Harding Kwong Roberts Hagler Reinisch

Lewis's Medical-Surgical Nursing

Assessment and Management of Clinical Problems

Eleventh Edition

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Lewis's Medical-Surgical Nursing

Assessment and Management of Clinical Problems

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To the Profession of Nursing and to the Important People in Our Lives

Mariann

My husband Jeff, our daughters
Kate and Sarah,
and my parents, Mick and Mary.

Jeff

My parents, Raymond and Virginia,
thank you for believing in me and
providing me the opportunity to become a nurse.

Dottie

My husband Steve and my children Megan, E.J., Jessica, and Matthew, who have supported me through four college degrees and countless writing projects; and to my son-in-law Al, our grandsons Oscar and Stephen, and my new daughter-in-law Melissa.

Debbie

My husband James, our children Matthew,
Andrew, Amanda, and Diana, and our granddaughter Emma.

Courtney

To future nurses and the advancement of health care globally.

PREFACE

The eleventh edition of *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems* incorporates the most current medical-surgical nursing information in an easy-to-use format. This textbook is a comprehensive resource containing the essential information that students need to prepare for class, examinations, clinical assignments, and safe and comprehensive patient care. The text and accompanying resources include many features to help students learn key medical-surgical nursing content, including patient and caregiver teaching, gerontology, interprofessional care, cultural and ethnic considerations, patient safety, genetics, nutrition and drug therapy, evidence-based practice, and much more.

To address the rapidly changing practice environment, all efforts were directed toward building on the strengths of the previous editions while delivering this more effective new edition. To help students and faculty members focus on the most important concepts in patient care, most chapters open with a conceptual focus that introduces students to the common concepts shared by patients experiencing the main exemplars discussed in the chapter. This edition features more body maps and has many new illustrations. Lengthy diagnostic tables in the assessment chapters have been separated into specific categories, including radiologic studies and serology studies. The previously combined visual and auditory content is now in separate chapters focusing on the assessment and management of vision and hearing disorders. New Promoting Population Health boxes address strategies to improve health outcomes.

For a text to be effective, it must be understandable. In this edition, great effort has been put into improving the readability and lowering the reading level. Students will find more clear and easier-to-read language, with an engaging conversational style. The narrative addresses the reader, helping make the text more personal and an active learning tool. The language is more positive. For example, particular side effects and complications are referred to as *common,* as opposed to *not uncommon.*

International Classification for Nursing Practice (ICNP) nursing diagnoses, one of the terminologies recognized by the American Nurses Association, are used throughout the text and ancillary materials. The language is similar to that of NANDA-I. ICNP nursing diagnoses are used in many facilities worldwide to document nursing care in electronic health records. By introducing students to the ICNP nursing diagnoses, students will learn a more shared vocabulary. This should translate into the more accurate use of diagnostic language in clinical practice across healthcare settings.

Contributors were selected for their expertise in specific content areas; one or more specialists in a given subject area have thoroughly reviewed each chapter to increase accuracy. The editors have undertaken final rewriting and editing to achieve internal consistency. The comprehensive and timely content, special features, attractive layout, full-color illustrations, and student-friendly writing style combine to make this the textbook used in more nursing schools than any other medical-surgical nursing textbook.

ORGANIZATION

Content is organized into 2 major divisions. The first division, Sections 1 through 3 (Chapters 1 through 16), discusses general concepts related to the care of adult patients. The second division, Sections 4 through 13 (Chapters 17 through 68), presents nursing assessment and nursing management of medical-surgical problems. At the beginning of each chapter, the Conceptual Focus helps students focus on the key concepts and integrate concepts with exemplars affecting different body systems. Learning Outcomes and Key Terms assist students in identifying the key content for that chapter.

The various body systems are grouped to reflect their interrelated functions. Each section is organized around 2 central themes: assessment and management. Chapters dealing with assessment of a body system include a discussion of the following:

1. A brief review of anatomy and physiology, focusing on information that will promote understanding of nursing care
2. Health history and noninvasive physical assessment skills to expand the knowledge base on which treatment decisions are made
3. Common diagnostic studies, expected results, and related nursing responsibilities to provide easily accessible information

Management chapters focus on the pathophysiology, clinical manifestations, diagnostic studies, interprofessional care, and nursing management of various diseases and disorders. The nursing management sections are presented in a consistent format, organized into assessment, nursing diagnoses, planning, implementation, and evaluation. To emphasize the importance of patient care in and across various clinical settings, nursing implementation of all major health problems is organized by the following levels of care:

1. Health Promotion
2. Acute Care
3. Ambulatory Care

SPECIAL FEATURES

The 6 competencies for registered nursing practice identified by QSEN serve as the foundation of the text and are highlighted in the core content, case studies, and nursing care plans.

- ***New!*** **Nursing Management** tables and boxes focus on the actions nurses need to take to deliver safe, quality, effective patient care.
- ***New!*** **Diagnostic Studies** tables focus on the specific type of study, such as interventional, serologic, or radiologic, with more detailed information on interpreting results and associated nursing care.
- **Cultural and ethnic health disparities** content and boxes in the text highlight risk factors and important issues related to the nursing care of various ethnic groups. A special Culturally Competent Care heading denotes cultural and ethnic content related to diseases and disorders. Chapter 2 (Health Equity and Culturally Competent Care) discusses health status differences among groups of people related to access to care, economic aspects of health care, gender and cultural issues, and the nurse's role in promoting health equity.
- **Interprofessional care** is highlighted in special Interprofessional Care sections in all management chapters and Interprofessional Care tables throughout the text.

- **Focused Assessment boxes** in all assessment chapters provide brief checklists that help students do a more practical "assessment on the run" or bedside approach to assessment. They can be used to evaluate the status of previously identified health problems and monitor for signs of new problems.
- **Safety Alert boxes** highlight important patient safety issues and focus on the National Patient Safety Goals.
- **Pathophysiology Maps** outline complex concepts related to diseases in a flowchart format, making them easier to understand.
- **Patient and caregiver teaching** is an ongoing theme throughout the text. Chapter 4 (Patient and Caregiver Teaching) emphasizes the increasing importance and prevalence of patient management of chronic illnesses and conditions and the role of the caregiver in patient care.
- ***New!* Conceptual Focus** at the beginning of each chapter helps students focus on the key concepts and integrate concepts with exemplars affecting different body systems.
- **Gerontology and chronic illness** are discussed in Chapter 5 (Chronic Illness and Older Adults) and included throughout the text under Gerontologic Considerations headings and in Gerontologic Differences in Assessment tables.
- **Nutrition** is highlighted throughout the textbook. Nutritional Therapy tables summarize nutritional interventions and promote healthy lifestyles in patients with various health problems.
- ***New!* Promoting Population Health boxes** present health care goals and interventions as they relate to specific disorders, such as diabetes and cancer, and to health promotion, such as preserving hearing and maintaining a healthy weight.
- **Extensive drug therapy** content includes Drug Therapy tables and concise Drug Alerts highlighting important safety considerations for key drugs.
- **Genetics content** includes:
  - Genetics in Clinical Practice boxes that summarize the genetic basis, genetic testing, and clinical implications for genetic disorders that affect adults
  - A genetics chapter that focuses on practical application of nursing care as it relates to this important topic
  - Genetic Risk Alerts in the assessment chapters, which call attention to important genetic risks
  - Genetic Link headings in the management chapters, which highlight the specific genetic bases of many disorders
- **Gender Differences** boxes discuss how women and men are affected differently by conditions such as pain and hypertension.
- **Check Your Practice boxes** challenge students to think critically, analyze patient assessment data, and implement the appropriate intervention. Scenarios and discussion questions are provided to promote active learning.
- **Complementary & Alternative Therapies boxes** expand on this information and summarize what nurses need to know about therapies such as herbal remedies, acupuncture, and yoga.
- **Ethical/Legal Dilemmas boxes** promote critical thinking for timely and sensitive issues that nursing students may deal with in clinical practice—topics such as informed consent, advance directives, and confidentiality.
- **Emergency Management tables** outline the emergency treatment of health problems most likely to require emergency intervention.
- **Nursing care plans** on the Evolve website focus on common disorders or exemplars. These care plans incorporate ICNP nursing diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) in a way that clearly shows the linkages among NIC, NOC, and nursing diagnoses and applies them to nursing practice.
- Coverage on delegation and prioritization includes:
  - Specific topics and skills related to delegation and the nurse's role in working with members of the interprofessional team, which are detailed in Nursing Management tables.
  - Delegation and prioritization questions in case studies and Bridge to NCLEX Examination Questions.
  - Nursing interventions throughout the text, listed in order of priority.
  - Nursing diagnoses in the nursing care plans, listed in order of priority.
- **Assessment Abnormalities tables** in assessment chapters alert the nurse to commonly encountered abnormalities and their possible etiologies.
- **Nursing Assessment tables** summarize the key subjective and objective data related to common diseases. Subjective data are organized by functional health patterns.
- **Health History tables** in assessment chapters present key questions to ask patients related to a specific disease or disorder.
- **Evidence-based practice** is covered in Applying the Evidence boxes and evidence-based practice-focused questions in the case studies. Applying the Evidence boxes use a case study approach to help students learn to use evidence in making patient care decisions.
- **Informatics boxes and content** in Chapter 4 (Patient and Caregiver Teaching) reflect the current use and importance of technology as it relates to patient self-management.
- **Bridge to NCLEX® Examination Questions** at the end of each chapter are matched to the Learning Outcomes and help students learn the important points in the chapter. Answers are provided just below the questions for immediate feedback, and rationales are provided on the Evolve website.
- **Case Studies** with photos bring patients to life. Management chapters have case studies at the end of the chapters. These cases help students learn how to prioritize care and manage patients in the clinical setting. Unfolding case studies are included in each assessment chapter, and case studies that focus on managing care of multiple patients are included at the end of each section. Discussion questions with a focus on prioritization, delegation, and evidence-based practice are included in all case studies. Answer guidelines are provided on the Evolve website.

LEARNING SUPPLEMENTS FOR STUDENTS

- The handy **Clinical Companion** presents approximately 200 common medical-surgical conditions and procedures in a concise, alphabetical format for quick clinical reference. Designed for portability, this popular reference includes the essential, need-to-know information for treatments and procedures in which nurses play a major role. An attractive and functional four-color design highlights key information for quick, easy reference.
- An exceptionally thorough **Study Guide** contains over 500 pages of review material that reflect the content found in

the textbook. It features a wide variety of clinically relevant exercises and activities, including NCLEX-format multiple choice and alternate format questions, case studies, anatomy review, critical thinking activities, and much more. It features an attractive four-color design and many alternate-item format questions to better prepare students for the NCLEX examination. An answer key is included to provide students with immediate feedback as they study.

- The **Evolve Student Resources** are available online at *http://evolve.elsevier.com/Lewis/medsurg* and include the following valuable learning aids organized by chapter:
  - Printable **Key Points** summaries for each chapter.
  - 1000 NCLEX examination **Review Questions.**
  - **Answer Guidelines** to the case studies in the textbook.
  - **Rationales for the Bridge to NCLEX® Examination Questions** in the textbook.
  - 55 **Interactive Case Studies** with state-of-the-art animations and a variety of learning activities, which provide students with immediate feedback. Ten of the case studies are enhanced with photos and narration of the clinical scenarios.
  - Customizable **Nursing Care Plans** for over 60 common disorder or exemplars.
  - **Conceptual Care Map Creator.**
  - **Audio glossary** of key terms, available as comprehensive alphabetical glossary and organized by chapter.
  - **Fluids and Electrolytes Tutorial.**
  - **Content Updates.**
- More than just words on a screen, **Elsevier eBooks** come with a wealth of built-in study tools and interactive functionality to help students better connect with the course material and their instructors. In addition, with the ability to fit an entire library on one portable device, students have the ability to study when, where, and how they want.

TEACHING SUPPLEMENTS FOR INSTRUCTORS

- The **Evolve Instructor Resources** (available online at *http://evolve.elsevier.com/Lewis/medsurg*) remain the most comprehensive set of instructor's materials available, containing the following:
  - **TEACH for Nurses Lesson Plans** with electronic resources organized by chapter to help instructors develop and manage the course curriculum. This exciting resource includes:
    - Objectives
    - Pre-class activities
    - Nursing curriculum standards
    - Student and instructor chapter resource listings
    - Teaching strategies, with learning activities and assessment methods tied to learning outcomes
    - **Case studies** with answer guidelines
  - The **Test Bank** features over 2000 NCLEX examination test questions with text page references and answers coded for NCLEX Client Needs category, nursing process, and cognitive level. The test bank includes hundreds of prioritization, delegation, and multiple patient questions. All alternate-item format questions are included. The ExamView software allows instructors to create new tests; edit, add, and delete test questions; sort questions by NCLEX category, cognitive level, nursing process step, and question type; and administer and grade online tests.
  - The **Image Collection** contains more than 800 full-color images from the text for use in lectures.
  - An extensive collection of **PowerPoint Presentations** includes over 125 different presentations focused on the most common diseases and disorders. The presentations have been thoroughly revised to include helpful instructor notes/teaching tips, unfolding case studies, illustrations and photos not found in the book, new animations, and updated audience response questions for use with iClicker and other audience response systems.
  - Course management system.
  - Access to all student resources listed above.
- The **Simulation Learning System (SLS)** is an online toolkit that helps instructors and facilitators effectively incorporate medium- to high-fidelity simulation into their nursing curriculum. Detailed patient scenarios promote and enhance the clinical decision-making skills of students at all levels. The SLS provides detailed instructions for preparation and implementation of the simulation experience, debriefing questions that encourage critical thinking, and learning resources to reinforce student comprehension. Each scenario in the SLS complements the textbook content and helps bridge the gap between lecture and clinical. The SLS provides the perfect environment for students to practice what they are learning in the text for a true-to-life, hands-on learning experience.

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We sincerely hope that this book will assist both students and clinicians in practicing truly professional nursing.

Mariann M. Harding
Jeffrey Kwong
Dottie Roberts
Debra Hagler
Courtney Reinisch

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1

Professional Nursing

Mariann M. Harding

Caring is the essence of nursing.

Jean Watson

http://evolve.elsevier.com/Lewis/medsurg/

CONCEPTUAL FOCUS

Care Competencies
Leadership
Professional Identity

LEARNING OUTCOMES

1. Describe professional nursing practice in terms of domain, definitions, and recipients of care.
2. Compare the different scopes of practice available to professional nurses.
3. Describe the role of critical thinking skills and using the nursing process to provide patient-centered care.
4. Apply the SBAR procedure and effective communication techniques in the clinical setting.
5. Explore the role of the professional nurse in delegating care to licensed practical/vocational nurses and unlicensed assistive personnel.
6. Discuss the role of integrating safety and quality improvement processes into nursing practice.
7. Evaluate the role of informatics and technology in nursing practice.
8. Apply concepts of evidence-based practice to nursing practice.

KEY TERMS

advanced practice registered nurse (APRN), p. 2
case management, p. 7
clinical pathways, p. 9
clinical reasoning, p. 8
critical thinking, p. 8
delegation, p. 9
electronic health records (EHRs), p. 13
evidence-based practice (EBP), p. 13
interprofessional team, p. 8
nursing, p. 2
nursing process, p. 4
SBAR (Situation-Background-Assessment-Recommendation), p. 9
serious reportable event (SRE), p. 10
telehealth, p. 8

This chapter presents an overview of professional nursing practice, discussing the wide variety of roles and responsibilities that nurses fulfill to meet society's health care needs. This overview includes several key concepts that are part of competent nursing practice. These include safety, quality, informatics, and collaboration.

