Health & Physical

Fourth Edition

Assessment in Nursing

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Brief Contents

Health & Physical

Fourth Edition

Assessment in Nursing

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Thank You

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We would like to extend our deepest gratitude and appreciation to our colleagues who have given their time to help create this updated edition of our health and physical assessment textbook. These individuals helped us plan and shape our book by providing valuable feedback through the review of chapter content, art, design, and more. *Health & Physical Assessment in Nursing*, Fourth Edition, has reaped the benefit of your collective expertise, and we have improved the materials due to your efforts, suggestions, objections, endorsements, and inspiration. Those who generously gave their time include the following:

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Preface

This updated edition of *Health & Physical Assessment in Nursing*, along with its comprehensive collection of digital resources, will help instructors guide pre-licensure nursing students and facilitate their learning of the art, science, and skills of health and physical assessment. The focus of this book is assessment of the whole person and recognizing the wide diversity of patients and settings where nurses practice. The professional nurse will assess the entirety of the patient experience, including the physical, emotional, cultural, and spiritual aspects of their lives. Because learning the practice of nursing is complex, this text provides a systematic and detailed look at health and physical assessment as the fundamental first step in the nursing process. We approach assessment holistically while emphasizing the scientific, evidence-based knowledge and skills needed for professional practice. We introduce concepts related to health, wellness, communication, culture, and human development to underscore the importance of health assessment as an integral part of the expanded role of the nurse.

ORGANIZATION OF THIS TEXTBOOK

Health & Physical Assessment in Nursing is composed of four units. Unit I, Foundations of Health Assessment, introduces foundations of nurses' role in comprehensive health assessment. The chapters within this unit examine the definitions and concepts important to assessment, as well as the social and cultural influences. Nursing assessment includes all of the factors that impact the patient and health. Chapter 1 describes the knowledge, skills, and processes that comprise the role of professional nurses in holistic health assessment and health promotion. Among these processes is evidence-based practice (EBP). This is introduced in Unit I, and references to evidence-based guidelines, recommendations, and practices are addressed throughout this text. The professional nurse functions within the healthcare delivery system and has a responsibility to partner with other professionals and patients to maximize health. We introduce all the steps of the nursing process, then provide a detailed explanation of assessment. Chapter 2 discusses many concepts related to health and wellness, including health promotion. This chapter also provides definitions of health and examples of several health promotion models. Chapter 3 discusses how the patient's culture, heritage, and spirituality have significant influences on the individual's health-related activities. This chapter provides an overview of cultural concepts and describes methods to incorporate and address the patient's culture, values, and beliefs in the assessment process. Chapter 4 discusses the expanded understanding of health disparities across populations. An examination of the assessment of vulnerable patient groups includes factors that place certain populations at risk for health disparities.

Unit II, Techniques for Health Assessment, introduces the fundamental skills for performing the health and physical assessment. This unit emphasizes current evidence-based nursing practice and guidelines. Chapter 5 presents the skills, knowledge, and attitudes needed to gather the subjective data through interviewing and collecting the health history. The nurse's ability to communicate effectively is essential to the interview process, and this chapter presents details of the communication process and examples of effective communication techniques. Chapter 6 covers the key principles of nursing documentation across a variety of settings. We describe techniques and equipment required for physical assessment in Chapter 7. Chapter 8 provides an in-depth explanation of the initial steps of the objective physical assessment—the general survey and measurement of vital signs. Chapters 9, 10, and 11 discuss factors that are of crucial importance to health assessment: pain; nutrition; and assessment of mental health, substance use, and violence. Each chapter describes concepts related to these areas and includes measurements, methods, and tools to guide data gathering and interpretation of findings for patients across the lifespan.

Unit III, Physical Assessment, introduces the methods and techniques that nurses use to obtain objective data. Current evidence-based practice knowledge and guidelines are highlighted throughout this unit. The chapters in Unit III are organized by body system, and each chapter begins with a review of anatomy and physiology. This is followed by a Special Considerations section with discussion of the issues the nurse must consider when collecting subjective and objective data, including health promotion; age; developmental level; and cultural, psychosocial, and emotional wellness. These highly structured chapters use a consistent format to guide students through the steps of assessment and build their skills step by step.

Unit IV, Specialized Assessment, contains three chapters that provide information about physical assessment of specialized patient groups. These chapters focus on assessment concepts and issues relevant to pregnant females; newborns, infants, children, and adolescents; and older adults. Chapter 28 presents a comprehensive overview of the complete health assessment along with a focus on hospitalized patients.

NEW CHAPTERS

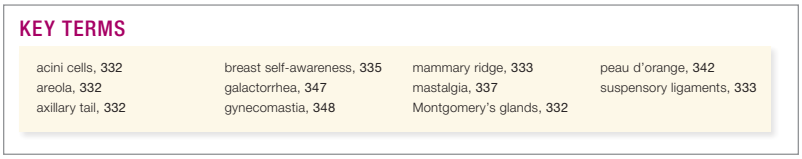
Several chapters have been combined, reorganized, and amended in this edition. Completely new chapters include the following:

- Chapter 6, Documenting Your Findings, provides the rationale for accurate documentation, as well as the core principles for solid documentation. Differentiating the methods of documentation for subjective and objective data is emphasized. We also provide charting for narrative notes, problem-oriented charting, flow sheets, and more.
- Chapter 26, Newborns, Infants, Children, and Adolescents, describes the assessment of pediatric populations. This content has been brought together in this chapter, showing the changes in practices as children age.

- Chapter 27, Older Adults, presents assessment techniques and consideration for the older adult patient. Abnormal conditions related specifically to the aging process are identified.
- In Appendix C we present advanced skills that offer step-by-step instructions for some skills that, while less common, may still be performed by nurses in certain situations.

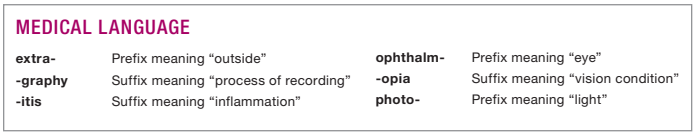
FEATURES TO HELP YOU USE THIS TEXT

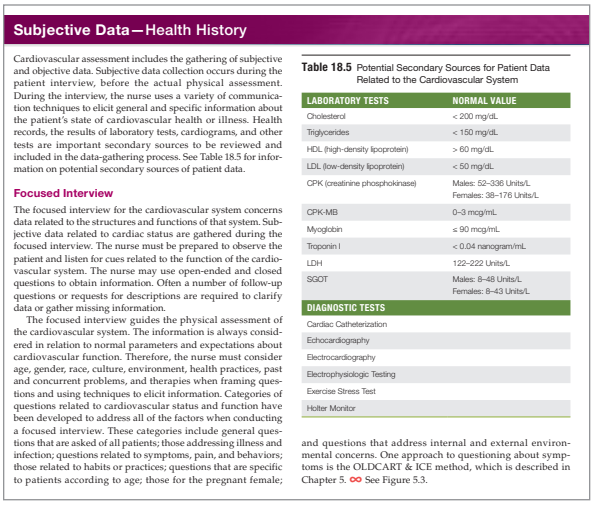
Features are designed to enhance the learning process and help you use this text successfully. New features for this edition—Medical Language, Evidence-Based Practice, and the Documenting Your Findings section—are shown and described along with those from previous editions.



Key Terms at the beginning of chapters identify the terminology that the student encounters in conducting assessment and the pages where the student can find the definitions. Key terms are boldfaced throughout and defined in the text and in the glossary.

Knowing components of medical language can improve and enhance the learning experience. Prefixes, suffixes, and root words found in the chapter are provided in the **NEW Medical Language** features after the Key Terms to reinforce learning of these fundamental parts of medical terminology.





Subjective Data—Health History

Cardiovascular assessment includes the gathering of subjective and objective data. Subjective data collection occurs during the patient interview, before the actual physical assessment. During the interview, the nurse uses a variety of communication techniques to elicit general and specific information about the patient's state of cardiovascular health or illness. Health records, the results of laboratory tests, cardiograms, and other tests are important secondary sources to be reviewed and included in the data-gathering process. See Table 18.5 for information on potential secondary sources of patient data.

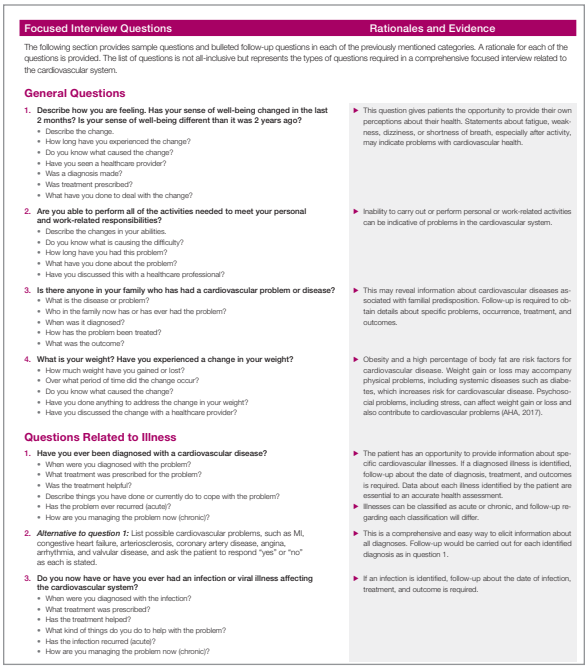
Focused Interview

The focused interview for the cardiovascular system concerns data related to the structures and functions of that system. Subjective data related to cardiac status are gathered during the focused interview. The nurse must be prepared to observe the patient and listen for cues related to the function of the cardiovascular system. The nurse may use open-ended and closed questions to obtain information. Often a number of follow-up questions or requests for descriptions are required to clarify data or gather missing information.

The focused interview guides the physical assessment of the cardiovascular system. The information is always considered in relation to normal parameters and expectations about cardiovascular function. Therefore, the nurse must consider age, gender, race, culture, environment, health practices, past and concurrent problems, and therapies when framing questions and using techniques to elicit information. Categories of questions related to cardiovascular status and function have been developed to address all of the factors when conducting a focused interview. These categories include general questions that are asked of all patients; those addressing illness and infection; questions related to symptoms, pain, and behaviors; those related to habits or practices; questions that are specific to patients according to age; those for the pregnant female; and questions that address internal and external environmental concerns. One approach to questioning about symptoms is the OLDCART & ICE method, which is described in Chapter 5. ∞ See Figure 5.3.

Table 18.5 Potential Secondary Sources for Patient Data Related to the Cardiovascular System

LABORATORY TESTS	NORMAL VALUE
Cholesterol	< 200 mg/dL
Triglycerides	< 150 mg/dL
HDL (high-density lipoprotein)	> 60 mg/dL
LDL (low-density lipoprotein)	< 50 mg/dL
CPK (creatinine phosphokinase)	Males: 52–336 Units/L Females: 38–176 Units/L
CPK-MB	0–3 mcg/mL
Myoglobin	≤ 90 mcg/mL
Troponin I	< 0.04 nanogram/mL
LDH	122–222 Units/L
SGOT	Males: 8–48 Units/L Females: 8–43 Units/L
DIAGNOSTIC TESTS	
Cardiac Catheterization	
Echocardiography	
Electrocardiography	
Electrophysiologic Testing	
Exercise Stress Test	
Holter Monitor	



Focused Interview Questions | **Rationales and Evidence**

The following section provides sample questions and bulleted follow-up questions in each of the previously mentioned categories. A rationale for each of the questions is provided. The list of questions is not all-inclusive but represents the types of questions required in a comprehensive focused interview related to the cardiovascular system.

General Questions

1. **Describe how you are feeling. Has your sense of well-being changed in the last 2 months? Is your sense of well-being different than it was 2 years ago?**
   - Describe the change.
   - How long have you experienced the change?
   - Do you know what caused the change?
   - Have you seen a healthcare provider?
   - Was a diagnosis made?
   - Was treatment prescribed?
   - What have you done to deal with the change?

   ▸ This question gives patients the opportunity to provide their own perceptions about their health. Statements about fatigue, weakness, dizziness, or shortness of breath, especially after activity, may indicate problems with cardiovascular health.

2. **Are you able to perform all of the activities needed to meet your personal and work-related responsibilities?**
   - Describe the changes in your abilities.
   - Do you know what is causing the difficulty?
   - How long have you had this problem?
   - What have you done about the problem?
   - Have you discussed this with a healthcare professional?

   ▸ Inability to carry out or perform personal or work-related activities can be indicative of problems in the cardiovascular system.

3. **Is there anyone in your family who has had a cardiovascular problem or disease?**
   - What is the disease or problem?
   - Who in the family now has or has ever had the problem?
   - When was it diagnosed?
   - How has the problem been treated?
   - What was the outcome?

   ▸ This may reveal information about cardiovascular diseases associated with familial predisposition. Follow-up is required to obtain details about specific problems, occurrence, treatment, and outcomes.

4. **What is your weight? Have you experienced a change in your weight?**
   - How much weight have you gained or lost?
   - Over what period of time did the change occur?
   - Do you know what caused the change?
   - Have you done anything to address the change in your weight?
   - Have you discussed the change with a healthcare provider?

   ▸ Obesity and a high percentage of body fat are risk factors for cardiovascular disease. Weight gain or loss may accompany physical problems, including systemic diseases such as diabetes, which increases risk for cardiovascular disease. Psychosocial problems, including stress, can affect weight gain or loss and also contribute to cardiovascular problems (AHA, 2017).

Questions Related to Illness

1. **Have you ever been diagnosed with a cardiovascular disease?**
   - When were you diagnosed with the problem?
   - What treatment was prescribed for the problem?
   - Was the treatment helpful?
   - Describe things you have done or currently do to cope with the problem?
   - Has the problem ever recurred (acute)?
   - How are you managing the problem now (chronic)?

   ▸ The patient has an opportunity to provide information about specific cardiovascular illnesses. If a diagnosed illness is identified, follow-up about the date of diagnosis, treatment, and outcomes is required. Data about each illness identified by the patient are essential to an accurate health assessment.

   ▸ Illnesses can be classified as acute or chronic, and follow-up regarding each classification will differ.

2. ***Alternative to question 1:*** List possible cardiovascular problems, such as MI, congestive heart failure, arteriosclerosis, coronary artery disease, angina, arrhythmia, and valvular disease, and ask the patient to respond "yes" or "no" as each is stated.

   ▸ This is a comprehensive and easy way to elicit information about all diagnoses. Follow-up would be carried out for each identified diagnosis as in question 1.

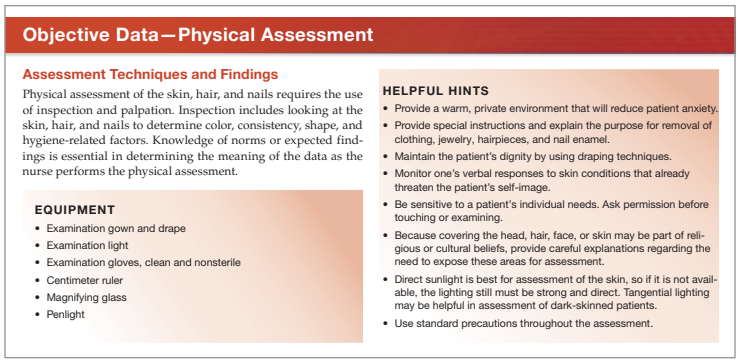
3. **Do you now have or have you ever had an infection or viral illness affecting the cardiovascular system?**
   - When were you diagnosed with the infection?
   - What treatment was prescribed?
   - Has the treatment helped?
   - What kind of things do you do to help with the problem?
   - Has the infection recurred (acute)?
   - How are you managing the problem now (chronic)?

   ▸ If an infection is identified, follow-up about the date of infection, treatment, and outcome is required.

In the **Subjective Data—Health History** sections, students learn how to gather subjective data while conducting a patient interview. We provide Focused Interview Questions that ask the patient about general health, illness, symptoms, behaviors, and pain. We also provide follow-up questions to help the student gather more data from the interview, as well as rationales and supporting evidence so the student understands why the nurse must ask these questions. We provide reminders about specific communication techniques to increase student confidence and competence while performing the health assessment. A Potential Secondary Sources for Patient Data table is included in each of the assessment chapters in Unit III. The table includes laboratory tests with the normal values and other possible diagnostic tests relevant to the particular system.

In **Objective Data—Physical Assessment**, we show the student how to collect objective data and conduct a physical assessment—from the preparation of the room and gathering of equipment, to greeting the patient and the examination, to sharing findings with the patient. **Equipment** features help students prepare for the assessment by identifying the equipment needed to conduct the assessment. **Helpful Hints** boxes provide suggestions and reminders about conducting the physical assessment. We offer clinical guidance to prepare the student for the assessment and promote patient comfort.

Throughout the Objective Data–Physical Assessment section are two columns. The left-side column demonstrates step-by-step instruction for patient preparation, position, details for each technique in assessment, and the expected findings. The right-side column includes corresponding abnormal findings and special considerations, such as an alternate method, technique, or finding in relation to age, development, culture, or specific patient condition such as obesity. This format helps the student differentiate normal from abnormal findings while interpreting and analyzing data to plan nursing care. Hundreds of photos and illustrations help the student envision how to perform the techniques precisely and thoroughly. Documentation samples for each chapter are presented to help students practice this skill.



Objective Data—Physical Assessment

Assessment Techniques and Findings

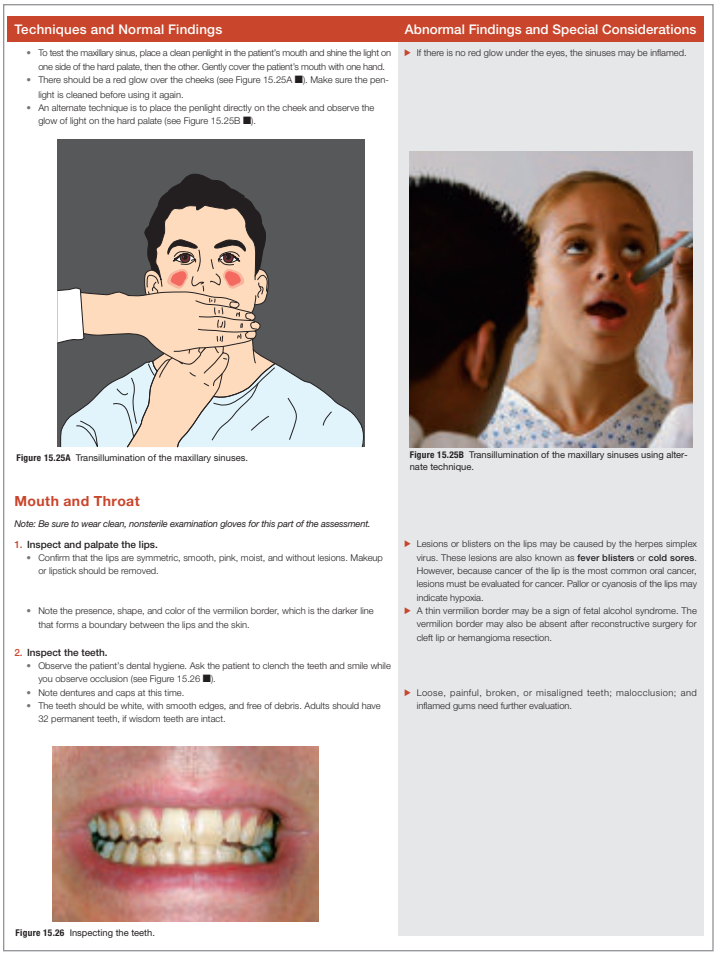
Physical assessment of the skin, hair, and nails requires the use of inspection and palpation. Inspection includes looking at the skin, hair, and nails to determine color, consistency, shape, and hygiene-related factors. Knowledge of norms or expected findings is essential in determining the meaning of the data as the nurse performs the physical assessment.

EQUIPMENT

- Examination gown and drape
- Examination light
- Examination gloves, clean and nonsterile
- Centimeter ruler
- Magnifying glass
- Penlight

HELPFUL HINTS

- Provide a warm, private environment that will reduce patient anxiety.
- Provide special instructions and explain the purpose for removal of clothing, jewelry, hairpieces, and nail enamel.
- Maintain the patient's dignity by using draping techniques.
- Monitor one's verbal responses to skin conditions that already threaten the patient's self-image.
- Be sensitive to a patient's individual needs. Ask permission before touching or examining.
- Because covering the head, hair, face, or skin may be part of religious or cultural beliefs, provide careful explanations regarding the need to expose these areas for assessment.
- Direct sunlight is best for assessment of the skin, so if it is not available, the lighting still must be strong and direct. Tangential lighting may be helpful in assessment of dark-skinned patients.
- Use standard precautions throughout the assessment.



Techniques and Normal Findings

- To test the maxillary sinus, place a clean penlight in the patient's mouth and shine the light on one side of the hard palate, then the other. Gently cover the patient's mouth with one hand.
- There should be a red glow over the cheeks (see Figure 15.25A ■). Make sure the penlight is cleaned before using it again.
- An alternate technique is to place the penlight directly on the cheek and observe the glow of light on the hard palate (see Figure 15.25B ■).

Abnormal Findings and Special Considerations

▶ If there is no red glow under the eyes, the sinuses may be inflamed.

Figure 15.25A Transillumination of the maxillary sinuses.

