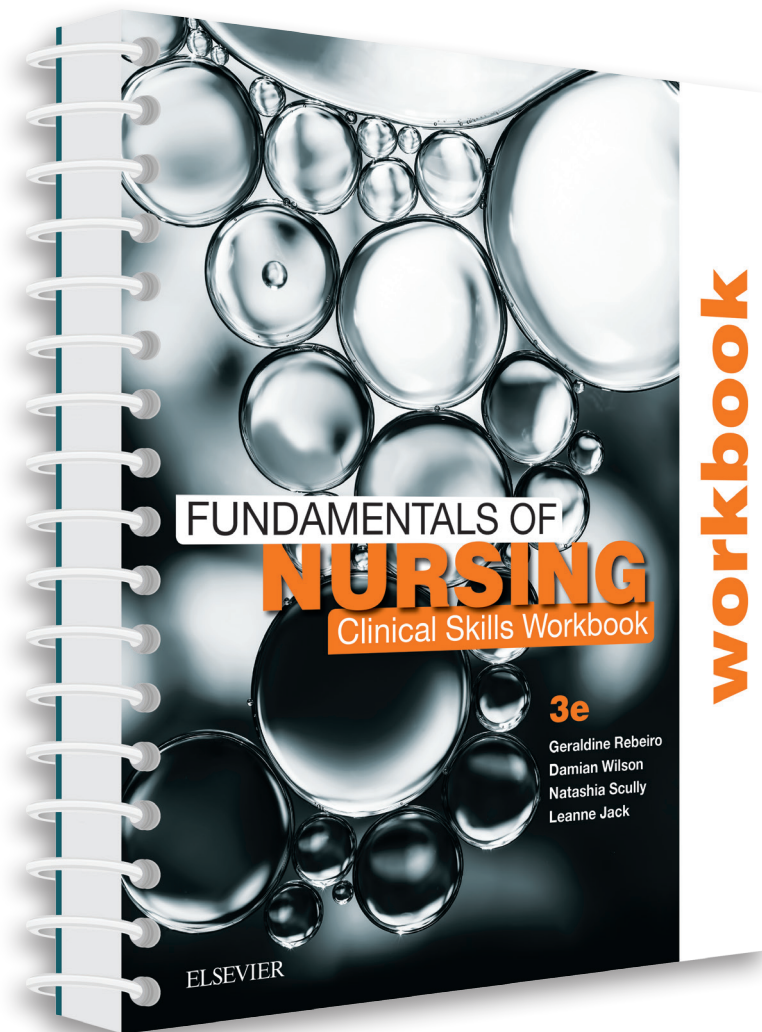
Claire Minton

Lecturer, School of Nursing, Massey University

“This book is comprehensive and easy to read –an excellent book for beginning nurses to be used throughout their degree.

The short sections make it easy for the reader to follow and maintain interest – this is very important for undergraduates who can be overwhelmed with too much information.

The critical reflections throughout the chapters are appropriate and a core part of nursing education today.”



Fundamentals of Nursing Clinical Skills Workbook 3e

Fundamentals of Nursing Clinical Skills Workbook 3e is an indispensable tool that will assist students in mastering the clinical skills that are essential in becoming a confident, effective and agile nurse.

Each skill has been fully revised to align to the updated skills in *Potter and Perry's Fundamentals of Nursing 5e*, including a total of 14 new skills to reflect contemporary nursing practice.

This 3rd edition continues to support student nurses in building their clinical knowledge and practice through clear instructions, thorough assessment tools and reflective learning.

[View Sample Chapter](#)

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Monitoring vital signs: using a primary survey approach for patient assessment

Undertaking a focused assessment: physical assessment of body systems

Undertaking infection control

Maintaining skin integrity and undertaking wound care

Administering medications

Promoting mobility

Ongoing hygiene

Sustaining nutrition

Maintaining bowel elimination

Maintaining urinary elimination

Balancing fluid, electrolyte and acid-base status

Additional fluid and electrolyte nursing skills

- Management of central venous catheters (CVC) **NEW!**

Preserving oxygenation

Managing pain

Working in acute care environments

- Management and assessment of a deteriorating patient (ABCDE) **NEW!**

Meeting the mental health needs of individuals and their carers

Registered Nurse Standards for Practice 2016 (AUS)

Competencies for Registered Nurses 2007 (NZ)

KEY FEATURES

- **78 Clinical Skills linking applied nursing skills to effective clinical practice**, each featuring:
 - **An overview of each skill**, containing rationales to help understand how and why the skill is performed
 - **A focus on therapeutic relationships and patient considerations**, reminding students that the patient is central to care provision
 - **Equipment checklist**
 - **A step-by-step approach**, clearly explaining how to perform each skill
 - **Critical decision points**, alerting students to critical steps to ensure quality and safety in patient care
 - **Competency checklist**, providing a valuable tool for assessment, including the five-point Bondy Rating Scale
 - **Reflection opportunity** at the end of each competency checklist to encourage learning

The five-point Bondy Rating Scale

The five-point Bondy Rating Scale is a useful tool for assessing professional competency and, subsequently, the amount of supervision needed to successfully master the nursing skills included in this workbook. The scale is also a useful indicator of students' ability to carry out these skills with accuracy, safety and satisfactory effect.