PROFESSIONAL NURSING PRACTICE

Domain of Nursing Practice

Nursing practice today consists of a wide variety of roles and responsibilities necessary to meet society's health care needs. As a nurse, you are the frontline professional of health care (Fig. 1.1). You can practice in virtually all health care settings and communities. You have never been more important to health care than you are today. As a nurse, you (1) offer skilled care to those recuperating from illness or injury, (2) advocate for patients' rights, (3) teach patients to manage their health, (4) support patients and their caregivers at critical times, and (5) help them navigate the complex health care system. Although many nurses work in acute care facilities, nurses also practice in long-term care, home care, community health, public health centers, schools, and ambulatory or outpatient clinics. Wherever you practice, recipients of your care include individuals, families, groups, or communities.

The American Nurses Association (ANA) states that the authority for nursing practice is based on a contract with society that acknowledges professional rights and responsibilities, as well as mechanisms for public accountability.[1] The knowledge and skills that make up nursing practice are based on

FIG. 1.1 Nurses are frontline professionals of health care. (© Michael Jung/iStock/Thinkstock.)

society's expectations and needs. Nursing practice continues to evolve according to society's health care needs and as knowledge and technology expand. This chapter introduces concepts and factors that affect professional nursing practice.

Definitions of Nursing

Well-known definitions of nursing show that the basic themes of health, illness, and caring have existed since Florence Nightingale described nursing. Following are 2 such examples:

- Nursing is putting the patient in the best condition for nature to act (Nightingale).[2]
- The nurse's unique function is to aid patients, sick or well, in performing those activities contributing to health or its recovery (or to peaceful death) that they would perform unaided if they had the necessary strength, will, or knowledge—and to do this in such a way as to help them gain independence as rapidly as possible (Henderson).[3]

In 1980 the ANA defined **nursing** as "the diagnosis and treatment of human responses to actual and potential health problems."[1] In this context, your care of a person with a fractured hip would focus on the patient's response to impaired mobility, pain, and loss of independence. The 2010 edition of the ANA's *Nursing: A Social Policy Statement* provided a new definition of nursing that reflects the continuing evolution of nursing practice:

> ***Nursing*** *is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.*[1]

Nursing's View of Humanity

A person has physiologic (or biophysical), psychologic (or emotional), sociocultural (or interpersonal), spiritual, and environmental components or dimensions. In this book, we consider a person to be in constant interaction with a changing environment. A person is composed of interrelated dimensions and not separate entities. Thus a problem in 1 dimension may affect 1 or more of the other dimensions. A person's behavior is meaningful and oriented toward fulfilling needs, coping with stress, and developing one's self. However, at times a person needs help to meet these needs, cope successfully, or develop his or her unique potential.

Scope of Nursing Practice

The essential core of nursing practice is to deliver holistic, patient-centered care. It includes assessment and evaluation, giving a variety of interventions, patient and family teaching, and being a member of the interprofessional health care team.

The extent that nurses engage in their scope of practice depends on their educational preparation, experience, role, and state law. To enter practice, a nurse must complete an accredited program and pass an examination verifying that the nurse has the knowledge necessary to provide safe care. Entry-level nurses with associate or baccalaureate degrees are prepared to function as generalists. At this level, nurses provide direct health care and focus on ensuring coordinated and comprehensive care to patients in a variety of settings. Nurses work collaboratively with other health care providers to manage the needs of persons and groups.

With experience and continued study, nurses may specialize in a specific practice area. Certification is a formal way for nurses to obtain professional recognition for having expertise in a specialty area. A variety of nursing organizations offer certification in nursing specialties.[4] Certification usually requires a certain amount of clinical experience and successful completion of an examination. Recertification usually requires ongoing clinical experience and continuing education. Common nursing specialties include critical care, women's health, geriatric, medical-surgical, perinatal, emergency, psychiatric/mental health, and community health nursing.

Additional formal education and experience can prepare nurses for advanced practice. An **advanced practice registered nurse (APRN)** is a nurse educated at the master's or doctoral level, with advanced education in pathophysiology, pharmacology, and health assessment and expertise in a specialized area of practice. APRNs include clinical nurse specialists, nurse practitioners, nurse midwives, and nurse anesthetists. APRNs play a vital role in the health care delivery system. In addition to managing and delivering direct patient care, APRNs have roles in leadership, quality improvement, evidence-based practice, and informatics.

The doctor of nursing practice (DNP) degree is a practice-focused terminal nursing degree. With raising the educational preparation for APRNs to the doctoral level, nursing is at the same level as other health professions that offer practice doctorates (e.g., pharmacy [PharmD], physical therapy [DPT]). Nurses with a research-focused doctorate (PhD) typically are used in health care settings as nurse faculty, clinical experts, researchers, and health care system executives.

Standards of Professional Nursing Practice

To guide nurses in how to perform professionally, the ANA defined Standards of Professional Nursing Practice. There are 2 parts, Standards of Practice and Standards of Professional Performance.[5] The Standards of Practice describe a competent level of nursing care, based on the nursing process. The Standards of Professional Performance describe behavioral competencies expected of a nurse. You are following the performance standards when you practice ethically and use evidence-based practice. Communicating effectively and staying

competent in practice are important. You must be able to work in collaboration with other interprofessional team members, patients, and caregivers.

INFLUENCES ON PROFESSIONAL NURSING PRACTICE

Expanding Knowledge and Technology

Ever-changing technology and rapidly expanding clinical knowledge add to the complexity of health care. The increased treatment, diagnostic, and care options available are changing care delivery and extending patients' lives. Discoveries in genetics are changing the way we think about diseases such as cancer and heart disease. For example, genetic information guides breast cancer screening. If a woman has cancer, this information allows for treatment and drug therapy based on her genetic makeup. Ethical dilemmas and controversies arise about the use of new scientific knowledge and the disparities that exist in patients' access to technologically advanced health care. Throughout this book, genetics, informatics, and ethical/legal boxes highlight expanding knowledge and technology's impact on nursing practice.

Diverse Populations

Patient populations are more diverse than ever. Americans are living longer, with the number of people with chronic illnesses and multiple co-morbidities increasing. Unlike those who receive acute, episodic care, patients with chronic illnesses have complex needs. They see different health care providers in various settings over an extended period. With care shifting from hospitals and nursing homes to managed care in the community, you need to be able to manage and coordinate care when patients are transitioning among different settings.

At the same time, you will be caring for a more culturally and ethnically diverse population. When delivering care, you must consider the patient's and caregiver's cultural beliefs and values. Immigrants, particularly undocumented immigrants, often lack the resources necessary to access health care. Inability to pay for health care is related to a tendency to delay seeking care, resulting in illnesses that are more serious at the time of diagnosis. Boxes throughout this book emphasize the influence of such factors as gender, culture, and ethnicity on nursing practice.

Consumerism

Health care is a consumer-focused business, and patients today are more involved in their health care. They want more control over their health care and expect high-quality, coordinated, and financially reasonable care. Health information is readily available. Many patients are very knowledgeable about their health and seek information about health problems and health care from media and Internet sources. They gather information so that they can have a voice in making decisions about their health care. As a nurse, you must be able to help patients access, interpret, and use safe health care information (Fig. 1.2).

Health Care Financing

High health care costs are a growing problem. There are many reasons for the continued increase in costs. These include the rising use of prescription medications, administrative costs, and new medical innovations and treatments.[6] Many changes in health care systems that influence nursing care delivery are started by the government, employers, insurance companies, and regulating agencies. They are usually in effort to contain spending and provide more cost-effective health care. Historically, the most notable event related to reimbursement was the establishment of prospective payment systems in the Medicare program. With this system, payment for hospital services for Medicare patients are based on flat fees determined by the diseases and problems treated during the admission. For example, if a patient had a total knee replacement, the hospital receives a set sum of money, such as $45,000, for the patient's care.

FIG. 1.2 The patient, family, and nurse collaborate as part of coordinating high-quality care. (© monkeybusinessimages/iStock/Thinkstock.)

Other health care systems followed by introducing managed care systems that use prospective payment as a means of offering cost-effective health care delivery. In health maintenance organizations (HMOs) and preferred provider organizations (PPOs), charges are negotiated before the delivery of care using fixed reimbursement rates or capitation fees for medical care, hospitalization, and other health care services.

Now, quality and performance initiatives are driving further changes in health care financing. Value-based purchasing programs base reimbursement to health care providers on their performance on certain quality measures. These quality measures include clinical outcomes, patient safety, patient satisfaction, and the provider's adherence to evidence-based practice. Those who provide quality care at a lower cost may receive more payment.

As part of value-based purchasing, payment for care can be withheld if a patient experiences events such as developing a pressure injury during a hospital stay or having something happen that is considered preventable (e.g., a fall-related injury, having wrong-site surgery).[7] This type of event is considered a *serious reportable event (SRE)*. SREs are discussed later in this chapter on p. 10.

Health Policy

Legislation has serious implications for health care delivery and nursing practice. The 2010 Patient Protection and Affordable Care Act (ACA) was the most important health care legislation since the creation of Medicare in 1965. The ACA triggered changes throughout the health care system. The ACA's main goal was to increase access to health care. The ACA created new health care delivery and payment models that emphasized teamwork, care coordination, and quality care.

The ACA encourages the creation of accountable care organizations (ACOs). ACOs are groups of physicians, hospitals, and other health care providers who unite to coordinate care for Medicare patients. The goal of an ACO is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding duplicate services and preventing errors. As a nurse, you must take a leadership role in creating health care systems that provide safe, quality, patient-centered care.

Professional Nursing Organizations

The ANA is the primary professional nursing organization. There are many professional specialty organizations, such as the American Association of Critical-Care Nurses (AACN), National Association of Orthopedic Nurses (NAON), and Oncology Nursing Society (ONS). Professional organizations play a role in promoting quality patient care and professional nursing practice. These roles include developing standards of practice and codes of ethics, supporting research, and lobbying for legislation and regulations. Major nursing organizations promote research into the causes of errors, develop strategies to prevent future errors, and address nursing issues that affect the nurse's ability to deliver patient care safely. Nurses join a professional organization to keep current in their practice and network with others who are interested in a specific practice area.

A program that supports nurses is the American Nurses Credentialing Center's Magnet Recognition Program. The Magnet program "recognizes health care organizations for quality patient care, nursing excellence and innovations in professional nursing practice."[8] Magnet designation shows a high quality of nursing care and achievement of a positive practice environment for nurses. Nurses who work in Magnet facilities have low turnover and burnout rates and more opportunities for professional and personal growth. This leads to better patient outcomes and greater career satisfaction.

Nursing Core Competencies

Several high-profile reports over the past 20 years have highlighted problems with the quality of health care. One of these reports, *The Future of Nursing: Leading Change, Advancing Health,* acknowledged the link between professional nursing practice and health care delivery. The report discussed how health care providers, including nurses, were not being adequately prepared to provide the highest quality care possible. It recommended making changes so that nurses will have the skills to advance health care and play leadership roles in the health care system[9] (Table 1.1).

To address nursing's role in solving these problems, the Robert Wood Johnson Foundation funded the *Quality and Safety Education for Nurses (QSEN) Institute.* QSEN has made a major contribution to nursing by defining specific competencies that nurses need to have to practice safely and effectively in today's complex health care system. The rest of this chapter describes each of the 6 QSEN nursing core competencies and the knowledge, skills, and attitudes (KSAs) necessary in each area: (1) patient-centered care, (2) teamwork and collaboration, (3) safety, (4) quality improvement, (5) informatics, and (6) evidence-based practice[10] (Table 1.2). When you are licensed as a registered nurse, you accept responsibility to base your practice on these core competencies.

TABLE 1.1 Key Messages for the Future of Nursing

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve high education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other health professionals in redesigning health care.
- Effective workforce planning and policy making require better data collection and information infrastructure.

Source: IOM (now HMD) recommendations. Retrieved from *www.thefutureofnursing.org/recommendations.*

PATIENT-CENTERED CARE

Nurses have long shown that they deliver patient-centered care based on each patient's unique needs and understanding of the patient's preferences, values, and beliefs. Patient-centered care is interrelated with quality and safety. In a patient-centered care model, patients and caregivers seek and receive care from competent and knowledgeable health care professionals. In addition, patients and caregivers are involved in making decisions and coordinating care.

Nursing Process

Nurses provide patient-centered care using an organizing framework called the *nursing process*. The **nursing process** is a problem-solving approach to the identification and treatment of patient problems that is the foundation of nursing practice. The nursing process framework provides a structure for delivering nursing care and the knowledge, judgments, and actions that nurses use to achieve best patient outcomes. Once started, the nursing process is continuous and cyclic.

The nursing process consists of 5 phases: assessment, diagnosis, planning, implementation, and evaluation (Fig. 1.3). There is a basic order to the nursing process, beginning with assessment. *Assessment* is the collection of subjective and objective patient information on which you will base your plan of care. *Diagnosing* is the act of analyzing the assessment data and making a judgment about the nature of the data. It includes your identifying nursing diagnoses or problems and collaborative problems. During *planning,* you use nursing diagnoses and problems to develop patient outcomes or goals and identify nursing interventions to accomplish the outcomes. *Implementation* is the activation of the plan with the use of nursing interventions. *Evaluation* is a continual activity. During evaluation you decide whether the patient outcomes have been met because of the nursing interventions. If the outcomes were not met, a review of the steps of the process is necessary to figure out why not. You may need to revise the assessment (data collection), nursing diagnoses, planning (determining patient outcomes), or implementation (nursing interventions).

Standard Nursing Terminologies

The demands of the health care system challenge nursing to define its contribution to health care. The nursing profession can describe its unique role by answering questions such as: What do nurses do? How do they do it? How does it make a measurable difference in the health of those for whom they care? How are nursing's contributions different from those of medicine?

In response to these questions, nursing uses standard terminologies (also called *classification systems* or *taxonomies*) to define and evaluate nursing care. This promotes continuity of patient care and gives data showing nursing's impact on patient outcomes. Instead of using a variety of words to describe the

TABLE 1.2 QSEN Competencies

Competency	Knowledge, Skills, and Attitudes
Patient-Centered Care	
Recognize the patient and caregiver as full partners in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs	• Provide care with sensitivity and respect, taking into consideration the patient's perspectives, beliefs, and cultural background • Assess level of comfort and treat appropriately • Engage the patient in an active partnership that promotes health, well-being, and self-care management • Facilitate patient's informed consent for care
Teamwork and Collaboration	
Function effectively within nursing and interprofessional teams	• Value the expertise of each interprofessional member • Initiate appropriate referrals • Follow communication practices that minimize risks associated with hand-offs and transitions in care • Take part in interprofessional rounds
Safety	
Minimize risk of harm to patients and providers	• Follow recommendations from national safety campaigns • Appropriately communicate concerns related to hazards and errors • Contribute to designing systems to improve safety
Quality Improvement	
Use data to monitor the outcomes of care and to improve the quality and safety of health care systems	• Use quality measures to understand performance • Identify gaps between local and best practices • Take part in investigating the circumstances surrounding a sentinel event (never event) or serious reportable event (SRE)
Informatics	
Use information and technology to communicate, manage knowledge, reduce errors, and support decision making	• Protect confidentiality of patient's protected health information • Document appropriately in electronic health records • Use communication technologies to coordinate patient care • Respond correctly to clinical decision-making alerts
Evidence-Based Practice	
Integrate best current evidence with clinical expertise and the patient/family preferences and values for delivery of optimal health care	• Read research, clinical practice guidelines, and evidence reports related to area of practice • Base patient care plan on patient's values, clinical expertise, and evidence • Continuously improve clinical practice based on new knowledge

Source: QSEN competencies. Retrieved from *www.qsen.org/competencies*.

