EDITION 7

Medical-Surgical Nursing

Linton Matteson

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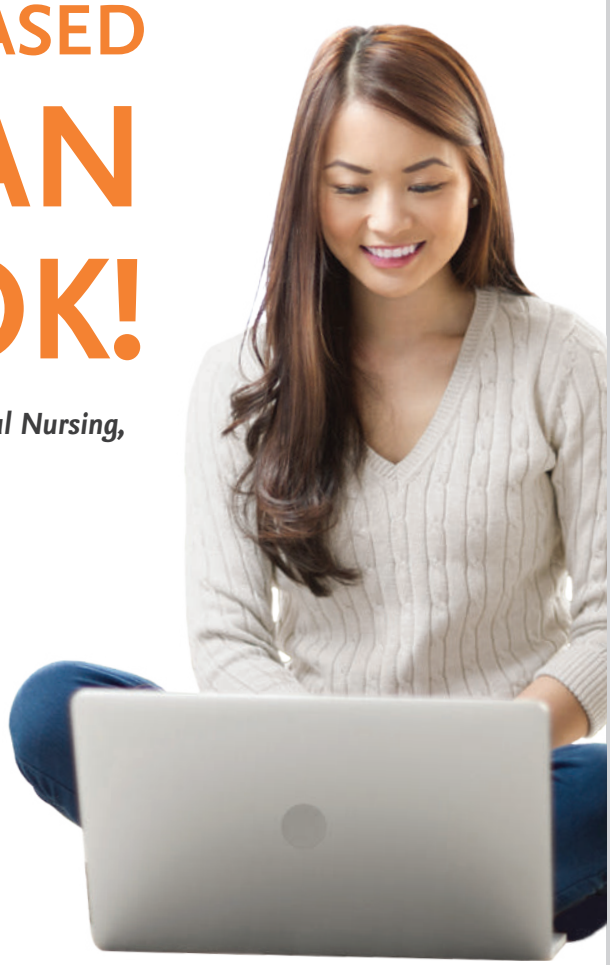

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EDITION

7

Medical-Surgical Nursing

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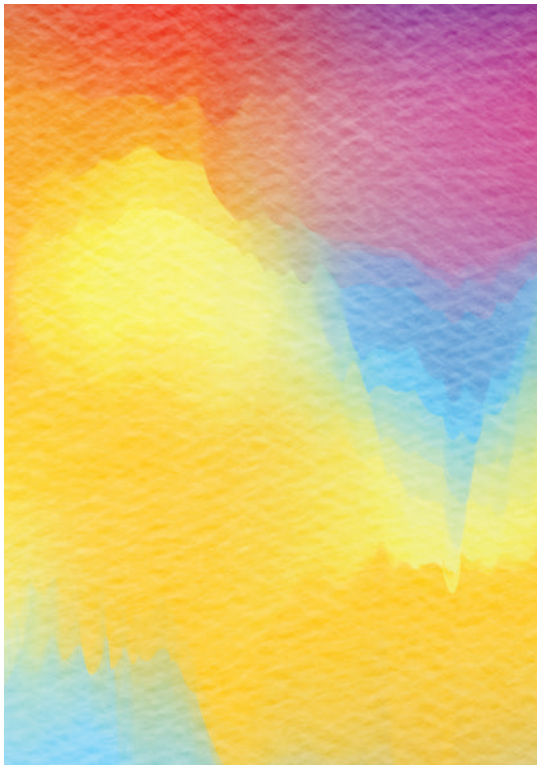

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Dedicated to our colleague and friend,
Dr. Nancy Maebius,
a champion of LVN education who provided guidance and inspiration
for this textbook since the first edition.

Adrianne Dill Linton and Mary Ann Matteson

Acknowledgments

The seventh edition of *Introduction to Medical-Surgical Nursing* is the product of multiple teams of amazing people. Before revisions began, chapters from the previous edition were reviewed by experienced LVN/LPN educators and content experts. The input of these individuals ensured readability, accuracy, appropriateness for the LVN/LPN student, and timeliness. Using the reviews and extensive literature searches, chapter authors crafted new manuscripts that reflect the best practices known to us as of the publication date. Once again, reviewers were invited to provide feedback on the new manuscripts.

The incredible Elsevier staff managed this entire process and then pulled all the pieces together to create this fine edition. We particularly wish to acknowledge the following individuals who each brought unique knowledge and skills to the production process. Kelly Skelton, Senior Content Development Specialist, has worked to develop and carry this edition to publication with great skill and creativity. The Elsevier team included Nancy O'Brien, Senior Content Strategist; Kristen Oyirifi, Marketing Manager; Renee Duenow, Book Designer; Julie Eddy, Publication Services Manager; and Jodi Willard, Senior Project Manager. Behind the scenes are many other individuals involved in the development of the ancillary materials.

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To the Instructor

The first six editions of this text were designed to provide practical and vocational nursing students with accessible, comprehensive coverage of the nursing care of adults with disorders that require medical, surgical, and psychiatric management in addition to related nursing fundamentals content. The needs of older adults and residents of nonacute care settings received special attention.

Since the first edition of this textbook, the LVN profession has continued to evolve. Increased complexity of patient care has created a need for additional resources for LVN education. Whereas previous editions of this text merged fundamentals and medical-surgical nursing content, this edition has removed content that is covered in the excellent fundamentals texts now available. The title of the text has been changed to *Medical-Surgical Nursing* to reflect the current focus.

ORGANIZATION

Unit I defines medical-surgical nursing and describes the role of the LVN/LPN in medical-surgical care. Essential knowledge and skills are explained. Ethical and legal concepts and principles of leadership and management are applied to medical-surgical care. The settings of care in which medical-surgical patients are seen are described with emphasis on the role of the LVN/LPN. Attention is given to community health and community-based settings, home health, long-term care and rehabilitation facilities. **Unit II** focuses on the application of concepts from sociology and psychology that are vital in the care of medical-surgical patients. The patient's needs and the care provided must consider cultural influences and developmental stage in the context of the patient's social network (i.e., the family). Major health issues at each stage of life are identified. Family stages of development and coping strategies are explored. The in-depth coverage of topics in **Unit III** provides both a foundation for understanding many disorders and a scientific basis for many aspects of nursing care. Pathological processes are described and the adaptive responses to deviations are explored. Included are concepts of health and illness; stress and coping; immunity, inflammation, and infection; fluid and electrolyte imbalances; cancer; pain; and shock. This approach avoids repetition of content such as common electrolyte imbalances that are encountered in numerous conditions.

Because LVN/LPNs are the backbone of nursing care in settings that serve older adults, **Unit IV** provides a detailed overview of the aging process and needs of the older patient as well as comprehensive coverage of four major clinical problems (falls, incontinence, confusion, and immobility). The last of the introductory units, **Unit V**, focuses on therapeutic interventions including nutrition, intravenous therapy, surgery, ostomies, complementary and alternative therapies, and palliative and hospice care. This unit creates a foundation on which the student can build when studying a variety of systems and disorders. Care of patients with specific types of cancer is addressed in later chapters. **Units VI** through **XVI** follow a systems approach to medical-surgical disorders. An introductory chapter for each system provides a thorough nursing assessment, age-related considerations, diagnostic tests and procedures, drug therapy, and other common therapeutic measures. The specific role of the LVN/LPN in data collection for focused assessments is emphasized. Common therapeutic measures are intended not to replace a fundamentals text but instead to provide a limited summary or review of key aspects of nursing care. The introductory systems chapters eliminate much duplication of content in each of the subsequent chapters. Introductory chapters are followed by one or more chapters that cover specific disorders requiring medical-surgical treatment. Aspects covered are pathophysiology, signs and symptoms, complications, diagnosis, and medical treatment. Nursing care is organized in the traditional nursing process format with patient problem statements, goals, and outcome criteria. Sample nursing care plans illustrate the application of the nursing process in realistic patient scenarios. **Unit XVII** consists of two chapters that address psychobiologic disorders and substance use disorders and addiction. The content on psychosocial responses to illness has been combined with earlier content in Units II and III. **Unit XVIII** presents first aid, emergency care, and disaster management. This chapter has been moved to the end of the text because it draws on content covered throughout the book.

KEY FEATURES

We anticipate that faculty will find *Medical-Surgical Nursing* to be more streamlined with less duplication of nursing fundamentals and non-nursing content. We have emphasized the application of previously learned material rather than repeating the basics.

ACCESSIBLE LANGUAGE

The text is straightforward and direct, avoiding the cumbersome third person. What's more, we have continued to improve consistency and to standardize the reading level throughout.

KEY TERMS WITH PHONETIC PRONUNCIATIONS

Complex medical, nursing, and scientific words can be tricky to understand and pronounce. A Key Terms list at the beginning of each chapter shows students how to pronounce important terms they may encounter as nurses. All phonetic pronunciations have been reviewed by a specialist in English as a Second Language (ESL). Key terms appear in color in the text and are defined.

PATIENT PROBLEMS, GOALS, AND OUTCOME CRITERIA

Nursing care is the heart of this text, which is organized according to the steps of the nursing process. For each major disorder covered, patient problems, goals, outcome criteria, and relevant interventions are presented. Faculty familiar with our textbook will note that we are now using *patient problem* rather than NANDA nursing diagnoses. Because LVNs/LPNs do not formulate NANDA diagnoses, patient problems define issues that are more amenable to LVN/LPN identification and management. We believe this new terminology will be better understood by our student readers.

KEY POINTS

To succeed in the fast-paced world of health care, the nurse must be able to put it all together. Each chapter brings students a few steps closer by summarizing the most important points in a succinct and memorable way.

BOXED FEATURES CONTENT

Features described in the Student Introduction highlight important points such as pharmacology alerts ("capsules"), cultural considerations, and complementary and alternative therapies. These features emphasize and reinforce chapter content.

OTHER FEATURES

UPDATED CONTENT THROUGHOUT

Medical-Surgical Nursing continues the tradition of presenting innovative, accurate, and up-to-date content. Every chapter has been updated and reviewed by content and clinical experts.

REVIEW QUESTIONS

Multiple-choice, multiple-response, and short answer review questions are provided at the end of each chapter for immediate reinforcement of chapter content. Answers and rationales for these questions are located in the Evolve Student Resources. As with NCLEX® items, most of these questions are in multiple-choice format with single and multiple correct answers. Items with more than one correct answer direct the student to "Select all that apply." Although short-answer items are not in NCLEX format, we believe they are useful for students. See the To the Student section for additional key features within the text.

ANCILLARIES

FOR THE INSTRUCTOR

Evolve Resources

- ExamView Test Bank with NCLEX®–style questions and answers and separate test bank in Word for alternate format questions; over 1400 questions total. Each question in the test bank includes topic, nursing process step, objective, cognitive level, correct answer, rationale, and text page number references.
- Suggestions for working with English as a Second Language (ESL) students
- Image collection
- TEACH Instructor Resources
  - Lesson Plans based on textbook chapter learning objectives, which provide a roadmap to link and integrate all parts of the educational package
  - PowerPoint Presentation, including Audience Response Questions
  - Student handouts of the PowerPoint slides
- Chapter pretests
- Study Guide Answer Key

FOR STUDENTS

Study Guide

Practical and student-friendly, this useful study guide based on the textbook chapter objectives is designed to help students master the content presented in the text. It includes learning activities (including listing, matching, and labeling exercises) and multiple-choice and critical thinking questions.

Evolve Resources

- Answer Keys—In-text NCLEX Review Questions, Put on Your Thinking Cap Questions, and Nursing Care Plan Critical Thinking Questions
- Appendix—Laboratory Reference Values
- Spanish/English Glossary
- Review Questions—NCLEX-PN® Examination
- Fluid & Electrolyte Tutorial
- Bibliography and Reader References

To the Student

KEY FEATURES

Designed with the student in mind, *Medical-Surgical Nursing*, 7th edition, has a visually appealing and easy-to-use format that will help you to master medical-surgical nursing.

Following are some of the numerous special features and aids that will help you as you study.

READING AND REVIEW TOOLS

Objectives introduce the chapter topics and **Key Terms** are listed, with difficult medical, nursing, or scientific terms accompanied by simple phonetic pronunciations. Key terms are presented in color the first time they appear in the narrative and are briefly defined in the text, with complete definitions in the Glossary.

Each chapter ends with a section called **Get Ready for the NCLEX Examination! Key Points** follow the chapter objectives and serve as a useful chapter review. An extensive set of **Review Questions for the NCLEX Examination** provides an immediate opportunity to test your understanding of the chapter content. Most are in the same format you will see on the NCLEX-PN examination. **Answers** are located in the Evolve Student Resources.

Introductory systems chapters prepare you for the following chapters that address specific disorders. They provide a succinct review of system anatomy and physiology, the complete nursing assessment, related diagnostic procedures, drug classifications, and common therapeutic measures.