Scale label	Score	Standard of procedure	Quality of performance	Level of assistance required
Independent	5	Safe Accurate Achieved intended outcome Behaviour is appropriate to context	Proficient Confident Expedient	No supporting cues required
Supervised	4	Safe Accurate Achieved intended outcome Behaviour is appropriate to context	Proficient Confident Reasonably expedient	Requires occasional supportive cues
Assisted	3	Safe Accurate Achieved most objectives for intended outcome Behaviour generally appropriate to context	Proficient throughout most of performance when assisted	Requires frequent verbal and occasional physical directives in addition to supportive cues
Marginal	2	Safe only with guidance Not completely accurate Incomplete achievement of intended outcome	Unskilled Inefficient	Requires continuous verbal and frequent physical directive cues
Dependent	1	Unsafe Unable to demonstrate behaviour Lack of insight into behaviour appropriate to context	Unskilled Unable to demonstrate behaviour/procedure	Requires continuous verbal and continuous physical directive cues
X	0	Not observed		

www.edcan.org/pdf/EdCanFactSheetCAT.pdf
 Published with permission from SLACK Incorporated.
 Adapted from RN Bondy 1983. Criterion-referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education* 22(8):376-382.

Assessing the radial and apical pulses

Delegation considerations

Pulse measurement can be delegated to enrolled nurses who are informed of:

- patient history or risk of irregular pulse
- frequency of pulse measurement
- the usual reportable levels for the patient
- the need to report any abnormalities.

Equipment

- Stethoscope (apical pulse only)
- Watch with second hand or a digital display
- Pen, observation chart
- Alcohol swab

Therapeutic relationship and patient considerations

- Confirms patient identity
- Gains patient consent
- Initiates communication by introductions and clarification of patient's immediate needs and problems
- Identifies how the skill will affect the patient
- Discusses procedure with the patient to clarify understanding
- Provides reassurance
- Assesses patient knowledge and expectations and ensures patient understanding
- Where necessary, provides further clarification
- Explains actions and potential discomfort at all stages of procedure

STEPS

- Determine the frequency of monitoring the radial or apical pulse:
 - Consider previous medical conditions for alterations in apical pulse.
- Assess for signs and symptoms of altered cardiac output such as dyspnoea, fatigue, chest pain, orthopnoea, syncope, palpitations (person's unpleasant awareness of heartbeat), jugular venous distension, oedema of dependent body parts, cyanosis or pallor of skin.
- Assess for factors that normally influence apical pulse rate and rhythm:
 - Age
 - Exercise
 - Position changes

Certain conditions place patients at risk of pulse alterations. Heart rhythm can be affected by heart disease, cardiac arrhythmias, onset of sudden chest pain or acute pain from any site, invasive cardiovascular diagnostic tests, surgery, sudden infusion of large volume of intravenous fluid, internal or external haemorrhage and administration of medications that alter heart function.

Physical signs and symptoms may indicate alteration in cardiac function.

Allows for accurate assessment of presence and significance of pulse alterations.

Acceptable range of heart rate changes with age (see Table 23-5).

Physical activity requires an increase in cardiac output that is met by an increased heart rate and stroke volume.

Heart rate increases temporarily when changing from lying to sitting or standing position.

¹ See Potter and Perry's *Fundamentals of Nursing* 5e.

NEW TO THE THIRD EDITION

- Directly aligned to *Potter and Perry's Fundamentals of Nursing 5e*
- Aligned to the Registered Nurse Standards for Practice, 2016 (AUS) and Competencies for Registered Nurses, 2007 (NZ)
- **11 new skills**, including patient handover, making a postoperative bed, assessment of fluid status, and assessment and management of the deteriorating patient
- **Three additional skills** (not featured in the main text):
 - Pouching a urostomy
 - Regulating CVC intravenous flow rate
 - CVC dressing change and flush

MONITORING VITAL SIGNS: USING A PRIMARY SURVEY APPROACH FOR PATIENT ASSESSMENT 21

Assessing the radial and apical pulses

DEMONSTRATES: The ability to effectively and safely assess the radial and apical pulses

CLINICAL SKILLS COMPETENCY

STANDARDS (AUS): Thinks critically and analyses nursing practice; Engages in therapeutic and professional relationships; Develops a plan for nursing practice; Provides safe, appropriate and responsive quality nursing practice; Evaluates outcomes to inform nursing practice

DOMAINS (NZ): Professional responsibility; Management of nursing care; Interpersonal relationships; Interprofessional healthcare and quality improvement

PERFORMANCE CRITERIA

(Numbers indicate the Registered Nurse Standards for Practice, 2016 (AUS) and the Competencies for Registered Nurses, 2007 (NZ))

AUS 1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.5, 2.6, 2.7, 5.1, 5.2, 5.3, 6.1, 6.2, 7.1, 7.3