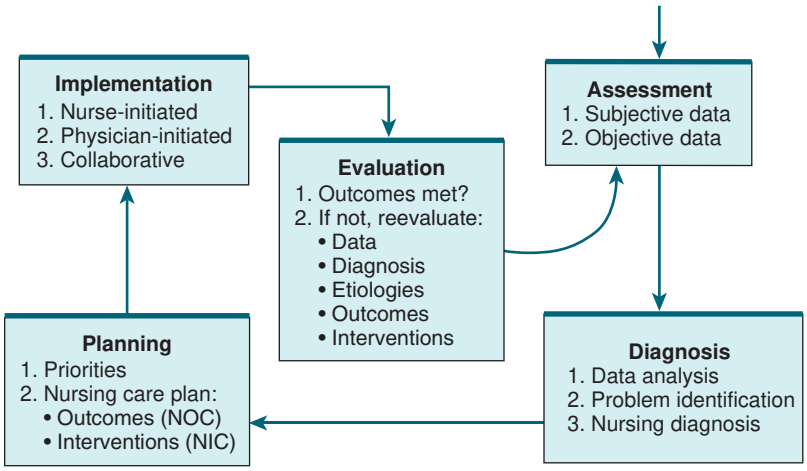

FIG. 1.3 *Nursing process.*

same patient problems and nursing interventions, nurses use a common language to improve communication.

Standard languages are essential in exchanging information between different electronic records systems. The need for quality care makes it necessary to be able to share information in a meaningful way across care settings. Using the same language reduces ambiguity and confusion. For example, do the patient problems of pressure injury and skin breakdown mean the same thing? Does turning the patient every 2 hours mean the same thing as repositioning the patient every 2 hours? If you turn or reposition the patient every 2 hours, what is the result? Does placing the patient on a pressure-relieving mattress or a standard mattress change the results? When you use a standard language, each nurse reading and documenting in the electronic record understands the diagnosis, can provide the interventions, and can measure the outcome.

The ANA recognizes several nursing and multidisciplinary languages. Three nursing languages focus on specific phases of

the nursing process: (1) NANDA International (NANDA-I): Nursing Diagnoses, Definitions, and Classification; (2) the Nursing Outcomes Classification (NOC); and (3) the Nursing Interventions Classification (NIC). Two other nursing languages, each with their own nursing diagnoses, outcomes, and interventions, include the International Classification of Nursing Practice (ICNP) and the Clinical Care Classification (CCC).

Nursing Diagnoses. The ANA defines a nursing diagnosis as the nurse's clinical judgment about the patient's response to actual or potential health conditions or needs.[11] You determine nursing diagnoses based on your analysis of the assessment data. Delivering care based on accurately identified nursing diagnoses results in more effective and safer patient care. They are the basis for selecting nursing interventions to achieve patient outcomes for which nursing is accountable. This book uses the ICNP nursing diagnosis terminology (see Appendix B).

Outcome Identification. The next step is to create the framework for delivering care by identifying outcomes and goal indicators. After choosing an outcome, you need to identify short- and/or long-term measurable goals and then list the behaviors or observations you will use to determine if the goal was attained. By identifying the right outcomes and goals, you can measure and evaluate the impact of the interventions you provide as part of your nursing practice. They also guide the interprofessional team so that we are all working to achieve the same outcomes. The outcomes achieved by patients are the most important indicator of quality in health care.[12]

Nursing Interventions. An intervention is "a single nursing action, treatment, procedure, activity, or service designed to achieve an outcome of a nursing or medical diagnosis for which the nurse is accountable."[13] This includes treatments that you perform in all settings and includes direct and indirect care. The ICNP includes more than 1100 interventions. That many interventions may seem overwhelming. You will discover the interventions you will use most often with your patient population. When planning care for a patient, choose specific interventions for the patient based on the nursing diagnosis and desired patient outcomes. You make the crucial decision of when and which interventions to use for a specific patient and situation based on your knowledge of the patient and the patient's condition.

Nursing Care Plans

In any clinical setting, you are responsible for providing a custom plan of care that includes nursing diagnoses, outcomes, and interventions. In clinical practice, electronic care plans often follow a standard format that has been adapted for that specific setting. These plans are guides for routine nursing care. You customize each to your patient's unique needs and problems.

In nursing education, the nursing process is often documented differently from clinical practice. The nursing process is often recorded in nursing care plans similar to those found on the website for this book (http://evolve.elsevier.com/Lewis/medsurg). These nursing care plans are teaching and learning tools. You practice and learn the nursing process by collecting assessment data, identifying nursing diagnoses, and selecting patient outcomes and nursing interventions. You usually should give rationales for the selected interventions.

NURSING CARE PLAN 1.1

Patient With Heart Failure*

Nursing Diagnosis†*

Impaired Gas Exchange

Etiology: Increased preload, alveolar-capillary membrane changes

Supporting data: Abnormal O_2 saturation, hypoxemia, dyspnea, tachypnea, tachycardia, restlessness, patient's statement, "I am so short of breath"

Patient Goal

Maintains adequate O_2/CO_2 exchange at the alveolar-capillary membrane to meet O_2 needs of the body

Outcomes (NOC)	Interventions (NIC) and Rationales
Respiratory Status: Gas Exchange • O_2 saturation ___ • Arterial pH ___ • PaO_2 ___ • $PaCO_2$ ___ • Chest x-ray findings ___ **Measurement Scale** 1 = Severe deviation from normal range 2 = Substantial deviation from normal range 3 = Moderate deviation from normal range 4 = Mild deviation from normal range 5 = No deviation from normal range • Dyspnea with exertion ___ • Dyspnea at rest ___ • Restlessness ___ • Impaired cognition ___ **Measurement Scale** 1 = Severe 2 = Substantial 3 = Moderate 4 = Mild 5 = None	**Respiratory Monitoring** • Monitor pulse oximetry, respiratory rate, rhythm, depth, and effort of respirations *to detect changes in respiratory status.* • Auscultate breath sounds, noting areas of decreased or absent ventilation and presence of adventitious sounds *to detect presence of pulmonary edema.* • Monitor for increased restlessness, anxiety, and work of breathing *to detect increasing hypoxemia.* **Oxygen Therapy** • Administer supplemental O_2 or other noninvasive ventilator support (e.g., bilevel positive airway pressure [BiPAP]) as needed *to maintain adequate O_2 levels.* • Monitor the O_2 liter flow rate and placement of O_2 delivery device *to ensure O_2 is adequately delivered.* • Change O_2 delivery device from mask to nasal prongs during meals as tolerated *to sustain O_2 levels while eating.* • Monitor the effectiveness of O_2 therapy *to identify hypoxemia and establish range of O_2 saturation.* **Positioning** • Position patient to alleviate dyspnea (e.g., semi-Fowler's position), as appropriate, to improve ventilation by decreasing venous return to the heart and increasing thoracic capacity.

*This example presents 1 nursing diagnosis for heart failure. The complete nursing care plan for heart failure is available on *http://evolve.elsevier.com/Lewis/medsurg*.

†Nursing diagnoses are listed in order of priority.

The nursing care plans associated with this book list nursing diagnoses, in order of priority, based on the ICNP, along with outcomes and interventions (NCP 1.1). When you use these care plans, you will need to customize the plan for your specific patient. You must use critical thinking to continually evaluate the situation and revise the nursing diagnoses, outcomes, and interventions to fit each patient's unique care needs.

Collaborative problems are certain physiologic complications that nurses must monitor to detect the onset of or changes in patient status.[14] Nurses manage collaborative problems using physician and nurse prescribed interventions to prevent morbidity and mortality. You identify these risks during the diagnosis phase of the nursing process. Identifying collaborative problems requires knowledge of pathophysiology and possible complications of medical treatment. Collaborative problem statements are usually written as "potential complication: _____" or "PC: _____" without a *related to* statement. An example is "PC: pulmonary embolism."

A *concept map* is another method of recording a nursing care plan. A concept map records the nursing process in a visual diagram. The map displays patient problems and interventions and shows relationships among clinical data. Nurse educators use concept mapping to teach nursing process and care planning. There are various formats for concept maps.

Conceptual care maps blend a concept map and a nursing care plan. On a conceptual care map, assessment data used to identify the patient's primary health concern are centrally positioned. Diagnostic test data, treatments, and medications surround the assessment data. Positioned below are nursing diagnoses or problems that represent the patient's responses to the health state. Listed with those are the supporting assessment data, outcomes, nursing interventions with rationales, and evaluation. After completing the map, you draw connections between identified relationships and concepts. A conceptual care map creator is available online on the website for this book. Concept maps for select case studies at the end of management chapters are available on the website at *http://evolve.elsevier.com/Lewis/medsurg*.

Continuum of Patient Care

Nursing is part of health care at all points along the patient care continuum. Depending on their health status, patients often move among a multitude of different health care settings. For example, a young man is in a trauma unit of an acute care hospital following a motor vehicle crash. After he is stable, he is transferred to a general medical-surgical unit and then to an acute rehabilitation facility. After rehabilitation is complete, he is discharged home to continue with outpatient rehabilitation, with follow-up by home health care nurses and care in an ambulatory clinic.

Decisions about the best setting for obtaining health care often depend on the cost of care and the patient's health care insurance plan and personal finances. Although the hospital is the mainstay for acute care interventions, community-based settings offer patients the opportunity to live or recover in settings that maximize their independence and preserve human dignity.

Community-based health care settings include ambulatory care, transitional care, and long-term care. *Transitional care* settings provide care in between the acute care and the home or long-term care setting. Patients may receive transitional care at an acute rehabilitation facility after head trauma or a spinal cord injury. *Long-term care* refers to the care of patients for a period longer than 30 days. It may be needed for those who are severely developmentally disabled, who are mentally impaired, or who have physical deficits requiring continuous medical and nursing care (e.g., patients who are ventilator dependent or have Alzheimer's disease). Long-term care facilities include skilled nursing facilities, assisted living facilities, and residential care facilities.

There is a new emphasis on care coordination when patients transition between care settings. *Transitions of care* refer to patients moving among health care practitioners, settings, and home as their condition and care needs change.[15] As a nurse, you are an essential part of care coordination by stressing actions that meet patients' needs and facilitate safe, quality care. Collaborating with other members of the interprofessional team is critical. A lack of communication can result in an ineffective care transition, leading to drug errors and higher hospital readmission rates. For example, you are a nurse in acute care admitting a long-term care patient who has been receiving propranolol 20 mg/5 mL twice a day. The admitting orders read "propranolol 20 mg/mL, give 5 mL twice a day." You avert a potential drug error by using communication techniques to reconcile the difference.

Delivery of Nursing Care

Nurses deliver patient-centered care in collaboration with the interprofessional health care team and within the framework of a care delivery model. A care delivery model outlines how responsibilities and authority are structured to carry out patient care.[16] More positive care outcomes occur when the number and type of care providers match patient needs and there is a designated care coordinator.

In acute care settings, 2 basic models are used: team care and total patient care. *Team care* models involve a group of providers who work together to deliver care. A professional nurse is usually the team leader. As team leader, you manage and coordinate care with others, such as licensed practical/vocational nurses (LPN/VNs) and unlicensed assistive personnel (UAP). You have accountability for the quality of care delivered by team members during a work period. In total patient care models, you are responsible for planning and providing all care.

Other care models include case management and telehealth. **Case management** is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes."[17] Although health care agencies implement case management in various ways, it involves managing the patient's care with other interprofessional team members across multiple care settings and levels of care.

A professional nurse often serves as the case manager. In this role, the nurse assesses the needs of patients and/or caregivers, coordinates services for them, makes appropriate referrals, and evaluates the progress toward meeting care goals. For example, a nurse case manager in an outpatient clinic has been working for 3 months with an older male patient who has multiple co-morbidities, including severe coronary artery disease, diabetes, and osteoarthritis. After he is scheduled for a coronary artery bypass, the nurse manager coordinates his care with other members of the interprofessional team. She arranges his preoperative appointments and informs the other team members so that all health care providers understand the patient's

unique needs. After the patient has surgery, he develops a deep venous thrombosis in his leg. The case manager then works with the interprofessional team to evaluate the patient's discharge needs and decide whether rehabilitation or home health care is necessary for the patient. With the patient and caregiver, the team decides to discharge the patient to a rehabilitation facility. The case manager helps with the transition, again coordinating care so that the providers at the rehabilitation facility are aware of the patient's needs.

Telehealth nursing is the delivery of health care and information through telecommunication technologies, including high-speed Internet, wireless, satellite, and video communications.[18] Among the many uses of telehealth are triaging patients, monitoring patients with chronic or critical conditions, helping patients manage symptoms, providing patient and caregiver education and emotional support, and providing follow-up care. Telehealth can increase access to care. The nurse engaged in telehealth can assess the patient's health status, deliver interventions, and evaluate the outcomes of nursing care while separated geographically from the patient (Fig. 1.4).

Critical Thinking

Complex health care environments require that you use critical thinking and clinical reasoning skills to make decisions that lead to the best patient outcomes. **Critical thinking**, your ability to focus your thinking to get the results you need in various situations, has been described as knowing how to learn, be creative, generate ideas, make decisions, and solve problems.[19]

Critical thinking is not memorizing a list of facts or the steps of a procedure. Instead, it is the ability to make judgments and solve problems by making sense of information. Learning and using critical thinking is a continual process that occurs inside and outside of the clinical setting.

Clinical reasoning is using critical thinking to examine and analyze patient care issues.[19] It involves understanding the medical and nursing implications of a patient's situation when making decisions about patient care. You use clinical reasoning when you identify a change in a patient's status, consider the context and concerns of the patient and caregiver, and decide what to do about it.

Given the complexity of patient care today, nurses need to learn and implement critical thinking and clinical reasoning skills before they gain those skills through experience in professional practice. Various experiences in nursing school offer opportunities for you to learn and make decisions about patient care. Various education activities, including interactive case studies and simulation exercises, promote practice in critical thinking and clinical reasoning. Throughout this book, select boxes, case studies, and review questions promote your use of critical thinking and clinical reasoning skills.

FIG. 1.4 An older adult performing remote blood pressure monitoring. (From Cooper K, Gosnell K: *Foundations of nursing,* St Louis, 2015, Elsevier.)

TEAMWORK AND COLLABORATION

Interprofessional Team

To deliver high-quality care, you need to have effective working relationships with members of the health care team. The **interprofessional team** is made up of providers from various disciplines, working together and sharing their expertise to provide customized care. It may consist of physicians, nurses, pharmacists, occupational and physical therapists, and others (Table 1.3). To be competent in interprofessional practice, you must collaborate in many ways by exchanging knowledge, sharing responsibility for problem solving, and making patient care decisions. You may be responsible for coordinating care among the team members, taking part in interprofessional

TABLE 1.3 Interprofessional Team Members

Team Member	Description of Services Provided
Dentist	Provides preventive and restorative treatments for problems affecting the teeth and mouth
Dietitian	Provides general nutrition services, including dietary consultation about health promotion or specialized diets
Occupational therapist (OT)	May help patient with fine motor coordination, performing activities of daily living, cognitive-perceptual skills, sensory testing, and the construction or use of assistive or adaptive equipment
Pastoral care	Offers spiritual support and guidance to patients and caregivers
Pharmacist	Prepares medications and infusion products
Physical therapist (PT)	Works with patients on improving strength and endurance, gait training, transfer training, and developing a patient education program
Physician (medical doctor [MD])	Practices medicine and treats illness and injury by prescribing medication, performing diagnostic tests and evaluations, performing surgery, and providing other medical services and advice
Physician assistant	Conducts physical exams, diagnoses and treats illnesses, and counsels on preventive health care in collaboration with a physician
Respiratory therapist	May provide oxygen therapy in the home, give specialized respiratory treatments, and teach the patient or caregiver about the proper use of respiratory equipment
Social worker	Assists patients with developing coping skills, meeting caregiver concerns, securing adequate financial resources or housing, or making referrals to social service or volunteer agencies
Speech pathologist	Focuses on treatment of speech defects and disorders, especially by using physical exercises to strengthen muscles used in speech, speech drills, and audiovisual aids that develop new speech habits

TABLE 1.4 Guidelines for Communicating Using SBAR

Purpose: SBAR is a model for effective transfer of information by providing a standard structure for concise factual communications from nurse-to-nurse, nurse-to-physician, or nurse-to–other health professionals.

Steps to Use: Before speaking with a physician or other health care professional about a patient problem, assess the patient yourself, read the most recent physician progress and nursing notes, and have the patient's chart available.