Figure 15.25B Transillumination of the maxillary sinuses using alternate technique.

Mouth and Throat

Note: Be sure to wear clean, nonsterile examination gloves for this part of the assessment.

1. **Inspect and palpate the lips.**
   - Confirm that the lips are symmetric, smooth, pink, moist, and without lesions. Makeup or lipstick should be removed.
   - Note the presence, shape, and color of the vermilion border, which is the darker line that forms a boundary between the lips and the skin.

▶ Lesions or blisters on the lips may be caused by the herpes simplex virus. These lesions are also known as **fever blisters** or **cold sores**. However, because cancer of the lip is the most common oral cancer, lesions must be evaluated for cancer. Pallor or cyanosis of the lips may indicate hypoxia.

▶ A thin vermilion border may be a sign of fetal alcohol syndrome. The vermilion border may also be absent after reconstructive surgery for cleft lip or hemangioma resection.

2. **Inspect the teeth.**
   - Observe the patient's dental hygiene. Ask the patient to clench the teeth and smile while you observe occlusion (see Figure 15.26 ■).
   - Note dentures and caps at this time.
   - The teeth should be white, with smooth edges, and free of debris. Adults should have 32 permanent teeth, if wisdom teeth are intact.

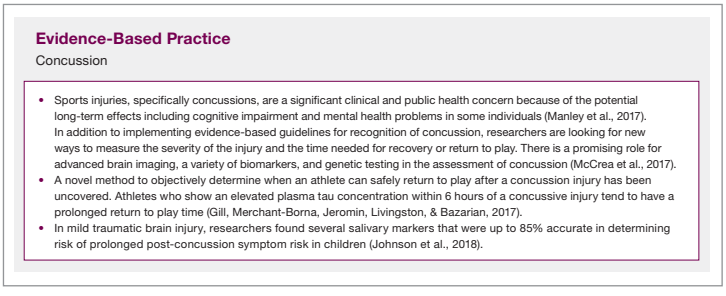
▶ Loose, painful, broken, or misaligned teeth; malocclusion; and inflamed gums need further evaluation.

Figure 15.26 Inspecting the teeth.

ALERT! *Do not percuss or palpate the patient who reports pain or discomfort in the pelvic region. Do not percuss or palpate the kidney if a tumor of the kidney is suspected, such as a neuroblastoma or Wilms' tumor. Palpation increases intra-abdominal pressure, which may contribute to intraperitoneal spreading of this neuroblastoma. Deep palpation should be performed only by experienced practitioners.*

Alert! boxes remind students of specific nursing care tips or signs to be aware of when performing a physical assessment and identify critical findings that the nurse should report immediately.

Familiarity with evidence-based practice information is critical for student success and nursing excellence. **NEW Evidence-Based Practice** boxes summarizing the findings of recent studies related to chapter content appear throughout the text.



Evidence-Based Practice

Concussion

- Sports injuries, specifically concussions, are a significant clinical and public health concern because of the potential long-term effects including cognitive impairment and mental health problems in some individuals (Manley et al., 2017). In addition to implementing evidence-based guidelines for recognition of concussion, researchers are looking for new ways to measure the severity of the injury and the time needed for recovery or return to play. There is a promising role for advanced brain imaging, a variety of biomarkers, and genetic testing in the assessment of concussion (McCrea et al., 2017).
- A novel method to objectively determine when an athlete can safely return to play after a concussion injury has been uncovered. Athletes who show an elevated plasma tau concentration within 6 hours of a concussive injury tend to have a prolonged return to play time (Gill, Merchant-Borna, Jeromin, Livingston, & Bazarian, 2017).
- In mild traumatic brain injury, researchers found several salivary markers that were up to 85% accurate in determining risk of prolonged post-concussion symptom risk in children (Johnson et al., 2018).

The **NEW Documenting Your Findings** sections explain the importance of documentation of assessment findings. There is a focus on the clear distinction between subjective and objective findings. Examples of findings for each body system are presented.

Documenting Your Findings

Documentation of assessment data—subjective and objective—must be accurate, professional, complete, and confidential.

Focused History (Subjective Data)

This is information from Review of Systems (ROS) and other pertinent history information that is or could be related to the patient's neurologic function.

Patient reports a change in coordination and balance. States difficulty in climbing stairs and doing usual stretching exercise routine. Denies history of head injury, seizures, migraines, or other neurologic illnesses. States no change in vision, hearing, taste, smell, sensation, or memory.

Physical Assessment (Objective Data)

Grooming and hygiene appropriate, posture erect, body language and facial expressions appropriate. Able to follow directions, complete calculations accurately, speech and language clear, abstract thinking and judgment intact. Oriented × 3. CN I–X11 intact. Positive Babinski. Unable to complete tandem walk or standing on one foot without losing balance. Upper extremity coordination and RAM intact. Sensation intact to light touch, sharp/dull, temperature, vibration, stereognosis.

Patient-Centered Interaction

Source: Olena Kachmar/123RF.

Ms. Angela Carbone, age 55, comes to the Medi-Center at 10:30 a.m. with the chief complaint of left back pain. She has some nausea but denies vomiting. She complains of dysuria and gross hematuria and indicates she had a kidney stone on the right side several years ago. The following is an excerpt from the focused interview with Ms. Carbone.

Interview

Nurse: Good morning. Ms. Carbone. Are you having pain now?

Ms. Carbone: **Yes, I am.**

Nurse: On a scale of zero to ten with ten being the highest, how do you rate your pain?

Ms. Carbone: **Now it is about four, but I'm afraid it will become ten or twelve like the last time.**

Nurse: I need to ask you some questions to get information from you. Will you be able to talk to me for a few minutes?

Ms. Carbone: **I think so! I'll try. I'll let you know if I can't sit any more.**

Nurse: Tell me about the pain.

Ms. Carbone: **I have back pain on my left side, right here (pointing to the left costovertebral area). It feels like it moves down my back but not all the time. It really hurts and is getting worse each day.**

Nurse: When did the pain start?

Ms. Carbone: **It started about five days ago. That's when I noticed my urine was darker than usual.**

Nurse: Did you do anything to help reduce the pain?

Ms. Carbone: **Not really. At first I thought I slept funny. Then my urine got darker. I tried to drink three glasses of water a day, but I became nauseated and had to stop drinking.**

Nurse: Earlier you commented that you are afraid the pain will become ten or twelve like the last time. Tell me more.

Ms. Carbone: **I had a kidney stone about three years ago on my right side. Now the pain is similar on the left side.**

Analysis

The nurse immediately asked Ms. Carbone about her current pain status to determine her ability to participate in the interview. Throughout the interview, the nurse used open-ended questions and leading statements. These statements encouraged verbalization by the patient to explore and describe actions and feelings in detail. The open-ended questions and leading statements permitted the patient to provide detail, thereby eliminating the need for multiple closed questions.

The **Patient-Centered Interaction** feature teaches effective communication skills. It presents a brief clinical scenario and interaction between the patient and the nurse. Each Patient-Centered Interaction includes assessment cues to help the student develop strong communication skills by addressing body language, cultural sensitivity and values, language barriers, and noncompliance. These are common issues that present challenges to nurses, and the Analysis at the end of each interaction offers the student goals that the nurse must obtain with this specific patient.

In **Abnormal Findings**, we provide a vivid atlas of illustrations and photographs that feature examples of abnormal findings, diseases, and conditions. This section helps the student recognize these conditions and distinguish them from normal findings before they see them in the clinical setting.

Abnormal Findings

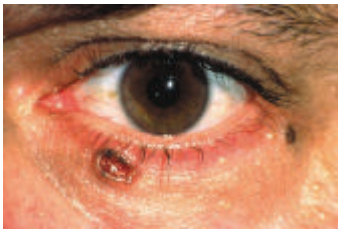
Abnormalities of the eye arise for a variety of reasons and can be associated with vision, eye movement, and the internal and external structures of the eye. The following sections address abnormal findings associated with the eyelids (see Table 14.2), the eye (see Table 14.3), and the **fundus** (see Table 14.4). In addition, an overview of conditions that may be associated with an impaired pupillary response is provided (see Table 14.5).

Table 14.2 Abnormalities of the Eyelids

Blepharitis
Blepharitis is inflammation of the eyelids. Staphylococcal infection leads to red, scaly, and crusted lids. The eye burns, itches, and tears.

Blepharitis.
Source: Gromovataya/Shutterstock.

Basal Cell Carcinoma
Usually seen on the lower lid and medial canthus. It has a papular appearance.



Basal cell carcinoma on lower eyelid.
Source: DR ZARA/BSIP SA/Alamy Stock Photo.

Application Through Critical Thinking

CASE STUDY

Source: logoboom/Shutterstock.

John Jerome is a 45-year-old male who made an appointment for an annual employment physical assessment. Mr. Jerome completed a written questionnaire in preparation for his meeting with a healthcare professional. He checked "none" for all categories of family history of disease except diabetes. He indicated that he knew of no changes in his health since his last assessment.

The focused history reveals the following:

A male wearing eyeglasses entered the room; he appears his stated age of 45 yrs. He turned his head to the left and right and looked about the room before sitting across from the examiner. The patient had some redness in the sclera of both eyes. During the interview, the patient reveals that his last eye examination occurred 6 months ago, and he received a prescription for new glasses. He states that he is still having a problem with the new glasses and needs to have them checked. When asked to describe the problem, Mr. Jerome replies, "I just don't feel right with these glasses, and these are the second pair in a little over a year." He further states, "I just think I am overworking my eyes lately. I need to rest them more than ever, and I have had some headaches. I thought the glasses would help, but it hasn't gotten better." The patient denies any other problems. In response to inquiries about family history, he reports that his mother had diabetes but had no problems with her eyes. He doesn't know of any other eye problems in his family, except his mother had told him that an aunt of hers had been blind for some time. He reiterates that his only problem of late has been "this thing with my glasses, otherwise I feel fine."

The physical assessment reveals the following:

- Vital signs: BP 128/84—P 88—RR 22
- Height 6'3", weight 188 lb
- Eyeballs firm to palpation
- Moderately dilated pupils

SAMPLE DOCUMENTATION

The following information is summarized from the case study.

SUBJECTIVE DATA: Visit for annual employment physical assessment. Negative family history except diabetes. No changes in health since last assessment. Last eye assessment 6 months ago—result prescription for new glasses. Stated he was having a problem with the new glasses. "I don't feel right with them." Stated, "I think I'm overworking my eyes lately. I thought the new glasses would help, but it hasn't gotten better." History of aunt with blindness.

OBJECTIVE DATA: Turns head to left and right and looked around room before sitting across from examiner. Scleral redness bilaterally. Eyeballs firm to palpation. Pupils moderate dilation. Cupping of optic discs. Height 6'3", weight 188 lb. VS: BP 128/84—P 88—RR 22.

CRITICAL THINKING QUESTIONS

1. What conclusions would the nurse reach based on the data?
2. How was this conclusion formulated?
3. What information is missing?
4. What is the priority for this patient, and what options would apply?
5. As Mr. Jerome ages, for what age-related vision changes will he be at risk?

In the **Application Through Critical Thinking** sections, we challenge students to apply critical thinking and clinical reasoning by working through a Case Study. After a detailed patient scenario, students will answer critical thinking questions and prepare documentation.

MYLAB NURSING

MyLab Nursing is an online learning and practice environment that, in tandem with the text, helps students master key concepts, prepare for the NCLEX-RN exam, and develop clinical reasoning skills. Through a new mobile app experience, students can study Pathophysiology: Concepts of Human Disease anytime, anywhere. New adaptive technology with remediation personalizes learning, moving students beyond memorization to true understanding and application of the content. MyLab Nursing contains the following features.

Dynamic Study Modules

New adaptive learning modules with remediation personalize the learning experience by allowing students to increase both their confidence and their performance while being assessed in real time.

NCLEX-Style Questions

Practice tests with more than a thousand NCLEX-style questions of various types build student confidence and prepare them for success on the NCLEX-RN exam. Questions are organized by chapter.

Decision-Making Cases

Clinical case studies provide opportunities for students to practice analyzing information and making important decisions at key moments in patient care scenarios. These 15 unfolding case studies are designed to help prepare students for clinical practice.

Pearson eText

Student learning is enhanced both in and outside the classroom. Students can take notes, highlight, and bookmark important content, or they can engage with interactive and rich media to achieve greater conceptual understanding of the text content. Physical examination sections are enhanced by videos illustrating the steps of the processes.

RESOURCES FOR FACULTY SUCCESS

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

- **TestGen Test Bank**
- **Lecture Note PowerPoints**
- **Instructor's Resource Manual**
- **Teaching Resources, including laboratory guides, laboratory activities, games, and demonstration videos**

ACKNOWLEDGMENTS

The fourth edition of this book would not have been possible without the contributions of many individuals. We especially want to thank Pamela Lappies, our development editor, who has provided invaluable support and guidance. Thanks also goes to Executive Portfolio Manager Pamela Fuller for her commitment to excellence in nursing education and dedication to shaping this updated book into the greatest possible resource for students. Special thanks goes to Portfolio Management Assistant Erin Sullivan for scheduling, supporting, and coordinating many pieces of this project.

DEDICATION

We dedicate this book to our families, friends, colleagues, and students.
We have been privileged to receive their loving support and encouragement.

Contents

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Chapter 1

Health Assessment

LEARNING OUTCOMES

Upon completion of the chapter, you will be able to:

1. Explain the roles of the professional nurse in healthcare.
2. Explain evidence-based practice and its significance in nursing.
3. Explain the steps of the nursing process.
4. Define health assessment and identify key components.
5. Apply the critical thinking process to health assessment in nursing.
6. Describe the concepts of health, wellness, and health disparities.
7. Examine how national health policy is structured to enhance individual and population health.

KEY TERMS

assessment, 4
critical thinking, 4
documentation, 6
focused interview, 6
health, 7
health assessment, 5
health disparity, 7
health history, 6
interpretation of findings, 5
interview, 6
nursing diagnosis, 5
nursing process, 4
objective data, 4
patient record, 6
physical assessment, 6
subjective data, 4
wellness, 7

Introduction

The complex nature of health, wellness, and provision of care in today's healthcare system in the United States has necessitated an expansion of the role of the nurse. In the past, healthcare focused on treatment of patients' illnesses and symptoms. The focus today is on a healthcare model that emphasizes wellness, health promotion, and disease prevention. This change in focus is behind the push for nurses to develop an expanded knowledge base, greater flexibility, and the ability to work in a variety

of settings and to practice to the full extent of their education and training (Institute of Medicine, 2011). Today's patients are taking a more active role in all aspects of their healthcare, from planning, screening, and decision making to choosing treatment modalities and prevention techniques. This chapter introduces the nursing process and focuses on the important first step: the foundational concepts of health and physical assessment that are the basis for the remaining chapters.

Health assessment is an integral part of the expanded role of the nurse and is performed in a variety of settings with patients across the lifespan. A broad definition of the assessment process is introduced in this chapter, whereas subsequent chapters in this unit provide detailed information in critical areas of health assessment (Health and Wellness; Cultural and Spiritual Considerations; and Health Disparities). Unit II provides detailed information regarding Techniques for Health Assessment, including Interviewing and Health History, Documentation, Techniques and Equipment, the Physical Exam, Pain Assessment, Nutrition Assessment, and Mental Health, Substance Use, and Violence Assessment. Unit III provides step-by-step guides for learning how to perform physical assessment of each body system. ∞

Role of the Professional Nurse

Nursing care is based on a foundation of education in the biologic and physical sciences, as well as the humanities and social sciences. From this foundation, the professional nurse may perform a variety of roles, including direct patient care, teaching, advocacy, and manager or coordinator of care. Using research data, standards of care, and the nursing process, the professional nurse provides competent care to individuals, families, communities, and populations. Additionally, the nurse may participate on interprofessional teams to plan and provide care for those with complex healthcare needs. The actions of the professional nurse will be directed to promote and support health and wellness, prevent injury and champion safety, and to treat and care for the ill and dying. To perform these actions, the nurse works in a variety of settings, including patients' homes, hospitals, clinics, nursing homes, schools, and workplaces. Advanced practice roles in nursing include researcher, nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), and clinical nurse specialist (CNS), as well as roles in administration and education. Each of these advanced roles requires education beyond that for entry into practice; this usually means earning a master's or doctoral degree in nursing or a related field.

Regardless of the setting, the role of the professional nurse is multifaceted. Each situation requires the professional nurse to use critical thinking and the nursing process. To provide the highest quality of care, the nurse will base all actions on the foundation of scientific evidence and best clinical judgment. Brief descriptions of the roles of the nurse are provided, but remember, in any situation, a nurse may perform multiple roles.

Teacher

As a teacher, the nurse helps the patient to acquire knowledge required for health maintenance or improvement, to prevent illness or injury, to manage therapies, and to make decisions about health and treatment. Teaching occurs in all settings and for a variety of reasons and may be informal or formal. Teaching is an important intervention to promote wellness and prevent illness or injury. Teaching is used when collection and analysis of patient data reveal a knowledge deficit or a need for education about an identified risk or when the patient displays a readiness to learn to enhance health. Teaching is a critically important role for nurses in all settings. The need for learning in individuals, families, and groups arises in response to lack of knowledge about common changes or risks that occur with aging, role change and development, illness, health promotion, and disease prevention. Teaching to help people and populations avoid illness and injury is called health promotion, which is addressed in detail in Chapter 2. ∞

Caregiver

The caregiver role has always been the traditional role of the nurse. Historically, physical care was the primary focus. Today, the nurse uses a holistic approach to nursing care. Using critical thinking and the nursing process, the professional nurse provides direct and indirect care to the patient. Indirect care is accomplished with the delegation of activities to other members of the team. As patient advocate, the nurse acts as a protector. Patients are kept informed of their rights, given information to make informed decisions, and encouraged to speak for themselves. As a case manager or care coordinator, the professional nurse helps to coordinate care, participates in the interprofessional team, and plans patient outcomes within a specific time frame. Providing care, containing costs, and identifying the effectiveness of the plan are all responsibilities of the professional nurse.

Advanced Practice Roles

Health policy and legislation provide for roles in nursing that require advanced formal education and may require certification. Professional nurses function in advanced roles, including but not limited to nurse researcher; nurse practitioner (NP); certified registered nurse anesthetist; certified nurse midwife (CNM); clinical nurse specialist (CNS); hospital, healthcare agency, or academic administrator; and various types of nurse educator. A brief description of these roles is included below. Please see the Appendix C for advanced practice assessment techniques usually used by NPs, CNSs, CNMs, and other advanced practice patient care roles. ∞

Nurse Researcher The nurse researcher identifies problems regarding patient care, designs plans of study, and develops tools. A nurse researcher may work in a clinic, hospital, or laboratory and be focused on patient care outcomes, administering treatments for a clinical trial, or collecting data to help understand population-based outcomes. The nurse performing the research adds to the body of knowledge of the profession, gives direction for future research, and improves patient care. Nurse researchers may also be engaged in continuous quality improvement projects in institutions and agencies. These advanced practice nurses may be doctorally prepared to conduct primary research or to lead in the dissemination of new evidence.

Nurse Practitioner The nurse practitioner has advanced degrees and is certified by the American Nurses Credentialing Center, American Association of Nurse Practitioners (AANP), Pediatric Nurse Certification Board, and other organizations. The NP practices independently in a variety of primary care or acute care settings. NPs typically specialize in a population, including family (FNP), geriatric (GNP), psychiatric–mental health (PMHNP), women's health (WHNP), pediatrics (PNP), or adults (ANP), as well as acuity-level acute care (AC) or primary care (PC). Nurse practitioners are clinicians who combine expertise in diagnosis and treatment of illness with a nurse's understanding of health promotion and prevention (AANP, 2017).

Nurse Anesthetist In addition to undergraduate nursing education, the CRNA has completed an accredited nurse anesthesia education program and passed a national certification examination. In collaboration with other healthcare providers, including anesthesiologists and surgeons, CRNAs provide a full range of anesthesia services. CRNAs are the sole providers of anesthesia care in most rural hospitals (American Association of Nurse Anesthetists, n.d.). CRNAs must maintain registered nurse licensure, as well as credentialing by the National Board of Certification and Recertification for Nurse Anesthetists.

Certified Nurse Midwife The American Midwifery Certification Board (AMCB) is the national certifying body for registered nurses who have earned their graduate-level education in an accredited program. A certified nurse midwife (CNM) is an advanced practice nurse who can practice independently and attends to the health and well-being of women in all ages and stages of life. Midwives provide general healthcare services; gynecologic services; family planning needs; care for pregnancy, labor, and birth; and menopause care.

Clinical Nurse Specialist Clinical nurse specialists have advanced education and degrees in a specific population of patients and/or aspect of practice. They provide direct patient care, direct and teach other team members providing care, and conduct nursing research within their area of specialization.

Nurse Administrator Today, the role of the nurse administrator, nurse leader, or nurse manager varies and may include professional titles of chief nursing officer, vice president of nursing services, supervisor, or clinical manager. The responsibilities vary and could include management of complex patient care areas, staffing, budgets, organizational and staff performance, consulting, and ensuring that the goals of the agency are being accomplished. Advanced degrees are usually required for these positions. It is common to find nurse administrators with advanced degrees in several disciplines, such as nursing and business administration (Martin & Warshawsky, 2017).