ADDITIONAL LEARNING RESOURCES

The online **Evolve Student Resources** at **http://evolve.elsevier.com/Linton/medsurg** gives you access to even more review questions for the NCLEX Examination and much more.

CHAPTER FEATURES

Nursing Care Plans, with critical thinking questions at the end of each care plan, encourage students to synthesize key concepts. Answer guidelines are given in the Evolve Student Resources site.

Patient Problems, Goals, and Outcome Criteria are screened and set apart in the text in a clear, easy-to-understand format to help you learn to participate in the development of a nursing care plan.

Drug Therapy tables developed for specific system disorders provide quick access to action, dosage, side effects, and nursing considerations for commonly used drug classes.

Diagnostic Tests and Procedures tables in the systems chapters provide quick references to relevant drugs and tests. Patient preparation and post-procedure care are included.

Health Promotion boxes highlight timely wellness and disease prevention topics.

Patient Teaching boxes appear frequently in the text to help develop awareness of the vital role of patient and family teaching in health care today.

Coordinated Care boxes help nurses to prioritize tasks and assign them safely and efficiently.

Complementary and Alternative Therapies boxes provide a breakdown of specific nontraditional therapies, along with precautions and possible side effects.

Cultural Considerations boxes explore the range of cultural preferences and how to address the needs of a culturally diverse patient and resident population when planning nursing care.

Nutrition Considerations boxes emphasize the role that nutrition plays in disease and nursing care.

Pharmacology Capsule boxes alert students to important precautions, interactions, and adverse effects of medications.

Put on Your Thinking Cap! boxes encourage analysis of content for application to clinical situations.

Contents

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Aspects of Medical-Surgical Nursing

1

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Objectives

1. Identify the most appropriate source of information about the roles of the licensed vocational nurse/licensed practical nurse (LVN/LPN) in medical-surgical nursing settings.
2. Describe the essential knowledge and skills needed by the medical-surgical nurse.
3. Describe principles of ethics that may apply when caring for medical-surgical patients.
4. Provide examples of nurse behaviors that violate laws governing the profession.
5. Describe the characteristics of effective leaders and managers.
6. Describe essential elements of delegation.
7. Describe the following in relation to LVN/LPN as a manager: making assignments, accountability, conflict resolution, and safety.

Key Terms

bioethics
ethnocentrism
leadership
malpractice
management
tort

DESCRIPTION

Medical-surgical nursing is a specialty that employs an array of knowledge and skill to provide care for adult patients with a variety of conditions requiring medical and/or surgical management. Medical-surgical nurses are prepared to provide care from adolescence through the end of life. Depending on the setting of care, the nurse may work with families and groups as well as with individuals.

PROFESSIONAL ORGANIZATIONS

The Academy of Medical-Surgical Nurses (AMSN) is the professional organization for nurses practicing in medical-surgical settings. It establishes the scope of practice and sets the standards for nursing practice. The AMSN welcomes licensed vocational nurses/licensed practical nurses (LVNs/LPNs) as associate members. LVNs/LPNs are eligible for full membership in the National Gerontological Nursing Association, which is dedicated to the clinical care of older adults across diverse settings.

ROLES

Depending on nursing preparation, education, practice settings, and specialized education, the medical-surgical nurse may function as a caregiver, care coordinator, patient-educator, case manager, counselor, patient advocate, consultant, researcher, administrator/manager, staff educator, and expert witness. The roles that LVNs/LPNs may assume are specified in their state nurse practice act. Some roles require collaboration with a registered nurse (RN), others require specialized training or certification. Because the risk of harm is inherent in the provision of nursing care, each state has a Nursing Practice Act and a set of Rules and Regulations that are enacted to protect the public. The National Association for Practical Nurse Education (NAPNES) has published *Standards of Practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs*. The standards and competencies define the roles of the LVN/LPN in relation to Professional Behaviors, Communication, Assessment, Planning, Caring Interventions, and Managing.

See the Coordinated Care box for the NAPNES document.

PRACTICE SETTINGS

Medical-surgical nurses are prepared to function in a variety of settings. Examples include acute and subacute care facilities, home health care, ambulatory care clinics, outpatient services, residential facilities, skilled nursing facilities, medical offices, adult day care, primary care,

Coordinated Care

NAPNES Standards of Practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs

These Standards and Competencies are intended to better define the range of capabilities, responsibilities, rights, and relationships to other health care providers for scope and content of practical/vocational nursing education programs.

Professional Behaviors

Professional behaviors, within the scope of nursing practice for a practical/vocational nurse, are characterized by adherence to standards of care, accountability for one's own actions and behaviors, and use of legal and ethical principles in nursing practice. Professionalism includes a commitment to nursing and a concern for others demonstrated by an attitude of caring. Professionalism also involves participation in lifelong self-development activities to enhance and maintain current knowledge and skills for continuing competency in the practice of nursing for the licensed practical nurse/licensed vocational nurse (LPN/LVN), as well as individual, group, community and societal endeavors to improve health care.

Upon completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Demonstrate professional behaviors of accountability and professionalism according to the legal and ethical standards for a competent LPN/LVN.

Competencies which demonstrate this outcome has been attained:

1. Comply with the ethical, legal, and regulatory frameworks of nursing and the scope of practice as outlined in the LP/VN nurse practice act of the specific state in which licensed.
2. Utilize educational opportunities for lifelong learning and maintenance of competence.
3. Identify personal capabilities and consider career mobility options.
4. Identify own LP/VN strengths and limitations for the purpose of improving nursing performance.
5. Demonstrate accountability for nursing care provided by self and/or directed to others.
6. Function as an advocate for the health care consumer, maintaining confidentiality as required.
7. Identify the impact of economic, political, social, cultural, spiritual, and demographic forces on the role of the LPN/LVN in the delivery of health care.
8. Serve as a positive role model within health care settings and the community.
9. Participate as a member of a practical/vocational nursing organization.

Communication

Communication is defined as the process by which information is exchanged between individuals verbally, nonverbally, and/or in writing or through information technology. Communication abilities are integral and essential to the nursing process. Those who are included in the nursing process are the LPN/LVN and other members of the nursing and health care team, client, and significant support person(s). Effective communication demonstrates caring, compassion, and cultural awareness, and is directed toward promoting positive outcomes and establishing a trusting relationship.

Upon completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Effectively communicate with patients, significant support person(s), and members of the interdisciplinary health care team, incorporating interpersonal and therapeutic communication skills.

Competencies which demonstrate this outcome has been attained:

1. Use effective communication skills when interacting with clients, significant others, and members of the interdisciplinary health care team.
2. Communicate relevant, accurate, and complete information.
3. Report to appropriate health care personnel and document assessments, interventions, and progress or impediments toward achieving client outcomes.
4. Maintain organizational and client confidentiality.
5. Utilize information technology to support and communicate the planning and provision of client care.
6. Utilize appropriate channels of communication.

Assessment

Assessment is the collection and processing of relevant data for the purpose of appraising the client's health status. Assessment provides a holistic view of the client which includes physical, developmental, emotional, psychosocial, cultural, spiritual, and functional status. Assessment involves the collection of information from multiple sources to provide the foundation for nursing care. Initial assessment provides the baseline for future comparisons to individualize client care. Ongoing assessment is required to meet the client's changing needs.

Upon completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Collect holistic assessment data from multiple sources, communicate the data to appropriate health care providers, and evaluate client responses to interventions.

Competencies which demonstrate this outcome has been attained:

1. Assess data related to basic physical, developmental, spiritual, cultural, functional, and psychosocial needs of the client.
2. Collect data within established protocols and guidelines from various sources, including client interviews, observations/measurements, health care team members, family, significant other(s), and review of health records.
3. Assess data related to the client's health status, identify impediments to client progress, and evaluate response to interventions.
4. Document data collection, assessment, and communicate findings to appropriate members of the health care team.

Planning

Planning encompasses the collection of health status information, the use of multiple methods to access information, and the analysis and integration of knowledge and information to formulate nursing care plans and care actions. The nursing care plan provides direction for individualized care and assures the delivery of accurate, safe care through a definitive pathway that promotes the client's and the support persons' progress toward positive outcomes.

Coordinated Care—cont'd

NAPNES Standards of Practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs

Upon completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Collaborate with the registered nurse or other members of the health care team to organize and incorporate assessment data to plan/revise patient care and actions based on established nursing diagnoses, nursing protocols, and assessment and evaluation data.

Competencies which demonstrate this outcome has been attained:

1. Utilize knowledge of normal values to identify deviation in health status to plan care.
2. Contribute to formulation of a nursing care plan for clients with noncomplex conditions and in a stable state, in consultation with the registered nurse, and, as appropriate, in collaboration with the client or support persons, as well as members of the interdisciplinary health care team, using established nursing diagnoses and nursing protocols.
3. Prioritize nursing care needs of clients.
4. Assist in the review and revision of nursing care plans with the registered nurse to meet the changing needs of clients.
5. Modify client care as indicated by the evaluation of stated outcomes.
6. Provide information to client about aspects of the care plan within the LP/VN scope of practice.
7. Refer the client, as appropriate, to other members of the health care team about care outside the scope of practice of the LP/VN.

Caring Interventions

Caring interventions are those nursing behaviors and actions that assist clients and significant others in meeting their needs and the identified outcomes of the plan of care. These interventions are based on knowledge of the natural sciences, behavioral sciences, and past nursing experiences. Caring is the "being with" and "doing for" that assists clients to achieve the desired outcomes. Caring behaviors are nurturing, protective, compassionate, and person-centered. Caring creates an environment of hope and trust where client choices related to cultural, religious, and spiritual values, beliefs, and lifestyles are respected.

On completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Demonstrate a caring and empathic approach to the safe, therapeutic, and individualized care of each client.

Competencies which demonstrate this outcome has been attained:

1. Provide and promote the client's dignity.
2. Identify and honor the emotional, cultural, religious, and spiritual influences on the client's health.
3. Demonstrate caring behaviors toward the client and significant support persons.
4. Provide competent, safe, therapeutic, and individualized nursing care in a variety of settings.
5. Provide a safe physical and psychosocial environment for the client and significant others.
6. Implement the prescribed care regimen within the legal, ethical, and regulatory framework of practical/vocational nursing practice.
7. Assist the client and significant support persons to cope with and adapt to stressful events and changes in health status.
8. Assist the client and significant others to achieve optimum comfort and functioning.
9. Instruct the client regarding individualized health needs in keeping with the LPN's/LVN's knowledge, competence, and scope of practice.
10. Recognize the client's right to access information and refer requests to appropriate persons.
11. Act in an advocacy role to protect client rights.

Managing

Managing care is the effective use of human, physical, financial, and technologic resources to achieve the client identified outcomes while supporting organizational outcomes. The LPN/LVN manages care through the processes of planning, organizing, and directing.

Upon completion of the practical/vocational nursing program, the graduate will display the following program outcome:

Implement patient care, at the direction of a registered nurse, licensed physician, or dentist, through performance of nursing interventions or directing aspects of care, as appropriate, to unlicensed assistive personnel (UAP).

Competencies which demonstrate this outcome has been attained:

1. Assist in the coordination and implementation of an individualized plan of care for clients and significant support persons.
2. Direct aspects of client care to qualified UAPs commensurate with abilities and level of preparation and consistent with the state's legal and regulatory framework for the scope of practice for the LP/VN.
3. Supervise and evaluate the activities of UAPs and other personnel as appropriate within the state's legal and regulatory framework for the scope of practice for the LP/VN as well as facility policy.
4. Maintain accountability for outcomes of care directed to qualified UAPs.
5. Organize nursing activities in a meaningful and cost-effective manner when providing nursing care for individuals or groups.
6. Assist the client and significant support persons to access available resources and services.
7. Demonstrate competence with current technologies.
8. Function within the defined scope of practice for the LP/VN in the health care delivery system at the direction of a registered nurse, licensed physician, or dentist.

As approved and adopted by NAPNES Board of Directors, May 6, 2007. http://napnes.org/drupal-7.4/sites/default/files/pdf/standards/standards_read_only.pdf.

Put on Your Thinking Cap!

Use the website for the National Council of State Boards of Nursing (https://www.ncsbn.org/nurse-practice-act.htm) to access the Nursing Practice Act and Rules and Regulations in the state where you work. Read and be prepared to discuss the information about licensed vocational nurse/licensed practical nurse practice.

schools, correctional facilities, and private businesses. Regardless of the setting, LVNs/LPNs must practice within the scope of their state nurse practice act. Chapter 2 provides additional information about the settings of care that most commonly employ LVNs/LPNs.