S **Situation**	• What is the situation you want to discuss? What is happening right now? • Identify self, unit. State: I am calling about: *patient, room number.* • Briefly state the problem: what it is, when it happened or started, and how severe it is. State: I have just assessed the patient and am concerned about: *describe why you are concerned.*
B **Background**	• What is the background or circumstances leading up to the situation? State pertinent background information related to the situation that may include: • Admitting diagnosis and date of admission • List of current medications, allergies, IV fluids • Most recent vital signs • Date and time of any laboratory testing and results of previous tests for comparison • Synopsis of treatment to date • Code status
A **Assessment**	• What do you think the problem is? What is your assessment of the situation? State what you think the problem is: • Changes from prior assessments • Patient condition unstable or worsening
R **Recommendation/Request**	• What should we do to correct the problem? What is your recommendation or request? State your request. • Specific treatments • Tests needed • Patient needs to be seen now

Source: Institute for Health Care Improvement: SBAR technique for communication: A situational briefing model. Retrieved from *www.ihi.org/resources/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx*.

team meetings or rounds, and making referrals when you need expertise in specialized areas to help the patient. To do so, you must be aware of the knowledge and skills of other team members and be able to communicate effectively with them.

To help you develop the competencies necessary to practice within an interprofessional clinical environment, you may take part in education activities with students from other disciplines. Throughout this book, case studies and review questions discuss the roles others have in managing patient care.

Coordinating Care

Communication. Effective communication is key to fostering teamwork and coordinating care. To provide safe, effective care, everyone involved in a patient's care should understand the patient's condition and needs. Unfortunately, many issues result from a breakdown in communication. Miscommunication often occurs during transitions of care. One structured model used to improve communication is the **SBAR (Situation-Background-Assessment-Recommendation)** technique (Table 1.4). This technique offers a way to talk about a patient's condition among members of the health care team in a predictable, structured manner. Other ways to enhance communication during transitions include using bedside rounds, having standard processes for patient hand-offs, and conducting interprofessional rounds to identify risks and develop a plan for delivering care.

Clinical Pathways. **Clinical pathways**, also known as care maps, are interprofessional care plans that outline the care and desired outcomes for a specific time period for patients with a specific diagnosis. Think of a clinical pathway as a road map the patient and health care team should follow. As the patient progresses along the road, the patient should receive specific care and accomplish specific goals. If a patient's progress differs from the planned path, a variance has occurred. A negative variance occurs when specific goals are not met. The nurse usually identifies when a negative variance is present and works with the interprofessional team to create a plan to address the issue.[16]

The exact content and format of clinical pathways vary among agencies and settings. Each agency usually develops its own pathways based on evidence-based practice guidelines. Common components include assessment guidelines, laboratory and diagnostic testing, medications, activity, diet, and teaching. In acute care, clinical pathways often describe which patient care components are needed at specific times (Fig. 1.5). The case types selected for this type of pathway are usually those that are high volume or high risk and predictable, such as myocardial infarction and surgical procedures (e.g., endoscopy, cholecystectomy, cataract surgery).

Delegation and Assignment. As a registered nurse (RN), you will delegate nursing care and supervise those who are qualified to deliver care. **Delegation** allows a care provider to perform a specific nursing activity, skill, or procedure that is beyond their usual role.[20] Delegating and assigning nursing activities is a process that, when used appropriately, results in safe, effective, and efficient patient care. Delegating can allow you more time to focus on complex patient care needs. Delegating care and supervising others will be one of your essential roles as a professional nurse.

Delegation usually involves tasks and procedures that licensed practical/vocational nurses (LPN/VNs) and unlicensed assistive personnel (UAP) perform. Nursing interventions that require independent nursing knowledge, skill, or judgment (e.g., initial assessment, patient teaching, evaluating care) are your responsibility and cannot be delegated. State nurse practice acts and agency policies identify activities that you can delegate to LPN/VNs and UAP. You will use professional judgment to select which activities to delegate. Your decision will be based on the patient's needs, the LPN/VN's and UAP's education and training, and the amount of supervision needed. The most common delegated nursing actions occur during the implementation phase of the nursing process. For example, you can delegate measuring oral intake and urine output to UAP, but you use your nursing judgment to decide if the intake and output are adequate.

The general guideline for LPN/VN practice is that they can function independently in a stable, routine situation. However, they must work under the direct supervision of a professional nurse in acute, unstable situations in which a patient's condition can rapidly change. In most states, LPN/VNs may give medications, perform sterile procedures, and perform a wide variety of interventions planned by the RN. The procedure itself is not the issue when an RN is determining what to delegate. Rather, the stability of the patient determines whether it is appropriate for an RN to delegate a procedure to an LPN/VN. For example, the LPN/VN can change a dressing on an abdominal surgical wound, but the RN should do the first dressing change and wound assessment.

Patient Name _____ Date _____

DRG# _____ Expected LOS <23 hours

	Preprocedure	Preoperative	Intraoperative	Postoperative Phase I PACU	Postoperative PHASE II PACU	Discharge	Postoperative PHASE II PACU
Medication	Review medical history	Start IV	Administer meperidine, propofol, midazolam	Administer naloxone, flumazenil pm	Pain med prn	Start on Rx omeprazole	Continue medications
Diagnostic tests	H-&-P chest x-ray, ECG, blood work	Review tests	Endoscopy procedure	None, unless complications	None	None	None
Diet	Regular	NPO	NPO	NPO	Clear liquids & progress	Regular	Regular
Activity	Not restricted	Ambulate	None	Turn, cough, and deep breathe	Increase activity to ambulation	Normal ambulation	Not restricted
Nursing action	Assessment	Vital signs	Vital signs, O_2 saturation	Vital signs, level of consciousness, O_2 saturation	Monitor as before	Prepare for discharge	Follow-up evaluation via phone
Teaching/ discharge planning	Phone call	Patient education about procedure	Transport to PACU	Discharge when Aldrete criteria I met	Discharge when Aldrete criteria II met	Instructions reviewed	Phone call for follow-up

FIG. 1.5 Clinical pathway for endoscopy. (From Arnold EC, Boggs KU: *Interpersonal relationships,* ed 6, St Louis, 2011, Mosby.)

UAP hold many titles, including nurse aides, certified medication aides, nursing assistants, patient care assistants, or technicians. The activities UAP perform typically include obtaining routine vital signs on stable patients, feeding and helping patients at mealtimes, ambulating stable patients, and helping patients with bathing and hygiene.

Delegation can occur among professional nurses. For example, if 1 RN has accountability for an outcome and asks another RN to perform a specific intervention related to that outcome, that is delegation. This type of delegation typically occurs when 1 RN leaves the unit/work area for a meal break.

Assignment is different from delegation. The term *assign* is used when you direct an LPN/VN or UAP to do an activity or procedure that is part of their everyday job.[20] An assignment must be within the authorized scope of practice of the LPN/VN or part of the routine function of the UAP. For example, you can assign an LPN/VN to give medications to a patient, because this is within the LPN/VN's scope of practice. You cannot assign an LPN/VN to a patient who needs an admission assessment because an RN must perform the initial patient assessment.

Whether you delegate or are working with staff to whom you assign tasks, you are responsible for the patient's total care during your work period. You need to decide what patient care tasks must be carried out during the given period, identify who will do them, and prioritize the order in which the tasks must be completed. You are responsible for supervising UAP or LPN/VNs. Clearly communicate the tasks that must be done and give necessary guidance. Because you are accountable for ensuring that delegated tasks are completed in a competent manner, evaluate the care given, follow up as needed, and make sure no care was missed.

Delegation is a skill that is learned, and you must practice to be proficient in managing patient care. You need to use critical thinking and professional judgment to ensure that you follow the 5 Rights of Delegation (Table 1.5). To help you, information on delegation is presented in the nursing management tables and case study questions at the end of the management chapters.

SAFETY

It is estimated that about 250,000 patients each year die because of preventable medical errors.[21] Several groups are addressing this issue by outlining safety goals for health care organizations and identifying safety competencies for health professionals. By implementing various procedures and systems that improve patient safety, health care systems are working to attain a culture that minimizes the risk of harm to the patient. Because of your closeness to patients, you are in a unique position to promote patient safety.

Serious Reportable Events

The National Quality Forum (NQF) uses the term **serious reportable event (SRE)**, also called a *never event,* to describe

TABLE 1.5 5 Rights of Delegation

The 5 Rights of Delegation

The registered nurse uses critical thinking and professional judgment to be sure that the delegation or assignment is:

1. The right task
2. Under the right circumstances
3. To the right person
4. With the right directions and communication
5. Under the right supervision and evaluation

Rights of Delegation	Description	Questions to Ask
Right Task	One that can be delegated for a specific patient	Is it appropriate to delegate based on legal and agency factors? Has the person been trained and evaluated in performing the task? Is the person able and willing to do this specific task?
Right Circumstances	Appropriate patient setting, available resources, and considering relevant factors, including patient stability	What are the patient's needs right now? Is staffing such that the circumstances support delegation strategies?
Right Person	Right person is delegating the right task to the right person to be performed on the right person	Is the prospective delegatee a willing and able employee? Are the patient needs a "fit" with the delegatee?
Right Directions and Communication	Clear, concise description of task, including its objective, limits, and expectations	Have you given clear communication about the task? With directions, limits, and expected outcomes? Does the delegatee know what and when to report? Does the delegatee understand what needs to be done?
Right Supervision and Evaluation	Appropriate monitoring, evaluation, intervention, and feedback	Do you know how and when you will interact about patient care with the delegatee? How often do you need to directly observe? Will you be able to give feedback to the staff member if needed?

Source: National Guidelines for Nursing Delegation. Retrieved from *www.ncsbn.org/1625.htm*.

serious, largely preventable, and harmful clinical events.[22] The current list of SREs consists of 29 events. These events include such things as a patient acquiring a stage III or greater pressure injury while hospitalized and death or disability from a fall or hypoglycemia.

To reduce the occurrence of SREs, the NQF has a list of effective *Safe Practices* that health care settings should use to provide safe patient care *(www.qualityforum.org)*. You are implementing NQF practices when you perform a time-out before a surgical procedure, reconcile medication records, and implement interventions to prevent hospital-acquired infections, pressure injuries and falls.

National Patient Safety Goals

The Joint Commission (TJC), the accrediting agency for health care organizations, gathers and reports data on serious errors they call sentinel events. A *sentinel event* is a patient safety event not related to the patient's illness or underlying condition that reaches a patient and results in death, permanent harm, or severe temporary harm.[23] Events are "sentinel" because they signal the need for immediate investigation and response. Many sentinel events are also serious reportable events. If the patient undergoes a wrong-site or wrong-procedure surgery, experiences an assault in the health care setting, or receives an incompatible blood product, the occurrence is both a sentinel event, reportable to TJC, and a serious reportable event, reportable to NQF.

To address specific patient safety concerns, TJC issues National Patient Safety Goals (NPSGs).[24] NPSGs promote patient safety by offering evidence-based solutions to common safety problems. The 2017 NPSGs are listed in Table 1.6.

The latest safety goal, focusing on improving the safety of clinical alarm systems, greatly affects nursing. Patient monitoring systems provide vital information. Alarms that work well improve patient safety and care by telling you when a patient needs your attention. However, so many alarms can go off that *alarm fatigue* occurs, and nurses can become desensitized to the sounds. By better managing alarms, we reduce alarm fatigue and improve patient safety.

Because you have the greatest amount of interaction with patients, you play a key role in promoting safety. Many describe nurses as the patient's last line of defense. Every nurse has the responsibility to ensure the patient receives care in a manner that prevents errors and promotes patient safety. Throughout this book, safety alerts highlighting patient care issues and NPSGs will help you in learning to apply safety principles.

QUALITY IMPROVEMENT

Quality care and safety are related: the higher the culture of safety, the better the quality of care. Health care systems focused on quality outcomes use practice standards and protocols based on best evidence while considering the patient's unique preferences and needs. Your role is to coordinate the complex aspects of patient care, including the care delivered by others, and identify and correct issues associated with poor quality and unsafe care.

Quality improvement (QI) programs involve systematic actions that monitor, assess, and improve health care quality. QI is an interprofessional team effort that is required by accrediting agencies. As part of professional nursing practice, you need to be able to collect data using QI tools, implement interventions to improve quality of care, and monitor patient outcomes. Several public and private groups focusing on improving health care quality have developed standard QI measures. These performance measures assess how well the health care team cares

TABLE 1.6 National Patient Safety Goals

Safety Goal	Examples
Identify patients correctly	• Use at least 2 ways to identify patients (e.g., have them state full name and date of birth). • Give the correct patient the correct blood with every blood transfusion.
Improve communication among the health care team	• Get critical test results to the right person on time.
Use medicines safely	• Before a procedure, label all medicines. Discard any found unlabeled. • Use proper precautions with patients who take anticoagulants. • Find out what medicines each patient is taking. Make certain that it is safe for the patient to take any new medicines with his or her current ones. • Give a medication list to the patient and the caregiver before discharge. Explain the list.
Use alarm systems safely	• Respond to alarms promptly. • Do not turn alarms off.
Prevent health care–associated infections	• Use soap, water, and hand sanitizer before and after every patient contact. • Use evidence-based practices to prevent infections related to central lines, indwelling urinary catheters, and multidrug-resistant organisms
Identify patient safety risks	• Assess patients at risk for suicide. • Assess any risks, such as fires, for patients who are getting home oxygen therapy.
Prevent mistakes in surgery	• Conduct a time-out before the start of any surgery. • Confirm correct patient, procedure, and site.

Adapted from The Joint Commission (TJC): *2016 National patient safety goals,* Oakbrook Terrace, IL. Retrieved from *www.jointcommission.org/assets/1/6/2017_NPSG_HAP_ER.pdf*.

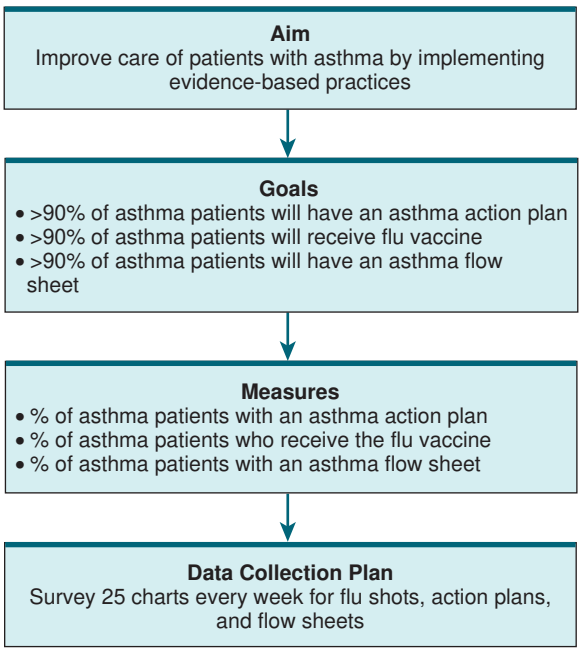

FIG. 1.6 Quality improvement system. (Adapted from Courtlandt CD, Noonan L, Leonard GF: Model for improvement—Part 1: A framework for health care quality, *Pediatr Clin North Am* 56:757, 2009.)

for a patient with a certain condition or receives a specific treatment. They describe what data the team must collect and monitor. Fig 1.6 shows an example of a QI system for adult patients with asthma. In this example, you would review patient medical records to decide if the rate of flu vaccine administration exceeds 90%. You would share the results with the team and, if the identified standard was not met, work as a team to implement measures to correct the deficiency.

National Database of Nursing Quality Indicators

The National Database of Nursing Quality Indicators (NDNQI) provides data on nursing-sensitive measures to evaluate the impact of nursing care on patient outcomes. Patient outcomes are nursing sensitive if they improve with a greater quantity or quality of nursing care. NDNQI outcomes are unique because they identify how nursing workforce factors, including nurse staffing and skill mix, directly influence patient outcomes. NDNQI data show the incidence of falls and health care–associated pressure injuries and infections decreases with adequate staffing and increased nurse education and satisfaction with the work environment. Table 1.7 lists the current NDNQI.