Nurse Educator The nurse educator is a nurse with advanced degrees and is employed to teach nursing in a variety of settings such as a university, community college, healthcare agency, or hospital. Teaching may include topics for pre-licensure students, nursing staff development, or continuing education for all levels of nurses. The educator is responsible for didactic and clinical teaching, curriculum development, clinical placement, and evaluation of learning.

Evidence-Based Practice

Evidence-based practice (EBP) in nursing is the use of a focused problem-solving approach to clinical decision making that involves the conscientious use of the best available scientific evidence, clinical expertise, and patient preferences and values (Melnyk & Fineout-Overholt, 2015). Evidence-based practice evolved from Florence Nightingale's work in the 1800s, through medical practice changes in the 1970s, and to the nursing profession beginning in the 1990s (Nightingale, 1969). Its origins came from Nightingale's revolutionary idea that through improvements in sanitation and nutrition, patients' health would improve. She kept records of patient conditions and outcomes before and after implementation of hygiene practices. This evidence, determined through experimentation, helped create the "best practice" guidelines for nurses in that era (Nightingale, 1969).

The modern beginnings of EBP can be traced to the 1970s and the work of Cochrane (Mackey & Bassendowski, 2017). Before his work, much of medical practice was carried out based on the individual physician's choices and assumptions. In the early 1970s systematic research studies, such as randomized controlled trials (RCT), were developed. It was discovered that many assumptions upon which medical care was implemented were unfounded. "Cochrane believed that limited resources would always be an issue within the healthcare system, and clinicians should strive to utilize only those procedures that had been proven to be the most effective" (Mackey & Bassendowski, 2017, p. 52). To be proven effective, an intervention, procedure, medication, or treatment regimen that was tested using the RCT methodology would be considered to be the highest quality evidence. In 1992, the term *evidence-based medicine* was coined and defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71)

In order to provide safe, effective, and competent care, nurses must incorporate evidence from the sciences, practical research, and best practice. As a nurse, you are expected to implement changes to practices based on scientific studies showing improvement in patient outcomes, increased patient satisfaction, and other metrics. The amount of time from bench research proving a positive outcome to implementation in practice-based policy has been as long as 15 years. That time gap has shortened in recent years because of a focus on quality improvement projects led by nurses, to the implementation of practice innovations, to the recognition of excellence by organizations, and from government agencies holding hospitals and other healthcare facilities to higher standards. The faster that best evidence is disseminated, the better the quality of patient care can be. It is the job of the nurse to stay abreast of changes to practice and to the innovations in medicine and healthcare (Melnyk & Fineout-Overholt, 2015).

The EBP movement is intended to influence outcomes in healthcare through the development of best practice policies and guidelines. The Agency for Healthcare Research and Quality (AHRQ), through Evidence-based Practice Centers (EPCs) in the United States and Canada, reviews scientific literature on clinical, behavioral, organizational, and financial topics to produce evidence reports and technology assessments. The

resulting evidence reports and technology assessments are used by federal and state agencies, private sector professional societies, health delivery systems, providers, payers, and others committed to evidence-based healthcare (AHRQ, n.d.). The work of the AHRQ is intended to improve healthcare through the support of research on the quality of services and patient outcomes. Further, the AHRQ translates research into practice through the provision of information needed to make critical decisions about healthcare (AHRQ, n.d.).

To promote the use of EBP and to facilitate achievement of the best possible patient outcomes, numerous clinical practice guidelines and recommendations have been developed. There are many sources for specific practice guidelines and recommendations, including the public resource: AHRQ's National Guideline Clearinghouse (https://www.guideline.gov). Nurses must make use of the best available evidence as they provide care and assist patients, families, and communities to achieve optimum health outcomes.

Nursing Process

The **nursing process** is a systematic, rational, dynamic, and cyclic process used by the nurse for assessing, planning, implementing, and evaluating care for the patient. To guide the practice of the professional nurse, the American Nurses Association (ANA) suggests the use of the *Standards of Practice* (ANA, 2015), which are based on the nursing process. The nursing process has five steps (see Figure 1.1 ■) including assessment, diagnosis, planning, implementation, and evaluation. Nurses use the nursing process along with critical thinking skills as the basis for the implementation of safe, competent patient care. **Critical thinking** may be defined as using cognitive skills to acquire new knowledge and making judgments in the processes of delivering safe quality healthcare (Nelson, 2017). The nursing process, along with critical thinking, can be used in any setting, with patients of all ages, and in all levels of health and illness.

To ensure that nursing care is comprehensive, evidence based, and appropriate, the nursing process begins with a comprehensive and systematic assessment of the patient. **Assessment** is the gathering of complete, accurate, and relevant data about the patient. The data gathered will include information that the patient tells the nurse—**subjective data**—and information the nurse measures or observes on the patient—**objective data**. During the process of gathering the subjective data from the patient, the nurse must be attuned to what the patient says, along with the signs, symptoms, behaviors, and cues offered by the patient. This situational awareness and focused data collection will enable the nurse to create a comprehensive database about the patient. Beginning with assessment, each step of the nursing process is defined in the following sections. Although the steps of the nursing process are identified as separate steps, in practice they are interrelated and overlap to varying degrees. It should be understood that the nursing process is cyclical, and when something changes for the patient, further information should be collected, which may change the diagnoses, interventions, and outcomes. The application and effective use of the

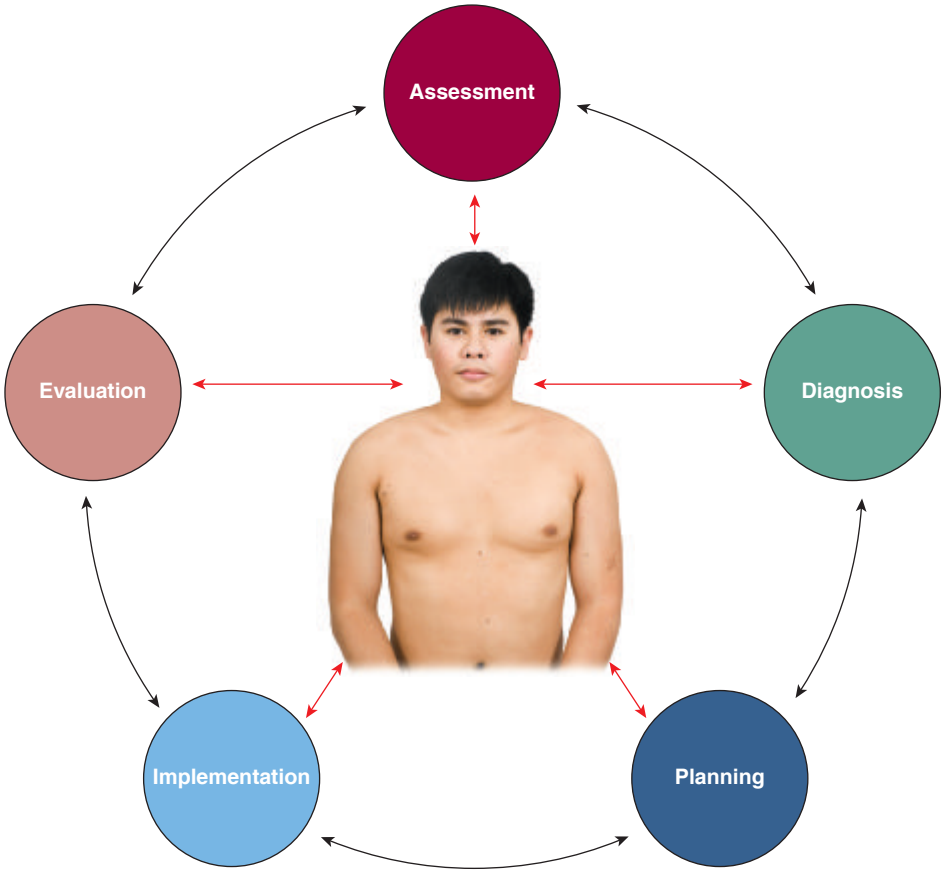

Figure 1.1 The nursing process.

nursing process is influenced by the ability of the nurse to adapt to changing conditions and to obtain comprehensive, accurate data. The comprehensive health assessment includes subjective and objective data obtained from primary or secondary sources. This information is collected to create a patient database from which a plan of care can be created that is patient centered and patient specific. This first step in the nursing process is then analyzed using the nurse's knowledge base and critical thinking skills to formulate patient-specific health goals to be addressed in the plan of care.

Assessment

Assessment, the first step of the nursing process, is the collection, organization, and validation of subjective and objective information or "data." It is imperative that the nurse understand the difference between subjective data, which consist of information that the patient experiences and reports to the nurse, and objective data, which are observed or measured by the nurse and include information that is heard, felt, seen, or sensed by the nurse. Subjective data are what the "subject" tells the nurse. Subjective data include the patient's perception of their health status, level of pain, history of health and illness, list of allergies, recall of food eaten, and medications being taken. Objective data may be found in charts and be relevant to growth and development or in laboratory values (e.g., hemoglobin, hematocrit, total cholesterol, blood glucose). Objective data also will be found upon examination of the patient and include vital signs, rate and quality of pulses, blood pressure, heart and lung sounds, skin texture, body temperature, and language development, among others. These two concepts are further examined throughout this text. This information forms a comprehensive *patient database*, which is used by the nurse to create the plan of care. The patient database describes the social, emotional, physical, and spiritual health status of the patient. Data are collected and documented in what is referred to as the patient's chart; the chart may be on paper or in the electronic health record (EHR), also known as an electronic medical record (EMR). In an assessment, the nurse gathers data about a patient by asking questions, taking measurements, and performing examinations, all in a systematic manner, which is covered in detail in this text.

Assessment begins when the nurse first encounters the patient or the patient chart. The nurse will use a variety of methods of data collection during the assessment process. The nurse will talk with the patient as well as look, listen, touch, and smell. Each sense will allow the nurse to learn different things about the patient. Each piece of information collected about a patient is important and adds to the picture of the total health status of the patient. As the assessment progresses, the answers and **interpretation of findings** will guide the nurse about what questions to ask next, and what additional information is needed.

Diagnosis

The second step of the nursing process is the formulation of a **nursing diagnosis**. The nurse uses critical thinking and applies knowledge from the sciences and other disciplines to organize, analyze, and synthesize the data. Subjective and objective data are compared with normative—expected—values and standards. All of the data, subjective and objective, are taken into consideration to determine areas where nursing intervention will support or improve health and wellness. Along with the assessment data, the nurse's knowledge base, experience, and personal characteristics influence the critical thinking process. Nursing diagnoses are relevant to patient problems and will be the focus of nursing care to reach a goal or outcome that is determined during the planning phase of the nursing process. To begin to develop nursing diagnoses, data are clustered or grouped together thematically. After analyzing and synthesizing the collected data, the nurse identifies an applicable nursing diagnosis, which is the basis for planning and implementing nursing care.

Planning

Planning is step three of the nursing process and involves identifying measurable patient goals or outcomes, setting priorities, and selecting evidence-based nursing interventions that promote achievement of the measurable patient goals or outcomes. When possible, the nurse must practice patient-centered care by including input from the patient, the family, and other involved healthcare providers. When formulating goals for nursing care, a useful mnemonic to remember is SMART. A nursing goal should always be specific, measurable, attainable, and relevant and should include a time element. These qualities are critical to the next steps of implementation and evaluation.

Implementation

Implementation is step four of the nursing process. During implementation, the nurse carries out specific, relevant nursing interventions meant to achieve the goals set in the planning phase. Implementation of evidence-based nursing interventions promotes the patient's achievement of the goals. If the nursing interventions are well thought out and specific to the patient and setting, they are more likely to be achieved. It is important to note that an intervention that works for one patient may need to be altered to work for a different patient. A thorough and comprehensive assessment will aid in the creation of patient-centered interventions.

Evaluation

The final step of the nursing process is evaluation. During this phase, the nurse evaluates the degree to which the patient has accomplished the identified goals or outcomes. If a SMART goal was developed in the planning phase, it should be easily measurable—for example, ambulation of 50 feet. Based on the evaluation, the nurse may need to revise or add to the elements of the nursing care plan—for example, revisions may include adding, changing, or discontinuing nursing diagnoses or nursing interventions.

It is important to point out that a single nursing diagnosis may generate more than one patient goal. Likewise, achievement of a single patient goal may require multiple nursing interventions.

Health Assessment

Health assessment is a process undertaken by the nurse to systematically collect subjective and objective information about a patient to create a comprehensive database for use in

planning care. The focus may be to determine the patient's current or ongoing health status, to predict risks to health and well-being, or to identify health-promoting activities. The setting and context in which the assessment takes place will guide the actions of the nurse during this process. Data related to the patient's health status will be collected and will include physical, social, cultural, environmental, and emotional factors. Further information may include wellness behaviors, illness signs and symptoms, patient strengths and weaknesses, and risk factors. During the health assessment process, the nurse will use a variety of sources to gather both subjective and objective data. The nursing knowledge base along with effective communication techniques and use of critical thinking skills are essential in helping the nurse to gather the detailed, complete, and relevant data needed to formulate a plan of care to meet the needs of the patient. The three parts of the complete health assessment are the interview, the physical assessment, and documentation of the findings. Each of these components is described in detail in Chapter 5, Interviewing and Health History: Subjective Data, Chapter 6, Documentation, and Chapter 8, General Survey and Physical Exam: Objective Data. ∞ Below you will find an overview of basic considerations related to health assessment of the ambulatory patient. A focus on the hospitalized and critically ill patient may require considerably more in-depth assessment processes and will be discussed in detail in Chapter 28, Complete Health Assessment. ∞

Subjective Data: The Interview

The nurse gathers subjective data throughout the interview, which is composed of the health history and either a comprehensive or focused **interview**. The data collected will come from primary and secondary sources.

Subjective data are sometimes referred to as covert (hidden) data or as a symptom because they are perceived by the primary source—the patient—and cannot be observed by others. In some situations, secondary sources—the family members or caregivers—report subjective data based on perceptions the patient has shared with them. This information is relevant when the patient is very ill and unable to communicate, and it is required when the patient is an infant or a child.

In the interview, the nurse will systematically gather information about the patient's health history and about the current state of health.

The Health History The purpose of the **health history** is to obtain information about the patient's health in his or her own words and based on the patient's own perceptions. During the health history portion of the interview, the nurse collects biographic data, perceptions about health, past and present history of illness and injury, family history, a review of body systems, and health patterns and practices. The health history provides cues regarding the patient's health and guides further data collection. The health history is the most important aspect of the assessment process. Detailed information on how to obtain a complete health history is presented in Chapter 5, Interviewing and Health History: Subjective Data. ∞ Following up on the information presented in the history, the nurse may determine areas where further details would be useful. This determination will lead the nurse to perform a focused interview.

The Focused Interview The **focused interview** is the portion of the interview in which the nurse asks the patient to clarify points, provide missing information, and elucidate information identified in the health history. The focused interview might zero in on one body system, for example, or on the family history of a disease. The nurse does not use a prepared set of questions but, rather, applies knowledge and critical thinking when asking specific and detailed questions or requesting descriptions of symptoms, feelings, or events. Therefore, the focused interview provides the means and opportunity to expand the subjective database regarding specific strengths, weaknesses, symptoms, or risk factors expressed by the patient or required by the nurse to begin to make reliable judgments about information and observations as part of planning care. In-depth information about the focused interview in health assessment is included in each chapter in Unit III of this text. ∞

Objective Data: Physical Assessment

The second phase of the health assessment is the **physical assessment**, the hands-on examination of the patient. Components of the physical assessment are the general survey and an examination of body systems. Objective data, observed or measured by the professional nurse during the physical assessment, will be combined with all other reliable sources of information to complete the comprehensive database on which care planning may be based. Objective data can be seen, felt, heard, or measured by the nurse—for example, skin color can be seen, a pulse can be felt, a cough can be heard, and a blood pressure can be measured. These objective data will be used in conjunction with the subjective data to complete the patient database. The accuracy of the objective data depends on the nurse's ability to systematically and consistently use evidence-based methods of data collection. Chapter 7, Physical Assessment Techniques and Equipment, and Chapter 8, General Survey and Physical Exam, provide more detailed information. ∞ Unit III includes descriptions of the physical assessment process for each body system. ∞

Documentation and Privacy

The last step in the preparation of a comprehensive patient database is **documentation**, the accurate and complete recording of all subjective and objective data collected during the interview and physical examination. The information is written or "charted" in a new patient record or added to an existing health record. This **patient record** is a legal document used to plan care, to communicate information between and among healthcare providers, and to monitor quality of care. Further, the patient record provides information used for reimbursement of services and is often a source of data for research. The patient record is reviewed by accrediting agencies to determine adherence to standards. Nursing documentation should be concise, precise, succinct, and professional; the data recorded are to be free of judgment, bias, or value statements. The types and amounts of documentation are determined by the purpose of the healthcare service and often by the setting. Chapter 6, Documentation, provides more detailed information. ∞

The documentation in the patient record must be kept confidential according to federal regulations regarding patient privacy including the Health Insurance Portability and Accountability Act (HIPAA). Regulations under this law became effective in April 2003 to create a national standard for privacy and to provide individuals with greater control over personal health information. The HIPAA regulations protect medical records and other individually identifiable health information, whether communicated in writing, orally, or electronically. Identifiable health information includes demographic data and any information that could be used to identify an individual. For further information about HIPAA regulations, contact the U.S. Department of Health and Human Services (USDHHS, 2012).

Critical Thinking

Critical thinking in nursing is a cognitive process of purposeful and rational analysis of information to enable clinical reasoning, judgment, and decision making. Key elements of critical thinking include collection of information, analysis of situation, generation of alternatives, selection of alternatives, and evaluation, as shown in Figure 1.2 ■. Chan's (2013) systematic review of qualitative studies reported that critical thinkers demonstrate four characteristics: seek and gather information; question the quality of the data and investigate sources; examine, analyze, and evaluate data to draw conclusions; and finally, apply the theory or solution to the problem. Competence in critical thinking is central to all nursing activities and is at the core of the application of the nursing process (Perez et al., 2015). Critical thinking is more than problem solving; it is a way to apply logic and cognitive skills to the complexities of patient care. It requires nurses to avoid bias and prejudice in their approach while using all of the knowledge and resources at their disposal to assist patients in achieving health goals or maintaining well-being (Alfaro-LeFevre, 2013). The process of critical thinking parallels the nursing process in that information is gathered (assessment); problems are identified (diagnosis); goals, outcomes, or solutions are chosen (planning); interventions or possible solutions for meeting the goals are selected and implemented (implementation); and finally the nurse evaluates whether or not the problem is solved and determines if the interventions worked, reexamines the original problem, and determines if a new problem exists to examine (evaluation).

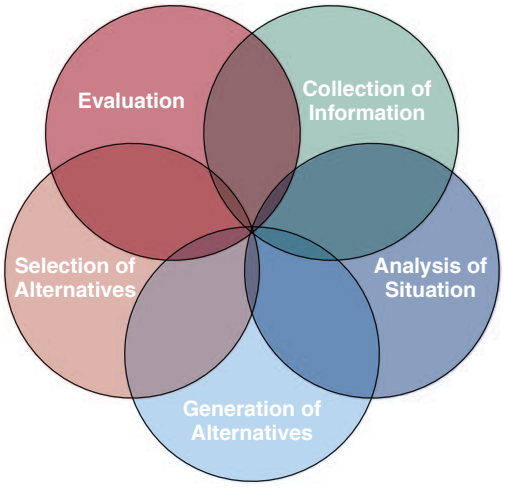

Figure 1.2 Elements of critical thinking.

Health and Health Disparities

Traditionally, **health** has been thought of as the absence of disease. The terms *health* and *wellness* are often used interchangeably to describe the state when one is not sick. However, the concept of health extends beyond freedom from physical illness. When considered from a holistic approach, health include psychosocial and spiritual components as well. **Wellness** describes a state of being that is balanced, personally satisfying, and characterized by the ability to adapt and to participate in activities that enhance quality of life. Health and wellness, which incorporate personal responsibility and choices regarding lifestyle and environmental factors, are discussed in depth in Chapter 2, Health and Wellness. ∞

The nurse must understand that health, when examined from a national perspective, is more than an individual concern. Health and wellness are also considered relative to populations or groups of individuals. In the United States, the USDHHS joined the healthcare reform movement with its 1979 report entitled *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. The efforts of this agency to address national concerns for health and safety continue with reports by an advisory committee to the Secretary of the USDHHS. The committee, made up of industry and academic leaders in health policy, medicine, nursing, oral health, child health, wellness, safety, and disease prevention, develops a 10-year plan, the first of which was called *Healthy People 1990*. It has revised and republished the report for the subsequent decades: 2000, 2010, and 2020. *Healthy People 2030*, which has not been released as of this writing, will contain national health promotion and disease prevention objectives based on public input, scientific knowledge, and outcome evaluation from previous years (Office of Disease Prevention and Health Promotion [ODPHP], 2017b).

The initiatives of *Healthy People*, as well as the focus on prevention and wellness, take into account the needs of a wide range of individuals and communities. An important concept when considering the health of individuals, communities, and populations is that health outcomes and conditions affect different groups in uneven ways. This is the concept of **health disparity**: "[I]f a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, gender, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health" (ODPHP, 2017b, para. 1). What this means for nurses is recognizing that these social determinants will have an impact on the health outcomes on specific populations. The nurse, in the assessment process, is careful to understand the variety of factors that will impact the patient's health status. Disparities in healthcare are discussed in depth in Chapter 4, Health Disparities. ∞

Application Through Critical Thinking

CASE STUDY

Source: Pressmaster/ Shutterstock.