NZ 1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 3.1, 3.2, 3.3, 4.1, 4.2

COMPETENCY CRITERIA	PERFORMANCE CRITERIA/EVIDENCE	I	S	A	M	D
Identifies indication/rationale	Confirms patient identity Determines need to perform pulse measurement Identifies appropriate timing for measuring pulses Identifies any contraindication to measuring pulses					
Therapeutic relationship and person considerations	Initiates communication by introductions and clarification of patient's immediate needs and problems Clarifies patient knowledge and provides education where necessary Explains actions at all stages of procedure Gains patient consent Educates patient to relax and not to speak during procedure					
Assesses person	Assesses patient for signs and symptoms of altered stroke volume, such as dyspnoea, fatigue, chest pain, syncope, palpitations, distended jugular veins, dependent oedema, cyanosis, skin pallor Assesses factors influencing apical pulse rate and rhythm (e.g. age, recent exercise, medications, body temperature, emotional stress, fear, anxiety)					
Performs hand hygiene	Performs social handwash Adheres to '5 moments for hand hygiene' as outlined by Hand Hygiene Australia Wears appropriate PPE					
Gathers equipment	Observation chart and pen Watch with second hand Stethoscope (apical pulse only) Clean non-sterile gloves if appropriate					
Prepares equipment	Considers privacy and appropriateness of setting Cleans apical pulse of stethoscope Cleans stethoscope Tests diaphragm of stethoscope					

22 FUNDAMENTALS OF NURSING CLINICAL SKILLS WORKBOOK

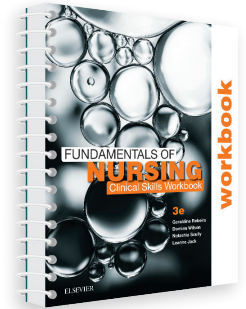
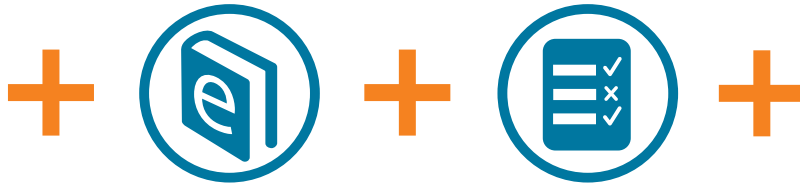
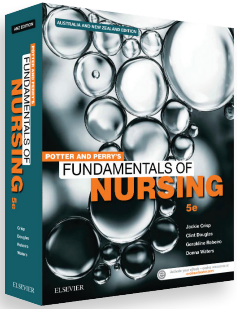
COMPETENCY CRITERIA	PERFORMANCE CRITERIA/EVIDENCE	I	S	A	M	D
Performs clinical procedure	<p>Radial pulse</p> <ol style="list-style-type: none"> 1. Places patient's arm across torso 2. Places tips of first two fingers over groove along radial or thumb side of patient's inner wrist 3. Lightly compresses against radius to obliterate pulse then slightly releases pressure to palpate pulse 4. Notes quality of pulse (e.g. weak, thrready, bounding) <p>Apical pulse</p> <ol style="list-style-type: none"> 1. Removes patient's gown to expose chest 2. Locates point of maximal impulse (PMI); locates angle of Louis to locate second intercostal space (ICS) and slides fingers down left sternum to fifth ICS and mid-clavicular line 3. Cleans stethoscope 4. Warms diaphragm of stethoscope in palm of hand for 5–10 seconds 5. Places diaphragm of stethoscope over PMI to auscultate S₁ and S₂ (lub-dub) 6. Counts the number of S₁ and S₂ beats 7. Replaces patient's gown and bed linen <p>If pulse is regular, counts for 30 seconds and multiplies total by 2 If pulse is irregular or patient is receiving cardiovascular medications, counts for 60 seconds</p> <p>Assesses frequency and pattern of irregularity Compares peripheral pulse rate with apical pulse rate, noting any discrepancies Compares assessment with baseline data including blood pressure and associated signs and symptoms (e.g. dizziness)</p>					
Cleans and disposes of equipment appropriately	Disposes of PPE in appropriate receptacle Performs hand hygiene Cleans and restocks equipment					
Completes documentation	Documents observation (including pulse and site used) and associated assessment/complications Records pulse rate with date and time of assessment Reports abnormal findings					

REFLECTION: _____

SUPERVISOR: _____

STUDENT NAME: _____ DATE: _____

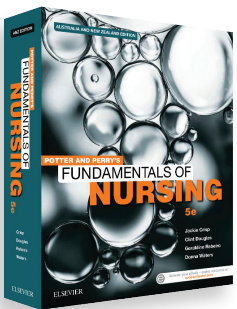
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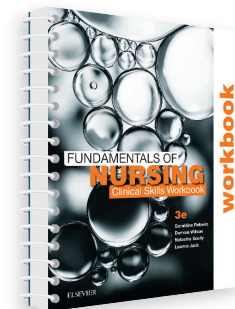
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