ESSENTIAL KNOWLEDGE AND SKILLS

Medical-surgical practice requires knowledge of an array of medical-surgical conditions including the related pathophysiology, manifestations, complications, treatments, nursing interventions, and expected patient responses. This knowledge guides the nursing assessment, planning, intervention, and evaluation. The LVN/LPN performs these functions in collaboration with or under the supervision of the RN. Other essential skills for medical-surgical nursing are communication, organization, teamwork, technical skills, and the ability to multitask. Because patients with medical-surgical conditions are commonly treated with medications, the LVN/LPN must have basic knowledge of pharmacology, access to detailed information about any medications he or she administers, and skill in medication administration.

ETHICAL CONSIDERATIONS

Ethics deals with values relevant to human conduct that are specific to a group. For example, nurses have professional codes of ethics. Ethics is concerned with defining what actions are right and wrong and whether the motives and outcomes of those actions are good or bad. If choices were simply two opposite actions, with one clearly good and the other clearly bad, ethical decision making would be simple, but all choices are not simple. The choices are often shades of gray rather than black and white. Sometimes a choice must be made between two good or two bad options. Ethical dilemmas are perplexing situations because ethics does not prescribe one right answer. Rather, ethics defines formal processes to explore what is proper conduct. **Bioethics** is concerned with the ethical questions that arise in the context of health care.

The concept of morality is closely related to ethics because moral beliefs provide a personal foundation for rules of action. Whereas ethics is prescribed by a given group, morals are the views of right and wrong held by an individual. For example, a patient might choose to discontinue renal dialysis knowing that he will die from renal failure. As a professional, you know that the patient has a right to make that decision. However, your personal moral beliefs might include the view that life should be preserved at all costs. In this situation, a conflict exists between the ethics of the profession and your morals. You may feel powerless when personal moral beliefs cannot be followed as a result of institutional or other barriers. Experiences like this are thought to be one reason some nurses leave nursing. The key steps to resolve an ethical dilemma are summarized in Box 1.1.

Box 1.1 Key Steps in the Resolution of an Ethical Dilemma

Step 1: Ask the question, is this issue an ethical dilemma? If a review of scientific data does not resolve the question, if the question is perplexing, and if the answer will have relevance for areas of human concern, an ethical dilemma probably exists.
Step 2: Gather information relevant to the case. Patient, family, institutional, and social perspectives are important sources of relevant information.
Step 3: Clarify values. Distinguish among fact, opinion, and values.
Step 4: Verbalize the problem. A clear, simple statement of the dilemma is not always easy, but it helps to ensure effectiveness in the final plan and facilitates discussion.
Step 5: Identify possible courses of action.
Step 6: Negotiate a plan. Negotiation requires a confidence in one's own point of view and a deep respect for the opinions of others.
Step 7: Evaluate the plan over time.

From Ecker M: Ethics and values. In Potter PA, Perry AG, Stockert PA, Hall AM, editors: *Fundamentals of nursing*, ed 9, St. Louis, 2017, Elsevier.

Principles of ethics and values can guide you when faced with situations that do not have simple solutions. Principles include autonomy (respect individual rights), beneficence (act in the patient's best interests), justice (consider fairness, equity, appropriateness), nonmaleficence (do no harm), confidentiality (protect patient privacy), and veracity (be truthful, honest).

Values are specific beliefs and attitudes that are important to a person and that influence the choices a person makes on a daily basis. For example, one person may value kindness and honesty whereas another may value financial success and material possessions. One's values affect their choice of friends, mates, and professions. Values that have been identified as essential for professional nurses include altruism, equality, esthetics, freedom, human dignity, justice, and truth (American Association of Critical Care Nurses, 1986). Nursing faculty often encourage students to become aware of their personal values and how those values affect their behavior through the process of values clarification. Values clarification enables people not only to understand themselves better but also to understand their patients and to help patients explore what is important

to them. Nurses need to be aware of the tendency toward **ethnocentrism**—the belief that one's own culture and its values are superior to others.

Cultural Considerations

What Does Culture Have to Do With Values?

Ethnocentric beliefs about issues such as drug use and sexual orientation can influence a nurse's attitude toward patients so subtly that he or she might not even be aware of it. Values clarification helps nurses to be aware of their own values and to respect the values of others so that the patient receives optimal care regardless of a nurse's personal convictions.

To reveal your own cultural bias tests, you may want to take a quiz available at https://implicit.harvard.edu/implicit/takeatest.html.

The term *values conflict* is used when the values of individuals or institutions, or both, are different. In this situation, a risk exists that the patient's values may not be recognized or respected. A positive response to values conflicts is to try to understand the other person's views and to find common ground. Nurses sometimes experience values conflicts with employers. For example, an agency may institute cost-saving measures that nurses believe negatively affect the quality of care.

LEGAL CONSIDERATIONS

The law defines the boundaries of nursing practice. Nurses are obliged to know their legal functions and limitations to protect both their patients and themselves. A nursing license is granted only to persons who have met specific educational standards and demonstrated the minimal required level of knowledge as assessed by an examination. The state board of nursing can revoke or suspend the license of a nurse who violates the provisions on the licensing statutes. Administrative bodies such as state boards of nursing create regulatory laws in the rules and regulations that address the conduct of nurses.

Nurses in all specialties are at risk for committing a **tort**, which is a civil wrong against a person or property. Examples of torts are: threatening contact without the patient's consent, restraining or medicating a patient against his or her wishes, invasion of privacy by sharing or publishing personal patient information, giving false information that can damage the patient's reputation, and acting in a negligent manner.

Professional negligence is called ***malpractice***. To be found liable for malpractice, the following conditions must be met: The nurse owed a duty to the patient, the nurse did not carry out that duty, the patient was injured, and the injury was caused by the nurse's failure to carry out that duty. Dupler (2017) provides examples of negligent acts that resulted in lawsuits against hospitals and nurses include:

- Failure to monitor a patient
- Failure to document findings
- Failure to notify other staff of changes in patient status
- Failure to maintain or correctly use equipment
- Failure to respond to or correctly carry out orders
- Failure to follow the six rights of medication administration
- Failure to convey discharge instructions appropriately
- Failure to ensure patient safety, especially those who are at risk for injury
- Failure to follow policies and procedures
- Failure to properly delegate and supervise

Medical-surgical nurses often work with acutely ill patients in various functional states. They administer medications and perform procedures that carry risk, are responsible for communicating with other team members, and prepare patients for self-care after discharge. These are examples of duties that could result in patient injury if not done properly. The nurse's best protection against negligence and malpractice is to adhere to standards of care. Nursing students are held to the same standard of care as are licensed nurses. Students should never perform care for which they have not been prepared. Health care institutions commonly provide malpractice insurance for nurses they employ. This coverage generally covers legal fees and awards if a nurse is sued for professional negligence or malpractice. The agency insurance covers the nurses only when working within the employing institution. As an LVN/LPN, you are wise to seek legal advice whether to carry personal liability insurance as well as the institutional insurance.

Additional information about legal roles and responsibilities can be found at the website of the National Council of State Boards of Nursing (www.ncsbn.org) and from individual state licensing bodies.

LEADERSHIP AND MANAGEMENT IN MEDICAL-SURGICAL SETTINGS

In the evolving system of health care, nurses at all levels are being called upon to add new skills and functions. Cost control measures seek to maximize the contribution of each member of the health care team. LVNs/LPNs bring valuable knowledge and skills to many practice arenas and are positioned to be both leaders and strong collaborative followers in managing and providing care. The increase in long-term residential care required by the growing older adult population and the movement of care increasingly into the community is shifting the focus and increasing the demand for LVNs/LPNs.

LVNs/LPNs manage the care of medical-surgical patients in many health care settings. Long-term homes are frequently staffed by LVNs/LPNs and nursing assistants, who often provide the bulk of "hands-on" care. LVNs/LPNs have traditionally filled leadership or management positions in long-term care, often as team leaders and charge nurses. These roles require the

LVN/LPN to have a working knowledge of leadership, management, and safe health care delivery. We are seeing a shift to LVNs/LPNs who not only must manage their assigned patients but also must plan, organize, direct, coordinate, and control care provided by others. As changes evolve, LVNs/LPNs must stay informed of the laws that define their practice. State nurse practice acts vary and respond over time to changes in their citizens' health needs. The practice acts address nurses' scope of practice to protect the public.

The terms ***leadership*** and ***management*** are sometimes used interchangeably but, in fact, have different meanings. Leadership is a broader and more future-oriented role whereas management is more local and task focused. A leader creates a vision that, when combined with unifying values, creates a mission for the group to work toward. The role of the manager is to focus on the day-to-day work of the organization. In the work setting, leadership is often considered the inspiration and management the perspiration. Ideally, leadership and management complement each other. Leaders and managers must have certain characteristics to be effective (see the Coordinated Care box).

Coordinated Care

Characteristics of an Effective Leader

- Is an effective communicator
- Is consistent in managing conflict
- Is knowledgeable and competent in all aspects of delivery of care
- Is a role model for staff
- Uses participatory approach in decision making
- Shows appreciation for a job well done
- Delegates work appropriately
- Sets objectives and guides staff
- Displays caring, understanding, and empathy for others
- Motivates and empowers others
- Is proactive and flexible
- Focuses on team development

Modified from Dunham-Taylor J: Quantum leadership: love one another. In Dunham-Taylor J, Pinczak JZ, editors: *Financial management for nurse managers*, ed 2, Boston, 2010, Jones & Bartlett; Huber DL: *Leadership & nursing care management*, ed 5, St Louis, 2014, Elsevier.

ISSUES RELATED TO LEADERSHIP AND MANAGEMENT

MAKING ASSIGNMENTS AND DELEGATION

In management positions, such as team leader, the LVN/LPN must be able to assign tasks to others who are hired to perform them and make certain that those tasks are carried out. Delegation allows nurses to accomplish nursing care for more patients than one individual could provide alone. Before you make assignments or delegate as a team leader, you must consult your state nurse practice act. Among nurses working in clinical settings, delegation involves "working with and through others" and assignment describes "the distribution of work that each staff member is to accomplish" (National Council of State Boards of Nursing, 2005, p. 1). Although state delegation regulations vary, LVNs/LPNs can assist RNs in the management process. Following delegation by an RN to unlicensed personnel, the LVN/LPN may assist in the supervision of unlicensed personnel, may assist in training unlicensed assistive personnel, and may verify competencies of those personnel. Making assignments requires that you know the care required by each patient and the strengths and weaknesses of each staff member. In many states the delegating RN remains accountable for the tasks delegated to unlicensed assistive personnel. See the Coordinated Care box.

Coordinated Care

Essential Elements of Effective Delegation by the LVN/LPN

- Compliance with state nurse practice act statement on delegation
- Compliance with institutional policies and procedures related to delegation by LVNs/LPNs
- Knowledge of specific condition and needs of each patient
- Knowledge of training and background of individuals to whom tasks are delegated
- Determination of tasks that can be safely delegated
- Monitoring of staff performance
- Documentation of outcomes

ACCOUNTABILITY

Accountability means that a person is answerable for his or her actions and may be called on to explain or justify them. An LVN/LPN who makes assignments or delegates tasks to other providers is accountable not only for his or her own actions, but for the actions of the staff he or she is directing. A team leader is legally responsible for all nursing care and documentation. The LVN/LPN must ensure that proper and accurate charting is done. The RN team leader is responsible for ensuring that proper and accurate documentation is done for all nursing assessments, interventions, and evaluations.

One aspect of accountability involves communicating patient needs to others. A common form of communication is the handoff (report) at the end (or beginning) of every shift. The LVN/LPN is usually responsible for reporting to the RN in charge but may also be indirectly responsible for the report. Guidelines for a clear and complete handoff are as follows:

- Organize information before beginning
- State the patient's name, room number, name, age, diagnosis, and physician
- Provide a brief, objective account of the patient's condition, including new or changed orders
- Report relevant clinical information: deviations from the patient's or expected norm (vital signs, orientation, intake and output, etc.); identify pain

medications including dosage, frequency, and patient response.
- For surgical patients, review preoperative checklist items. For postoperative patients, report time of return to the nursing unit, general condition, vital signs, intravenous fluids ordered (type, flow rate), dressing status, voiding, diet, tubes (type, location, patency)
- Convey any specific requests or concerns expressed by the patient or family

One systematic communication is called *SBAR* (situation, background, assessment, recommendation). SBAR facilitates the exchange of important information between professionals. It may be used to alert physicians, RNs, and other care providers to changes in a patient's condition, to seek new care orders, and for shift handoffs or transfers within and across systems.

CONFLICT RESOLUTION

LVNs/LPNs in leadership or management positions must be able to facilitate conflict resolution. Conflicts arise from differences in many factors such as beliefs, knowledge, values, personalities, culture, and age. If may also be caused by unclear roles; multiple, shifting, or conflicting priorities; and competition for scarce resources. Current issues may be exacerbated by prior unresolved conflicts. When a conflict occurs, it creates stress and negative feelings that can adversely affect the work situation. A conflict may be within an individual (intrapersonal conflict), between two or more people (interpersonal conflict), or between individuals and organizations (organizational conflict).