Mary Wong is a 19-year-old college freshman living in the dormitory. She has come to the University Health Center with the following complaints: nausea, vomiting, abdominal pain increasing in severity, diarrhea, a fever, and dry mouth. She tells you, the nurse, "I have had abdominal pain for about twelve hours with nausea, vomiting, and diarrhea." These symptoms, she tells you, "all started after supper in the student cafeteria on campus."

You conduct an interview and follow it with a physical assessment, which reveals the following: symmetric abdomen, bowel sounds in all quadrants, tender to palpation in the lower quadrants, guarding. Mary's skin is warm and moist, her lips and mucous membranes are dry.

CRITICAL THINKING QUESTIONS

1. Identify the findings as objective or subjective data.
2. What factors must be considered in conducting the comprehensive health assessment of Mary Wong? Provide a rationale.
3. How would you cluster the data you obtained from your history and physical examination of Mary?
4. Before developing a nursing diagnosis, what must you do?

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Chapter 2

Health and Wellness

LEARNING OUTCOMES

Upon completion of this chapter, you will be able to:

1. Describe the importance of nursing theory to the practice of nursing and health assessment.
2. Describe the concepts of health, wellness, and health promotion.
3. Relate perspectives of health promotion to the individual, family, and community.
4. Demonstrate how to use the nursing process to encourage health promotion.

KEY TERMS

health promotion, 12
primary prevention, 11
secondary prevention, 12
tertiary prevention, 12
wellness, 11
wellness theories, 11

Introduction

To expand on the definitions of health and wellness introduced in Chapter 1, this chapter presents an overview of the importance of nursing theory to the science and art of nursing. In addition, this chapter presents the concept of health promotion in nursing as it applies to patients, families, and communities. It is within this context that you will conduct the practice of nursing and develop a broad foundation for the use of the nursing process. This chapter introduces the notion that *how* the nursing assessment is conducted gives the nurse vital information about the patient's perceptions of health, wellness, and health promotion. In order to gather the data that will be relevant to the care of a specific patient in a specific setting, you must be able to choose an appropriate approach to the process. Having an understanding of the various ways of thinking about nursing care will enable you to choose the relevant questions to ask, to prioritize the patient's needs, and to be efficient and effective in carrying out your nursing care. The remainder of Unit I consists of an overview of cultural and spiritual considerations as they relate to health and physical assessment, and populations at risk for poor health outcomes—health disparities—are covered in depth.

Nursing Theory and Foundations

Nursing is more than a set of skills or a functional process. As a discipline and profession, it has a unique identity and is underpinned by a "commitment to values, knowledge, and processes to guide the thought and work of the discipline" (Parker & Smith, 2015, p. 4). This body of knowledge has been built over time and has at its foundation the theories of nursing. The act of explaining, describing, or predicting what goes on around you is the simplest definition of a theory. Nurses, as scientists, may wonder "Why do my patients get well?" or "Why does the young patient regress while hospitalized?" or "Why does the body become hypoglycemic?" These questions, stemming from curiosity about the phenomena nurses see happening around them, are the starting point for theorizing (McKenna, Pajnkihar, & Murphy, 2014). Modern nursing care is founded on the innate curiosity of nurses, and the testing of theories about health and wellness.

Florence Nightingale (1865), for example, developed questions about why patients were dying from infection; these questions were based on her observations and experience. She theorized that if the environment were more sanitary, soldiers would be in the best position to let nature cure them (Nightingale, 1865). This deceptively simple way of thinking is the way that theories of nursing have developed. There are many books that go into great detail about nursing theory. This chapter will introduce just a few of the common nursing theories that have been tested over time and have been shown to help nurses organize their thinking about nursing as well as the practice of nursing care.

Models of Health

The following are commonly accepted models that explain the concept of health:

- In the *clinical model*, health is defined as the absence of disease or injury. The aim of the care by the health professional is to relieve signs and symptoms of disease, relieve pain, and eliminate malfunction of physiologic symptoms.
- The *adaptive model* highlights the individual's abilities and flexibility in a challenging environment (Ebrahimi, Wilhlemson, Moore, & Jakobsson, 2012).
- The *ecologic model* developed by Leavell and Clark (1965) examines the interaction of agent, host, and environment. Health is present when these three variables are in harmony. When this harmony is disrupted, health is not maintained at its highest level and illness and disease occur.
- In the *role performance model*, health is defined in terms of an individual's ability to perform social roles (Anderson & Tomlinson, 1992). This model also includes the concept of the "sick role."
- The *eudaemonistic model* views individuals as civilized and cultured who have the capacity for continued growth. In this model, the definition of health is the fulfillment of a person's potential (Ebrahimi et al., 2012).
- The *health promotion model* defines health as the actualization of inherent and acquired human potential through goal-directed behavior, competent self-care, and satisfying relationships with others while adjustments are made to maintain structural integrity and harmony with relevant environments (Pender, Murdaugh, & Parsons, 2015).

Health is highly individualized, and the definition one develops for one's self will be influenced by many factors. These factors will include but are not to limited to age, gender, race, family, culture, religion, socioeconomic conditions, environment, previous experiences, and self-expectations.

Nurses must recognize that each patient will have personal definitions for health, illness, and wellness. Likewise, health-related behaviors will be unique for each patient. Nurses must be aware of their own personal definition of health while also accepting and respecting the patient's definition of health. When health is defined in terms of physical change, the practice focus is on improvement of physical function. When health is considered to be reflective of physical, cultural, environmental, psychologic, and social factors, the focus of nursing practice is more holistic and wide ranging. Any combination of the previously mentioned health models may be used by the professional nurse and other members of the health team as a paradigm for the design and delivery of health care.

Health, Wellness, and Health Promotion

The state of healthcare today underscores the importance of health, wellness, health promotion, disease prevention, and health maintenance. Consumers of healthcare are sophisticated and have access to a wealth of ever-expanding medical knowledge. They are more active in making healthcare decisions and want to have input on how their healthcare is delivered. As the patient now has more control regarding the planning, implementation, and evaluation of strategies and outcomes of health, so the roles of the healthcare providers, including the nurse, have expanded.

Individuals are more conscious of health and wellness than in the past and have become more proactive regarding health and healthcare practices. This requires a stronger emphasis on wellness, health promotion, and disease prevention. A national focus on prevention is supported by several governmental agencies. One is the creation in 1984 of the U.S. Preventive Services Task Force (USPSTF), an independent group of national experts in prevention and evidence-based medicine. The USPSTF makes recommendations based on the best current evidence about screenings, counseling services, and preventive medications (Agency for Healthcare Research and Quality, 2017). Another is *Healthy People 2020*, whose agenda describes 10-year national objectives for improving the health of all Americans (Office of Disease Prevention and Health Promotion [ODPCP], 2017). Each topic area is linked to objectives related to health improvement. The objectives serve as a foundation for the development of plans to improve health for both individuals and communities. Many of the plans to improve health incorporate the promotion of screening for health problems as well as implementation of preventive measures, including immunization, increased physical activity, and education regarding all aspects of health (ODPHP, 2017).

Healthy People 2020 is a comprehensive framework that includes 42 topic areas, each with objectives, interventions, and resources for achievement of the health goal. The vision of *Healthy People 2020* is to achieve "a society in which all people live long, healthy lives" (ODPHP, 2017). Goals to meet this vision include factors that influence individual and community health and wellness. You are encouraged to explore the HealthyPeople.gov website to learn more about all of the initiatives, goals, and stories related to community engagement. ∞

Definitions of Health

In 1947, the World Health Organization (WHO) presented a definition of health that remains active today: Health is "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity" (WHO, 2018, para. 1). Although this definition is accepted and understood by most people in developed countries, there are efforts to adapt this definition to include concepts more relevant to indigenous populations across the world (Charlier et al., 2017). In addition to the accepted model of health as incorporating body, mind, and social health, the authors propose to include the concept of "equilibrium of human mankind within its environment" (p. 34). This refers to the interface between humans and the environment that may be conceptualized as "planetary health" and adds a new dimension to the historic definitions of health (Charlier et al., 2017). The traditional definition may also be of limited usefulness when referring to the health status of individuals living with chronic conditions and disabilities (Witt et al., 2017). In the definition, there is a focus on complete well-being, which may not be attainable for some individuals (Witt et al., 2017). These ideas are encouraging nurses to reexamine how they provide nursing care to the patients, families, and communities they serve and to expand the focus of nursing care beyond the traditional definitions. Some of the traditional models and definitions related to health, wellness, and health promotion described in this chapter provide evidence that nurses view health as far more than the absence of illness, disease, and symptoms.

The following traditional definitions of health reflect the work of selected nursing theorists:

- A state of being and the process of becoming whole and integrated in a way that reflects person and environment mutuality (Roy & Andrews, 1999)
- The state of a person as characterized by soundness or wholeness of developed human structures, and mental and bodily functioning that requires therapeutic self-care (Orem, 1971)
- A culturally defined, valued, and practiced state of well-being reflective of the ability to perform role activities (Leininger, 2007)
- A state of well-being and use of every power the person possesses to the fullest extent (Nightingale, 1865)

Definitions and Theories of Wellness

Wellness describes a state of life that is balanced, personally satisfying, and characterized by the ability to adapt and to participate in activities that enhance quality of life. Concepts basic to wellness include self-responsibility and decision making regarding nutrition, physical fitness, stress management, emotional growth and well-being, personal safety, and healthcare. **Wellness theories** describe ways the nurse may approach patient care. An understanding of the patient's perceptions of wellness influence the nurse's approach to patient care. When using a wellness perspective, the nurse focuses on the patient's personal strengths and abilities to enhance health. The goals of nursing care are to assist the patient to participate in health-promoting activities, prevent illness, and seek help for needs and problems. In addition, the nurse focuses on the wellness concerns of the patient and supports the patient's spiritual and end-of-life needs. Theories regarding wellness can assist nurses to clarify their perceptions of wellness. The following theories focus on wellness but also, in some cases, include prevention of illness or injury.

Dunn (1973) defined wellness for the individual as an integrated method of functioning that is oriented toward maximizing the potential of which the individual is capable. It requires the individual to maintain a continuum of balance and purposeful direction within the environment where he or she is functioning. This theory is seen as a grid with two intersecting axes. Health intersects with environment, creating four quadrants (see Figure 2.1 ■). The health axis extends from peak wellness to death, creating various degrees of health and illness. The environmental axis moves from a very favorable environment to a very unfavorable environment. This model takes into consideration the uniqueness of the individual and the influence of family and community regarding healthcare practices (Dunn, 1973).

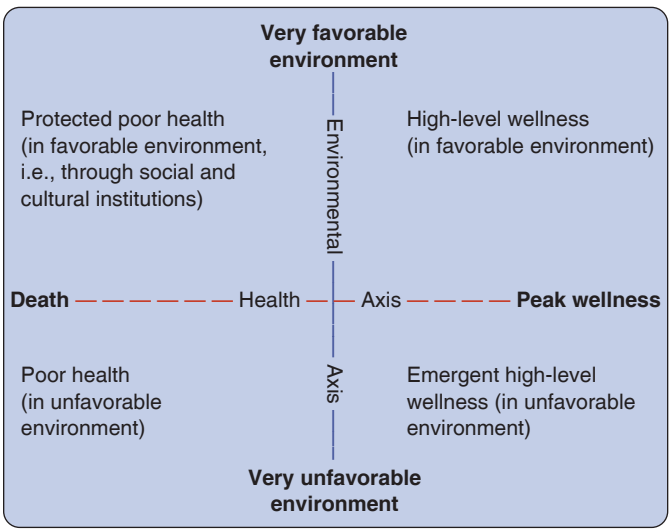

Figure 2.1 Dunn's model of wellness.

Leavell and Clark (1965) described primary, secondary, and tertiary levels of prevention in the healthcare system. In their model, actions are taken to maintain health, prevent illness, provide early detection of a disease, and restore the individual to the highest level of optimum functioning (see Figure 2.2 ■). The key word to emphasize as the focus of primary prevention is *prepathogenic*—that is, before the development of disease or pathology. Actions are taken to prevent disease, illness, or injury. **Primary prevention** implies health and a high level of wellness for the individual. Immunizations, a healthy diet, health teaching, genetic counseling, and the correct use of safety equipment at work are examples of primary prevention strategies (Leavell & Clark, 1965).

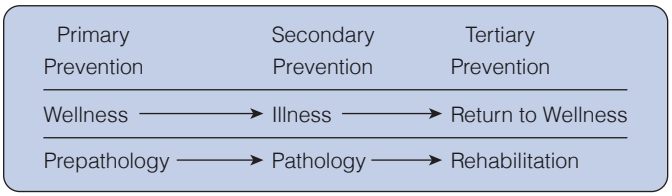

Figure 2.2 Levels of prevention.

Early diagnosis of health problems—and prompt treatment with the restoration of health—is the focus of **secondary prevention**. Emphasis is on resolving health problems and preventing serious consequences. Screenings, blood tests, x-rays, surgery, and dental care are strategies used at this level of prevention. **Tertiary prevention** is activity aimed at restoring the individual to the highest possible level of health and functioning. Rehabilitation is the focus for tertiary prevention. Strategies include use of rehabilitation centers for orthopedic and neurologic problems. Teaching the patient and family members interventions to improve coping with a chronic illness and recognition of complications are examples of tertiary prevention strategies. Table 2.1 provides examples of nursing considerations in relation to the levels of prevention.

Hattie, Myers, and Sweeney (2004) endorse a holistic model of wellness and prevention that incorporates an awareness of the many factors that influence individuals, including global events, family and community, religion, media and the government, education, and business. These outside forces are viewed through the lens of five life tasks, including work and leisure, friendship, love, self-direction, and spirituality. The life task of self-direction is influenced by personal choices about nutrition, exercise, self-care, stress management, gender identity, cultural identity, sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, and sense of humor. These tasks must be in balance for individuals to attain wellness (Hattie et al., 2004).

Definitions of Health Promotion

Health promotion refers to those actions used to increase health or well-being and the improvement of the health of individuals, families, and communities. At its core, health promotion includes the work required for the prevention of disease and injury, but it also includes teaching and guidance to help patients reach the goals of optimum health. These efforts which lead to absence of illness are the activities of health promotion.

Pender et al. (2015) define *health promotion* as "behavior motivated by the desire to increase well-being and actualize human health potential" (p. 5). Examples of health promotion activities include but are not limited to health screenings and vaccinations, weight-control measures, exercise, management of stress, smoking cessation, anticipatory guidance for families, and coping with life experiences.

Perspectives on Health Promotion

The role of the nurse as teacher is often employed in the promotion of health for individuals, families, and communities. Understanding nursing theories, knowing the definitions of health and wellness, and having a comprehensive nursing knowledge base are necessary in order to help patients reach or maintain their optimum level of health. Health promotion is often part of the process of the interview—as you learn what the patient needs to know, you determine the best way to convey that information. Nurses must take into account the individual's health status or level of wellness, relevant risk factors, physical fitness, nutrition, health behaviors, and lifestyle. This information is revealed during the nursing assessment and while obtaining the health history. Health promotion is based on a patient's current health status along with an assessment of teaching needs.

Health promotion may be viewed from the perspective of the patient, the family unit, or a community or population. Individuals may have risk factors that make them vulnerable to certain conditions, illnesses, diseases, or injury. Some of these are modifiable, some are not. Those risk factors that are inherent to the individual and cannot be controlled include age, genetic factors, biologic characteristics, and family history. Individual health promotion includes the identification of lifestyle and environmental risks that influence the level of wellness, as well as promoting efforts to reduce or eliminate those risks. Families and communities can be understood to experience risk factors as well. Families in rural communities may have limited access to specialty healthcare; particular geographic areas have populations at higher risk for disease such as the Zika virus outbreak in the southern

Table 2.1 Levels of Prevention

LEVEL OF PREVENTION	FOCUS	EXAMPLES
Primary	Improving overall health	Education about diet, exercise, environmental hazards, accident protection
	Health promotion	Immunization
	Prevention of illness, injury	Assessment of risks for injury, illness
Secondary	Early identification of illness	Health screening and diagnostic procedures
		Promotion of regular healthcare examinations across the life span
	Treatment for existing health problems	Regimens for treatment of illness
Tertiary	Return to optimum level of wellness after an illness or injury has occurred	Education to reduce or prevent complications of disease
	Prevention of recurrence of problems	Referral to rehabilitation services

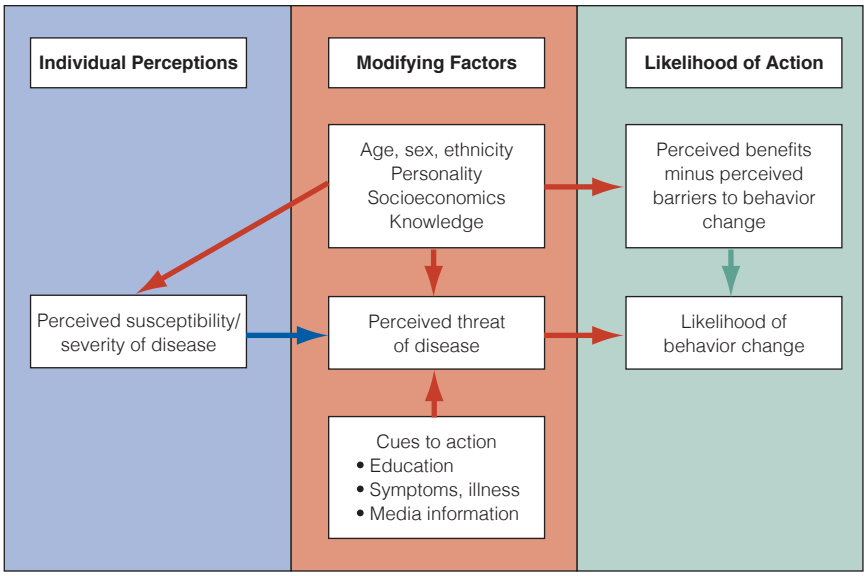

Figure 2.3 Health belief model.

United States. The following models illustrate approaches to health promotion at the individual patient level. These models may help you understand individual health behaviors and guide you in planning nursing interventions.

Health Belief Model

The *health belief model* (Rosenstock, 1974) was developed to predict who would participate in health screenings or obtain vaccinations (see Figure 2.3 ■). According to the health belief model, the following individual perceptions and beliefs influence the decision to act to prevent illness:

- One is vulnerable to an illness.
- The effects of the illness are serious.
- The behavior prevents the illness.
- The benefit of reducing a risk is greater than the cost of the preventive behavior.

Mediating variables influence individual perceptions. The first of the variables is *perceived susceptibility*—that is, the belief about the likelihood of developing an illness. *Perceived severity* is the second variable and refers to the individual's determination of how serious an illness would be. The severity includes the physical, psychologic, and social effects of illness. Another variable is the *perceived cost* of the health-promoting behavior. This refers to factors that interfere with the performance of a behavior. The individual must weigh the physical and psychologic costs versus the benefit.

The health belief model includes two constructs: (1) cues to action and (2) self-efficacy. Cues to action are internal and external stimuli that affect the individual's motivation to participate in health-promoting activities. For example, heart disease in a family member or knowledge about the Great American Smokeout, a mass media campaign by the American Cancer Society, may motivate one to stop smoking. Self-efficacy refers to the level of self-confidence an individual has about the ability to perform or be successful in the activity.

Last, mediating factors affect the health-promoting behaviors by influencing the perceptions of vulnerability, severity, effectiveness, and cost. Mediating factors include age, gender, ethnicity, education, and economic status.

Theory of Reasoned Action/Planned Behavior

The theory of reasoned action/planned behavior is a prediction theory representing a sociopsychologic method for predicting health behavior (see Figure 2.4 ■). The theory of reasoned action/planned behavior is based on the assumptions that behavior is under volitional control and that people are rational beings. The theory holds that the intention to perform a behavior is a determinant in performance of the behavior (Ajzen, 1991).

Three variables affect the intention to perform a behavior: subjective norms, attitudes, and self-efficacy. *Subjective norms* refer to the individual's perception of what significant others believe or expect in relation to the individual's performance of a behavior. For example, whether one intends to begin a daily exercise program would be influenced by what one believes a spouse's opinion of the activity would be. *Attitudes* refer to value assigned to a particular behavior. An attitude someone

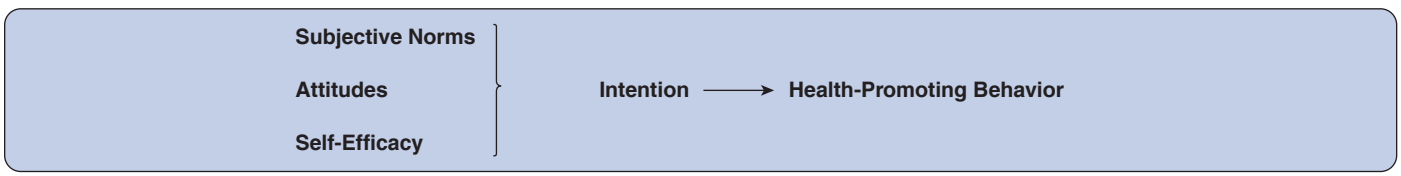

Figure 2.4 Theory of reasoned action/planned behavior.

holds may be that eliminating saturated fat from the diet is a good way to prevent heart disease. *Self-efficacy* refers to the level of confidence in one's ability to perform a behavior (e.g., feeling confident that one can avoid saturated fats in the diet). According to the theory of reasoned action/planned behavior, an individual is likely to engage in health-promoting behavior when the individual believes that the benefit outweighs the cost.