INFORMATICS

Nursing is an information-intense profession. Advances in informatics and technology have changed the way nurses plan, deliver, document, and evaluate care. All nurses, regardless of their setting or role, use informatics and technology every day in practice. Informatics has changed how you obtain and review diagnostic information, make clinical decisions, communicate with patients and health care team members, document, and provide care.

Technology advances have increased the efficiency of nursing care, improving the work environment and the care nurses provide. Computers and mobile devices allow you to document at the time you deliver care and give you quick and easy access to information, including clinical decision-making tools, patient education materials, and references. Texting, video chat, and e-mail enhance communication among health care team members and help you deliver the right message to the right person at the right time.

Technology plays a key role in providing safe, quality patient care. Medication administration applications improve patient

TABLE 1.7 National Database of Nursing Quality Indicators

- Structure indicators
  - RN turnover rate
  - Nursing hours per patient day
  - RN education and certification
  - Staff mix: RNs, LPN/VNs, UAP, agency staff
- Process and outcome indicators
  - Patient falls and falls with injury
  - Pressure injury rate
  - RN surveys on job satisfaction and practice environment scale
- Outcome indicators
  - Physical/sexual assault rate
  - Restraint use
- Health care–associated infections (HAI) rate

Source: National Database of Nursing Quality Indicators. Retrieved from *www.nursingquality.org*.

safety by flagging potential errors, such as look-alike and sound-alike medications and adverse drug interactions, before they can occur. Computerized provider order entry (CPOE) systems can reduce errors caused by misreading or misinterpreting handwritten orders. Sensor technology can decrease the number of falls in high-risk patients. Care reminder systems give cues that decrease the amount of missed nursing care.

Being able to use technology skills to communicate and access information is now an essential part of your professional nursing practice. You must be able to use word processing software, communicate by e-mail and book messaging, access information, and follow security and confidentiality rules. You need to have the ability to safely use patient care technologies and navigate electronic documentation systems.

Protected health information (PHI) is highly sensitive. *The Health Insurance Portability and Accountability Act (HIPAA)* is part of federal legislation that addresses actions for how PHI is used and disclosed. With the increased use of informatics and technology come new concerns on how to comply with HIPAA regulations and maintain a patient's privacy. Wireless technologies, increased use of e-mail and computer networking, and the ongoing threat of computer viruses increase the need for properly protecting a patient's privacy. We must assure patients of their privacy and that only those with a right to know are accessing protected information.

As a nurse, you have an obligation to ensure the privacy of your patient's health information. To do so, you need to understand your agency's policies about the use of technology. You need to know the rules about accessing patient records and releasing PHI, what to do if information is accidentally or intentionally released, and how to protect any passwords you use. If you are using social networking, you must be careful not to place any individually identifiable PHI online. Throughout this book, Informatics in Practice boxes offer suggestions on how to use informatics in your practice.

FIG. 1.7 Members of the interprofessional team review a patient's electronic health record. (From Arnold EC, Boggs KU: *Interpersonal relationships,* ed 6, St Louis, 2011, Mosby.)

ETHICAL/LEGAL DILEMMAS

Social Networking: HIPAA Violation

Situation

You log into a closed group on a social networking site and read a posting from a fellow nursing student. The posting describes in detail the complex care the student gave to an older patient in a local hospital the previous day. The student comments on how stressful the day was and asks for advice on how to deal with similar patients in the future.

Ethical/Legal Points for Consideration

- Protecting and maintaining patient privacy and confidentiality are basic obligations defined in the Code of Ethics for Nurses, which nurses and nursing students should uphold.[1]
- As outlined in the Health Insurance Portability and Accountability Act (HIPAA), a patient's private health information is any information that relates to the person's past, present, or future physical or mental health. This includes not only specific details such as a patient's name or picture but also information that gives enough details that someone may be able to identify that person.
- You may unintentionally breach privacy or confidentiality by posting patient information (diagnosis, condition, situation) on a social networking site. Using privacy settings or being in a closed group does not guarantee the secrecy of posted information. Others can copy and share any post without your knowledge.
- Potential consequences for improperly using social networking vary based on the situation. These may include (1) disciplinary action by the state board of nursing; (2) being disciplined, suspended, or fired by an employer; (3) dismissal from a nursing program; and (4) civil and/or criminal charges.
- A student nurse who experienced a stressful day and is looking for advice and support from peers (e.g., "Today my patient died. I wanted to cry.") could share the experience by clearly limiting the posts to the student's personal perspective and not sharing any identifying information. This is 1 area in which it is safest to err on the side of caution to avoid the appearance of impropriety.

Discussion Questions

1. How would you deal with the situation involving the fellow nursing student?
2. How would you handle a situation in which you saw a staff member who violated HIPAA?

Reference

1. Code of Ethics for Nurses. Retrieved from *www.nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html*.

Electronic Health Records

The largest use of informatics is **electronic health records (EHRs)**, also called *electronic medical records*. An EHR is a computerized record of patient information. It is shared among all health care team members involved in a patient's care and moves with the patient—to other providers and across care settings. The ideal EHR provides a single place for team members to review and update a patient's health record, document care given, and enter patient care orders, including medications, procedures, diets, and diagnostic and laboratory tests (Fig. 1.7).

Several obstacles are still in the way of fully implementing EHRs. Systems are technologically complex, requiring many resources and training to implement and maintain. Communication is still lacking among computer systems and software applications. Finally, perceived challenges in the use of EHRs, including increased workload and the need for workarounds, affect implementation.

EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP) is a problem-solving approach to clinical decision making. Using the best available evidence (e.g., research findings, QI data), combined with your expertise

TABLE 1.8 Steps of Evidence-Based Practice (EBP) Process

1. Ask the clinical question using the PICOT format:
   - Patients/population
   - Intervention
   - Comparison or comparison group
   - Outcome(s)
   - Time (as applicable)
2. Search for the best evidence based on the clinical question.
3. Critically appraise and synthesize the evidence.
4. Implement the evidence in practice.
5. Evaluate the practice decision or change.
6. Share the outcomes of the decision or change.

and the patient's unique circumstances and preferences, leads to better clinical decisions and improved patient outcomes. EBP closes the gap between research and practice, providing more reliable and predictable care than that based on tradition, opinion, and trial and error.

EBP does not mean that you conduct a research study. Instead, EBP depends on you to take an active role in using the best available evidence when delivering care. You need to have an ongoing curiosity about what are the best nursing practices and routinely ask questions about your patient's care. Recognize when you need more information. When you base your practice on valid evidence, you are solving problems and supporting best patient outcomes.

Steps of EBP Process

The EBP process has 6 steps (Table 1.8).

Step 1. Step 1 is asking a clinical question in the PICOT format. Developing the clinical question is the key step in the EBP process.[25] A good clinical question sets the context for integrating evidence, clinical judgment, and patient preferences. In addition, the question guides the literature search for the best evidence to influence practice.

An example of a clinical question in PICOT format is, "In adult abdominal surgery patients (**P** = patients/population) is splinting with an elasticized abdominal binder (**I** = intervention) or a pillow (**C** = comparison) more effective in reducing pain associated with ambulation (**O** = outcome) on the first postoperative day (**T** = time period)?" A clinical question may not have all components of PICOT. Some only include 4 components. The (T) timing or (C) comparison components are not appropriate for every question. The (C) component of PICOT may include a comparison with a specific intervention, the usual standard of care, or no intervention at all.

Step 2. Step 2 is searching for the best evidence that applies to the clinical question. Technology provides you with ready access to data. You can easily search several online resources and collect large amounts of clinical information and evidence. It is important to evaluate all data sources for their credibility and reliability. Not all evidence is equal. Fig. 1.8 presents the hierarchy of evidence. As you go down the pyramid, the strength of the evidence becomes weaker. Systematic reviews and evidence-based clinical practice guidelines save time and effort in the EBP process. However, they are available for only a limited number of clinical topics and may not suit all types of clinical questions. When insufficient research exists to guide practice, recommendations from expert panels and authority figures may be the best evidence available.

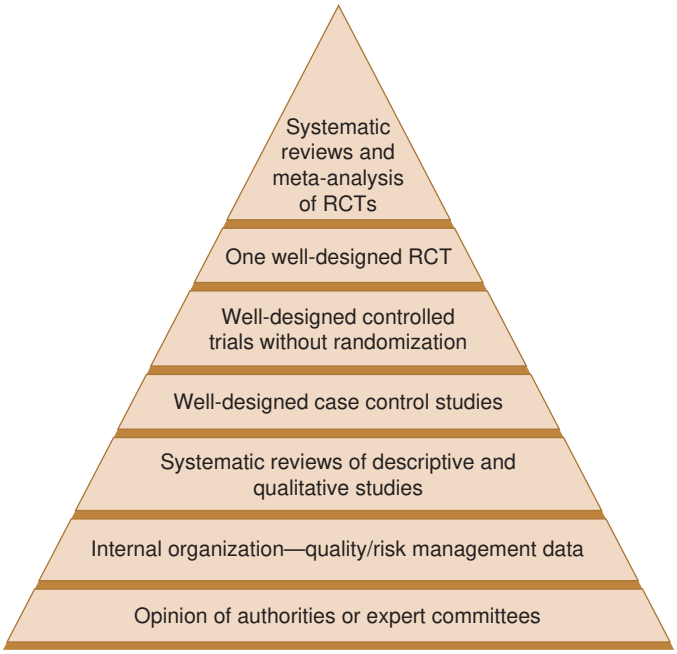

FIG. 1.8 Hierarchy of evidence. (Modified from Melnyk BM, Fineout-Overholt E: *Evidence-based practice in nursing and healthcare: A guide to best practice,* ed 3, Philadelphia, 2014, Lippincott Williams & Wilkins.)

Step 3. Step 3 is to critically appraise the evidence you found. A successful critical appraisal process focuses on 3 essential questions: (1) What are the results? (2) Are the results reliable and valid? and (3) Will the results help me in caring for my patients? You decide the strength of the evidence and synthesize the findings related to the clinical question to conclude what is the best practice. For example, you find strong evidence supporting effectiveness of elasticized binders and pillows in reducing pain associated with ambulation. However, the binder appears to be more effective if the patient is obese or has had prior abdominal surgery.

Step 4. Step 4 involves implementing the evidence in practice. The decision to implement change is made by combining the evidence, clinical judgment, and preferences and values of patients and caregivers. You may be part of an interprofessional team charged with implementing a practice change or applying evidence in a specific patient care situation. This may include developing clinical practice guidelines, policies and procedures, or new assessment, teaching, or documentation tools. For example, you may be part of a team implementing a new postoperative protocol focused on using elasticized abdominal binders with patients who are obese or had prior abdominal surgery.

Step 5. Step 5 is evaluating the outcome of the practice change. After implementing the change for a specific period, you should monitor outcomes to determine whether the change has improved patient outcomes. Accrediting bodies require documentation of outcome measures to show that the organization is using evidence to improve patient care.

Step 6. Step 6 is sharing the results of the EBP change. If you do not share the outcomes of EBP, then other health care providers and patients cannot benefit from what you learned from your experience. You can share information locally using unit- or hospital-based newsletters and posters and regionally and nationally through journal publications and presentations at conferences.

Implementing EBP

To implement EBP, you must develop the skills to be able to seek and incorporate into practice scientific evidence that supports best patient outcomes. Throughout this book, Evidence-Based Practice boxes provide an opportunity for you to practice your critical thinking skills in applying EBP to patient scenarios. To help you identify the use of evidence in this book, an asterisk (*) in the reference list at the end of each chapter indicates evidence-based information for clinical practice.

BRIDGE TO NCLEX EXAMINATION

The number of the question corresponds to the same-numbered outcome at the beginning of the chapter.

1. An example of a nursing activity that best reflects the American Nurses Association's definition of nursing is
   - **a.** treating dysrhythmias that occur in a patient in the coronary care unit.
   - **b.** diagnosing a patient with a feeding tube as being at risk for aspiration.
   - **c.** setting up protocols for treating patients in the emergency department.
   - **d.** offering antianxiety drugs to a patient with a disturbed sleep pattern.
2. A nurse working on the medical-surgical unit at an urban hospital would like to become certified in medical-surgical nursing. The nurse knows that this process would most likely require
   - **a.** a bachelor's degree in nursing.
   - **b.** formal education in advanced nursing practice.
   - **c.** experience for a specific period in medical-surgical nursing.
   - **d.** membership in a medical-surgical nursing specialty organization.
3. The nurse is assigned to care for a newly admitted patient. Number in order the steps for using the nursing process to prioritize care. (Number 1 is the first step, and number 5 is the last step.)
   - ___ Evaluate whether the plan was effective.
   - ___ Identify any health problems.
   - ___ Collect patient information.
   - ___ Carry out the plan.
   - ___ Decide a plan of action.
4. Using the SBAR format, number in order the steps for how the nurse would communicate information with the provider. (Number 1 is the first step, and number 4 is the last step.)
   - ____ "I would like you to order an IV medication and come evaluate the patient as soon as possible."
   - ____ "This is Nurse M.H. I am calling from the unit because your patient, D.R., has a new onset of atrial fibrillation."
   - ____ "The atrial fibrillation started about 10 minutes ago. The heart rate is 124; BP 90/60. The patient is experiencing dizziness."
   - ____ "D.R., who is 2 days postoperative for a bowel resection for diverticulitis, has a history of mitral valve disease."
5. The nurse is caring for a diabetic patient in the ambulatory surgical unit who has undergone wound debridement. Which task is appropriate for the nurse to delegate to unlicensed assistive personnel (UAP)?
   - **a.** Check the patient's vital signs.
   - **b.** Assess the patient's pain level.
   - **c.** Palpate the patient's pedal pulses.
   - **d.** Monitor the patient's IV catheter site.
6. The nurse's role in addressing the National Patient Safety Goals established by The Joint Commission includes *(select all that apply)*
   - **a.** answering all patient monitoring alarms promptly.
   - **b.** memorizing all the rules published by The Joint Commission.
   - **c.** obtaining a correct list of the patient's medications on admission.
   - **d.** encouraging patients to be actively involved in their own health care.
   - **e.** using side rails and alarm systems as necessary to prevent patient falls.
7. Advantages of using informatics in health care delivery are *(select all that apply)*
   - **a.** reduced need for nurses in acute care.
   - **b.** increased patient anonymity and confidentiality.
   - **c.** the ability to achieve and maintain high standards of care.
   - **d.** access to standard plans of care for many health problems.
   - **e.** improved communication of the patient's health status to the health care team.
8. When using evidence-based practice, the nurse
   - **a.** must use clinical practice guidelines developed by national health agencies.
   - **b.** should use findings from randomized controlled trials to plan care for all patient problems.
   - **c.** uses clinical decision making and judgment to decide what evidence is appropriate for a specific clinical situation.
   - **d.** analyzes the relationship of nursing interventions to patient outcomes to discover evidence for patient interventions.

1. b, 2. c, 3. 5, 2, 1, 4, 3, 4. 4, 1, 3, 2, 5. a, 6. a, c, e, 7. c, d, e, 8. c.

For rationales to these answers and even more NCLEX review questions, visit *http://evolve.elsevier.com/Lewis/medsurg*.

EVOLVE WEBSITE/RESOURCES

http://evolve.elsevier.com/Lewis/medsurg

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*Evidence-based information for clinical practice.

2

Health Equity and Culturally Competent Care

Andrew Scanlon

We may have different religions, different languages, different colored skin, but we all belong to one human race. We all share the same basic values.