Conflict is a process with four stages:

1. Frustration: People believe that their goals are being blocked; they feel frustrated. Individuals may become angry or resigned to the situation.
2. Conceptualization: Each party formulates a view of the basis for the conflict. Conflicts typically center on perceived differences in facts, goals, how to achieve goals, and the values on which goals are based.
3. Action: The conflict leads to various behaviors that may or may not help resolve the conflict.
4. Outcomes: Outcome follows the action; goals may be reformulated so that they are acceptable to all parties; one party may "win," the other "lose"; emotions may be positive or negative.

Identifying the root cause of the conflict and related prior history before beginning the resolution process is beneficial.

There are multiple approaches to conflict resolution, each with various advantages and disadvantages. The positive and negative consequences of each are summarized in Table 1.1. The leader must select the best approach in each situation. To understand how each of these approaches works in a "real" situation, consider the following scenario: You are the charge nurse on a 30-bed unit in a long-term care facility. Certified nursing assistants (CNAs) are assigned to equal numbers of residents in adjacent rooms. During report, Alice, a CNA, states that her assignment is unfair because all but two of her patients require almost total care. She says that all of the other CNAs have easier assignments. Using various strategies, possible solutions are:

- *Accommodation*: You shift the care of two residents to other CNAs.
- *Collaboration*: You reassess the needs of each group of assigned residents. Recognizing that Alice is correct, you work with the CNAs to identify more equitable distribution of assignments to ensure good patient care.
- *Compromise*: You tell Alice that you will alternate CNAs assigned to that group of residents.
- *Competition*: You tell Alice that everyone has some residents who require a lot of care and the assignment will stand.
- *Avoidance*: You tell Alice that you have more important things to deal with right now and go to your office.

For each of these "solutions," think about the positive and negative outcomes. Again, realize that the best solution will vary with the situation. The art of management is to select the best approach for the situation.

SAFETY

Every health care facility must meet minimum safety regulations established by law in addition to those adopted by the agency to meet its unique needs. All staff members, particularly team leaders, should learn these regulations during orientation to the job. The team leader should know the regulations and be sure that staff members are aware of them. Everyone must understand the procedures to follow in case of disasters such as fires, floods, tornadoes, or hurricanes. In addition, everyday safety related to handling equipment, using proper procedures, and working with potentially dangerous drugs must constantly be addressed to ensure that knowledge and skills are up to date. Organizations are responsible for providing timely information as changes in standards occur and new procedures are developed. Each nurse is accountable for knowing them, and leaders are accountable for ensuring adherence. Medication safety and infection control measures are increasingly complex challenges of primary focus on the national health care agenda.

Table 1.1 Modes of Conflict Resolution

MODE	POSITIVE OUTCOMES	NEGATIVE OUTCOMES	WHEN TO USE
Accommodation	Agreement is reached	Differences are suppressed; resentment	You are wrong The other person really has a better idea The issue is more important to the other party than to you You are outnumbered or outranked
Collaboration	Generates commitment to work together; focuses on shared higher goals such as good patient care, not on individual immediate needs Builds understanding and empathy	Wastes time if used for resolution of trivial issues or when the outcome has already been decided	To build understanding To find creative solutions that accommodate higher common goals To address difficult issues that affect productivity
Compromise	Can produce mutually acceptable solutions Both parties have achieved something they wanted	The compromised solution may not be the best even though it "keeps the peace"	When time pressures require quick solution When each party is firmly committed to different views A compromise can produce acceptable outcomes
Avoidance	Temporarily defuses highly charged, emotional disagreement Allows both parties to "cool off" until a reasonable approach can be considered	The conflict is not resolved Neither party is satisfied	To deal with trivial issues when more important issues are waiting To delay a decision until parties are calmer, more information has been obtained, etc. When one party's demands cannot possibly be met When others could resolve the issue more readily
Competition	Reflects a strong stance to defend important principles and protect vulnerable parties Person in power takes responsibility for a decision	Can generate bad feelings Creates a winner and a loser May generate behaviors that block the actions of the "winner"	When a quick decision is essential To implement unpopular nonnegotiable actions To defend important principles, individual rights, and group welfare

Get Ready for the NCLEX® Examination!

Key Points

- The roles that LVNs/LPNs may assume are specified in their state nurse practice act.
- Medical-surgical nursing employs an array of knowledge and skill to provide care for adult patients with a variety of conditions requiring medical and/or surgical management.
- The standards for nursing practice and educational competencies of graduates of LVN/LPN programs are defined by the National Association for Practical Nurse Education and Service (NAPNES, 2007).
- Medical-surgical practice requires knowledge of an array of medical-surgical conditions including the related pathophysiology, manifestations, complications, treatments, nursing interventions, and expected patient responses.
- Ethical dilemmas are perplexing situations because ethics does not prescribe one right answer.
- Principles of ethics include autonomy (respect individual rights), beneficence (act in the patient's best interests), justice (consider fairness, equity, appropriateness), nonmaleficence (do no harm), confidentiality (protect patient privacy), and veracity (be truthful, honest).
- Nurses are obliged to know their legal functions and limitations to protect both their patients and themselves.
- A tort is a civil wrong against a person or property such as restraining or medicating a patient against his or her wishes.

- Criteria for malpractice include the following: the nurse owed a duty to the patient, the nurse did not carry out that duty, the patient was injured, and the injury was caused by the nurse's failure to carry out that duty.
- Nursing students are held to the same standard of care as are licensed nurses.
- An LVN/LPN who makes assignments or delegates tasks to other providers is accountable not only for his or her own actions but also for the actions of the staff he or she is directing.
- A leader creates a vision that, when combined with unifying values, creates a mission for the group to work toward.
- The role of the manager is to focus on the day-to-day work of the organization.
- SBAR (situation, background, assessment, recommendation) is a systematic communication that facilitates the exchange of important information between professionals.
- When a conflict occurs, it creates stress and negative feelings that can adversely affect the work situation.
- The stages of conflict are frustration, conceptualization, action, and outcomes.
- Approaches to conflict resolution include accommodation, collaboration, compromise, competition, and avoidance
- Safety requires that all health care agency staff understand the procedures to follow in case of disasters in addition to everyday safety related to handling equipment, using proper procedures, and working with potentially dangerous drugs.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

Go to your Evolve website (http://evolve.elsevier.com/Linton/medsurg) for the following learning resources and much more:

- Fluid & Electrolyte Tutorial
- Review Questions for the NCLEX® Examination

Review Questions for the NCLEX® Examination

1. What is the best source of information regarding the roles of the LVN/LPN in a medical-surgical setting?
   1. The Human Resources department of the employing agency
   2. The State Board of Nursing
   3. Other staff members working on the same unit
   4. Medical-surgical nursing textbooks

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
2. Which of the following are characteristics of an effective leader and manager? (Select all that apply.)
   1. Is a role model for staff
   2. Has a graduate nursing degree
   3. Focuses on team development
   4. Motivates and empowers others
   5. Uses only an autocratic approach in decision making.

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
3. When preparing to administer medications, the nurse carefully confirms the drug order and the patient's identity. This is an example of which ethical principle?
   1. Nonmaleficence
   2. Veracity
   3. Autonomy
   4. Justice

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
4. A nurse uses his cell phone to take a photograph with a celebrity patient. The nurse posts the photograph on social media. This may be considered:
   1. Malpractice
   2. Negligence
   3. Assault
   4. Tort

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
5. Essential elements of effective delegation by the LVN/LPN include which of the following? (Select all that apply.)
   1. Knowledge of each patient's condition
   2. Compliance with state and institutional policies
   3. Determination of tasks that can be safely delegated
   4. Direct supervision of tasks assigned to others
   5. Evaluation of the patient's response to the care

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care

2 Medical-Surgical Practice Settings

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Objectives

1. Describe the role of the licensed vocational nurse/licensed practical nurse (LVN/LPN) in community health, community-based care, home health care, rehabilitation facilities, and long-term care settings.
2. Differentiate community health nursing and community-based nursing.
3. Describe the types of specialty care that may be provided in home health care.
4. Explain the requirements for Medicare coverage of home care and implications for the LVN/LPN.
5. Describe the role of the nurse in home health care.
6. Explain the definition of *skilled nursing care* in the context of home health nursing.
7. Describe the key concepts and goals of rehabilitation.
8. Discuss the impact of legislation on individuals with disabilities.
9. Describe the types of long-term care facilities.
10. Discuss the effects of institutionalization on the individual.
11. Describe the principles of nursing care in long-term residential facilities.

Key Terms

disability
domiciliary care
handicap
impairment
rehabilitation

Chapter 1 briefly introduced the most common settings in which health care is delivered. Throughout this book, the care of patients in acute care settings is covered in detail. As the health care system changes, however, LVNs/LPNs are finding a variety of opportunities for employment in community, rehabilitation, long-term care, and other settings. This chapter provides a more complete description of the more common employment settings where medical-surgical nurses work.

COMMUNITY AND HOME HEALTH NURSING

Community health nursing and home health nursing are specialized areas of nursing practice that are often considered as being similar. This viewpoint probably comes from defining community health nursing as anything that occurs outside the hospital setting. However, despite sharing common historic roots, these two practice areas have significant differences.

COMMUNITY HEALTH NURSING

For both humane and economic reasons, keeping people healthy is better than waiting until disease or disability occurs. Traditional community health nursing focuses on (1) improving the health status of communities or groups of people (called *aggregates*) through public education, (2) screening for early detection of disease, and (3) providing services for people who need care outside the acute care setting.

Community Health Nursing Roles

The following example demonstrates typical community health nursing roles.

A community health nurse notices a rise in blood pressure, an increase in weight, and a general lack of fitness in members of a senior citizen high-rise in her district. Her assessment shows that no recreational facilities are available nearby, the meals served at the high-rise tend to be high in fat and sodium, and social activity is generally lacking at the facility. On the positive side, a residents' organization exists, although it has never been very active. By working with the residents' organization and a local church, the nurse initiates a group exercise program to improve the strength, cardiovascular fitness, and weight control of the residents. By working with the management of the high-rise and the residents' association, the nurse gets the building manager to serve healthier meals. The nurse also asks a local school of nursing to hold a monthly blood pressure and health education clinic for the residents.

In this example, the community health nurse not only gave direct service to individual clients but also worked with three existing community groups to provide a significant number of services designed to enhance the health of the senior citizen group. Community health nurses often work with many different individuals and

groups to create or modify systems of care to improve the health of a defined group. This function requires the nurse to assume several roles to accomplish care goals. The roles listed in the example include case finder, care manager, teacher, advocate, and coalition builder. To perform all aspects of the community health nurse role requires at least a bachelor's degree in nursing. However, the LVN/LPN is increasingly visible in community health settings such as clinics, retirement/senior centers, and schools.

Community-Based Nursing

The term *community-based nursing* has been used in several contexts but should not be confused with community health nursing. Community-based nursing may be described as the delivery of health care services that meet the needs of citizens at various levels of wellness and illness based on identified community needs. In a more general sense, the term is sometimes used to describe the provision of various levels of care in traditional and nontraditional community settings.

HOME HEALTH NURSING

Home health nursing blends direct nursing care and community health nursing. The main difference between home health nursing and traditional public health nursing is that home health nursing provides more direct care to patients. The main difference between home health nursing and nursing in an institution is the increased emphasis on the family and the environment in the home.

Medical-surgical nurses working in home health must adapt their knowledge and skills to this new setting. Home health nursing requires careful consideration of the family and its role in the care of the ill family member. Although giving direct care to an individual is an important part of home health care, a more important nursing role is to teach the patient and family to care for themselves (Fig. 2.1). This important role is similar to that of the rehabilitation nurse, for whom the goal is the independent functioning of the patient and family. The LVN/LPN who works in home health settings must be aware of the legal scope of practice in his or her state, as well as agency policies. LVNs/LPNs must recognize their limitations and inform the supervisor if they are not prepared to perform the tasks or activities required in a particular patient's home.

The environment in which home health nursing is practiced is very different from the hospital practice environment. Homes often have only a fraction of the resources of the hospital. Small bedrooms, low beds, inadequate climate control, and limited space are common. Maintaining asepsis can be challenging because of inconvenient or absent hand washing facilities and the lack of biohazard disposal devices. Families are often overwhelmed by the task of caring for ill loved ones. They need instruction not only in the care of the patient but also in how to perform the care in a home that was not designed for that purpose, while continuing to function as a family.

Fig. 2.1 Home health agencies deliver the services of a variety of professionals. (From Maurer FA, Smith CM: *Community/public health practice*, ed 5, St. Louis, 2013, Saunders.)