Health Promotion Model

The *health promotion model* (Pender et al., 2015) is a competence model. This model describes "the multidimensional nature of persons interacting with their interpersonal and physical environments as they pursue health" (p. 44). Along with emphasizing individual characteristics and behaviors, the health promotion model focuses on variables that impact motivation and behavioral outcomes (see Figure 2.5 ■). The health promotion model provides a framework through which nurses can develop strategies to assist individuals to engage in health-promoting activities. Each aspect of the model is discussed in the following sections of this chapter.

Individual Characteristics and Behaviors According to the health promotion model, prior related behaviors and personal factors have an effect on future behaviors. Prior related behaviors include knowledge, skill, and experience with health-promoting activities. Prior behavior can have a positive or negative effect on health promotion. When one has engaged in health promotion and recognized the benefit, it is likely that health-promoting behavior will occur in the future. Conversely, when health-promoting activities have been difficult or when barriers to participation have arisen, one is less likely to participate in health promotion in the future.

Personal factors that can influence behavior are biologic, psychologic, and sociologic. Biologic factors include age, gender, body mass index, strength, agility, and balance. Psychologic factors refer to self-esteem, motivation, and perceptions of one's health status. Socioeconomic status, education, race, and ethnicity are among the sociologic factors considered within the health promotion model.

Behavior-Specific Cognition and Affect Behavior-specific cognition and affect are variables that impact motivation to begin and continue activities to promote health. These variables include perceived benefit of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational influences.

PERCEIVED BENEFITS OF ACTION Engagement in a particular behavior is determined by the belief that the behavior is beneficial or results in a positive outcome. Benefits may be intrinsic, such as stress reduction, or extrinsic, such as financial reward. Perceived benefits of action motivate the individual to participate in health-promoting activities.

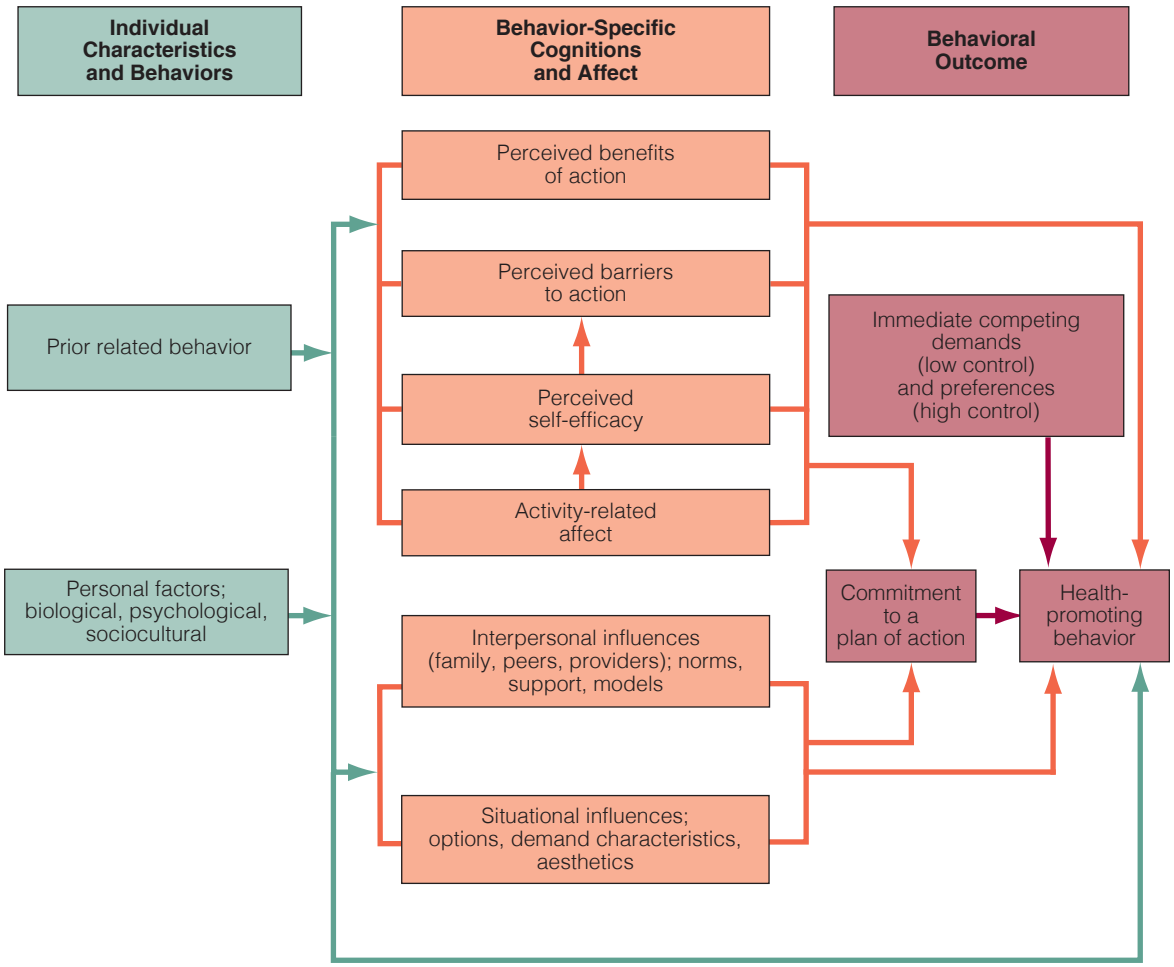

Figure 2.5 Health promotion model.

PERCEIVED BARRIERS TO ACTION Barriers to participation in health-promoting activities may be real or imagined. The barriers include perceptions about the availability, expense, convenience, difficulty, and time required for an activity. Barriers are seen as hurdles and personal costs of participating in a behavior.

PERCEIVED SELF-EFFICACY Perceived self-efficacy is a judgment of one's ability to successfully participate in a health-promoting activity to achieve a desired outcome. Individuals with high self-efficacy are more likely to overcome barriers and commit to health-promoting activity. Those with low self-efficacy have diminished efforts or cease participation in activities.

ACTIVITY-RELATED AFFECT Activity-related affect refers to subjective feelings before, during, and after an activity. The positive or negative feelings influence whether a behavior will be repeated or avoided.

INTERPERSONAL INFLUENCES Interpersonal influences are the individual's perceptions of the behaviors, beliefs, or attitudes of others. The family, peers, and health professionals are interpersonal influences on health-promoting behaviors. These influences also include expectations of others, social support, and modeling the behaviors of others.

SITUATIONAL INFLUENCES Situational influences include perceptions and ideas about situations or contexts. Situational influences on health-promoting activities include perceptions of available options, demand characteristics, and aesthetics of an environment. Access to a cafeteria offering healthy foods at work or having a gym nearby are examples of available options that promote health. Demand characteristics include policies and procedures in employment and public environments. No-smoking policies in public buildings and work environments are demand characteristics that promote health. Aesthetics refers to the physical and interpersonal characteristics of environments. Environments that are safe and interesting and promote comfort and acceptance versus alienation are factors that facilitate health promotion.

Situational influences may be direct or indirect. For example, the requirement to wear protective eyewear and gloves in a microbiology laboratory creates a direct demand characteristic—that is, employees must comply with the regulation.

COMMITMENT TO A PLAN OF ACTION Commitment to a plan of action includes two components: The first component is commitment to carry out a specific activity. The second component is identification of strategies for carrying out and reinforcing the activity. Commitment without strategies often leads to "good intentions" but results in failure to actually carry out the activity.

IMMEDIATE COMPETING DEMANDS AND PREFERENCES Competing demands are alternative activities over which the individual has little control. These demands include family or work responsibilities. Neglect of competing demands may have a more negative impact on health than nonparticipation in a planned health-promoting activity. Competing preferences are alternative behaviors over which the individual has high control. The control is dependent on the ability to self-regulate. Choosing to have lunch with a friend at the health club rather than participating in the aerobics class is an example of choosing the competing preference over the health-promoting activity. Unless an individual can recognize, address, or overcome competing demands and preferences, a plan for health promotion may unravel.

BEHAVIORAL OUTCOMES Health-promoting behavior is the expected outcome in the health promotion model. Health-promoting behaviors can lead to improved health, better functional ability, and improved quality of life across the age span. An example of application of each of the models is presented in Figures 2.6 ■, 2.7 ■, and 2.8 ■. The information is derived from the following case study.

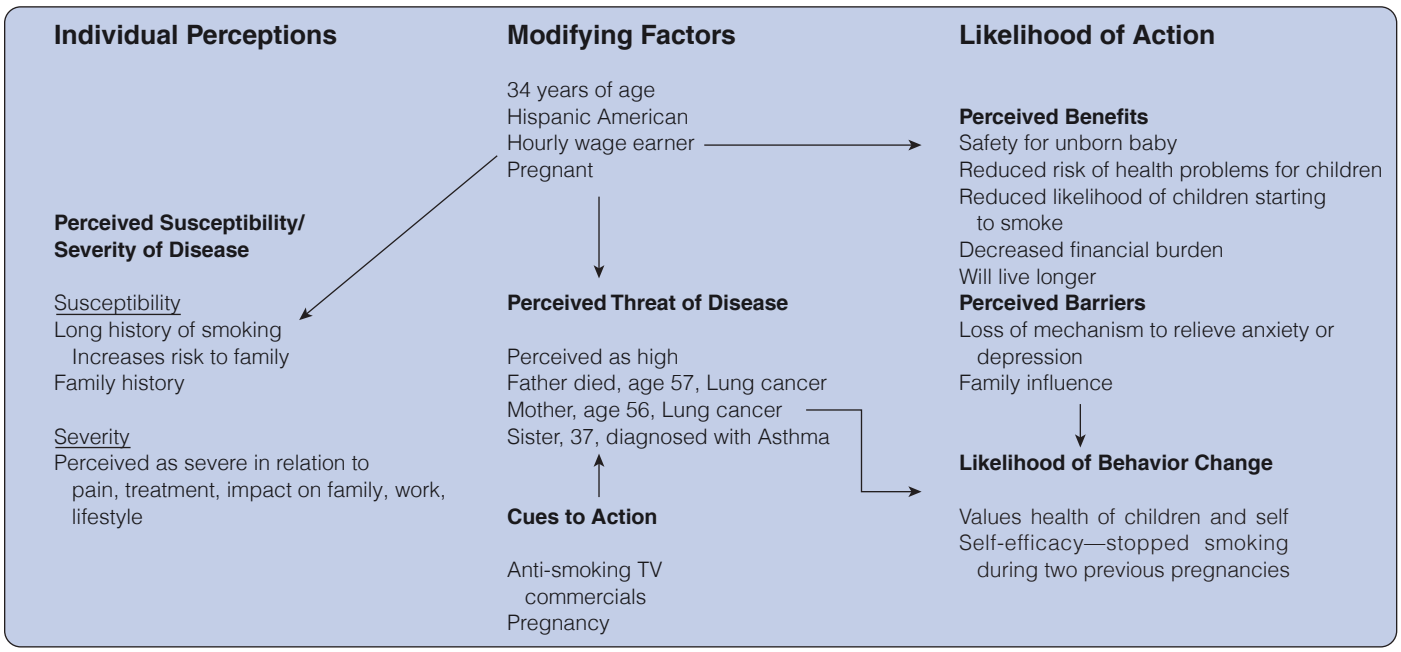

Figure 2.6 Application of the health belief model.

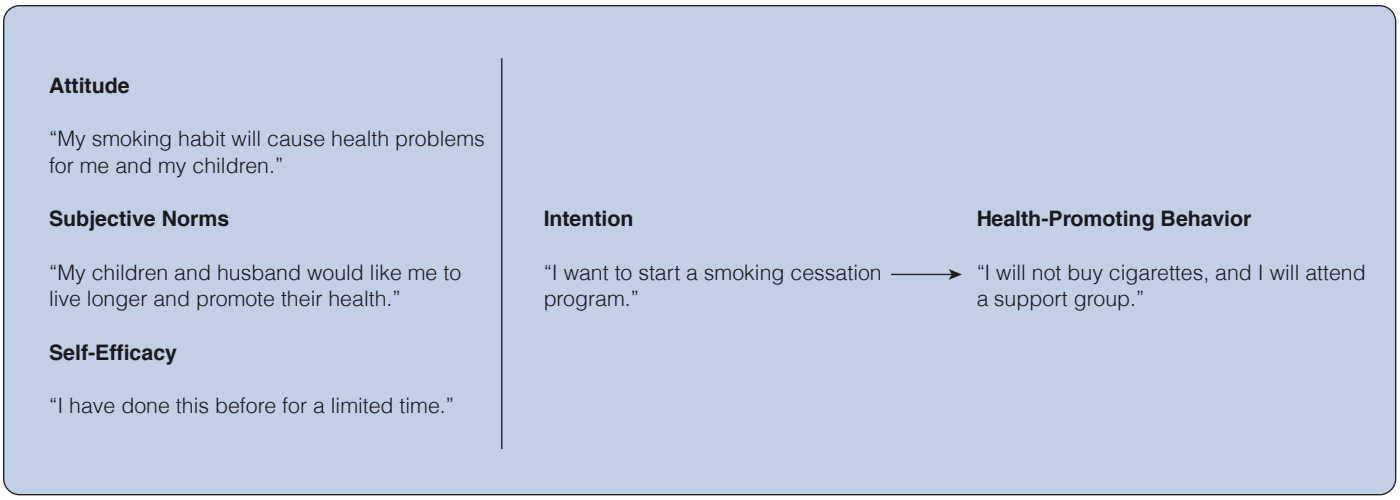

Figure 2.7 Application of the theory of reasoned action/planned behavior model.

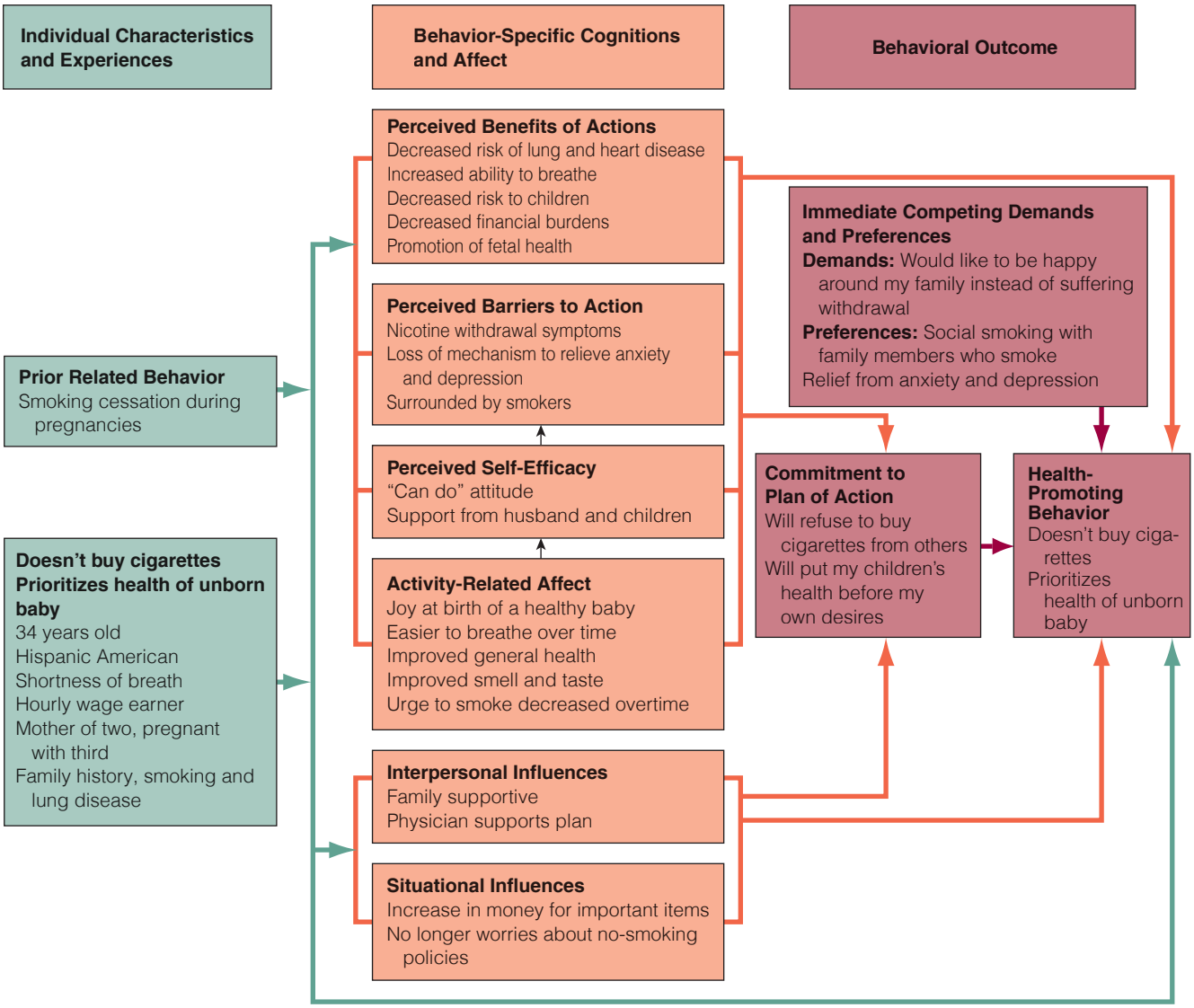

Figure 2.8 Application of the health promotion model.

CASE STUDY

Mrs. Lucia Alvarado is a 34-year-old Hispanic American. She has been a heavy smoker for the past 21 years. Both of her parents and two of her siblings also have a history of smoking. Her father died at age 57 from lung cancer, her mother was recently diagnosed with early stage lung cancer, her older sister suffers from asthma, and her younger brother often struggles with shortness of breath. Mrs. Alvarado is married and the mother of a 13-year-old boy and a 5-year-old girl. She is currently pregnant with her third child. She was able to quit smoking while she was pregnant with her first two children and plans to do the same during her current pregnancy. However, after her second pregnancy, she started smoking again. Mrs. Alvarado works as an hourly employee at a local hotel, and she often has a hard time catching her breath during repeated bending, lifting, and walking. Mrs. Alvarado realizes that her smoking habit can create physical, emotional, family, and economic problems. She frequently sees anti-smoking commercials on TV, and she knows the dangers of smoking during pregnancy, the effects of secondhand smoke on her children's health, and the reality that her children are likely to smoke if they see her smoking. She wants to use her pregnancy as a stimulus to quit smoking for good. Mrs. Alvarado will start a smoking cessation program with the support of her physician and family.

As stated, the models for health promotion guide intervention. Nurses promote positive health-promoting behaviors by emphasizing the benefits of the behaviors, assisting the patient to overcome barriers, and providing positive feedback for success. Personal factors influence health behaviors. Some of the factors such as age, gender, and family history cannot be changed. Nursing interventions will generally focus on factors that can be modified. However, it is also important to develop interventions to address factors that cannot be changed. For example, a patient with a family history of colon cancer may avoid screening programs because of fear or a belief that the development of colon cancer is inevitable. Nurses can provide support for these patients and emphasize the importance of early detection in improved outcomes in colon cancer.

Health assessment and screening provide a rich database from which the nurse can assist the patient, family, or community to identify the current health status, risks for illness or injury, strengths and weaknesses, and resources required to begin or continue appropriate health promotion activities. A variety of strategies including education, support, and modeling are used in health promotion. The nurse assists the individual to develop a plan of action and serves as a resource to guide the activity, monitor progress, and evaluate outcomes.

Health Promotion and the Nursing Process

Once a comprehensive patient database is developed from the health and physical assessment, the nurse works with the patient as the nursing process is applied in problem identification. The process continues through the development and implementation of the plans for care and is completed when the nurse and patient evaluate the outcomes. The following outlines the nursing process as related to health promotion.

Assessment

Comprehensive assessment of the patient is essential to health promotion and patient teaching. Through the health history and physical assessment, the nurse gathers information about the patient's current health status, risk factors, and predisposing factors associated with specific diseases. These risk factors are revealed through data about age, gender, race, and family history. The physical findings yield information including height, weight, and vital signs, as well as data about behaviors and lifestyle practices. Additional assessments are conducted in relation to health promotion. These include physical fitness, nutritional status, a health risk appraisal, lifestyle inventories, assessment of current stressors, and stress management strategies. Social structure assessments include family and support systems, level of education, income, roles, and other activities. Areas included in most health risk appraisals are presented in Box 2.1. Available to the nurse are a variety of tools and resources that will help in understanding assessment of patients related to health promotion. The Centers for Disease Control and Prevention (CDC) has many links for information about chronic disease tracking and prevention (CDC, 2017). Also, instructions for patient self-assessment are available in written form, in English and Spanish, and online through organizations such as the American Diabetes Association and the American Heart Association.