Kofi Annan

http://evolve.elsevier.com/Lewis/medsurg/

CONCEPTUAL FOCUS

Culture

Health Disparities

LEARNING OUTCOMES

1. Identify the key determinants of health and equity.
2. Describe the factors that contribute to health disparities and health equity.
3. Define the terms *culture, values, acculturation, ethnicity, race, stereotyping, ethnocentrism, cultural imposition, cultural competency,* and *culture-bound syndrome.*
4. Explain how culture and ethnicity may affect a person's physical and psychologic health.
5. Apply strategies for incorporating cultural information in the nursing process with all patients.
6. Describe the role of nursing in promoting health equity.
7. Examine ways that your own cultural background may influence nursing care.
8. Describe strategies for successfully communicating with a person who speaks a language that you do not understand.

KEY TERMS

acculturation, p. 21
cultural competence, p. 22
culture, p. 20
culture-bound syndromes, p. 27
determinants of health, p. 17
ethnicity, p. 18
ethnocentrism, p. 21
folk healers, p. 23
health disparities, p. 18
health equity, p. 18
health status, p. 17
lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ), p. 20
place, p. 19
race, p. 18
sexuality, p. 20
stereotyping, p. 21
transcultural nursing, p. 22
values, p. 20

This chapter discusses health disparities and culture. Health is a cultural concept because culture frames and shapes our experiences. Cultural beliefs influence health promotion practices and attitudes about seeking health care. Cultural differences can lead to problems that decrease the chance of receiving equitable health care. Nurses play a key role in recognizing and reducing health disparities. Understanding the concept of culture is important in your ability to provide patient-centered care.

DETERMINANTS OF HEALTH

Why are there differences in people's health status? How do these differences occur? The **determinants of health** are factors that (1) influence the health of individuals and groups and (2) help explain why some people experience poorer health than others.[1] Where people are born, grow up, live, work, and age helps determine their health status, behaviors, and care.

Health status is a holistic concept that is more than the presence or absence of disease. It encompasses life expectancy as well as self-assessment of health. As such, many measures make up the concept of health status. For individuals, this means the sum of their current health problems plus their coping resources (e.g., family, financial resources). For a community, health status is the combination of health measures for all people living in the community. Community health measures include birth and death rates, life expectancy, access to care, and morbidity and mortality rates related to disease and injury.

Factors in a person's social and physical environment, including personal relationships, workplace, housing, transportation, and neighborhood violence, contribute to health status.[1] For example, the risk of youth homicide is much higher in neighborhoods with gang activity and high crime rates. The physical environment in which one lives, works, and plays may expose a person to such risks as environmental hazards (workplace

injuries), toxic agents (chemical spills, industrial pollution), unsafe traffic patterns (lack of sidewalks), or absence of fresh and healthy food choices.

A person's behavior is influenced by his or her environment, education, and economic status. Behaviors such as tobacco and illicit drug use are strongly linked to many health conditions (e.g., lung cancer, liver disease). A person's biologic makeup, such as genetics and family history of disease (e.g., heart disease), can increase the risk for specific diseases.

The availability of health care also contributes to a person's health. Though government initiatives are striving to reduce the number of uninsured Americans, millions remain uninsured and have limited access to care. This affects both individual and community health.

HEALTH DISPARITIES AND HEALTH EQUITY

Health disparities are differences in the incidence, prevalence, mortality rate, and burden of diseases that exist among specific population groups. In the United States this is because of social, economic, or environmental disadvantages. Health disparities can affect population groups based on gender, age, ethnicity, socioeconomic status, education, location, sexual orientation, or disability status.[2] **Health equity** is achieved when every person has the opportunity to attain his or her health potential, and no one is disadvantaged.

ETHICAL/LEGAL DILEMMAS

Health Disparities

Situation

E.M., a 47-yr-old Mexican American woman living with type 2 diabetes mellitus, comes to the clinic to have her blood glucose measured. It has been 12 months since her last visit. At that time, the nurse asked that she bring along her glucometer and strips to show how she checks her blood glucose because her glucose values were high at her previous visits.

When you check E.M.'s equipment and glucose strips, you find that the strips are for a different machine and they expired more than 2 years ago. When you inquire about the situation, E.M. explains that she cannot afford to come to the clinic or to buy new equipment and supplies to check her blood glucose level. During the day, E.M. cares for her 3 grandchildren so her daughter can work. E.M. spends most of her income on food for her family, so she has little money left for her health care.

Ethical/Legal Points for Consideration

- Ethnic minorities and other vulnerable or disadvantaged groups experience certain chronic illnesses at higher rates. Limited access to high-quality, accessible, and affordable health care services is associated with an increased incidence of illness and complications, as well as a reduced life span.
- People with certain health problems such as diabetes may have difficulty obtaining health care insurance. Consider these issues in the broader context of social justice.
- In many states, the legal definition of the role of the professional nurse includes patient advocacy. Advocacy includes the obligation to provide adequate follow-up care for all patients, especially those who are experiencing health care disparities.
- A nurse who observes disparities must consider the possibility of discrimination and abuse. Professional nurses are legally and ethically responsible for patient advocacy. The nurse may incur legal liability if failure to fulfill this obligation results in patient harm.

Discussion Questions

1. How would you work with E.M. to help her obtain the necessary resources and knowledge to care for her diabetes?
2. What can you do to begin working on the problems of health disparities in your community?

Factors and Conditions Leading to Health Disparities

Many factors and conditions can lead to the development of health disparities (Table 2.1). Awareness of these factors will help you provide optimal care for your patients.

Ethnicity and Race. The terms **ethnicity** and **race** are subjective and based on self-report. These terms are used interchangeably in conversation and are not defined by genetic markers. Social context and lived experiences influence people's decision about the ethnic and race category to which they identify or are assigned. For example, ethnic and race categories may differ on a person's birth certificate and death certificate.

People often identify their own ethnicity and race for health data collection (e.g., health plans, birth certificates). Collection of health data based on self-reported ethnic and race categories is important for research, to inform policy, and to understand and eliminate disparities. People identify their race using 1 or more categories. Law requires federal agencies to list a minimum of 5 race categories: white, black, American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander. Federal agencies must also list a minimum of 2 ethnicities for people who self-identify as either *Hispanic or Latino* and *Not Hispanic or Latino.* A Hispanic or Latino is typically a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish descent, regardless of race. In this book, we use the terms *ethnicity* and *race* interchangeably or together.

Although dramatic improvements in treatments have prolonged life and improved quality of life for many, racial and ethnic minorities have benefited far less from these advances. Disparities are generally determined by comparing population groups. In the United States, minority groups include Hispanics/Latinos (17.8% of the U.S. population), blacks (13.3%), Asian Americans (5.7%), Native Hawaiians and other Pacific Islanders (0.2%), Native Americans and Native Alaskans (1.3%), and 2 or more races (2.6%) population.[3] The number for most of these groups is expected to increase in the coming decades.

Obesity and chronic illness rates for diabetes, hypertension, chronic obstructive pulmonary diseases, cancer, and stroke are higher among minority people. Racial, ethnic, and cultural differences exist in health services, treatments provided, and access to health care providers (HCPs). Race and ethnicity also influence disease risk and outcomes. For example, after myocardial infarction, minority patients are at greater risk of rehospitalization and death but are less likely than nonminority patients to receive potentially beneficial treatments.[4] Native Americans have a higher incidence of several types of cancers and are often diagnosed at later stages of disease, resulting in a poorer prognosis.[5] Numerous strategies are being developed to promote health equity and reduce disparities.

TABLE 2.1 Factors and Conditions Leading to Health Disparities

- Age
- Disability status
- Education
- Ethnicity and race
- Gender
- Health care provider attitudes/biases
- Health literacy
- Income status
- Lack of health care services access
- Language barrier
- Occupation or unemployment
- Place
- Sexual orientation

PROMOTING HEALTH EQUITY

Promoting Health Equity Boxes Throughout Book

Title	Chapter	Page
Alzheimer's Disease	59	1386
Arthritis and Connective Tissue Disorders	64	1505
Brain Tumors	56	1318
Breast Cancer	51	1204
Cancer	15	265
Cancers of the Female Reproductive System	53	1241
Cancers of the Male Reproductive System	54	1263
Chronic Kidney Disease	46	1066
Colorectal Cancer	42	948
Coronary Artery Disease	33	700
Diabetes	48	1110
Heart Failure	34	735
Hematologic Problems	30	607
Hypertension	32	679
Liver, Pancreas, and Gallbladder Disorders	43	980
Lung Cancer	27	518
Obesity	40	869
Obstructive Pulmonary Diseases	28	542
Oral, Pharyngeal, and Esophageal Problems	41	894
Osteoporosis	63	1492
Sexually Transmitted Infections	52	1213
Skin Problems	23	411
Stroke	57	1332
Tuberculosis	27	510
Urologic Disorders	45	1036
Visual Problems	20	359

Place. **Place** refers to the geographic and environmental location where a person is born, grows, lives, works, and ages. Place affects the use of health services, health status, and health behaviors.

About 20% of Americans live in nonurban or rural areas.[6] Differences in access to health care services between rural and urban settings can create geographic health disparities. For example, rural populations and Native Americans living on reservations may need to travel long distances to receive health care. This can result in inadequate or less-frequent access to health care services. Some parts of the rural United States are "medically underserved" because of decreased numbers of HCPs per population.

People living in rural areas have higher rates of cancer, heart disease, diabetes, depression, and injury-related deaths than people living in urban areas. For example, in rural Appalachia the rates of lung, colon, cervical, and colorectal cancer are higher than the national average. Rural populations tend to be older than urban populations. Many rural areas have higher rates of obesity and chronic disease. The impact of social and physical environment on health choices can be illustrated by the problem of intimate partner violence in rural communities.[7] The decision to seek help is affected by geographic isolation, traditional gender roles, patriarchal attitudes, fear of lack of confidentiality, and economic factors that exist in some small rural communities.

Living in urban centers may also predispose a person to health disparities. Concerns about personal safety (e.g., clinics located in high-crime neighborhoods) can make patients reluctant to visit HCPs. High rates of chronic health problems and premature deaths occur in neighborhoods with social inequalities, including high poverty rates and residential segregation.

Among the most obvious health behaviors affected by place are physical activity and nutrition. Safe, walkable neighborhoods with playgrounds and sources of healthy foods promote physical activity and healthy eating. Social support positively affects coping with illness. Social networks are more likely to be found in communities where neighbors interact and rely on one another.

Income, Education, and Occupation. People of lower income, education, or occupational status experience worse health. In addition, they die at a younger age than those who are more affluent. Adults without a high school diploma or equivalent are 3 times more likely to die before age 65 than those with a college degree. Health care costs are 1 of the key factors that contribute to health disparities. People who have no insurance, are underinsured, or lack financial resources to pay for treatment of diseases may forgo health care visits, screenings, and treatments. Patients who lack the knowledge and/or access to apply for government assistance programs (e.g., Medicaid) are also at risk. Hazardous work environments and high-risk occupations of laborers increase health risk and contribute to higher rates of illness, injury, and death.

Health Literacy. *Health literacy* is defined as the degree to which a person has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. This includes the ability to (1) read, understand, and analyze information; (2) understand instructions; (3) weigh risks and benefits; and (4) make decisions and take action. Low health literacy is associated with more hospitalizations, greater use of emergency department care, decreased use of cancer screening and influenza vaccine, decreased ability to use medications correctly, and higher mortality rates among older adults.

On a daily basis, patients need to self-manage conditions such as diabetes and asthma. For example, patients with diabetes may not be able to maintain adequate blood glucose levels if they cannot read or understand the numbers on the home glucose monitoring system. The inability to read and understand medication labels can result in taking medications at the wrong time or in the wrong dose. See Chapter 4 for more about health literacy.

Gender. Health disparities exist between men and women. Adult women use health care services more than men. Women may not receive the same quality of care (Fig. 2.1). For example, women are less likely than men to receive procedures (e.g., coronary angiography) for cardiovascular disease.[8] When gender is combined with racial and ethnic differences, the disparities are

FIG. 2.1 Older Asian women are especially at risk for health disparities. (© szefei/iStock/Thinkstock.)

even greater. Gender Differences boxes throughout this book highlight gender differences in disease risk, manifestations, and treatment.

Age. Older adults are at risk for experiencing health disparities in the number of diagnostic tests done and aggressiveness of treatments used. Biases toward older adults that affect their care, or ageism, are discussed in Chapter 5. Older people of low socioeconomic status experience greater disability, more limitations in activities of daily living, and more frequent and rapid cognitive decline. Black and Latino older adults, in particular, are disproportionately affected by chronic illnesses, disability, depression, and substandard quality of life.[9]

Sexual Orientation. **Sexuality** is defined as a person's romantic, emotional, or sexual attraction to another person.

Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning. **Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ)** is a term that refers to the sexual orientation of these groups of people. LGBTQ persons encompass all races and ethnicities, religions, and social classes. Being LGBTQ places a person at risk for health disparities resulting from social, economic, or environmental disadvantages. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQ persons. Discrimination against LGBTQ people has been associated with high rates of psychiatric disorders, substance abuse, and suicide.

LGBTQ people are more likely to be obese when compared with their heterosexual counterparts. Lesbian and bisexual women have higher rates of breast cancer and increased risk factors for cardiovascular disease. Gay and bisexual men have higher rates of human immunodeficiency virus and hepatitis infections than other groups.[10] Older LGBTQ persons may face added barriers to health because of isolation and a lack of social services and culturally competent providers.[9]

Understanding the cause of disparities among LGBTQ persons is essential to providing safe and high-quality care. One of the barriers to accessing high-quality health care by LGBTQ adults is the current lack of HCPs who are knowledgeable about their health needs. LGBTQ people may also experience fear of discrimination in health care settings.

Some health care settings are addressing the negative stereotypes that health care professionals may have, but of which they may not be aware. The Joint Commission (TJC) requires that patients be allowed the presence of a support person of their choice. In addition, hospitals must adopt policies that bar discrimination based on factors such as sexual orientation and gender identification and expression.

PROMOTING POPULATION HEALTH

Improving the Health and Well-Being of LGBTQ Persons

- Provide supportive social services to reduce suicide among young LGBTQ persons.
- Inquire about and be supportive of a patient's sexual orientation to enhance the patient-provider interaction and patient's regular use of care.
- Implement antibullying policies in schools.
- Provide health care professionals with knowledge of the health needs of the LGBTQ community and training on LGBT mental health issues.
- Continue efforts to expand domestic partner health insurance coverage.
- Establish community advisory boards and LGBTQ health centers.
- Disseminate effective HIV and sexually transmitted infections interventions.

Health Care Provider Attitudes. Certain behaviors and biases of the HCP can contribute to health disparities. Factors such as bias and prejudice can affect health care-seeking behavior in minority populations. The health care system may also contribute to the problem of health disparities. For example, a clinic located in an area with a large population of Vietnamese immigrants that does not provide interpreters or educational materials and financial forms in Vietnamese may limit these families' ability to understand how to access health care.

Discrimination and *bias* based on a patient's race, ethnicity, gender, age, body size, sexual orientation, or ability to pay are likely to result in less aggressive or negative treatment practices. Discrimination can result in the delay of a proper diagnosis due to assumptions made about the patient. Sometimes discrimination is hard to recognize, especially when it occurs at the institutional level.

Because an HCP's overt discriminatory behavior may not be clear to the patient or yourself, it may be difficult to confront. Even well-intentioned providers who try to eliminate bias in their care can show their prior beliefs or prejudices through nonverbal communication. Many policies are in place to eliminate discrimination, but it still exists.

CULTURE

Culture is a way of life for a group of people. It includes the behaviors, beliefs, values, traditions, and symbols that the group accepts, generally without thinking about them. This way of life is passed along by communication and imitation from 1 generation to the next. You can also think of culture as cultivated behavior that one acquires through social learning. It is the totality of a person's learned, accumulated experience that is socially transmitted. The 4 classic characteristics of culture are described in Table 2.2.