Home health nurses must collect data for the plan of care about the patient, the family, and the environment. Ongoing data collection is critical, because the home health nurse often sees the patient more frequently than other care providers and can detect problems early. For example, the observation of weight gain and ankle edema alerts the nurse to possible heart failure in the cardiac patient. Prompt intervention may prevent serious consequences. The use of technology in the delivery of health care to patients is increasingly common. Examples include e-mail, videoconferencing, patient examination cameras, video otoscopes, and remote electrocardiogram (ECG) and vital sign monitoring. The nurse must become familiar with tools that permit patient communication and assessment from the home.

To illustrate the importance of collecting data about the family and the environment, consider the patient who requires wound care. In the home setting, decisions that need to be made include: Who can do the care? What does that person need to know? What supplies are needed and where can they be obtained? What is the best way to dispose of soiled dressings? Addressing these questions requires the home health nurse to be resourceful, knowledgeable, skillful, and creative.

Reimbursement Realities in Home Health Nursing

Medicare, although not the sole source of home health care funding, is probably the most important source. Reimbursement by the Medicare program depends on documentation that four basic conditions have been met: (1) the physician orders skilled nursing care for a

specific condition; (2) the patient needs intermittent skilled nursing care, or physical or speech-language therapy, or continued occupational therapy; (3) the patient is homebound; and (4) the agency providing the care is Medicare certified. The number of hours per day and days per week that Medicare will cover are limited. Medicare will not pay for 24-hour care at home; meals delivered to the home; homemaker services such as shopping, cleaning, or laundry; or personal care given by home health aides if this is the only care needed. Medical social services may be provided as directed by the physician if the service is intended to help with social and emotional concerns that might affect recovery. Medical supplies are covered when the physician orders them as part of the care. Durable medical equipment, if ordered by the physician, may be provided separately from the home health service. The patient may be required to pay a portion of the cost (usually 20%) of Medicare-covered medical equipment such as oxygen equipment, a wheelchair, or walker. Private insurance companies may have different eligibility requirements and benefits for home care.

Physician Must Design or Authorize a Plan of Care and Review It Regularly. All home care treatment must be authorized by a physician. A plan of care must include pertinent diagnoses, results of mental status evaluations, identification of the types of services needed, the supplies and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, nutritional requirements, medications, and treatments. This plan also must include safety measures to protect against injury and plans for discharge from home care.

In practice, the initial referral usually includes the patient's name, address, and telephone number, as well as the major medical diagnoses and a list of medications and treatments—not unlike a physician's orders in a hospital. On the first visit, the admitting nurse usually formulates the plan of care, adding all other required elements. This plan is sent to the physician for review and signature. Because the care provided in the home is predominately nursing care, it is appropriate that the nurse has a major role in developing the plan of care. The role of the LVN/LPN is to participate in patient data collection and contribute to the development and revision of the care plan. If assistive personnel are involved in the home care, the LVN/LPN may assign appropriate tasks, verify the staff member's abilities and limitations, and evaluate the staff member's performance. Disabled and frail persons may not be able to defend themselves and may have little contact with others besides the health care team. Therefore the home nurse must report evidence of abuse, neglect, and violation of rights according to agency policy.

Care Must Be Skilled, Intermittent, Reasonable, and Necessary. Medicare reimburses nursing care in the home provided that the care given is "skilled." This stipulation means that the care delivered must be the kind that only a nurse trained in that kind of care could be expected to do. However, not all care provided by a nurse qualifies as skilled care. Skilled nursing care is discussed subsequently with the types of home health services.

Nursing is one of three primary home health care services considered to be skilled. The others are physical therapy and speech therapy. Occupational therapy may be considered skilled, depending on the complexity of the patient's problems. Social work and home health aide services are not considered skilled in themselves but may be reimbursed if the patient has qualified for one of the three primary skilled services. These home care services are discussed in more detail later in this chapter.

The preceding definition of skilled care is an interpretation of the Medicare law. Some nursing activities that require the skill of a nurse may not be recognized as skilled under Medicare. Medicare law does not prevent nurses from giving the care they judge necessary; it only defines what care is reimbursable under that law.

Medicare reimbursement requires that the nursing visits be intermittent in nature, meaning that visits occur periodically and usually do not exceed 28 hours per week. Under normal circumstances, the patient is not seen daily. However, situations exist in which daily visits are justified. These situations usually indicate the need for family members to be trained in daily procedures such as diabetic care or wound care and dressing changes. Under these circumstances, Medicare will reimburse daily visits for 2 or 3 weeks. These instances are considered special cases, and reimbursement depends on clear and accurate documentation of the need for daily visits. Otherwise, visiting frequency can range from 3 to 4 times per week to monthly.

To demonstrate that care is reasonable and necessary, objective clinical evidence clearly justifying the type and frequency of services is required. The nurse must clearly document functional losses and goals for care. Ongoing progress or lack of progress toward treatment goals must be documented. Poor documentation not only jeopardizes patient care but also often results in denial of the agency's claim for payment because the documentation did not prove that the care given was "reasonable and necessary."

Patient Must Be Homebound. This criterion does not mean that the patient must be bedridden. It does mean, however, that the patient must exert considerable effort to leave the home. Medicare also requires that absences from the home be infrequent and of short duration. According to Medicare regulations, if patients are well enough to leave home frequently, they are able to visit a physician's office for treatment and therefore are not in need of home care.

Home Health Agency Must Be Medicare Certified. Medicare-certified home health agencies can be

located by using the telephone directory, by referral from a health care provider or other persons who have used these services, or from a list of Medicare-approved agencies on www.medicare.gov. The list is found by clicking on "find Home Health Services," then on "Home Health Compare." A home health agency can decline to accept a patient if it cannot meet the patient's needs.

Types of Home Health Services

The primary skilled services in home health care are (1) nursing, (2) physical therapy, and (3) speech therapy. Secondary services include occupational therapy (which may be primary under certain conditions), social work services, and home health aide services.

Skilled Nursing. According to Medicare regulations, skilled nursing includes skilled observation and assessment, teaching, and performing skilled procedures.

Skilled Observation and Assessment. The phrase *skilled observation and assessment* implies that the skills of a nurse are required to observe a patient's progress, to assess the importance of signs and symptoms, and to decide on a course of action. For example, good assessment skills and judgment are needed to detect the signs and symptoms of congestive heart failure early enough to prevent rehospitalization. LVNs/LPNs commonly perform focused assessments, meaning that they collect specified data related to specific health areas. The information obtained by the LVN/LPN can become part of the registered nurse's comprehensive assessment and help guide the nursing care plan.

Teaching. Teaching is considered a skilled task because to teach effectively the nurse must identify the patient's and the family's current level of knowledge, determine their learning style, relay information at an appropriate level and pace, and evaluate the results of the teaching.

Teaching is the most important skill in home care. Much care in the home must be done by the patient and caregiver. Good patient teaching should begin in the acute care setting, but newly discharged patients may need considerable teaching to manage their care at home. When high-technology therapies are involved, teaching is even more important.

Families that have difficulty understanding complex medical issues or high-technology equipment may be anxious when the nurse is not there to help or to answer their questions immediately. Skilled nurses understand this problem and ensure that their teaching is thorough and addresses precisely what the family needs to know to care successfully for their loved one at home. To accomplish this task, the nurse must identify the exact nature of the problem. A family member's difficulty in administering an injection may arise from a lack of knowledge of the procedure, a fear of needles, an inability to read the markings on the syringe, or a denial of the disease process. Identifying the specific learning need is critical to successful patient teaching. In teaching high-technology care, keeping instructions as simple and specific as possible is especially important. Each step in the procedure should be written down and reviewed with the patient and caregiver. The skill should be demonstrated several times, asking the family caregiver to cue the nurse for each step. After this task is performed a few times, the caregiver should perform a return demonstration of the skill.

Family caregivers must understand exactly what should be done in an emergency. Any questions about the family's ability to manage their portion of the care should be immediately referred to the home care nurse responsible for establishing the care plan and managing the case.

Performing Skilled Procedures. Skilled procedures include dressing changes, Foley catheter insertions, and venipunctures. However, after certain nursing procedures are taught to the family, they are no longer considered skilled procedures and are not reimbursable under Medicare. For example, injecting insulin is not considered skilled because most diabetics can inject insulin themselves. Teaching how to draw up the insulin and inject it properly, however, is considered skilled because teaching is considered a skilled activity. Once the injection skill is learned, the injection itself is no longer a skilled activity according to the Medicare definition. Also, procedures such as enema administration, unsterile dressing changes, care of small wounds, and administration of eye drops are not usually considered skilled because they can be performed safely by most people.

Specialty Home Care

The number of high-technology cases in the home has increased dramatically with patients who need intravenous therapy or are ventilator dependent.

Intravenous Therapy. Rising hospital costs and the development of reliable intravenous pumps have stimulated the growth of intravenous therapy in the home. The most common intravenous therapies provided in the home are hydration, antibiotics, pain control, total parenteral nutrition, and chemotherapy. Many different types of intravenous lines may be used (see Chapter 16). Nurses should be familiar with the devices commonly used in their communities. Chemotherapy drugs are almost always given through central lines by registered nurses. LVNs/LPNs must know their role and limitations in relation to all intravenous therapy.

High-technology therapies add to the complexity of home health care. Home care may be more cost effective than a hospital stay, but it also significantly increases the risk to the client and the liability of the home health agency. Agency policies and procedures should be current and specific enough to guide the nurse in managing the provision of intravenous therapy in the home. These policies protect not only the agency and the patient but also the nurse.

The safe and successful provision of any high-technology therapy in the home depends on the commitment of everyone involved. Families must be capable of understanding what is required and have the time to participate fully in the patient's care. Nurses delivering this type of care must be thoroughly trained in the procedures and use of equipment required in these therapies. Agencies must have appropriate staff to provide care at any time if needed, including days, evenings, nights, holidays, and weekends. The pharmacy or intravenous therapy company must provide high-quality products and support to both the nurse and the family. Finally, physicians must be closely involved and available to respond to emergency problems.

The nurse's role in the delivery of high-technology care in the home includes skilled observation and assessment, the performance of skilled procedures, and teaching. Skilled observation and assessment in the delivery of intravenous therapy includes determining the adequacy of the home environment and the patient's and the family's knowledge regarding care procedures. The intravenous access site must be inspected for swelling and redness. Any side effects of the treatment should be noted, along with the family's level of comfort with performing specific procedures.

Skilled procedures with home intravenous therapy include changing access site dressings and performing venipunctures. Because home care nurses are not instantly available 24 hours a day, some procedures must be taught to the family.

Ventilator Therapy. Ventilator-dependent patients are increasingly being cared for in the home setting. This type of care is complex and should be provided only by nurses and caregivers specifically trained in the use of necessary equipment and procedures. In many instances, the care of ventilator-dependent patients in the home is coordinated by the respiratory therapist. The home care nurse seeing the patient should be aware of policies and procedures followed by the respiratory therapy company, be familiar with respiratory therapy equipment, and be certified in cardiopulmonary resuscitation.

Initial assessment of the home environment includes an assessment of all factors important in other high-technology therapies, with the addition of an assessment of the electrical and structural condition of the home. This information is important to ensure proper functioning of the equipment and necessary backup generators.

As with intravenous therapy, committed family members or other caregivers must be available. In this case, the commitment is for around-the-clock observation. Physicians and respiratory therapists must be on call for any problems.

Communication Between Home Health Care Team Members

The importance of the team approach in home health care cannot be overemphasized. Quality home care requires the collaboration of several disciplines. Because these disciplines may provide their services in the home at different times, communication among health care team members is necessary if effective collaboration is to occur. Interdisciplinary communication is accomplished through clear, detailed documentation and case conferences.

Documentation. In any interdisciplinary work, the actions of one discipline often depend on the actions of another. A nurse's discovery of an unused walker in the corner of a room may prompt the physical therapist to recommend strengthening exercises and gait training. A social worker's attempts to find funding for a patient's medications may reveal that the patient is fearful of taking pain medications, which can be addressed by the nurse. If these concerns are not communicated, however, they will not be addressed. Most quality-of-care problems in home health care can be attributed to failure to communicate patient care problems. Most of the time, these problems result from either incomplete documentation or failure to keep the nursing case manager informed. Documentation of nursing care should be accurate, complete, and submitted in a timely manner.

As mentioned earlier, reimbursement for home health nursing visits depends on clear documentation of the patient's homebound status, the skilled nature of the services provided, and the medical need for the services. Failure to provide such documentation often results in denial of reimbursement by Medicare. Denials of reimbursement have serious consequences for the patient, family, and home health agency; when excessive, denials have resulted in agencies going out of business.