Diagnosis and Planning: The Plan of Care

Once data are gathered, the professional nurse works with the patient to identify current, ongoing, or potential problems, as well as strengths and supports. This information is combined with the nurse's knowledge base and critical thinking to establish patient-centered and appropriate goals. For example, problems may include obesity and smoking, and the patient goals

Box 2.1 Areas of Assessment in Health Risk Appraisal

- Demographic information (age, gender, height, weight)
- Type and amount of exercise
- Occupation
- Smoking
- 24-hour dietary history
- Family history of heart disease, diabetes, cancer
- History of screening tests according to gender and age (mammography, prostate-specific antigen [PSA] test)
- Oral hygiene and dental care history
- Immunization history
- Personal history of illness
- Safety measures (seat belt, sunscreen, condom)
- Sexual activity and reproductive history
- Use of alcohol, illicit drugs, prescription drugs
- Emotional state or mood

could be to lose a specific amount of weight and stop smoking by a specified date. Taking into account the patient strengths, supports, and challenges, the goals and priorities are established to develop a plan to meet the needs of the patient.

Implementation and Evaluation: Roles of the Professional Nurse

In implementing the plan, the nurse takes on the roles of educator, counselor, facilitator, researcher, nurturer, and role model. As educator, the nurse interprets and informs the patient of the significance of findings from all of the completed assessments. This can include subjective and objective data such as laboratory values. Education then may consist of one-on-one sessions related to specific aspects of care or preventive measures as dictated by need. The nurse provides education about specific problems, risks, treatments, or behaviors and may have to provide education about resources available to meet the needs of the patient and family.

As a counselor, the nurse creates and plans opportunities to discuss the implementation of specific activities and to review progress in behavior change or in goal attainment. The counseling role can occur in one-on-one sessions or with groups of patients involved in the same treatment, prevention, or promotion activity. In the facilitator role, the nurse may meet with the patient's family members to provide information, to encourage their participation with the patient in health-related activities, or to promote family support for the patient. As a facilitator, the nurse helps the patient and family gain access to services and facilities required to meet the identified health needs. Each of these roles may require the nurse to search for evidence-based guidelines to help the patient meet their health goals.

The nurturing role of the nurse includes providing the types and amounts of support and encouragement that will assist patients to meet their health-related goals. The nurturing role is particularly important when a patient is attempting to change or modify a behavior. The nurse models wellness and health-promoting behaviors and is willing to share experiences and difficulties in developing plans or meeting goals for healthy behaviors and lifestyles. Additionally, the nurse will identify individuals within the same culture or community who have experienced similar problems or have similar goals in relation to health promotion and wellness and with whom the patient can interact and relate to as a model.

The nurse and patient are involved in continual evaluation of progress in meeting goals. The evaluation process provides opportunities to address concerns. During evaluation, the patient has the opportunity to modify, continue, or discontinue the plan. As a result of evaluation, priorities may be reordered or the methods and tactics may be changed.

Application Through Critical Thinking

CASE STUDY

Source: Photofrenetic/Alamy Stock Photo.

You are participating in a health fair performing wellness screenings. *Gina Clark*, a 22-year-old female, approaches your table. She states that she is interested in seeing how healthy her habits are and wants to learn what suggestions you have to help her feel better about her health. Your screening findings show a blood pressure of 132/83, pulse 88, respirations 18, temperature 98.2°F, height 5 ft 4 in, and weight 190.

Gina reports that she drinks a lot of soda and eats fast food several times each week. She does not like vegetables and tends to "snack" a lot rather than sitting down for prepared meals. She states that she would like to eat better and exercise, but she never seems to find the time. She had joined a gym with a friend about a month ago but stopped going after 2 weeks when she became frustrated with sore muscles and lack of results. She would like to lose about 60 pounds and is interested in information on how to accomplish this goal. She tells you that she does not socialize much or go out with friends because she is self-conscious about her weight. Her weight, she says, makes her feel uncomfortable. She slowly leans forward and quietly tells you that she is "repulsed" by her body and does not ever want to look in a mirror or have a picture taken. She indicates that whenever she is stressed about something, she tends to eat even more. "It is like a vicious cycle. I don't know what to do."

CRITICAL THINKING QUESTIONS

1. Describe the importance of wellness in comprehensive health assessment.
2. Where does the patient see herself on the health–illness continuum?
3. What information is appropriate to share with Gina regarding healthy weight loss?
4. What guidelines around physical activity should you share with Gina?
5. How does the theory of reasoned action/planned behavior relate to Gina's situation and her intent to exercise?

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Chapter 3

Cultural and Spiritual Considerations

LEARNING OUTCOMES

Upon completion of this chapter, you will be able to:

1. Examine the components included in the definitions of culture and spirituality.
2. Practice using terms related to culture and spirituality.
3. Describe the impact of culture and spirituality on health and wellness.
4. Demonstrate cultural and spiritual sensitivity when interacting with patients.

KEY TERMS

assimilation, 23
cultural competence, 23
culture, 21
diversity, 22
ethnicity, 22
ethnocentrism, 22
heritage, 22
heritage consistency, 22
heritage inconsistency, 22
moral code, 27
race, 22
religion, 28
spiritual care, 28
spirituality, 28
spiritual distress, 28
spiritual state, 28
subcultures, 21

Introduction

The United States is made up of people of many races, ethnicities, religions, and heritages. It is expected that the diversity in the United States will continue to expand throughout this century. In 2015, 46,630,000 people living in the United States were born in other countries. Close to 26% of these immigrants came from Mexico, followed by China, India, the Philippines, and Puerto Rico, each having close to 4% (Pew Research Center, 2016). In 2014, the U.S. Census Bureau predicted that by 2060 the Asian population will have increased from 6% to 12% of the U.S. population (U.S. Census Bureau, 2014).

An individual's culture, race, religion, and ethnicity impact beliefs about health and illness and the practices related to both. The nurse must develop the ability to discover knowledge of different cultures and religions, as it is not possible to completely

understand all of them. The nurse must continue to learn about other cultures and religions and bring acknowledgment of personal cultural and spiritual beliefs and values to each nurse–patient encounter.

According to the Joint Commission (2014) and the American Association of Colleges of Nursing (2008), cultural and spiritual competence are aspects of patient-centered care that will help to ensure the same high-quality care to all patients and strengthen the delivery of healthcare. Nurses need to understand how various cultural and religious groups perceive life processes, define health and illness, maintain health, determine the causes of illness, and provide care and cure. It is also important to understand how the nurse's cultural and spiritual background influence care. When nurses understand diversity, apply cultural and spiritual knowledge, and act in culturally and spiritually competent ways, they can be more effective in assessing patients, developing culturally and spiritually sensitive interventions, and influencing healthcare policy and practice.

Culture

The National Institutes of Health (NIH) describes **culture** as a combination of knowledge, beliefs, and behaviors that often are specific to racial, ethnic, geographic, social, or religious groups (National Institutes of Health (NIH), 2018). In other words, it is the total of the various practices, beliefs, traditions, customs, language, thoughts, actions, values, and rituals learned from our families by way of socialization (Spector, 2017).

Culture frames an individual's perception of health and illness. Culture influences how healthcare information is received, how symptoms are perceived, and how rights and protections are exercised. It affects what is considered to be a health problem and the type of treatment to be provided. Culture is learned generally within the family group (see Figure 3.1 ■), is shared by the majority within the culture, and changes in response to interactions with events in the external environment. Culture has also been identified as the way a population or group finds a shared meaning for information.

Figure 3.1 Nuclear family interaction.
Source: Sergey Novikov/Shutterstock.

Subdivisions of Culture

Culture may be divided into material and nonmaterial culture. Objects such as dress, art, utensils, and tools and the ways they are used are components of the *material culture. Nonmaterial culture* is composed of verbal and nonverbal language, beliefs, customs, and social structures. Cultures may be further defined as *macrocultures*, that is, national, racial, or ethnic groups within which *microcultures* exist based on age, gender, or religious affiliation. **Subcultures** exist within larger cultural groups. Subcultures are composed of individuals who have a distinct identity based on occupation, membership in a social group, or heritage. For example, professional nurses are a subculture within the larger culture of healthcare professionals and are also part of the larger American culture (see Figure 3.2 ■). Many individuals refer to themselves according to an ethnic origin, such as Italian American, Greek American, or Arab American. These individuals often form associations with others of the same ethnic origin, thereby creating a subculture within the larger American culture.

Figure 3.2 Diversity within the subculture of nursing.
Source: michaeljung/Shutterstock.

Generational subcultures also exist. At present, the impact of this phenomenon is highlighted in the workplace setting as, for the first time in United States history, individuals from five generations are working side by side. Although diversity in knowledge and experience can be beneficial, generational differences also may create significant sources of miscommunication and conflict. The five generations are categorized as follows:

- ***Veterans:*** Born before 1946
- ***Baby boomers:*** Born 1946–1964
- ***Generation X:*** Born 1965–1981
- ***Generation Y (also called Millennials):*** Born 1982–2000 (Reynolds, Bush, & Geist, 2008)
- ***Generation Z:*** Born 1995–2012 (Levit, 2015)

Each generation differs with regard to numerous aspects of workplace behaviors and attitudes, including views about authority, preferences regarding communication style, and knowledge of various technologies (Levit, 2015; Reynolds et al., 2008). For the nurse, the dynamic of generational subcultures

is relevant both to interactions with other healthcare team members and to nurse–patient relationships.

Terms Related to Culture

The terms *culture, race,* and *ethnicity* are often used synonymously. However, these terms refer to different aspects and characteristics of populations and groups of people. These terms and others related to culture are defined in the following sections.

Race **Race** refers to the identification of an individual or group by shared genetic heritage and biologic or physical characteristics. Members of a given race have similarities in skin color, skeletal structure, texture of the hair, and facial features. Knowledge of the differences in racial characteristics is significant in health assessment because findings are interpreted according to norms for age, gender, and race. However, gene pools are becoming increasingly diverse. Skin color is not always a clear indication of racial identity. For example, dark-skinned individuals from Pakistan, Bangladesh, and parts of India are Caucasian by racial norms as far as medical findings are concerned. Also, racial blending is increasingly common in the United States. Many individuals identify themselves as biracial or multiracial. Definitions of minority racial and ethnic populations in the United States are provided by the Office of Minority Health (OMH, 2013). In 2010, the U.S. Census Bureau identified the following categories of race:

- Hispanic, Latino, or Spanish origin
- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- White (Colby & Ortman, 2015, p. 9)

Heritage According to the UMass Amherst Center for Heritage and Society (n.d.), **heritage** is defined as "the full range of our inherited traditions, monuments, objects, and culture. Most important, it is the range of contemporary activities, meanings, and behaviors that we draw from them." **Heritage consistency** describes the extent to which one's lifestyle reflects one's traditional heritage, as well as the degree to which the individual identifies with his traditional heritage. **Heritage inconsistency** describes the adoption and implementation of beliefs and practices obtained by way of acculturation into a dominant or host culture (Berman & Snyder, 2016; Spector, 2017). See Box 3.1 for an example of a heritage assessment tool.

Ethnicity The term *ethnic* refers to a group of people who share a common culture and who belong to a specific group. Ethnic groups are those with common social and cultural values over generations. **Ethnicity** is the awareness of belonging to a group in which certain characteristics or aspects such as culture and biology differentiate the members of one group from another. Ethnicity is defined by shared interest, ethnic heritage, religion, food, politics, or geography and nationality.

Ethnicity incorporates internal and external identification with a group. Internal identification means that one considers oneself a member of an ethnic group. For example, one may identify oneself as Arab, African, French, Irish, Italian, or Jamaican American. External identification means that those outside of the group perceive the person as a group member.

However, nurses must be aware that national origin is often more important to patients than broader ethnic categories—for example, "Asian American" is a recognized ethnic group, but Asian Americans are likely to identify themselves as Japanese, Filipino, Asian Indian, Korean, Vietnamese, Chinese, Hawaiian, or Samoan.

In the United States, ethnicity is often demonstrated by participation in groups that promote the heritage or traditions of the group. For example, Emerald Societies exist to promote Irish heritage; Italian American social groups promote bonds for those of Italian ancestry.

Ethnicity refers to the degree of attachment with ancestral groups, heritage, or place of birth. Some ethnic identities such as Polish or Syrian are traced to locations in which ancestors were born outside of the United States. Ethnic groups such as Cajuns or Pennsylvania Dutch evolved from geographic regions within the United States.

Ethnocentrism **Ethnocentrism** is the tendency to believe that one's own beliefs, way of life, values, and customs are superior to those of others. Ethnocentrism creates the belief that one's own customs and values are the standard for judging the values, customs, and practices of others. Ethnocentrism can interfere with collection and interpretation of data as well as the development of plans of care to meet patient needs. Awareness of one's own cultural beliefs, values, and biases can reduce ethnocentrism and foster culturally competent care.

Diversity **Diversity** is defined as the state of being different. Diversity occurs between and within cultural groups. Characteristics of diversity include nationality, race, color, gender, age, and religion. In addition, diversity is established by socioeconomic status, education, occupation, residence in urban versus suburban or rural areas, marital status, parental status, sexual orientation, and the time spent away from one's country of origin.

Box 3.1 Mini Heritage Assessment

1. Where were your parents and grandparents born?
2. In what country did they grow up?
3. If they were born and/or grew up outside the United States, when did they come to the United States?
4. If you have extended family nearby, how often do you see them?
5. If your native language is not English, how often do you read and speak in your native tongue?
6. What is your religious preference?
7. Do you belong to a religious institution? If so, how often do you attend services and activities there?
8. As an adult do you live in a neighborhood where the neighbors are the same religion and ethnic background as you?
9. Do you participate in ethnic activities and/or prepare ethnic foods?

Source: Spector, R. E. (2017). *Cultural diversity in health and illness* (9th ed.). Hoboken, NJ: Pearson.

For example, Arab Americans are considered a cultural group in the United States. They share tradition as descendants of tribes of the Arabian Peninsula and share Arabic as a common language. However, diversity within this group is characterized by differences in religion, occupation, geography, and period of immigration to the United States. Many of the early Arab immigrants were from Libya and Syria and identified themselves as Christians. However, because Muslims were forbidden to emigrate, fear of deportation may have influenced their recorded statement of religious faith. These immigrants came to the United States seeking economic opportunity (Abdelhady, 2014). Later immigrants settled in urban areas of the northeastern United States and, for the most part, were self-employed or in managerial and professional occupations. In contrast, Arab immigrants after World War II were and continue to be predominantly refugees from nations undergoing political strife. They were primarily followers of the Islamic religion who settled in the midwestern and western United States and maintained strong ethnic ties to the nations from which they emigrated, including Palestine, Iraq, Lebanon, and Egypt. Many Arab immigrants sought educational degrees or were professionals who remained in the United States.

Acculturation Acculturation refers to the process of adaptation and change that occurs when members of different cultures are exposed to one another (Spector, 2017). When the host group has the most power, the host group usually applies its power to influence change among incoming cultural groups (Spector, 2017). In contrast to this unidirectional change, acculturation also may produce bidirectional change, in which the dominant and nondominant cultural groups effect changes on one another (Smokowski & Bacallao, 2011).

Assimilation **Assimilation** refers to the adoption and incorporation of characteristics, customs, and values of the dominant culture by those new to that culture. Assimilation is unidirectional in nature (Smokowski & Bacallao, 2011). For example, immigrants to the United States may assimilate over time and adopt the values of one culture over another. The assimilation process occurs more easily for those who have willingly emigrated from their native land.

Assimilation is affected by several factors including beliefs, language, age, and geography. Those who hold similar values and speak the language of the adopted country more easily assimilate. Assimilation occurs more easily in second-generation immigrants. For example, children born to Chinese parents in Western countries may adopt Western culture more easily, whereas parents tend to maintain the traditional culture. Chinese Americans living in "Chinatown" districts in large cities of the United States are more likely to maintain much of their traditional Chinese cultural practices and beliefs (Smokowski & Bacallao, 2011).

Slow assimilation has occurred in the Cuban American population. Cuban Americans have established enclaves in Miami, Florida, and Union City, New Jersey. In these enclaves, Spanish remains the predominant language in the home and in many of the workplaces. The slow assimilation to English, as well as the isolation within Cuban communities, results in strong ethnic identity and some degree of insulation from the prevailing American culture (Smokowski & Bacallao, 2011).

Cultural Competence The capacity of nurses or health service delivery systems to effectively understand and plan for the needs of a culturally diverse patient or group constitutes **cultural competence**. Spector (2017) views cultural competence as a complex combination of knowledge, attitudes, and skills used by the healthcare provider to deliver services that attend to the total context of the patient's situation across cultural boundaries. The development of cultural competence is essential to nursing. Because cultural competence develops over time through knowledge acquisition and experience, the key to developing cultural competence is to be sensitive to each patient's culture even if you are initially unfamiliar with their specific cultural beliefs. Incorporating the patient's cultural values, beliefs, customs, and practices improves the nurse's ability to gather and interpret data and to plan care appropriate to meet the needs of diverse patients.

Cultural Phenomena That Impact Healthcare

Culture and heritage influence an individual's perceptions about internal and external factors that contribute to health or cause illness, as well as the practices the individual follows to prevent and treat health problems.

In many Westernized countries, beliefs about health and illness are derived from a scientific approach. The scientific approach includes "germ theory" as applied in infectious diseases; knowledge of changes in body structures and functions associated with aging, including arthritis, menopause, and vision changes; and the understanding that diet and lifestyle choices influence health and illness. Health practices include seeking healthcare from healthcare providers who use scientific methods to diagnose and treat illness. Healthcare practices also include following recommendations for disease prevention, such as screening for risks, screening for early detection of problems, and immunization.

In many cultures, beliefs about health and illness are built around nonscientific theories, such as diseases being caused by disturbance in the hot and cold balance of the body, requiring the consumption of foods that oppose these imbalances. Other cultures believe that health is related to achieving harmony with nature. Illness is explained as disruption in harmony, which is caused by some acts on the part of the ill person or by a curse having been placed on the person.

Two factors have influenced perceptions of health and healthcare practices in the United States. The first factor is that people of all nations continue to immigrate to the United States. As a result, the beliefs and practices of these individuals, families, and groups influence the ways in which individual healthcare is managed. Many of the immigrant populations have adapted to and use the healthcare system in the United States but retain cultural practices. For example, patients of some heritages may believe that eating a healthy diet, getting proper sleep, and not going to bed with wet hair promote health. Some patients may be more likely to use home remedies for colds and headaches, including the use of honey for a sore throat and applying a wet rag to the head for headaches (Spector, 2017). Some groups are accustomed to Westernized approaches to all aspects of healthcare yet may consult an elder or use herbal treatments before

seeking care and continue the use of herbs while receiving prescribed treatments (Spector, 2017). The adoption of scientific beliefs and practices is influenced by the length of time from immigration and often by the age of the patient. Conversely, the exposure to and knowledge of a variety of cultural beliefs and healthcare practices has promoted the adoption of many treatments, remedies, and therapies from those cultures by healthcare practitioners in the United States. For example, acupuncture, which is part of traditional Chinese medicine, has become a widely accepted therapy and is now used for pain relief in many modern healthcare settings, including some hospitals, although it has many other traditional uses as well (Spector, 2017).

Culture influences the patient's perceptions of healthcare providers as well. Some, for example, recognize the doctor as the head of the healthcare team and hold physicians in high regard. Others may respect healthcare professionals but fear seeking care because of concerns about confidentiality (Spector, 2017).

How nurses are viewed is often dependent on the individual's cultural view of women's roles in society as well as a lack of respect for those viewed as subservient to the physician. In many cultures, the assistance of a family member or cultural healer is sought before that of a healthcare professional. Furthermore, health-seeking behaviors are influenced by the type of illness, language barriers, and concerns that family and cultural rituals surrounding care of the sick and dying will not be respected or permitted.

From a broad perspective, categories of cultural phenomena that impact the provision of healthcare include temporal relationships, family patterns, dietary patterns, health beliefs and practices, and communication. Understanding these phenomena is essential to comprehensive health assessment and to the delivery of safe and effective nursing care. Selected examples of each of the phenomena are described in the following sections, and communication is included in Chapter 5, Interviewing and Health History: Subjective Data. ∞

Differences in language, beliefs, values, and customs exist within cultural groups. As such, cultural beliefs and behaviors are patient specific and may or may not include attributes that are generalized to a given culture. To avoid stereotyping, assessment of an individual's beliefs is essential. In every case, the patient—and the patient's beliefs—should be treated with respect.

Temporal Relationships

Temporal relationships refer to an individual's or group's orientation in terms of past, present, or future as well as clock-time orientation. Cultural variations exist in temporal orientation. For example, the temporal orientation of a patient who is a member of the Cherokee nation may be to the past. Their actions are based on tradition and respect for ancestral practices. The predominant cultures of Western countries are future-oriented as demonstrated by the propensity to invest in the future and "save for tomorrow." Individuals from Latino or Chinese cultures are more likely to be "present"—that is, concerned about the here and now. Another trait of Western cultures is concern with time in terms of abiding by the clock, schedules, and punctuality. In other cultures and groups, such as Cuban Americans, Mexican Americans, and Native Americans, clock time may not be regarded as important.

Family Patterns

Family patterns refer to the roles and relationships that exist within families. These roles and relationships include patterns for responsibilities, values, inclusion, and decision making. The roles and responsibilities of family members are often culturally specific in terms of age and gender. For example, patriarchal households, in which the male is responsible for all decisions, including those related to healthcare, are common in Appalachian, Italian, and Filipino groups. African American groups are more likely to follow matriarchal patterns.