Values are the sets of rules by which persons, families, groups, and communities live. They are the principles and standards that serve as the basis for beliefs, attitudes, and behaviors. Although all cultures have values, the types and expressions of those values differ from 1 culture to another. These cultural values develop over time, guide decision making and actions, and may affect a person's self-esteem. Cultural values often unconsciously develop early in life as a child learns about acceptable and unacceptable behaviors. The extent to which a person's cultural values are internalized influences that person's tendency toward judging other cultures, while usually using his or her own culture as the accepted standard. Table 2.3 provides some examples of cultural characteristics of different ethnic groups in the United States.

Although persons within a cultural group may have many similarities through their shared values, beliefs, and practices, there is also diversity within groups (Fig. 2.2). Each person is culturally unique. Such diversity may result from different perspectives and interpretations of situations. These differences may be based on age, gender, marital status, family structure, income, education level, religious views, and life experiences. Within any cultural group, there are smaller groups that may not hold all the values of the dominant culture. These smaller cultural groups have experiences that differ from those of the dominant group. These differences may be related to ethnic background, residence, religion, occupation, health, age, gender, education, or other factors that unite the group. Members

TABLE 2.2 Basic Characteristics of Culture

- *Dynamic* and ever-changing
- *Not always shared* by all members of a cultural group
- *Adapted* to specific conditions such as environmental factors
- *Learned* through oral and written histories, as well as socialization

TABLE 2.3 Cultural Characteristics of Different Ethnic Groups

Asian American
- Cultural foods
- Family loyalty
- Folk healing
- Harmonious relationships
- Harmony and balance within body vital for preservation of life energy
- Respect for elders
- Respect for one's parents and ancestors
- Extended family valued
- Interdependence and collectivism
- Involvement of family in social activities
- Religion and spirituality highly valued
- Respect for elders and authority

Black
- Cultural foods
- Family networks
- Folk healing
- Importance of religion
- Interdependence within ethnic group
- Music and physical activities valued

European American
- Equal rights of genders
- Independence and freedom
- Individualistic and competitive
- Materialistic
- Self-reliance valued
- Youth and beauty valued

Hispanic/Latino
- Cultural foods
- Folk healing

Native American
- Doing the honorable thing
- Folk healing
- Living in harmony with people and nature
- Respect for tribal elders and children
- Respect for all things living
- Return what is taken from nature
- Spiritual guidance

Pacific Islander American
- Collective concern and involvement
- Kinship alliance among nuclear and extended family
- Knowledge is collective; belongs to group, not a person
- Natural order and balanced relationships

Adapted from Andrews MM, Boyle JS: *Transcultural concepts in nursing care,* ed 7, Philadelphia, 2016, Lippincott Williams & Wilkins; and Giger JN, Davidhizar RE: *Transcultural nursing: Assessment and intervention*, ed 7, St Louis, 2016, Mosby.

of a subculture share certain aspects of culture that are different from those of the overall cultural group. For example, among Hispanics some seek professional health care right away when symptoms appear. Other Hispanics rely first on folk healers. Others first seek the opinion of family and friends before seeking formal health care.

Cultural beliefs about symptom tolerance and health care–seeking behavior can contribute to health disparities. Some cultures consider pain something to be endured or ignored, and as a result, the patient does not seek help. Some cultures may view diseases or problems fatalistically; that is, people see no reason to seek treatment because they believe it is unlikely to have any benefit. Some cultures view the signs and symptoms of an illness as "God's will" or as a punishment for some prior behavior. In some cultures, it may not be acceptable to see an HCP who is not of the same gender or ethnic group. Such beliefs can result in delays in seeking health care or inadequate treatment.

FIG. 2.2 Members of this family share a common heritage. (© Jack Hollingsworth/Photodisc/Thinkstock.)

Acculturation is the lifelong process of incorporating cultural aspects of the contexts in which a person grows, lives, works, and ages.[11] Acculturation is often bidirectional. In other words, the context changes as a person's culture influences it. Change may be in attitudes, behaviors, and values. For example, a sedentary person who loves to cook may change his or her attitude toward exercise when living with athletic roommates, who in turn also change as they begin to appreciate cooking. Behaviors change when an immigrant child learns the local language while influencing the conduct of classmates. A deeply held value such as self-sufficiency may change for a person exposed to a culture in which reliance on others dominates.

Newcomers may adopt both the strengths and limitations of the dominant culture. This is relevant when considering health behaviors and the quality of health care delivered by professionals. For example, an immigrant may be negatively influenced by a dominant cultural context in which unhealthy eating habits prevail.[12]

The result of acculturation may be new cultural variations in attitudes, behaviors, and values. All people take part in this process over their lives. People who move to a new cultural context are more aware of the acculturation experience than people who are not exposed to new experiences. Exposure to new cultural contexts increases a nurse's cultural competency.

Stereotyping refers to an overgeneralized viewpoint that members of a specific culture, race, or ethnic group are alike and share the same values and beliefs. This oversimplified approach does not consider the individual differences that exist within a culture. Being a member of a particular cultural, ethnic, or racial group does not make the person an expert on other members of that same group. Such stereotyping can lead to false assumptions and affect a patient's care. For example, it would be inappropriate for you to assume that just because a nurse is Mexican American, he would know how a Mexican American patient's beliefs may affect that patient's health care practices. As another example, a young Mexican American nurse born and raised in a large city has experienced a different culture than the older patient who was born and raised in a rural area of Mexico.

Ethnocentrism refers to the belief that one's own culture and worldview are superior to those of others from different cultural, ethnic, or racial backgrounds.[11] Comparing others' ways to your own can lead to seeing others as different or inferior. HCP's ethnocentrism can result in poor communication,

patient alienation, and potentially inadequate treatment. To avoid ethnocentrism, you need to remain open to a variety of perspectives and maintain a nonjudgmental view of the values, beliefs, and practices of others. Failure to do this can result in ethnic stereotyping or cultural imposition.

Cultural imposition occurs when we impose our own cultural beliefs and practices on another person or group of people. In health care, it can result in disregarding or trivializing a patient's health care beliefs or practices. Cultural imposition may happen when an HCP is unaware of the patient's cultural beliefs and plans and implements care without taking them into account.

Cultural safety describes care and advocacy for a person of another culture determined by that person or family. Care that is culturally safe prevents cultural imposition. Culturally safe practice requires cultural competency and action to ensure that cultural histories, experiences, and traditions of patients, their families, and communities are valued and shape health care approaches and policies.[13]

Madeleine Leininger coined the term **transcultural nursing** in the 1950s. Transcultural nursing is a specialty that focuses on the comparative study and analysis of cultures and subcultures. The goal of transcultural nursing is the discovery of culturally relevant facts that can guide the nurse in providing culturally appropriate care.[11]

CULTURAL COMPETENCE

Cultural competence is the ability to understand, appreciate, and work with people from cultures other than your own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of the patient's culture, and adaptation of skills to meet the patient's needs. The 4 components of cultural competence are (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, and (4) cultural encounter (Table 2.4).

We present specific information throughout this book to help you develop an awareness of cultural differences and learning assessment skills for different cultural groups. Table 2.8 (later in this chapter) presents a cultural assessment guide. It may be helpful to review general cultural characteristics associated with a cultural group when preparing to interview a patient. However, recognize that the patient may not identify with the assumed cultural group and the provider's own biases and stereotypes may affect the patient and result in more patient-provider barriers.

Providing culturally competent care may increase patient satisfaction, promote health equity, increase patient safety, and prevent misunderstandings between you and your patients.[14] It also involves integrating cultural practices into Western medicine. For example, before some diagnostic procedures and interventions, it is typical to have patients remove personal objects they are wearing on the body. Ask patients whether they wear personal objects and the significance of their removal, since they may have cultural or spiritual significance. You should know whether wearing these objects will compromise patient safety, test results, or outcomes of the intervention.

TABLE 2.4 How to Develop Cultural Competence

Description	Role of Nurse
Cultural Awareness	
• Ability to understand patients' unique cultural needs	• Understand your own cultural background, values, and beliefs, especially as related to health and health care. • Examine your own cultural biases toward people whose cultures differ from your own culture.
Cultural Knowledge	
• Process of learning key aspects of a group's culture, especially as it relates to health and health care practices • Patients are best source of information about their culture	• Learn basic general information about predominant cultural groups in your geographic area. Cultural pocket guides can be a good resource. • Assess patients for presence or absence of cultural traits based on an understanding of generalizations about a cultural group. • Do not make assumptions based on cultural background because the degree of acculturation varies among persons. • Read research studies that describe cultural differences. • Read ethnic newspaper articles and books. • View documentaries about cultural groups.
Cultural Skill	
• Ability to collect relevant cultural data • Performance of a cultural assessment	• Be alert for unexpected responses with patients, especially as related to cultural issues. • Become aware of cultural differences in predominant ethnic groups. • Develop assessment skills to do a competent cultural assessment for any patient (see Table 2.8). • Learn assessment skills for different cultural groups, including cultural beliefs and practices.
Cultural Encounter	
• Direct cross-cultural interactions between people from culturally diverse backgrounds • Extended contact with a cultural group to enhance understanding of its values and beliefs	• Create opportunities to interact with predominant cultural groups. • Attend cultural events, such as religious ceremonies, significant life passage rituals, social events, and demonstrations of cultural practices. • Visit markets and restaurants in ethnic neighborhoods. • Explore ethnic neighborhoods, listen to different types of ethnic music, and learn games of various ethnic groups. • Visit or volunteer at health fairs in local ethnic neighborhoods. • Learn about prominent cultural beliefs and practices and incorporate this knowledge into planning nursing care.

CULTURAL DIVERSITY IN THE HEALTH CARE WORKPLACE

Poorer health outcomes for minorities are linked to the shortage of culturally and ethnically diverse HCPs, who have historically been underrepresented in the health professions. A diversity gap exists between the ethnic composition of the interprofessional health care team and the overall population in the United States (Fig. 2.3). For example, the diversity of nurses in the United States is increasing but still lags that of the overall population. Blacks, Hispanic/Latino Americans, and Native Americans make up more than 35% of the population but only

FIG. 2.3 Interprofessional team working together in a multicultural health care environment. (© Thinkstock/Stockbyte/Thinkstock.)

24% of the nation's nurses.[3,15] Biased behaviors against nurses of diverse cultural and ethnic backgrounds by patients and health care professionals may contribute to their underrepresentation.

Cultural differences exist in how well patients think they can communicate with their HCP. In the United States, minority patients are more likely to have difficulty communicating with their HCP.[16] Communication issues include not understanding the HCP, feeling that they are not listened to, and having questions but not asking them. As more internationally educated nurses join the workforce, sufficient training and transitional support must be in place to ensure communication and quality of care.

When HCPs from different cultures work together as members of the health care team, opportunities for miscommunication and conflict can occur. This is termed *cultural conflict.* The cultural origins of miscommunication and conflict in the workplace are often interconnected with cultural beliefs, values, and etiquette. Seeking clarification about misperceptions and misunderstandings is a communication strategy to foster effective teamwork among a multicultural health care team. To ensure the recruitment and retention of nurses from minority populations, all members of the health care team and leadership must create an environment that promotes effective cross-cultural communication and reduces bias and discrimination.

CULTURAL FACTORS AFFECTING HEALTH AND HEALTH CARE

Many cultural factors affect the patient's health and health care. Several potential factors are outlined in Table 2.5.

Folk Healers and Traditions

Many cultures have **folk healers**, who are also known as *traditional healers.* Most folk healers speak the person's native language and cost less than conventional HCPs. Among the many folk healers found worldwide, Hispanics, particularly from regions in Mexico and Central and South America, may choose to use a *curandero* (or *curandera*); blacks may visit a *hougan;* Native Americans may seek help from a medicine man or *shaman;* and Asian Americans may use folk healers such as a Chinese herbal therapist. In addition to folk healers, some cultures involve lay midwives (e.g., *parteras* for Hispanic women) in the care of pregnant women.

TABLE 2.5 Cultural Factors Affecting Health and Health Care

Beliefs and Practices
- Care provided in established health care programs may not be perceived as culturally relevant.
- Religious reasons, beliefs, or practices may affect a person's decision to seek (or not seek) health care.
- Patients may delay seeking health care because of fear or dependence on folk medicine and herbal remedies.
- Patients may stop treatment or visits for health care because the symptoms are no longer present and they think that further care is not needed.
- Some patients associate hospitals and extended care facilities with death.
- The patient may have had a previous negative experience with culturally incompetent HCPs or discriminatory practices.
- Some people mistrust the majority population and institutions dominated by them.
- Some patients may feel apprehensive about unfamiliar diagnostic procedures and treatment options.

Communication and Language
- Patients may not speak English and may not be able to communicate with the HCP.
- It may be hard to communicate, even with interpreters.

Economic Factors
- Patients may not get health care because they cannot pay for it or because of the costs associated with travel for health care.
- Refugee or undocumented immigrant status may deter some patients from using the health care system.
- Immigrant women who are heads of households or single mothers may not seek health care for themselves because of child care costs.
- Patients may lack health insurance.

Health Care System
- Patients may not make or keep appointments because of the time lag between the onset of an illness and an available appointment.
- Hours of operation of health care facilities may not accommodate patients' need to work or use public transportation.
- Requirements to access some types of care may discourage some patients from taking the steps to qualify for health care or health care payment assistance.
- Some patients have a general distrust of HCPs and health care systems.
- Lack of ethnic-specific health care programs may deter some people from seeking health care.
- Transportation may be a problem for patients who must travel long distances for health care.
- Adequate interpreter services may be unavailable.
- Patients may not have a primary HCP and may use emergency departments or urgent care centers for health care.
- Shortages of HCPs from specific ethnic groups may deter some people from seeking health care.
- Patients may lack knowledge about the availability of existing health care resources.
- Facility policies may not be culturally competent (e.g., hospital policy may limit the number of visitors, which is problematic for cultures that value having many family members present).

Time Orientation
- For some cultures, it is more important to attend to a social role than to arrive on time for an appointment with an HCP.
- Some cultures are future oriented; others are past or present oriented.

TABLE 2.6 Health-Related Beliefs and Practices of Selected Religious Groups

Amish
- Prohibit drinking alcoholic beverages
- Prohibit abortion, artificial insemination, and stem cell use
- Seldom buy commercial health insurance
- Prohibit drugs unless prescribed by HCPs

Buddhism
- Prohibit drinking alcoholic beverages and using illicit drugs
- Practice moderation in diet and avoidance of extremes
- Central tenets are maintaining right views, intentions, speech, actions, livelihood, effort, mindfulness, and concentration

Catholicism
- Fast and abstain from meat and meat products on Ash Wednesday and the Fridays of Lent
- Prohibit artificial contraception and direct abortion
- Indirect abortion (e.g., treatment of uterine cancer in a pregnant woman) may be morally justified
- Sacrament of the Sick includes anointing of sick with oil, blessing by a priest, and communion (unleavened wafer made of flour and water)

Church of Jesus Christ of Latter-Day Saints (Mormons)
- Strict dietary code called Word of Wisdom prohibits all alcoholic beverages, hot drinks (nonherbal teas and coffee), tobacco, and recreational drugs
- Fast for a 24-hour period each month on "Fast Sunday"
- During hospitalization or serious illness, an elder anoints the ill person with oil while a second elder seals the anointing with a prayer and blessing (laying on of hands)
- Prohibit abortion except when the mother's life is in danger

Hinduism
- Prohibit eating meat because it involves harming a living creature
- Cremation is the usual form of body disposal, but fetuses or newborns are sometimes buried

Islam
- Fasting during daytime hours occurs during a month-long period called Ramadan
- Perform a ritual cleansing with water before eating and before prayer
- Prohibit eating pork or taking medicines with pork derivatives
- Prohibit drinking alcoholic beverages
- Artificial insemination is permissible only if from the husband to his own wife

Jehovah's Witness
- Prohibit transfusions of blood in any form or agents in which blood is an ingredient
- Blood volume expanders are acceptable if they are not derivatives of blood
- Prohibit transplants that involve bodily mutilation
- Prohibit artificial insemination and therapeutic and on-demand abortions

Judaism
- Prohibit eating pork, shellfish, or predatory fowl or mixing milk dishes and meat dishes when preparing foods
- Certain foods and drinks are designated as kosher, which means "proper." All animals must be ritually slaughtered
- On the eighth day after birth, boys are circumcised in a ritual called Brit Milah. Girls are given a dedication ceremony involving prayers and blessings
- Prohibit abortion except when the mother's life is in danger
- Organized support system for the sick includes a visit from the rabbi. The rabbi may pray with the sick person alone or in a minyan, a group of 10 adults over age 13
- If an autopsy is done, all body parts must be returned for burial

Seventh-Day Adventism
- Encourage a vegetarian diet
- Nonvegetarian members do not eat foods derived from any animal having a cloven hoof that chews its cud (e.g., pigs, goats).
- Prohibit eating shellfish; eating fish with fins and scales is acceptable
- Prohibit drinking alcoholic beverages
- Healthy church members practice voluntary fasting

Data from Andrews MM, Boyle JS: *Transcultural concepts in nursing care,* ed 7, Philadelphia, 2016, Lippincott Williams & Wilkins.