Case Conferences. Clear documentation of interdisciplinary case conferences can go a long way toward preventing reimbursement denials based on lack of medical necessity. These conferences often provide detailed information about the complexity of problems that justifies increased visits.

Usually, a home health nurse must report to a patient's case manager, who is responsible for admitting the patient, establishing the plan of care (including visit frequencies), and coordinating the efforts of other disciplines. The case manager schedules periodic formal case conferences in which all disciplines work together to solve clinical problems. The details of these conferences are documented in the patient's record.

In addition to these regularly scheduled conferences, the case manager should be kept informed of any changes in the response of the patient or family to the plan of care. For example, significant changes in vital signs, weight, and wound parameters are important physiologic indications for a call to the case manager. A change in the home environment, such as an absence of family caregivers, deterioration in sanitation, or signs of patient neglect or abuse, should also prompt a call to the case manager.

Communication by the case manager is also important. Field nurses have the right to expect clear and current information regarding recent changes in physicians' orders, current laboratory information, and the availability of documentation by other nurses and disciplines. High-quality patient care cannot be accomplished without meticulous communication from all disciplines involved in the care of the patient.

REHABILITATION

The acute phase of many illnesses is often followed by a prolonged chronic phase, which may last from days to years and may involve the delivery of a number of health care services in a variety of settings, such as rehabilitation centers, long-term care facilities, outpatient facilities, group residential homes, and, increasingly, the patient's own home. Rehabilitation focuses on restoring maximal possible function after illness or injury.

REHABILITATION CONCEPTS

Rehabilitation Is a Process of Restoration

Rehabilitation is the process of restoring an individual to the best possible health and functioning after a physical or mental impairment. The type of assistance provided allows people to care for themselves as much as possible. Inherent in this process is a commitment by the caregiver to provide the care and support that foster the client's independence.

Impairment Is a Disturbance in Functioning

Impairment refers to a disturbance in functioning that may be either physical or psychologic. An example of physical impairment is paralysis of an arm or leg as the result of a stroke. Mental impairment such as loss of memory may occur as a result of Alzheimer disease. In either case, a loss of function occurs.

Disability Is a Measurable Loss of Function

The term ***disability*** generally refers to a measurable loss of function and is usually delineated to indicate a diminished capacity for work. For example, individuals with an injured back may be classified as 50% disabled, meaning that they are incapable of doing 50% of their jobs. This type of measurable loss of function allows for specific reductions in work responsibility or may indicate how much compensation to which a worker may be entitled.

Handicap Is an Inability to Perform Daily Activities

The term ***handicap*** means that an individual is not able to perform one or more normal activities of daily living (ADL) because of a mental or physical disability. For example, the person who experienced a stroke may be handicapped in driving a car because of the related paralysis.

Remember that disability and handicap are not the same things. A person can be moderately disabled but still manage to perform routine daily activities. People who were born without arms are often able to perform all essential ADL by using their feet and certain assistive devices. Although these people are disabled, they are not handicapped. Impairments and their resulting disabilities may not be reversible, but handicaps often can be prevented or reduced with modifications of the environment and a community attitude that seeks to promote the abilities of the disabled (see the Cultural Considerations Box).

Cultural Considerations

What Does Culture Have to Do With Disabilities?

Research shows that minority groups in the United States are more vulnerable to health problems, including disabilities. Health care providers and agencies are working to raise awareness and to learn more about the physical health of minorities with disabilities, their ability to access health care, the process of becoming disabled among people in minority groups, and barriers to using rehabilitation facilities and other resources.

LEVELS OF DISABILITY

A disability is often classified by level to determine its impact on an individual's quality of life and appropriate levels of compensation:

- Level I: slight limitation in one or more ADL; usually able to work
- Level II: moderate limitation in one or more ADL; able to work but the workplace may need modifications
- Level III: severe limitation in one or more ADL; unable to work
- Level IV: total disability characterized by nearly complete dependence on others for assistance with ADL; unable to work

GOALS OF REHABILITATION

Rehabilitation aims to return the disabled individual to the highest possible level of functioning. The specific goals are to promote self-care, maximize independence, restore and maintain optimal function, prevent complications, and encourage adaptation. The rehabilitation team must treat the "whole" patient, meaning that it must consider not just the patient's physical condition but also the emotional state and psychologic and social needs of both the patient and the family.

Return of Function

The goal of return of function includes the restoration of as much function as possible in traditional ADL, such as bathing, dressing, eating, toileting, and walking. Ideal functioning includes independence in the instrumental activities of daily living (IADL) as well, such as preparing meals, shopping, doing laundry, and using the telephone. The ultimate goal of rehabilitation is to

live independently. Full independence implies a return to employment status. Not all patients can be restored to their previous state, but they can learn to adapt to the changes they have experienced, which requires emphasis on abilities rather than disabilities. Instead of focusing on what is lost, the patient and the care providers must focus on what remains.

Prevention of Further Disability

Rehabilitation also involves the prevention of further disability (secondary disability) that may potentially be caused by the patient's primary disability. Examples include prevention of problems in stroke patients such as pneumonia, decubitus ulcers, and limb contractures, which are often caused by lack of mobility. Attention to safety concerns also reduces the risk of further disability. For example, a walker and environmental modifications may be advised for a poststroke patient who is at risk for falls and fractures. The nurse plays a key role in the prevention of secondary disability.

Rehabilitation is a long-term process that requires the commitment of both the patient and the family. The process is often difficult and marked by periods of progress followed by occasional relapses in functional disability. These relapses can be frustrating to everyone involved and require determination on the part of the family, as well as patience and understanding by the nurse. The rehabilitation process can place additional burdens on family members when roles once filled by the disabled family member must be filled by other family members. Attention is frequently focused on the disabled member, leaving other family members feeling neglected. Ongoing family problems may intensify during this time, making the rehabilitation process even more difficult.

An important aspect when caring for a disabled patient is to be aware of the attitudes and behaviors of all family members. In many instances, families can be assisted in adjusting to role changes that occur during the rehabilitation process. The more consistently patients and family are involved in the process, the more likely it is that success will occur. Involvement in goal setting and a clear explanation of patient and family roles in daily rehabilitation activities help families to understand better the challenges of the process. This approach gives a sense of control and increases family strength.

LEGISLATION

Public attitudes toward people with disabilities play a significant role in the degree of handicap experienced by the disabled. Lack of knowledge about a disability often causes the public to react negatively to people who appear disabled. Individuals who are blind are sometimes treated as though they are deaf as well. People with conditions such as cerebral palsy that affect speech and muscle control are often treated as though they have cognitive impairment. Some employers are reluctant to hire disabled workers, fearing an increase in insurance rates or negative reactions from their customers (see the Health Promotion Box).

Health Promotion

Help Disabled Patients Understand Their Employment Rights Under the Americans With Disabilities Act

- Nurses and other providers should understand basic laws that affect their patients' well-being even after they leave the health care setting. One of the most important pieces of health care legislation to be passed in recent decades is the Americans with Disabilities Act of 1990.
- Title 1 of the Act prohibits private employers with 15 or more employees, state and local governments, employment agencies, and labor unions from discriminating against qualified individuals with disabilities. An employer is required to accommodate the disability of a qualified applicant or employee if doing so would not impose an undue hardship on the employer's business. However, an employer is not required to lower quality or production standards to make an accommodation. The employer is also not obligated to provide personal use items such as glasses and hearing aids.
- Employers may not ask job applicants about the existence, nature, or severity of a disability. They are allowed to ask applicants about their ability to perform specific job functions. A job offer may be made on the condition that the applicant passes a medical examination but only if the examination is required for all newly hired employees in similar jobs. These medical examinations must be job related and consistent with the employer's business needs. To learn more, visit the website for the Equal Employment Commission at www.eeoc.gov.

The federal government has passed laws over the years to protect the rights of the disabled. The first law passed to aid the rehabilitation of World War I servicemen was the Vocational Rehabilitation Act of 1920. This law provided job training for injured veterans. The Social Security Act of 1935 provided additional aid to states for both direct relief and vocational rehabilitation. The Rehabilitation Act of 1973, however, provided a comprehensive approach to problems experienced by the disabled. This Act not only expanded available resources for vocational training but also defined services to be included in rehabilitation programs. It also began affirmative action programs to assist in the employment of the disabled and prohibited discrimination against the disabled in programs receiving federal funds. In 1990 the Americans with Disabilities Act was passed. This law extended the protection given to the disabled in the public sector by the Rehabilitation Act of 1973 to the private sector as well. It was designed to give the disabled full access to housing, employment, transportation, and communications. As a result of this law, any business endeavor designed to serve the public must ensure that its services are accessible to the

disabled. In many cases, this requirement involves the installation of wheelchair ramps, the construction of restrooms that can accommodate wheelchairs, and the provision for communication services for the hearing and speech impaired. Public transportation authorities must ensure that buses, train cars, and concession shops are all accessible to the disabled. Businesses with fewer than 15 employees are currently exempt from many of the law's provisions. This law has prompted significant progress toward improving the quality of life of many disabled people.

REHABILITATION TEAM

Nurses who care for disabled clients must consider the whole person when planning interventions. Difficulties in physical functioning may affect many aspects of a person's life and require the coordinated services of a significant number of health care professionals to enable the individual to stay well and prevent complications or injuries.

The case of Mr. T. provides a good example of the kinds of expertise and the number of services that may be required during rehabilitation.

Mr. T., age 82 years, suffered a left-sided brain hemorrhage 3 weeks ago. Because of this injury, he was unable to speak or use his right arm or leg. He was also incontinent of urine and exhibited some right-sided facial paralysis. After 5 days in the hospital, care providers determined that Mr. T.'s condition had stabilized, and he was transferred to a rehabilitation facility to continue the rehabilitation process. At this time, his speech had returned but was slurred and halting. He had minimal movement in his right arm and leg but was still unable to walk or feed himself. The incontinence of urine persisted, and he had several reddened areas on his right hip and coccyx. Before his injury, Mr. T. had been living with only his wife of 55 years, who also was in poor health. They had no family living in the state, and she was quite concerned about how she would care for him once he was sent home.

When trying to comprehend all that is involved in helping Mr. T. to return to full functioning (if that is possible), the nurse should first imagine a typical day in the T. household and identify all the ADL and IADL competencies required to get through the day. Next, the types of people and services that may be necessary to prevent further injury and to increase functioning should be considered. At a minimum, the rehabilitation team will consist of the patient's wife, personal physician, rehabilitation physician, and rehabilitation nurse. Other likely members include the physical therapist, who assists the patient in all aspects of mobility from regaining strength and function in the extremities to the use of assistive devices such as crutches and walkers; the occupational therapist, who assists the patient with regaining fine-motor skills necessary for dressing, eating, and grooming; the speech therapist, who assists the patient in regaining swallowing or speaking functions; and the social worker, who may assist with coordinating resources for placement in the home or a convalescent facility after discharge. In other situations, the rehabilitation team might also include a clinical nurse specialist in rehabilitation nursing, a psychologist, a recreational therapist, and a vocational counselor.

The nurse's concern at this time should be that of becoming an effective member of the rehabilitation team. The successful resolution of rehabilitation problems often depends on the ability of health care workers to consider how the individual functions within the family and to work closely with other health professionals toward a common goal. If this goal is to be achieved, good communication skills are essential, which entail clear, specific documentation of the patient's functional deficits and abilities and active participation in multidisciplinary conferences to resolve patient problems.

APPROACHES TO REHABILITATION

Perhaps the most important goal of successful rehabilitation of a disabled person is independence. This fact is sometimes forgotten when a caregiver sees the slow, agonizing attempts to move an arm or a leg. The tendency is to do for patients that which is difficult for them to accomplish on their own. Occasionally, patients need to be helped to complete a task, especially when they become increasingly frustrated. However, caregivers who intervene too soon encourage dependence and delay rehabilitation. Rehabilitation patients should be cheerfully encouraged to do as much as possible for themselves. Praise for accomplishing a task should be given promptly and caregivers should reflect continuing optimism about the patient's progress.

Health professionals sometimes plan comprehensive programs of rehabilitation without much thought as to how the program will be implemented once the patient returns home. To be effective, the program should commence immediately after an injury and should involve the patient and family from the outset. Failure to involve the family in establishing goals and strategies often produces family dependence, just as doing too many things for the patient produces individual dependence.

Rehabilitation nurses undertake several roles, all designed to assist the patient and family in returning to a high level of functioning. These roles include care planner, teacher, caregiver, counselor, coordinator, and advocate. As in-home health care, the medical-surgical nurse brings a wealth of knowledge and skill but must learn to make adaptations consistent with the rehabilitation approach.