Dietary Patterns

Nutritional intake has an impact on health from infancy through old age. The types and amounts of foods that individuals include in the diet are often culturally determined. In addition, certain foods and beverages, as well as mealtimes, are part of cultural rituals or accepted practices. For example, Americans are known for morning coffee or coffee break rituals, and those from Hispanic cultures are known to eat dinner later in the evening. Eating practices are also associated with culturally determined events or holidays. Muslims may fast (no food or drink) from dawn to sunset during the month of Ramadan. Lent is a period during which Roman Catholics may fast by eating just one full meal and two small meals on Ash Wednesday and Good Friday, and they may abstain from meat on Ash Wednesday and all Fridays until Easter. In the United States, turkey is a traditional Thanksgiving meal. Certain foods are prohibited in some religious or cultural groups. For example, Muslims and Jews are prohibited from eating pork, although some followers of those religions do not abide by that restriction. Most cultures have theories about nutrition and health; different types of foods are selected, and food preparation practices vary according to needs in relation to health and illness. In traditional Mexican, Iranian, Chinese, and Vietnamese cultures, a patient may seek a balance between hot and cold foods to prevent illness and as one of the aids for cure in certain illnesses. When a culture adheres to guidelines from the Western healthcare perspective, foods high in fat and salt may be avoided as a way to prevent heart disease and some cancers.

Box 3.2 provides questions about diet to ask patients along with the reasons for doing so.

Health Beliefs and Health Practices

There are three general categories of health beliefs: magico-religious, biomedical, and holistic health. In a magico-religious belief system, health and illness are believed to be controlled by various supernatural or spiritual forces. This type of belief system is found in Latino and West Indian cultures in which illness may be attributed to evil eye (maldyok) or voodoo (spirits that control destiny and may be contacted to cure illness). Those who hold biomedical health beliefs consider illness to be caused by germs, viruses, or a breakdown in body processes and functions, and they believe that physiologic human processes can be affected by human intervention. Individuals who follow traditional Western medical practice hold this belief.

In a holistic health belief system, one holds that human life must be in harmony with nature and that illness results from disharmony between the two. The holistic belief system is consistent with the concepts of yin and yang in the Chinese culture, the hot and cold theory of illness in some Latino cultures, and

Box 3.2 Cultural Diet Influences

MODEL QUESTIONS	RATIONALES
• Do you speak or read any other languages?	• Understanding primary and secondary languages is important for both communication and education.
• Is there anyone else you would like us to include in this nutrition conversation?	• In some cultures, a patient may defer to an elder or authority figure when answering questions about health.
• Is there any time of the year that you change your diet for cultural reasons, including religion?	• Cultural and religious beliefs and traditions can affect food choices, beliefs, and practices in many ways, from the number of meals eaten in a day to choices of foods, preparation methods, and overall food beliefs.
• Are there any foods you avoid for cultural reasons?	• Diversity exists within cultural and religious groups. It is important to avoid applying general knowledge about cultural and religious food practices to all people within a group; instead, explore individual interpretation and influences.
• What types of foods do you believe promote health or keep you well?	• Assess common dietary staples, as well as foods believed to be associated with health or symbolic benefits. Some food is thought to promote health or cure conditions. Other beliefs may be related to life-span issues, such as the proper diet during pregnancy for easy delivery or to make the "hot" condition "colder."
• Are there any foods that you would try to consume if you were sick or for certain conditions?	• Many religious groups have dietary laws that are observed differently by subgroups within the population. Consumption of kosher meats, fasting, and avoidance of certain foods such as pork, crustaceans, birds of prey, beef, or other animal products are examples.
• Do you use any health remedies or practices that are related to your culture?	• Ask about food practices and special meals for special occasions and holidays. Some religious groups fast during parts of some religious holy days.
• *For the patient with a health diagnosis or condition*: Please tell me what you think caused this condition.	• Discuss food preparation methods. A variety of cultures make similar types of dishes but prepare them differently—for example, using different fats such as bacon drippings, lard, oils, or ghee (clarified butter).
• Is there anything else that you would like me to know about your dietary practices?	• Ask about medicinal herb use because this varies among cultures and is often an important aspect of health beliefs.
• *For the patient who has immigrated*: Has your diet changed in any way since you moved here? What is different? What is the same?	• Explore to what extent any acculturation has taken place and what traditional practices have changed resulting from living in a new dominant culture. Ask whether new foods have been added along with traditional foods, whether newer or different versions of foods have been substituted, and whether any traditional foods have been omitted. In some cases, traditional diets are healthier than the diet in the new culture, and encouragement to maintain healthy traditions may be helpful.

the dimensions of the medicine wheel as accepted by some Native Americans.

Seeking healthcare for illness and disease is one health practice that is influenced by culture—by one's health beliefs, as well as economics, geography, and knowledge. In some geographic regions and areas where there is limited access to Westernized healthcare, people often rely on folk healing or folk medicine. Folk healing is generally derived from cultural traditions and includes the use of teas, herbs, and other natural remedies to treat or cure illness. In many cultures, care is sought only when all other remedies have been exhausted or when the symptoms have become severe. This custom often results in complications and prolonged illness or hospitalization. This practice in some Appalachians and older European Americans may be a result of stoicism, or it may be a result of lack of knowledge and understanding of the healthcare system or language barriers that can occur in other cultural groups who have immigrated to the United States.

Access to healthcare impacts one's health practices as well. Those in lower socioeconomic groups or without insurance are more likely to self-medicate, use folk or family remedies, and seek episodic acute care than are those who have higher income levels and health insurance.

Ideally, the nurse should be familiar with the cultural beliefs of the groups who are most often served by a given institution or organization and should use reliable resources to obtain information about unfamiliar cultural groups. It is important to note that expertise with regard to every culture is neither expected nor needed in order to develop cultural competence. Instead, nurses must focus on patients' answers to questions in order to understand what ideas and beliefs patients hold about health and then consider how those beliefs might be implicated in treating patients.

Culture in Comprehensive Health Assessment

Comprehensive health assessment refers to obtaining subjective and objective data that are used to identify patient needs. The data are then used to develop and implement plans to meet those needs. Cultural data are essential to this process because they inform the nurse about a variety of factors and practices that impact the current and future health status of the patient. Cultural data in comprehensive assessment would include all of the cultural phenomena described in the previous section.

When conducting the assessment of culture, the nurse must be careful to avoid stereotyping—that is, the nurse must not assume because a patient looks a certain way or has a certain name that he or she belongs to or identifies with a certain cultural or religious group. For example, Mexico is considered a Catholic country, but not all Mexican people are Catholics. In addition, even if the nurse is of the same cultural or ethnic background as the patient, it cannot be assumed that the nurse's beliefs and practices are the same. The nurse and the patient may identify themselves as Hispanic. However, if the nurse relates to a Colombian culture, whereas the patient is from Cuba, the nurse must recognize that aspects of the Latin or Hispanic cultures from those areas can be quite different. A nurse who was born and raised in the United States must avoid assuming that a patient who states "I'm all American" shares the same beliefs and values. The nurse should ask patients to describe what identification with a specific culture means to them. The use of open-ended questions helps to obtain information about the meaning of the patient's statements about ethnic or cultural identity. Often the follow-up question about the family's cultural or ethnic identity can reveal areas to explore in relation to beliefs about illness or disease, diet, and relationships. For example, a patient who states "I'm all American" may reveal links with ethnic groups after further questioning by saying, "My parents are from Germany, and we eat lots of German foods, but I'm like all of my American friends."

Ethnic Identity and Culture

Information about ethnicity and culture is gathered because it enables the nurse to determine physical and social characteristics that influence healthcare decisions. Ethnicity and culture may influence a number of health-related factors for the patient. These factors include health beliefs; health practices; verbal and nonverbal methods of communication; roles and relationships in the family and society; perceptions of healthcare professionals; diet; dress and rituals; and rites associated with birth, marriage, child rearing, and death.

Information about the patient's ethnicity and culture is obtained by asking questions such as these:

- Do you identify with a specific ethnic group?
- How strong would you say that identity is?
- What language do you speak at home?
- Do you or members of your family speak a second language?
- Are you comfortable receiving information about your health in English?
- Would you like an interpreter during this interview?
- Would you like to have an interpreter during the physical examination?
- Are there rules in your culture about the ways an examination must be carried out?
- Are there rules about the gender of the person who is examining you?
- Do you need to have someone in your family participate in the interview or examination?

Information about health beliefs and practices, family, roles and relationships, cultural influences on diet, activity, emotional health, and other topics are included in other components of the health history, including the review of body systems. For example, when asking about the patient's health patterns, the nurse will gather information about cultural healing or rituals associated with health and health maintenance. Further, when asking about nutrition, the nurse will gather information about cultural influences on food selection, preparation, and consumption.

Information about ethnicity and culture can be obtained by conducting a complete cultural assessment at this point in the health history. Box 3.3 includes a "mini" cultural assessment with generalized questions and information on how to ask these questions. Box 3.4 includes the information to be obtained in a complete cultural assessment.

Box 3.3 Mini Cultural Assessment

The mini cultural assessment provides a starting point for asking patients about any cultural beliefs that would affect how you provide healthcare. Before beginning the cultural assessment, inform the patient that you will be asking questions about cultural beliefs. When asking the questions, provide examples to explain the type of information you are looking for. If the patient gives a positive answer to any of these questions, a more thorough cultural assessment should be conducted. Recording the patient's answers to these questions will be vital to providing ongoing, culturally sensitive care, especially for patients who are in the hospital for multiple shifts.

1. What is your preferred language? Would you feel more comfortable with an interpreter present?
2. Do you identify with a specific ethnic or other group? For example, do you identify as Mexican, Black, Chinese, LGBTQ . . . ?
3. Do you follow any cultural rules about how an examination should be carried out? For example, would you prefer a provider of the same sex? Are there rules about exposure of certain body parts?
4. Do you follow any cultural or spiritual practices that would affect your healthcare? For example, do you have any dietary restrictions? Do you have rituals that must be performed at certain times of the day? Do you have a spiritual leader you would like us to contact?
5. Do you prefer to have a family member present during exams or discussions about your health and treatment?

Box 3.4 Cultural Assessment

1. What racial group do you identify with?
2. What is your ethnic group?
3. How closely do you identify with that ethnic group?
4. What cultural group does your family identify with?
5. What language do you speak?
6. What language is spoken in your home?
7. Do you need an interpreter to participate in this interview?
8. Would you like an interpreter to be with you when health issues are discussed?
9. Are there customs in your culture about talking and listening, such as making eye contact or the amount of distance one should maintain between individuals?
10. How much touching is allowed during communication between members of your culture and between you and members of other cultures?
11. How do members of your culture demonstrate respect for another?
12. What are the most important beliefs in your culture?
13. What does your culture believe about health?
14. What does your culture believe about illness or the causes of illness?
15. What are the attitudes about healthcare in your culture?
16. How do members of your culture relate to healthcare professionals?
17. What are the rules about the sex of the person who conducts a health examination in your culture?
18. What are the rules about exposure of body parts in your culture?
19. What are the restrictions about discussing sexual relationships or family relationships in your culture?
20. Do you have a preference for your healthcare provider to be a member of your culture?
21. What do members of your culture believe about mental illness?
22. Does your culture prefer certain ways to discuss topics such as birth, illness, dying, and death?
23. Are there topics that members of your culture would not discuss with a nurse or doctor?
24. Are there rituals or practices that are performed by members of your culture when someone is ill or dying or when they die?
25. Who is the head of the family in your culture?
26. Who makes decisions about healthcare?
27. Do you or members of your culture use cultural healers or remedies?
28. What are the common remedies used in your culture?
29. What religion do you belong to?
30. Do most members of your culture belong to that religion?
31. Does that religion provide rules or guides related to healthcare?
32. Does your culture or religion influence your diet?
33. Does your culture or religion influence the ways children are brought up?
34. Are there common spiritual beliefs in your culture?
35. How do those spiritual beliefs influence your health?
36. Are there cultural groups in your community that provide support for you and your family?
37. What supports do those groups provide?

Spirituality

Spiritual and belief patterns reflect an individual's relationship with a higher power or with something, such as an ideal, a group, or humanity itself, that the person sees as larger than self and that gives meaning to life. The outward demonstration of spirituality may be reflected in religious practice, lifestyle, or relationships with others. A moral code is often included in one's belief patterns. A **moral code** comprises the internalized values, virtues, and rules one learns from significant others. It is developed by the individual to distinguish right from wrong. An individual's spiritual beliefs and moral code are affected by culture and ethnic background.

Spirituality impacts a person's life. Numerous studies have found that when spiritual practices are a part of a person's life, improvements are seen in their overall health, as well as an increased ability to handle stressful and life-changing events and decreased risk of mortality (Koenig, Larson, & Larson, 2001; Lucchetti, Lucchetti, & Koenig, 2011). Reliance on spiritual behaviors increases personal growth, reduces the effects of stress, and improves health during difficult life issues (Hellman, Williams, & Hurley, 2015; Park et al., 2013). Spiritual beliefs and religious practices have also been shown to have a positive impact on resilience (Murray-Swank & Pargament, 2005). Resilience occurs when people are able to adapt well in the face of adversity, including serious illness or loss of a loved one. Conversely, negative feelings about spirituality may be associated with poorer health outcomes, including depression, anxiety, anorexia, and drowsiness (Delgado-Guay et al., 2011). Negative feelings toward God, feeling punished by God, or believing that an evil force is at work in one's life has been associated with a higher incidence in mortality in older adults (Pargament, Koenig, Tarakeshwar, & Hahn, 2001).

Spiritual health has been closely linked to both emotional and physical health. When health challenges or other life difficulties occur, many people turn to their religious beliefs and practices as a means to maintain hope, gain a sense of meaning to their life, and reduce stress. Involvement in religious activities appears to enable those who are ill to cope more effectively and grow from their experiences, rather than being defeated by them (Koenig et al., 2001). Health challenges or other life difficulties often create the need for spiritual connection. Spiritual health is inextricably linked to both physical and emotional health, thus making it an important and impactful component of care. Holistic nursing care encompasses physical, psychologic, and spiritual dimensions as a means to treat the entire person rather than just the physical or emotional symptoms (Cooper, Chang, Sheehan, & Johnson, 2013).

Studies have shown that many patients desire to discuss their spiritual health with their healthcare providers during times of

physical and emotional stress, such as receiving news of a serious or life-threatening diagnosis (Taylor & Mamier, 2013). The nurse and physician are not generally viewed as the primary spiritual caregivers, but their availability as a support is important. Nurses are typically the members of the healthcare team who are most physically present to patients, which may aid in the development of trust within the nurse–patient relationship, allowing the patient to feel comfortable sharing their spiritual concerns. Therefore, it is important for nurses to have the skills needed to respond to patients' spiritual concerns in an efficient, effective, and ethical manner (Baldacchino, 2015; Taylor & Mamier, 2013).

Terms Related to Spirituality

Spirituality and religion are related terms, yet they are distinctly different. Spirituality is defined as "sensitivity or attachment to religious values and things of the spirit rather than material or worldly interests" (Spirituality, n.d.). This can be contrasted with the definition of **religion**, "the body of institutionalized expressions of sacred beliefs, observances, and social practices found within a given cultural context" (Religion, n.d.). In a broader sense, spiritualty's focus is one of attunement to ideals not of this earthly realm, whereas religion has a focus on the content of one's beliefs and how those beliefs are outwardly manifested. Spirituality may be evidenced by the act of doing spiritual things such as praying or meditating, but it tends to be more abstract than religion, which promotes a creed or certain set of beliefs, rituals, and ethics (Got Truth Ministries, 2018).

Spirituality refers to the individual's sense of self in relation to others and a higher being, what one believes gives meaning to life, and what fosters hope for one's will to live. The spirit is the part of each person that controls the mind, and the mind then controls what the body does. Spirituality may be a part of a particular religion, which is an organized faith system that includes rituals, beliefs, practices, and symbols to draw people close to God, a higher power, or ultimate truth. Spirituality can be separate from a religion as it provides meaning and purpose in life, even for those who do not believe in any god or higher power. A **spiritual state** describes the person's feelings about their spirituality that can fluctuate along a continuum of well-being to spiritual distress (Baldacchino, 2015).

Spiritual care is a part of the art of nursing care. Spiritual care is defined as meeting patients' spiritual needs by way of recognizing and respecting these needs, facilitating participation in religious rituals, engaging in active listening, promoting hope, demonstrating empathy, and making referrals to other professionals, including chaplains, pastors, rabbis, priest, and imams, for example, as additional support. Caring for patients through supportive and empathetic actions can help promote a sense of well-being. The goal in spiritual care is to help patients find meaning and purpose in their life, even in the midst of illness, so the delivery of care is not the most important aspect. The heart and spirit by which the care is provided is of the utmost importance. The nurse should take an active and involved approach to meet a patient's spiritual needs, including calling in an expert in the patient's theological beliefs to clarify beliefs and conflicts.

Spiritual Distress

Spiritual distress can be described as an interruption in one's value system or beliefs. This disruption affects the person's entire being by threatening their sources of hope, peace, and meaning for their life. The greater the degree to which unmet spiritual needs remain unmet, the greater is the spiritual distress experienced by the patient. Spiritual distress may have a harmful effect on a patient's well-being, prognosis, and quality of life and may cause depression. Spiritual distress can and does occur frequently, especially in the case of serious illness or injury. It is important to note that not everyone will experience spiritual distress in the same way or to the same degree (Monod et al., 2010; Taylor & Mamier, 2013).

Spiritual distress can be expressed in many ways. Defining characteristics of spiritual distress include these (Caldeira, Timmins, deCarvalho, & Vieira, 2017; King et al., 2017; Selby, Seccaraccia, Huth, Kurrpa, & Fitch, 2016):

- Expressing concern about or questioning the meaning of life and death and/or the patient's belief system
- Questioning feelings of anger at or of abandonment by God or a higher power
- Feeling a sense of emptiness
- Having difficulty sleeping, having nightmares, or being afraid to sleep
- Seeking spiritual guidance
- Experiencing a change in mood or behavior such as anger, withdrawal, anxiety, crying, apathy, hostility

How should nurses respond to spiritual distress to help resolve the issues? Wright (2008) offers helpful recommendations to nurses for "softening the suffering" during periods of spiritual distress:

1. ***Enter into the relationship completely committed to being present:*** Be truly present and focus all your attention on the patient and the distress the patient is experiencing. Allow the patient to talk about these experiences and focus on the story rather than trying to change the subject or cheer them up.
2. ***Ask the patient to share stories of suffering:*** Encourage the patient to talk about the experience of the illness on all aspects of life. Ask the patient about the impact on family, marriage, work, and other things that are important to the patient. Be willing to listen and reminisce.
3. ***Use active listening skills:*** Listen with your heart and mind, not just with your ears. Reflect back to the patient what you heard. This provides clarity as well as an opportunity for the patient to know that his or her suffering was heard and acknowledged. Be willing to be there for the patient without feeling the need to "do something."
4. ***Provide the patient with compassionate care:*** Enter fully into the relationship with the patient in distress to facilitate healing through a connection built on caring. Provide a calm and relaxing setting. Treat the patient respectfully and with dignity.
5. ***Acknowledge the suffering:*** This can provide the patient with a chance to thrive. Do not say you understand how the patient feels because you cannot. Instead ask the patient to help you understand more clearly what this situation has meant.
6. ***Help the patient explore the meanings associated with the distress:*** Explore the meaning and purpose the patient believes is behind the suffering. Work with the patient to

find ways to keep desired rituals and ways of life. Help the patient and family look for ways to create memories.

7. ***Offer hope:*** Hope can provide confidence that may help the patient heal. Support any desire the patient may have to maintain a relationship with friends and family. Contact the patient's spiritual advisor for additional support.

Spiritual Assessment

An important area of spiritual care is a systematic approach for collecting information for a spiritual history. As previously stated, a majority of patients want their caregivers to address their spiritual concerns, so it is important that the spiritual history contain more than just a simple listing of the patient's religion.

In order for a spiritual assessment to produce usable results, certain components must be present. Box 3.5 describes sample components of a general spiritual assessment.

Spiritual History Many spiritual history tools have been developed as a means to gain a broader understanding of the patient's beliefs, values, ability to find meaning and hope during suffering, and recognition of the role of religion in their life (Taylor, Testerman, & Hart, 2014). Numerous researchers have designed formal spiritual assessment tools, including the following well-known frameworks:

- Stoll (1979) introduced direct questioning as a method to assess spirituality and incorporated four basic areas for questioning: the patient's concept of God, sources of hope and strength, religious practices, and the relationship between spiritual beliefs and health.
- McSherry and Ross (2002) described methods for assessment of spirituality and spiritual needs as including direct questioning, indicator tools, and values clarification tools.
- Anadarajah and Hight (2001) developed the use of HOPE questions as a formal spiritual assessment in the patient interview. The mnemonic *HOPE* is explained as follows: *H* refers to questions about the patient's spiritual resources, including sources of hope, meaning, love, and comfort. *O* refers to participation in or association with organized religion. *P* includes personal spiritual practices. *E* refers to the effects of healthcare and end-of-life issues.
- Hodge (2001) described a narrative framework for spiritual assessment. This qualitative instrument incorporates a spiritual history and a framework to identify spiritual strengths as summarized in Box 3.6.