Folk medicine and traditions are culturally based forms of prevention and treatment. They traditionally rely on oral transmission of healing techniques from 1 generation to the next. The patient may not use the term *folk medicine* but thinks of these as cultural home remedies or treatment practices. A patient can be practicing folk medicine at home without using a folk healer. It is important to assess whether the patient is practicing traditional or folk healing.

Some traditions that are practiced as a rite of passage in some cultures are considered harmful in the dominant culture in the United States. For example, female genital cutting is a tradition that is illegal in most countries yet still practiced in many countries in Africa and the Middle East. It results in physical and emotional trauma and may affect childbirth. Nurses can advocate for immigrant women who have experienced this trauma and to prevent return of young girls to their country of origin for the procedure.

Spirituality and Religion

Spirituality and religion are aspects of culture that may affect a person's beliefs about health, illness, and end-of-life care. They may also play a role in nutrition and decisions related to health, wellness, and how to respond to or treat an illness.

Spirituality refers to a person's effort to find purpose and meaning in life. It is influenced by a person's unique life experiences and reflects one's personal understanding of life's mysteries. Spirituality relates to the soul or spirit more than to the body, and it may provide hope and strength for a person during an illness.

Religion is a more formal and organized system of beliefs, including belief in or worship of God or gods. Religious beliefs include the cause, nature, and purpose of the universe and involve prayer and rituals. Religion is based on beliefs about life, death, good, and evil. You can use several interventions to meet a patient's religious and spiritual needs, including prayer, scripture reading, listening, and referral to a chaplain, rabbi, or priest.

Many patients find that rituals help them during times of illness. Rituals help a person make sense of life experiences and may take the form of prayer, meditation, or other rituals that the patient may create. You should include spiritual questions in your patient assessment and plan care accordingly. Table 9.5 has a spiritual assessment guide that may be used with patients. Table 2.6 summarizes health-related beliefs and practices of selected religious groups.

Cross-Cultural Communication

Communication refers to an organized, patterned system of behavior that may be verbal or nonverbal (Fig. 2.4). *Verbal communication* includes not only one's language or dialect, but also voice tone, volume, timing, and ability to share thoughts and feelings. More than 45 million people in the United States speak a language other than English in their home, with Spanish being

FIG. 2.4 Co-workers from different cultures communicate with verbal and nonverbal cues. (© BananaStock/Thinkstock.)

FIG. 2.5 Family roles and relationships differ from 1 culture to another. (© Jupiterimages/Photos.com/Thinkstock.)

the most common. Hispanic people who do not speak English at home are less likely to receive a variety of health care services even if they are comfortable speaking English.

Nonverbal communication may take the form of writing, gestures, body movements, posture, facial expressions, and personal dress in some cultures. It also includes eye contact, use of touch, body language, style of greeting, and spatial distancing. Eye contact varies greatly among cultural groups. Patients who are Asian, Arab, or Native American may avoid direct eye contact and consider it disrespectful or aggressive. Hispanic patients may expect you to look directly at them but may not return that direct gaze. Other variables to consider include the role of gender, age, acculturation, status, or appropriate eye contact. For example, Muslim-Arab women exhibit modesty when avoiding eye contact with men other than their husbands and when in public situations.

Silence has many meanings. It is important to understand the meaning of silence for different cultural groups. Some people are comfortable with silence. Others become uncomfortable and may speak to decrease the amount of silent time. It is important to clarify what silence means in an interaction with a patient. Patients sometimes nod their head or say "yes" as if agreeing with you or to show they understand. Actually, they may be doing this because it is a culturally acceptable manner of showing respect, not because they understand or agree.

Many Native Americans are comfortable with silence and interpret silence as essential for thinking and carefully considering a response. In these interactions, silence shows respect for the other person and shows the importance of the remarks. In traditional Japanese and Chinese cultures, the speaker may stop talking and leave a period of silence for the listener to think about what was said before continuing. Silence may show respect for the speaker's privacy. In some cultures (e.g., French, Spanish, and Russian) the person may interpret silence as meaning agreement. Asian Americans may use silence to show respect for elders. Blacks may use silence as a response to what they perceive to be an inappropriate question.

Racism and microaggression affect communication. *Racism* is a belief that differences among the various racial/ethnic groups determine cultural or individual achievement. It usually involves the idea that one's own race/ethnicity is superior and has the right to dominate others or that a particular racial/ethnic group is inferior to the others.

Microaggression is social exchanges in which a person says or does something that can either intentionally or unintentionally belittle or alienate a person, especially someone of a different racial/ethnic group. It is imperative that nurses seek to understand racism and microaggression through education, self-awareness, and open dialogue with peers.[17]

Family Roles and Relationships

Family roles differ from 1 culture to another (Fig. 2.5). It is important for you to determine who should be involved in communication and decision making related to health care. Some cultural groups emphasize interdependence rather than independence. In the United States, many in the mainstream culture have strong beliefs related to autonomy. We expect a patient to sign consent forms when receiving health care. In some cultural groups, the patient may expect a family member to make health care decisions. When you encounter a patient who values interdependence over independence, the health care system may have difficulty with how the patient makes decisions. We may have to delay treatment while the patient waits for family members to arrive before giving consent for a procedure or treatment. In other instances, the patient may make a decision that is best for the family despite adverse outcomes for the patient. Being aware of such values will better prepare you to advocate for the patient.

Some cultural differences relate to expectations of family members in providing care. In some cultures, family members expect to provide care for the patient even in the hospital. The patient may expect that the family, along with the HCPs, will provide all care. This view is the opposite of the predominant Western expectation that the patient will assume self-care as quickly as possible.

Ask about culturally relevant gender relationships. For example, in some cultures, such as many Arab groups, it is not appropriate for a man to be alone with a woman other than his wife. Nor is it appropriate for a woman other than a man's wife

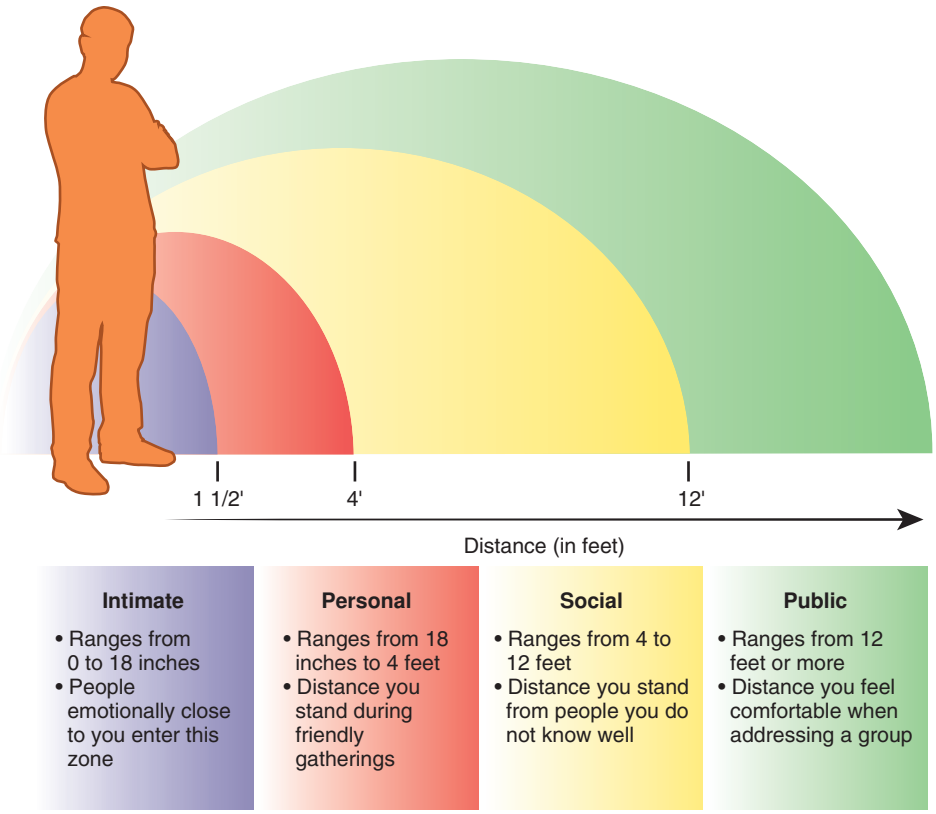

FIG 2.6 Personal space zones.

to provide physical care for him. The clinical implication of this cultural belief is that for many patients from Arab cultures, nurses cannot provide direct physical care for patients of the opposite gender. In some instances, patients may only receive procedures or treatments from providers of the opposite gender if a third party is present.

Personal Space

Personal space zones are the variable and subjective distance at which 1 person feels comfortable talking to another. A representative example of personal space zones for European Americans is shown in Fig. 2.6. Personal space distances vary from culture to culture, as well as within a culture. As a nurse, you often interact with patients in the intimate or personal distance, which may be uncomfortable for the patient.

Cultural groups have wide variations in their perception of appropriate distances. An American nurse of European descent may be comfortable with a certain distance. A person from a Hispanic or Middle Eastern background may believe that the distance is too far and will move closer, perhaps causing you to feel uncomfortable. If you then move away to a more comfortable distance, this may cause the other person to think that you are unfriendly or the person may be offended.

Touch

Physical contact with patients conveys various meanings depending on the culture. Performing a comprehensive assessment requires touching a patient. Many people of Asian and Hispanic heritage believe that touching a person's head is a sign of disrespect because the head is the source of one's strength and/or soul. Many people in the world believe in the evil eye, or *mal ojo*. In this culture-bound syndrome, the illness—usually in a child or a woman—resulted from excessive admiration by another person. In some cultures, the proper way to ward off the evil eye is to touch the area of admiration. For example, if the person admires the hair, the top of the head may be touched. It is important for you to ask permission before touching anyone, particularly if it is necessary to touch the person's head.

Nutrition

An important part of cultural practices is food, including both the foods that are eaten and rituals and practices associated with food. Muslims fast during the daytime during the Islamic month of Ramadan. Such practices may affect when and how patients take medications. Patients may need to make major changes in their diets because of health problems. A person may use food to cope with life changes such as homesickness. Specific foods may be considered essential to good health during pregnancy or other life stages. The HCP should consider food-related cultural beliefs, practices, and habits when discussing nutrition with patients and planning their diets.

When people immigrate to an area that is very different from their country of origin, they may experience unfamiliar foods, food-storage systems, and food-buying habits. They may come from countries that have limited food supplies because of poverty, wars, and poor sanitation. They may arrive with conditions such as malnutrition, diarrhea, and dental caries. Other problems may develop after the person arrives in the new country. For example, second-generation

Hispanic immigrants have a greater chance of becoming overweight than their first-generation counterparts. The increase in weight is related to the degree of acculturation experienced by the immigrant.

Immigrants and Immigration

Several conditions drive migration, such as overcrowding, natural disasters, geopolitical conflict, persecution, and economic forces. Because of these migrations, a rich diversity of cultures exists in many communities and countries today (Fig. 2.7).

Recent immigrants may be at risk for physical and mental health problems for many reasons. Conditions in their countries of origin (e.g., malnutrition, poor sanitation, civil war) may have resulted in chronic health problems. In addition, recent immigrants are at increased risk for health problems after arriving in a new area. Relocation is associated with many losses and can cause economic hardship, physical stress, and mental distress.

As new immigrants go through the acculturation process, many have cultural stress as they adjust to their new environment, especially if they have left relatives behind or are unable to return to their home country. Older immigrants are especially affected by changes in role and social position. This may result in depression. Immigrants who have survived wars and violence may have posttraumatic stress disorder. Immigrants may face barriers to social acceptance, such as prejudice or discrimination, and experience a lack of ethnic and cultural resources. For some, it may mean loss of the social status that they experienced in their countries of origin.

Another potential problem is tuberculosis (TB). Two-thirds of the TB cases in the United States occur in people born outside the country.[18] Those who have recently immigrated from areas that have a high endemic rate of TB are more likely to have TB. Foreign-born Hispanics and Asians combined account for 48% of the nation's TB cases. The top 5 countries of the origin of foreign-born people with TB are Mexico, Philippines, Vietnam, India, and China. The *Refugee Health Guidelines* from the Centers for Disease Control and Prevention supports early identification and treatment.[19]

During the past 45 years, the migration pattern of North America has shifted. Once most immigrants came from Europe. Now, most originate from Asia, Latin America, and Africa. Additionally, an increased number of first- and second-generation immigrants enter the United States after visiting friends and relatives. They have a higher risk for malaria, typhoid fever, cholera, and hepatitis A than people born in the United States. Many immigrants lack health insurance and may primarily obtain their health care in emergency departments and urgent care clinics. Therefore nurses in all settings need to be aware of refugee health screening, treatment recommendations, and resources for access to health care and social services.

Drugs

Genetic differences among people from diverse ethnic or racial groups may explain differences in drug choice, dosage, or administration. For example, some drugs are more effective in certain ethnic groups than others. Side effects may vary among persons from diverse backgrounds.

Genetic variations can affect how the body processes a drug and the overall effect of selected drugs on the body. Although race and ethnicity are imprecise indicators of genetic differences, they can be helpful in predicting variations in the response to drugs. For example, European Americans respond better to angiotensin-converting enzyme (ACE) inhibitors and β-blockers than blacks. Genetics and drug metabolism are discussed in Chapter 12.

FIG. 2.7 Recently arrived immigrants join a neighbor for a barbecue, a common American tradition. (© Jack Hollingsworth/Photodisc/Thinkstock.)

Regardless of their cultural origins, many people use cultural remedies and prescription drugs to treat illness. Problems can result from interactions of these substances. For example, some Mexican Americans may treat gastrointestinal problems with preparations that contain lead. Some people may self-treat their depression with St. John's wort, which can result in adverse effects if taken with prescription antidepressants.

Patients may avoid standard Western medicine until herbs and other remedies become ineffective or the illness becomes acute. The challenge for you is to try to accommodate the patient's desire for traditional aspects of care while using evidence-based approaches that are appropriate and acceptable to the patient. Evaluate the safety and appropriateness of the patient's traditional cultural healing therapies.

Develop a collaborative, trusting relationship with patients and encourage them to discuss their traditional approaches to healing. Seek out information on potential drug and herbal product interaction from the pharmacist. Honor the patient's choices, if safe and effective, since this will enhance collaboration and may have a positive impact on health outcomes.

Psychologic Factors

Symptoms are interpreted through a person's cultural norms and may vary from the recognized interpretations of Western medicine. All symptoms have meaning, and the meanings may vary from 1 culture to another. For example, the degree of depression following a cardiac diagnosis is mediated by cultural views. It is important to ask patients what their illness means to them, what they believe is the cause, and what they think is the best treatment.

Culture-bound syndromes are illnesses or afflictions that are recognized only within a cultural group (Table 2.7). The symptoms, course of the illness, and people's reactions to the illness are limited to specific cultures. Culture-bound syndromes are expressed through psychologic or physical symptoms.