In the home setting, nurses can best assist patients and families by helping them to adjust their activities to accommodate the disability (Fig. 2.2). Even though families may have been taught care routines in a previous setting, routines must often be adapted to the new setting and prioritized differently. In this role, the nurse is an expert caregiver and teacher. Problem-solving sessions

Fig. 2.2 An important nursing role in home health care is to teach patients to care for themselves. (Copyright © Jupiterimages/Stockbyte/Thinkstock.com.)

often identify ways in which care routines can be adapted to the realities of the home setting. Caregivers may not have thought through changes in sleeping arrangements, how they will transport the patient for follow-up office visits, or how to plan for periodic relief from their caregiver role. Nurses can help families to anticipate these predictable stress points and plan realistically for how they will handle them.

Nurses should also be prepared to handle a wide variety of patient and family emotions, ranging from extreme optimism to depression. At these times, families need a great deal of support and may need the assistance of outside community support systems. Local support groups can often be very effective in helping families to respond appropriately to the stresses of a disabled family member. Professional organizations such as the Association of Rehabilitation Nurses can be an invaluable resource to nurses working in the rehabilitation field.

LONG-TERM CARE

Long-term care is provided in a variety of settings, such as personal homes, board and care homes, supportive housing facilities, assisted living centers, continuing care retirement communities, and nursing homes. In the United States, approximately 16,000 nursing homes have been certified by both Medicare and Medicaid to provide residential skilled nursing care. The great majority of these are freestanding facilities, with the others being hospital-based entities. Several thousand other nursing facilities exist that are not certified or are certified only by either Medicaid or Medicare. After an acute care hospitalization of at least 3 days, Medicare covers 100 days per event in a skilled nursing facility.

The United States population in certified nursing homes is approximately 1.4 million people. Many people think only of older persons in institutional settings when they think of long-term care settings. Long-term care services, however, are required by people of all ages who are temporarily or permanently unable to function independently. Approximately 15% of nursing home residents are younger than 65 years. Thus long-term care refers to a range of services that address the health, personal care, and social needs of all people who lack some ability necessary for self-care. The number of older adults who live in institutions actually comprises a relatively small percentage of older adults; many more live with extended families or by themselves. Unfortunately, a significant number of older adults who live alone are poor and live in inadequate housing, often without adequate heat, ventilation, food, or telephones. Eventually, problems with mobility and mental functioning force many older adults into long-term care.

RISKS FOR INSTITUTIONALIZATION

With 40 million U.S. citizens over the age of 65 years, only about 4.2% are residing in a nursing home at any given time. The main reason for institutionalization, however, is not age. The best indicator of who will need nursing home placement is ADL dependency. As the number of ADL limitations increases, the likelihood of residing in a nursing home rises; half of older adults with five or six ADL limitations reside there. This figure highlights the fact that if home care services were available to assist older adults in meeting more ADL needs, costly residential care might be delayed. Individual characteristics associated with increased risk of nursing home residency include age 85 years and older, female gender, Caucasian race, cognitive impairment, functional dependence, and reliance on Medicaid. The long-term care resident today has more medical diagnoses and functional limitations than in the past. This trend has important implications for staffing these facilities. Among long-term care residents, the most common medical diagnoses are heart disease, stroke, diabetes mellitus, depression, and dementia.

Other factors bearing on who requires nursing home care include financial resources, whether the person lives alone or with family, the presence of mental illness, the type of disease process, and the degree of social support.

LEVELS OF CARE

Modern long-term residential care consists of four levels: (1) domiciliary care, (2) personal care homes, (3) intermediate care, and (4) skilled care. In many instances, one type of facility will offer more than one level of care (usually skilled and intermediate); however, in most states, institutions must have approval for whatever levels of care they plan to provide.

Domiciliary Care Homes

Facilities providing basic room, board, and supervision are sometimes called **domiciliary care** homes. In this arrangement, 24-hour care is not provided, and residents usually come and go as they please. The Domiciliary Care Program in the Department of Veterans' Affairs provides not only living quarters but also a variety of rehabilitation and treatment services.

Personal Care Homes

Personal care homes provide medically ordered medications and treatments, supervise residents in self-medication, and provide three or more personal services. Two types of personal care homes have been established. A personal care home with nursing (nursing care home) must employ at least one registered or licensed nurse; no more than one half of the residents receive nursing care. A personal care home without nursing has no residents who are receiving nursing care.

Intermediate Care Facilities

Intermediate care facilities provide custodial care at a level usually associated with nursing homes. Patients at this level often need assistance with two to three ADL (Fig. 2.3). Facilities offering this level of care must have personnel available 24 hours a day. They are not considered by the government to be medical facilities and thus receive no reimbursement under Medicare. Many of these facilities do, however, receive the bulk of their financing under Medicaid. Federal regulations require a registered nurse to serve as director of nursing and an LVN/LPN to be on duty for at least 8 hours a day.

Fig. 2.3 Patients in intermediate care facilities often need assistance with activities of daily living. (From Potter P, Perry A, Stockert P, Hall A, editors: *Fundamentals of nursing*, ed 8, St. Louis, 2013, Mosby Elsevier.)

Skilled Nursing Facilities

Skilled nursing facilities must have skilled health professionals present around the clock. The care of patients in skilled nursing facilities must be supervised by a physician and requires the services of a registered nurse, physical therapist, or speech therapist.

IMPACT OF RELOCATION

Relocation to a long-term care facility is rarely easy. In the best of circumstances, patients, families, and health professionals anticipate the possible future need for long-term care, set aside funds for that purpose, and make plans that are acceptable to everyone involved. Then when patients cannot make sound decisions for themselves, families seek help from extended family members and professionals in making decisions for long-term care placement. More commonly, however, the situation is quite different. A crisis situation often precipitates the decision. A sole caregiver may become ill, leaving the care of the disabled elder to the extended family members who may be either unable or unwilling to continue care. Patients may suddenly become physically or mentally incapable of caring for themselves or making their own decisions. Family members frequently feel guilty for considering institutional care. Few know very much about modern long-term care facilities and have not investigated potential placement.

In this situation, home health nurses, social workers, and other health professionals must work closely with the family to defuse the crisis situation and provide realistic options from which the family may choose. This time is when families need the utmost support and acceptance. Simply clarifying the situation, affirming the family's caring and concern, and pointing out realistic options will often return a family to effective functioning.

If relocation to a long-term care facility is the only logical choice, the patient and family must be prepared for the move. Research has shown that the more prepared the patient is, the better the adjustment will be. Preparation includes providing as much choice as possible for the patient and responding to patient questions and concerns. If possible, choices of facility, room location, types of personal belongings, and room decor are helpful, as are tours of the facility before entering. Also helpful is a professional staff member who can check on the new patient frequently during the first few weeks. Patients should be introduced to other residents with similar interests and invited or assisted to participate in appropriate activities.

EFFECTS OF RELOCATION TO A LONG-TERM CARE FACILITY

The response to moving into a long-term care facility varies with the individual resident. Positive effects can include improved nutrition, socialization, and management of medical problems. With support and assistance, the resident's overall function may improve. Other effects of institutionalization are predictable and must be

considered in helping the new nursing home resident adjust to the surroundings. Frequently observed effects include depersonalization, indignity, redefinition of "normal," regression, and social withdrawal.

Depersonalization

Depersonalization plays a major part in long-term care settings. Caregivers often know little of a resident's life history and therefore treat individual residents in light of their diagnosis or dysfunctional behavior patterns. The case study (Box 2.1) about Herman and Kristina illustrates this point.

Box 2.1 Case Study

I don't think I truly understood what depersonalization was until I met Herman. Herman and his wife, Kristina, lived alone in a small house in a northwestern city. Herman was 62 years old and had Alzheimer disease. I met them while working as a home health nurse. I was asked to look into respite services to help relieve Kristina of the strain of caring for Herman. I remember my first impression of Herman, formed after reading his chart and talking to the staff nurse about his care problems. He was starting to neglect his personal appearance. The staff nurse said he often put soup on the stove for lunch then went out to the garden to tend his flowers, forgetting about the soup. This and other images of his functioning created in me a picture of an incompetent and helpless old man.

Over a period of weeks, Kristina shared many stories with me about who this man was, what he cared about, how they had met, and her deep devotion to her husband of 35 years. Gradually, I was able to see the distorted image I held. Herman was an Olympic gold medal skier from Austria who came to this country as a young man. He held several jobs as a ski instructor and repaired ski equipment until he met and married Kristina and moved to the northwestern United States to become the owner and manager of a small ski resort. He was tall and muscular, with an easy smile and a kind word for everyone. He was admired by many in the community for his skill as a skier and his friendliness. He was a good father and family man who was known as "the rock" because all of his family and friends relied on him for advice and assistance.

Over a period of 5 years, Herman became more and more forgetful, less talkative, and often preoccupied with household tasks that he would start but not complete. He also failed to recognize many of his close friends and, at times, would wander off downtown without knowing why or where he was going. Throughout this, Kristina remained fiercely devoted to Herman, although the strain of the caregiver role was beginning to affect her health. "He cared for us for so many years. Now it is my turn to care for him."

I was surprised at how my view of Herman changed as I learned more about him. I was seeing him as dependent, helpless, and a burden to his small and frail wife—a view created by my observations of his behavior and what I knew of the Alzheimer disease process. A view that changed radically once I knew more about Herman. I doubt I will ever minimize the importance of learning about the whole patient.

One way to help see the resident of a long-term care facility as a whole person with past relationships, accomplishments, and interests is to ask family members to bring in photographs. The photographs may have been taken on significant occasions, such as on graduation or wedding days, or they may be simple family pictures that depict the older person's place in the family or community. The photographs can be mounted on poster board or placed on a bulletin board in the resident's room. This effort helps caregivers to see more than a frail, weak, older person and can open up conversation that encourages reminiscing, which is a therapeutic means of dealing with one's past life and preparing for death.

Indignity

Indignity is another effect of institutionalization. Residents may have to request help with routine activities such as toileting and obtaining food and drink. The prompt fulfillment of the request sometimes depends on the relationship between the patient and the caregiver. Residents of long-term care facilities may be exposed unnecessarily, especially when caregivers enter rooms without knocking. Simple courtesies such as using a person's title and last name, knocking before entering the room, and draping during care activities help the resident to maintain dignity. A useful exercise would be to consider: "How would I want to be treated if I were weak and frail and could not do the things that I can do for myself now?"

Assistive personnel are important members of the nursing care team in long-term care. Because they provide much personal care, the LVN/LPN should know what tasks can be assigned to them. Also the LVN/LPN must verify the skills of assistive personnel, provide guidance as needed, and participate in their evaluation.

Redefinition of "Normal"

Behaviors that were considered normal in one's home may be labeled abnormal or be unacceptable in a long-term care facility. Watching television at 3:00 AM, loud singing, or sexual activity may be frowned upon, depending on the residence's rules and routines. Although consideration of others is important, giving residents of long-term care facilities some flexibility and some measure of control in their daily lives is also important.

Regression

Over time, a resident's physical, mental, and social abilities may be lost because of disuse. If people are left in bed for a greater part of the day, it soon becomes impossible for them to walk. If visits from friends and relatives are few, the skill of conversation may also be lost. Encouraging independence and social interaction as much as possible is important. Avoid infantilizing older patients. Although simplifying language and

activities for those who are cognitively impaired may be necessary, avoid baby talk.

Social Withdrawal

If a resident never leaves the nursing home or if family visits are few and include little discussion of the outside world, the institution can become a barrier, cutting off interest and participation in the outside world. If this situation is allowed to continue, life in the facility becomes, for many patients, their entire world. They tend to withdraw into the boundaries of their own room (see the Cultural Considerations Box). Nurses can help by conversing with residents about events inside and outside the nursing home. When you know your patients well, you can bring up news that you expect will be of interest to them. Discussion of current events in small groups can broaden the resident's horizons.

Cultural Considerations

What Does Culture Have to Do With Social Withdrawal?

Most facilities are dominated by a single culture that is reflected in mealtimes, social mores, religious services, and holiday traditions. Consider how a person from a different culture might feel in this setting.

PRINCIPLES OF LONG-TERM RESIDENTIAL CARE

Long-term residential care has been called *custodial care*. This term invokes passive images such as maintenance, warehousing, or waiting to die. Some people have called such facilities "heaven's waiting rooms." Publicized abuses by some nursing homes are at least partly responsible for negative stereotypes of long-term residential care. However, long-term care facilities in general have changed substantially in recent years. Although some continue to provide care of questionable quality, many excellent facilities do exist.

Modern facilities care for individuals with a wide array of medical and surgical problems. People who reside in long-term care facilities are commonly referred to as *residents* rather than patients. Not all residents are admitted for permanent stays in the facility. In many communities, the nursing home has become a convalescent hospital for older persons who have recently undergone surgical procedures, such as repair of a fractured hip. These acute cases often strain already limited resources. Many individuals are admitted for short stays that are prompted by care demands that temporarily overwhelm the family. Illness of a family caregiver also can result in temporary admission to the facility. When the home situation has stabilized, these residents often return home. Increasingly, those admitted for long stays are older adults with mental health problems. In these cases, the family has exhausted most of its physical, emotional, and financial resources and home care is no longer feasible.