The FICA Spiritual History Tool, created in 1996 by Dr. Christina Puchalski, provides an efficient way to gather the key elements about a patient's spiritual beliefs. The FICA tool consists of four domains of spiritual assessment: *Faith* and belief; the *Importance* of spirituality in a person's life; the person's spiritual *Community*; and interventions to *Address* spiritual needs during care. The questions within the FICA tool are straightforward, are easily understandable, and identify the aspects of the patient's life that provide significant spiritual support. The information obtained opens the door for nurses and other healthcare providers to discuss issues of meaning to patients, including those involving healthcare decisions (Borneman, Ferrell, & Puchalski, 2010). See Box 3.7.

Spiritual Care Competence

Spiritual care competence by the nurse or healthcare provider is a continuous and holistic process that involves several aspects. Most important, it begins with an awareness and understanding of one's own spiritual values and beliefs. It is difficult to assess and support a patient experiencing spiritual distress without being comfortable knowing how your own spirituality influences your thinking, actions, and provision of care to others. Ask yourself the following questions:

- How comfortable are you asking patients about their spiritual beliefs, practices, and needs?
- How comfortable are you praying with a patient or asking a patient if prayer is desired?
- Do you have the skills needed to develop and implement a spiritual plan of care?
- How comfortable are you assessing a patient for signs of spiritual distress?

Your answers will indicate the areas that require growth in knowledge, comfort, and action (Hellman et al., 2015; Milner, Foito, & Watson, 2016).

Spiritual competence requires the nurse to know how to complete a spiritual assessment and be comfortable doing it. This

Box 3.5 Sample Components of a Spiritual Assessment

- Desire to discuss spirituality or religious beliefs
- Choice of individual with whom discussion of spirituality or region is preferred (e.g., nurse, hospital chaplain, physician, or another individual)
- Life philosophy or beliefs about life
- Affiliation with religion or particular spiritual beliefs
- Importance of spirituality or religion in daily life
- Significant spiritual rituals or practices, including prayer or meditation
- Conflicts between religious or spiritual beliefs and health-related treatments

Sources: Data from Williams, Meltzer, Arora, Chung, & Curlin. (2012). Attention to inpatients' religious and spiritual concerns: Predictors and association with patient satisfaction. *Journal of General Internal Medicine, 26*(11), 1265–1271; Hodge & Horvath. (2010). Spiritual needs in health care settings: A qualitative meta-synthesis of patients' perspectives. *Social Work, 56*(4), 306–316.

Box 3.6 Narrative Spiritual Assessment

Part I. Narrative Framework—Spiritual History

Sample Interview

1. Describe your personal and family religious traditions. (Include importance of religion and religious practices.)
2. What practices were important to you in youth? How have those experiences influenced your life?
3. How would you describe your religiosity or spirituality today? Do you believe your spirituality provides strength? How?

Part II. Interpretive Framework—Evokes Spiritual Strengths

1. ***Affect:*** How does spirituality affect joy, sorrow, coping? What part does spirituality play in providing hope?
2. ***Behavior:*** What rites or rituals do you use or follow? Do you have a relationship with a religious community or leader?
3. ***Cognition:*** Describe your current beliefs. Do your beliefs affect the ways you deal with difficulties or impact healthcare decisions?
4. ***Communion:*** What is your relationship with God? How do you communicate? Does your relationship help you in difficult times?
5. ***Conscience:*** Describe your values. How do you determine right and wrong?
6. ***Intuition:*** Have you experienced spiritual hunches, premonitions, or insights?

Source: Adapted from Hodge (2001). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46*(3), 203–214.

Box 3.7 FICA Spiritual History Tool©

F—Faith and Belief

"Do you consider yourself spiritual or religious?" or "Is spirituality something important to you?" or "Do you have spiritual beliefs that help you cope with stress/difficult times?" (Contextualize to reason for visit if it is not the routine history.)

If the patient responds "No," the healthcare provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

(The question of meaning should also be asked even if people answer yes to spirituality.)

I—Importance

"What importance does your spirituality have in your life? Has your spirituality influenced how you take care of yourself, your health? Does your spirituality influence you in your healthcare decision making (e.g., advance directives, treatment, etc.)?"

C—Community

"Are you a part of a spiritual community?" Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients. Can explore further: "Is this of support to you and how? Is there a group of people you really love or who are important to you?"

A—Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" (With the newer models, including diagnosis of spiritual distress, A also refers to the "Assessment and Plan" of patient spiritual distress or issues within a treatment or care plan.)

Source: Christina M. Puchalski, MD, FICA Spiritual History Tool, adapted from The FICA Spiritual History Tool #274, *Journal of Palliative Medicine, 17*(1), 2014.

includes collecting comprehensive information that is focused on the patient's spiritual history, beliefs, needs, and concerns. The assessment data must be collected on each patient and then incorporated into the patient's plan of care so it can be disseminated to all providers working with the patient. Recognition of the signs of spiritual distress and the plan of care that includes an empathetic response to the distress should be included. Evaluation of the plan of care should be completed frequently. Nurses must be able to care for the patient's physical needs while simultaneously incorporating the patient's spirituality, values, and beliefs into the plan of care (Taylor & Mamier, 2013; Williams et al., 2012).

The nurse has an obligation to prioritize meeting the holistic needs of all patients. Therefore, knowledge of cultural, spiritual, and language differences is essential in current practice. The nurse must examine his or her own cultural and spiritual values and beliefs and reflect on their significance to encounters and interactions with patients of diverse cultures and religions. The nurse must continue to learn about a variety of cultures, religions, and languages. When language differences exist, the nurse must use all resources possible to ensure that decisions are based on accurate information. These resources include the use of translators and written materials provided in the language of the patient. Last, the nurse must seek information about community resources to meet the needs of the diverse cultural and spiritual groups for whom care is provided.

Application Through Critical Thinking

CASE STUDY

Source: Eric Raptosh Photography/Getty Images.

Rachel Wood is a nursing student doing her rotation at a clinic that provides care to patients who do not have health insurance. Today she and the other students are seeing an older Latino woman from Mexico, Mrs. Reyes, who was in the United States visiting her granddaughter and became ill. Her granddaughter, Antonia, brought her to the clinic because she does not have any health insurance. Mrs. Reyes, whose native language is Spanish, does not speak English. Antonia speaks both English and Spanish, was born in the United States, and is a citizen. Her parents came here when they were in their twenties and are very happy here in the United States. Antonia lives with her parents and brother. Her grandmother wants to see a *curandero* (a traditional Latin American healer that she normally sees in Mexico), but her granddaughter is explaining to her that there are none in this area, and they need to see the nurse practitioner in the free clinic. Antonia says to her, "That is so old-fashioned, Grandma. No one does that here." The nurse practitioner requests a translator and then proceeds to interview the patient.

CRITICAL THINKING QUESTIONS

1. What is important for the nurse to understand about the culture as it relates to Mrs. Reyes?
2. Mrs. Reyes will need discharge educational materials. What standards support ensuring that these are available in Spanish?
3. Antonia's comment to her grandmother that "No one does that (sees a curandero) here" could be an example of assimilation. Why would that be true?
4. How should the nurse approach Mrs. Reyes's request for a curandero?
5. How should the nurse interact with the translator during the patient interview?

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Chapter 4

Health Disparities

LEARNING OUTCOMES

Upon completion of the chapter, you will be able to:

1. Explain health disparities in relation to vulnerable patient groups and their impact on the nurse's role in health assessment.
2. Identify the factors that influence health disparities in vulnerable populations.
3. Identify strategies to reduce and eliminate health disparities.

KEY TERMS

disabilities, 37
geography, 36
health disparities, 34
health equity, 35
mixed-status family, 38
social determinants of health, 37
vulnerable populations, 35

Introduction

Health disparities have been a major concern in healthcare for many years. They negatively affect groups of people who face socioeconomic and other burdens because of a variety of factors that are discussed in detail in this chapter. This often results in decreased quality of life, lack of access to healthcare, and poorer healthcare outcomes. It is essential for the nurse to have an understanding of the causes of health disparities, the impact disparities have on caring for patients, and strategies to address and remove these barriers so that all individuals can have equal access to healthcare.

Health Disparities

Some people in the United States, as well as globally, receive less or lower quality healthcare than others because of health disparities. **Health disparities** are "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (Centers for Disease Control and Prevention [CDC], 2015, para. 1). These gaps are grouped broadly into categories such as social, economic, demographic, and geographic disadvantages (CDC, 2013; National Partnership for Action to

End Health Disparities [NPA], n.d.; World Health Organization [WHO], 2018).

Disparity within a population is identified when there are higher rates of diseases, deaths, and suffering when compared with those in the general population (National Institute on Minority Health and Health Disparities, n.d.). **Vulnerable populations** are groups of individuals who are not well integrated into the healthcare system because of age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and other social risk factors. This isolation places members of these groups at risk for exclusion from necessary preventive or medical care, and thus it constitutes a potential threat to their health.

Many causes of disparities in vulnerable populations are controllable, but people within these populations often do not have the resources to be able to avoid these barriers and reach optimal health (NPA, n.d.). For example, a healthy living environment supports good health. However, many disadvantaged individuals live in housing that is older and may contain harmful mold, materials, or other substances (e.g., lead, asbestos). These individuals may also live in neighborhoods with high crime and violence that put them at risk for exposure to increased violence, causing a potential for physical injury, emotional stress, and a reduction in the ability to enjoy outdoor physical activity.

The WHO (2018) views health as a fundamental human right for all individuals. Therefore, attainment of equity is an essential goal. **Health equity** "is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (WHO, 2018, para. 1). Health equity means that all people have an equal opportunity to experience optimal health and healthcare (Office of Disease Prevention and Health Promotion [ODPHP], Healthy People 2020, 2017a; WHO, 2018). Although there have been some improvements toward the goal of equity, significant health disparities continue for vulnerable populations in the United States (National Quality Forum [NQF], 2017). Efforts to attain equity require a strong focus and commitment by all healthcare stakeholders to eliminate avoidable inequalities and address past and current injustices (NQF, 2017; ODPHP, Healthy People 2020, 2017a). Strategies for reducing disparities in vulnerable populations are discussed in more detail later in this chapter.

Health Disparities: Considerations for Nursing and Health Assessment

Nurses play a crucial role when performing health assessments for patients from vulnerable populations. The data from health assessments help to determine the patient's current and ongoing health status, predict risk, and identify health promotion activities. The data may assist the nurse in identifying barriers to healthcare caused by health disparities. Nurses can positively affect health disparities via interdisciplinary collaboration and by designing a plan of care with optimal health outcomes for the patient.

A focus on improving the availability and quality of care among persons who are experiencing health disparities—through patient history taking and physical examination—allows clinical interventions to become opportunities for each individual to attain his or her full health potential. For example, the Omaha System was developed for use in diverse practice settings such as public health, home health, and nurse-managed centers. It is a research-based system that documents patient assessment and nurse interventions directed toward wellness, support systems, and coping skills. Using this system identifies and categorizes teaching needs, guidance and counseling, treatments and procedures, case management, and surveillance to address health disparities of vulnerable populations (Thompson, Monsen, Wanamaker, Augustyniak, & Thompson, 2012).

Nurses also must be aware of the social factors linked to a patient's cultural identity during an assessment. Cultural competence in nursing is more than an understanding of race and ethnicity. It is an awareness and an acceptance of patients' health practices, beliefs, values, and attitudes in order to improve their health outcomes. Nurses must develop an awareness of their own cultural beliefs and cultural competence to effectively care for vulnerable individuals (NQF, 2017) (see Chapter 3, Cultural and Spiritual Considerations ∞).

Factors Influencing Health Disparities in Vulnerable Populations

The CDC (2013), in partnership with other organizations, continues to identify and address the different factors that may lead to health disparities. It assesses vulnerable populations as defined by the following:

- Race and ethnicity
- Age
- Gender
- Sexual orientation or gender identity
- Geography
- Disability status
- Socioeconomic status

Race and Ethnicity

People of color—often considered individuals of Asian, Hispanic/Latino, Black/African American, and American Indian/Alaska Native backgrounds (U.S. Department of Health and Human Services, Office of Minority Health, 2016)—make up more than 37% of the United States population (U.S. Census Bureau, 2016). Members of these communities of color tend to experience more issues with preventable diseases, death, and disabilities than do Caucasians (CDC, 2017a). These issues can be attributed to factors such as lack of access and utilization of care, as well as poor patient–provider interactions. In addition, minorities are more likely to be uninsured or underinsured and have an income below the poverty level (Artiga, Foutz, Cornachione, & Garfield, 2016). Box 4.1 gives examples of issues related to health disparities in communities of color.

Age

When performing a health assessment on a patient from the perspective of a vulnerable population, it is imperative that the nurse consider health issues that occur across the lifespan as they relate to a patient's cognitive and emotional development.

Box 4.1 Examples of Health Disparities among People of Color

- Some Asian Americans may contend with infrequent medical visits because of fear of deportation, language and cultural barriers, and lack of health insurance (U.S. Department of Health and Human Services, Office of Minority Health, 2017a).
- African Americans have the highest death rates from heart disease and stroke; the highest prevalence of hypertension, diabetes, and peritonitis; the largest HIV infection rate; and the highest death rate from homicide (National Institutes of Health, 2016).
- When compared with White individuals, African Americans are more likely to report barriers to seeing a healthcare provider because of cost (CDC, 2017b).
- Native Hawaiians/Pacific Islanders have higher rates of smoking, alcohol consumption, and obesity and have limited access to cancer prevention and screening programs (U.S. Department of Health and Human Services, Office of Minority Health, 2017c).
- Although the Indian Health Service (IHS) typically serves the health needs of the American Indian population, more than half of the people in this group do not permanently reside on reservations and have limited or no access to IHS services (U.S. Department of Health and Human Services, Office of Minority Health, 2017c).
- Factors that may contribute to poorer health outcomes among American Indians and Alaska Natives are cultural barriers, geographic isolation, inadequate sewage disposal, and economic factors (U.S. Department of Health and Human Services, Office of Minority Health, 2017c).
- There are higher rates of STDs among some communities of color compared with White individuals (CDC, 2017c).
- Hispanics/Latinos experience significantly higher rates of contracting gonorrhea, chlamydia, and syphilis when compared with White individuals, not because of ethnicity or heritage but because of social conditions (e.g., poverty, lower educational levels, lack of employment) that are more likely to affect people of color (CDC, 2017a).

Health disparities can affect individuals of certain age groups in different ways. In general, the very young and very old are often most vulnerable (Mid-America Regional Council [MARC], 2018). Examples of disparities related to certain age groups include the following:

- Infants and children who live in poverty and belong to certain communities of color, as described previously in this chapter, are at a higher risk for illness and death than infants and children in the broader population. Miller and Chen (2013) reported that childhood poverty rates in the United States have climbed steadily since the 2008 recession. Children of lower socioeconomic status may experience household crowding, inadequate nutrition, and more exposure to secondhand smoke.
- In adolescents, risky behaviors (e.g., alcohol and drug use, tobacco use, unhealthy dietary behaviors, sexual risk behaviors) are more prevalent in vulnerable populations (Thompson, Connelly, Thomas-Jones, & Eggert, 2013).
- Older adults often face unique healthcare challenges that predispose them to the need for medical care. However, accessing care can be an issue because of lack of transportation and cost (Psychology Benefits Society, 2016).

Gender

Healthcare disparities can also be addressed in the context of gender issues. Some studies have found that disparities between men and women exist in the diagnosis of certain health conditions and recommendations of treatment (Kent, Patel, & Varela, 2012). Nurses should be aware of resources to assist in reducing disparities because of gender.

For example, programs such as Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) provide low-income, under- or uninsured women with the knowledge, skills, and opportunities to improve their diet, physical activity, and other lifestyle behaviors to prevent, delay, and control cardiovascular and other chronic diseases (CDC, 2017d).

Sexual Orientation and Gender Identity

Researchers in the field of gender identity development have raised awareness that gender is not exclusively determined by an assigned sex at birth but, rather, is determined by a person's sense, belief, and ultimate expression of self (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, 2012). Lesbian, gay, bisexual, and transgender (LGBT) individuals experience health disparities associated with societal stigma, discrimination, and denial of their civil and human rights (ODPHP, Healthy People 2020, 2018). High rates of psychiatric disorders, substance abuse, and suicide are linked to discrimination against individuals in this group.

It is important to routinely ask all patients questions regarding gender identity and sexuality in a way that is free of bias and demonstrates cultural competence. When addressing patients, the nurse should always ask how they identify and/or how they wish to be addressed (BWHC LGBT & Allies Employee Resource Group, 2016). One must be careful not to assume how a patient identifies him or herself. Rather, the nurse must be skillful in understanding how to build a rapport and trusting relationship with the patient and how to ask questions as part of the health history to accurately document gender and sexuality. As with many vulnerable populations, in order to ensure sensitivity to LGBT individuals, nurses must possess an awareness and understanding of the terms and definitions that are specific to the LGBT population. Table 4.1 lists terms and definitions related to gender identity.

Geography

Geographic location can have a significant impact on the health of vulnerable populations. **Geography** refers to the country, region, section, community, or neighborhood in which one was born and raised or in which one currently resides or works. Residing in a metropolitan (urban) area or residing in a rural

Table 4.1 Terms and Definitions Specific to Sexual Orientation and Gender Identity

TERM	DEFINITION
Bigender	A person whose gender identity encompasses both male and female genders. Some may feel that one identity is stronger, but both are present.
Female to Male (FTM)	A person who transitions from female to male, meaning a person who was assigned the female sex at birth but identifies and lives as a male. Also known as a transgender man.
Gender Identity	A person's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.
Gender Nonconforming	A person whose gender expression is different from societal expectations related to their perceived gender.
Genderqueer	A term used by persons who may not entirely identify as either male or female.
Male to Female (MTF)	A person who transitions from male to female, meaning a person who was assigned the male sex at birth but identifies and lives as a female. Also known as a transgender woman.
Transgender	A person whose gender identity and/or expression are different from that typically associated with their assigned sex at birth. *Note: The term* transgender *has been used to describe a number of gender minorities including, but not limited to, transsexuals, cross-dressers, androgynous people, genderqueers, and gender nonconforming people.* Trans *is shorthand for* "transgender."
Transgender Man	A transgender person who currently identifies as a male (see also FTM).
Transgender Woman	A transgender person who currently identifies as a female (see also MTF).
Transsexual	A person whose gender identity differs from their assigned sex at birth.
Two-Spirit (2-S)	A contemporary term that references historical multiple-gender traditions in many First Nations cultures. Many Native/First Nations people who are lesbian, gay, bisexual, transgender, or gender nonconforming identify as Two-Spirit. In many First Nations, Two-Spirit status carries great respect and leads to additional commitments and responsibilities to one's community.

area presents geographic challenges for some individuals seeking healthcare. Individuals living in rural areas can be disproportionately affected by the physical locations of healthcare services. For example, hospitals may be farther away, the number of providers may be limited, and specialists may be unavailable. Patients with limited financial resources may be unable or reluctant to travel long distances for routine preventive care. Alternatively, for those living in urban areas, the cost of in-city transportation may pose a barrier to access to healthcare services. In either scenario, health conditions may consequently go undiagnosed or untreated and become more serious.

Disabilities

Individuals with **disabilities** are people who may be in need of healthcare services because of a variety of health concerns. They include people with mental health problems, learning disabilities, and physical disabilities or illnesses that result in a degree of dependence on others. Disabled persons are considered a vulnerable population and are at higher risk for experiencing barriers in healthcare than other members of the population. Several chronic disorders—such as asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and inflammatory bowel disease—can also be reasons for a person to experience disability, especially as the disease progresses.

Some disabilities can be hidden or difficult to recognize. The International Classification of Functioning, Disability and Health (ICF) provides a standard language for classifying changes in body function and structure, activity, participation levels, and environmental factors that influence health. The ICF can help assess the health and functioning activities and factors that can help or create barriers to fully participation in society (WHO, 2017a).

The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) demonstrates advantages over other assessment instruments for health and disability; this assessment is short, simple to administer, and applicable across cultures and clinical and general population settings (WHO, 2017b). The instrument covers cognition, mobility, self-care, getting along with others, life activities, and participation.

The Disability and Health Data System (DHDS) is an innovative disability and health data tool that is used to identify disparities in health between adults with and without disabilities. The DHDS allows for comparing answers to questions on a state-by-state basis for the percentage of disabilities by age, sex, race/ethnicity, and veteran status; percentage of those who smoke; obesity; vaccine coverage; and preventive services (CDC, 2016). Access this comprehensive data tool for the 50 United States by using this link: www.cdc.gov/ncbddd/disabilityandhealth/dhds.html.

Socioeconomic Status

Social determinants of health are the situations in which a person is born, lives, works, and ages, as well as the systems in place to deal with illness (ODPHP, Healthy People 2020, 2017b). The CDC (2014) further defines social determinants of health as "the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities" (para. 14). The WHO (2017a) addresses socioeconomic disparities as a major concern in the United States and globally.

Socioeconomic status (SES) is often a main contributor or compounding issue affecting health disparities in vulnerable populations. Income and education are two of the most common factors in determining SES. SES disparities within vulnerable populations have been noted in this chapter, but there are other groups of individuals who are considered vulnerable and for whom SES is often a contributing factor.