When a person is admitted to a long-term care facility, the care delivered should be based on three principles: (1) promotion of independence, (2) maintenance of function, and (3) maintenance of autonomy.

Put on Your Thinking Cap!

If you have a clinical experience in a long-term care facility, interview a resident there. Specifically, ask:

1. What circumstances brought you here to live?
2. What are the benefits and disadvantages of living in this type of facility?
3. What advice would you give to a new resident here?
4. What can nurses do to make adjustment to living here easier?

Discuss the resident's responses in relation to the effects of institutionalization and implications for nurses.

Promotion of Independence

Successful relocation to a long-term care facility depends, in part, on the ability of patients to do things for themselves and on the involvement of families to keep the family member in contact with the outside world. Feeding residents rather than spending time encouraging residents to feed themselves may be tempting for institutional caregivers. When the workday is a never-ending series of tasks, doing things quickly often takes priority over promoting independence. Watch for this type of behavior and try to restructure assignments of nursing assistants to reward the promotion of independence. This effort can be accomplished by setting specific goals for each resident that encourage independent functioning. Then, explain to the staff members how their efforts can contribute to the goal. Involvement of staff in this way often produces results.

Maintenance of Function

In many cases, loss of function prevents an older person from staying at home. Health professionals who are disease oriented often concentrate on the disease process at the expense of a functional assessment. An incontinent resident may be incorrectly perceived as having a complication of the aging process. This kind of thinking fosters an emphasis on maintenance care, leading to efforts to prevent skin breakdown by frequent changes of clothing and linens. A more thorough assessment would begin with the determination of possible causes of the incontinence. A functional assessment explores factors that might be responsible for the incontinence. Immobility may be the basic problem. Questions to ask include: Is the resident normally mobile? If so, does the room have a light that facilitates locating the bathroom? Is the resident able to manage clothing for independent toileting? Viewing this problem as a functional problem may lead to simple solutions, such as placing a light in the room at night or a urinal next to the bed. Interventions, whenever possible, should focus on restoring and preserving function.

Maintenance of Autonomy

Most people value control over their lives. Successful relocation to a long-term care facility depends on preserving as much autonomy as possible. Older adults who participate in selecting the facility adjust better than those who have no choice in the matter.

Allowing as much flexibility as possible in establishing a routine for the new resident is also important. Choices in activities, such as when to have a bath or how late to watch television, go a long way toward preserving the autonomy and self-esteem of the resident. As much as possible, encourage the resident to assist in establishing care goals. For example, the frequency and duration of exercise and goals for weight loss or gain require the facility resident's commitment. Mutually established goals are more likely to be achieved than those selected for the resident.

Families also have a role in maintaining autonomy in the resident. Autonomy depends on knowing one's place in the world and what roles one still holds in the family structure. Families who relate to their older adult members by stressing their importance in the family and keeping them up to date on family happenings and decisions reinforce the idea that the person remains a valued family member who simply resides at another address.

Put on Your Thinking Cap!

Identify one thing you can do to achieve each of the following: (1) maintain autonomy, (2) maintain function, and (3) promote independence in:

1. The long-term care facility resident
2. The hospitalized patient

ASSISTED LIVING

Assisted living facilities provide an alternative to nursing home care. These facilities are residences that provide self-contained living units for individuals who live independently but have on-site access to support if needed at any time. Typical services include congregate meals, recreation, housekeeping and laundry, social services, transportation, help with ADL (but not full-time nursing care), and some health-related services such as medication management. Medicare and Medicaid do not pay for assisted living care.

CONTINUING CARE RETIREMENT COMMUNITIES

Continuing care retirement communities (CCRCs) usually have various living options ranging from independent quarters, to assisted living, to skilled nursing units. As residents age, they may need to move from one level of care to another. In most CCRCs, residents pay an entry fee as well as monthly fees that may vary as the level of care changes. Medicare and Medicaid do not pay for CCRCs, except in the skilled nursing areas.

SUPPORTIVE HOUSING PROGRAMS

The federal and state governments have programs that offer low-cost housing to low-income older adults. The range of services varies but may include housekeeping, laundry, and shopping. With these supports, some older adults can continue to live independently despite some medical conditions and functional impairments.

OTHER PATIENT CARE SETTINGS

The settings addressed in this chapter represent many of those that traditionally employ licensed nurses. Other employment settings include clinics, physicians' offices, and schools, as well as adult day centers, respite care, hospice, and correctional facilities. Each setting presents unique experiences and challenges. In some of these settings, the LVN/LPN may be the only licensed nursing professional on site. Therefore the nurse's responsibilities must be clearly defined and consistent with legal functions.

Get Ready for the NCLEX® Examination!

Key Points

- The changing health care system has greatly increased the number and types of health care settings.
- Medical-surgical nurses have the knowledge and skills to work in numerous settings.
- Community health nurses work with individuals and aggregates (groups) to improve the health of the entire community.
- Traditional community health nursing focuses on (1) improving the health status of communities or groups of people (called *aggregates*) through public education, (2) screening for early detection of disease, and (3) providing services for people who need care outside the acute care setting.
- Public health is concerned with promoting and protecting the health of populations.
- The main difference between home health care nursing and public health nursing is that home health care is more focused on providing direct care to patients.
- A major nursing function in home health care is teaching patients and families to care for themselves so as to promote independent functioning.

- Medicare is a major source of home health care funding.
- To receive Medicare reimbursement for home health care, four conditions must be met: (1) the physician has determined the need for home care and has made or authorized a plan for home care; (2) the patient needs intermittent skilled nursing care, or physical or speech-language therapy, or continued occupational therapy; (3) the patient is homebound; and (4) the agency providing the care is Medicare certified.
- Specialty home care services include high-technology interventions (the provision of intravenous therapy and ventilator therapy), hospice services, pediatric care, and mental health care.
- The most common intravenous therapies provided in the home are hydration, antibiotics, pain control, total parenteral nutrition, and chemotherapy.
- The role of the LVN/LPN in planning home health care is to participate in patient data collection, contribute to the development and revision of the care plan, and to assign and evaluate assistive personnel.
- The LVN/LPN who works in home health settings must be aware of the legal scope of practice in his or her state, as well as agency policies.
- After certain nursing procedures such as insulin injection are taught to the family, they are no longer considered skilled procedures and are not reimbursable under Medicare.
- In addition to regular scheduled conferences, the case manager should be kept informed of any changes in the response of the patient or family to the plan of care.
- Rehabilitation focuses on restoring maximal possible function after illness or injury.
- Impairment is a disturbance in functioning; disability is a measureable loss of function; and, handicap is an inability to perform daily activities.
- The Americans with Disabilities Act of 1990 is designed to protect the rights of persons with disabilities in employment situations.
- Perhaps the most important goal of successful rehabilitation of a disabled person is independence.
- Rehabilitation is the process of restoring an individual to the best possible health and functioning following a physical or mental impairment and the prevention of further disability.
- Caring for disabled patients requires the coordinated services of a large number of health care professionals to help patients stay as healthy as possible and prevent complications or injuries.
- As an effective member of a multidisciplinary rehabilitation team, the nurse is a care planner, teacher, caregiver, counselor, coordinator, and advocate.
- Health care workers must consider the way in which a disabled individual functions within the family, and the patient and family should be involved from the outset in determining the plan of care.
- Dependence in ADL is the best indicator of who will need nursing home placement.
- Modern long-term residential care exists in four levels: (1) domiciliary care, (2) personal care homes, (3) intermediate care, and (4) skilled care.
- Alternatives to nursing home care include assisted living facilities, supportive housing programs, and continuing care retirement communities.
- Frequently observed effects of relocation to a long-term care facility include depersonalization, indignity, redefinition of "normal," regression, and social withdrawal.
- The key principles of long-term care are: (1) promotion of independence, (2) maintenance of function, and (3) maintenance of autonomy.
- The responsibilities of the LVN/LPN must be clearly defined and consistent with legal functions regardless of the employment location.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

Go to your Evolve website (http://evolve.elsevier.com/Linton/medsurg) for the following learning resources and much more:

- Interactive Prioritization Exercises
- Fluid & Electrolyte Tutorial
- Pharmacology Tutorial
- Review Questions for the NCLEX® Examination

Online Resource
http://www.medicare.gov/Publications/Pubs/pdf/10153.pdf

Review Questions for the NCLEX® Examination

1. A home health nurse performed all the following activities listed with Medicare patients. Which activities are reimbursable? (Select all that apply).
   1. Used sterile technique to clean and dress a large wound
   2. Took a frail older couple for a short walk to provide exercise
   3. Performed a venipuncture to obtain a blood sample for laboratory tests
   4. Taught a patient with recently diagnosed diabetes how to inject insulin
   5. Removed outdated food from the refrigerator and pantry

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
2. Which nursing activity might commonly be provided by community health nurses but not by home health nurses? (Select all that apply).
   1. Conducting health education programs in a senior citizen residence
   2. Monitoring the recovery of a postoperative patient at home
   3. Arranging blood pressure screening at a community shopping center
   4. Seeing patients in a clinic to monitor problems related to chronic illness
   5. Administering influenza vaccines at a public location

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care

3. LVN/LPN students are discussing the difference between community health nursing and community-based nursing. They correctly identify an example of community-based nursing as:
   1. Meeting with residents of low-income housing to identify their health needs
   2. Telephoning patients at home after discharge from the hospital
   3. Asking nurses to identify the health services lacking in their communities
   4. Developing a hospital-based home health care service

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
4. The LVN/LPN in a long-term care facility is caring for a patient who is unable to feed or dress herself independently because of a neurologic disease. Her status is most accurately described as:
   1. Impaired
   2. Handicapped
   3. Disabled
   4. Disadvantaged

   NCLEX Client Need: Physiological Integrity: Basic Care and Comfort
5. A nurse who has been diagnosed with a chronic illness, a nursing school applicant with hearing impairment, and a patient with cancer are all protected from discrimination in employment because of their health problems by the:
   1. Social Security Act
   2. Americans with Disabilities Act
   3. Rehabilitation Act of 1973
   4. Vocational Rehabilitation Act

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
6. A patient who is being discharged from a rehabilitation facility is applying for Medicare coverage for home health nursing care. The LVN/LPN knows that Medicare will reimburse nursing care in the home only if the care meets which criteria? (Select all that apply).
   1. Short-term
   2. Necessary
   3. Skilled
   4. Reasonable
   5. Intermittent

   NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care
7. A patient who has suffered a head injury is feeding herself with considerable difficulty. In terms of rehabilitation, what is the most appropriate nursing response?
   1. Offer to feed her so that she will not be embarrassed by her handicap
   2. Order a liquid diet so that she will not have to use eating utensils
   3. Point out that the sooner she can feed herself, the sooner she can go home
   4. Ensure that her food is accessible and compliment her efforts at self-feeding

   NCLEX Client Need: Physiological Integrity: Basic Care and Comfort
8. A patient's record indicates that he is able to perform only 25% of his usual job activities since his motorcycle accident. This information is a measure of the extent of his:
   1. Handicap
   2. Disability
   3. Incapacity
   4. Impairment

   NCLEX Client Need: Physiological Integrity: Physiological Adaptation and Psychosocial Integrity
9. A nursing home resident has his name printed neatly on the door to his room. The interior of the room is decorated in masculine colors. One wall is covered with pictures of the resident at various occasions in his personal and professional life. In one corner is a leather recliner with a reading lamp and table. This room best reflects an effort to:
   1. Prevent depersonalization
   2. Maintain the resident's dignity
   3. Prevent regression
   4. Prevent social withdrawal

   NCLEX Client Need: Psychosocial Integrity
10. At a health class for older adults, one participant comments: "I guess we will all end up in a nursing home one day." The LVN/LPN can inform the group that the best indicator of who will need nursing home placement is:
    1. The medical diagnosis
    2. The availability of family caregivers
    3. Dependence in ADL
    4. Financial resources

    NCLEX Client Need: Safe and Effective Care Environment: Coordinated Care

Medical-Surgical Patients: Individuals, Families, and Communities

3

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Objectives

1. Discuss the roles and practice settings of the medical-surgical nurse.
2. Provide examples of primary, secondary, and tertiary prevention.
3. Explain cultural influences on the interactions of patients and families with the health care system.
4. Discuss considerations in providing culturally sensitive nursing care.
5. Discuss concepts related to health promotion, disease prevention, and health maintenance.
6. List the developmental tasks for each stage of adulthood.
7. Identify health problems common to the young, middle, and older adult.
8. Discuss the family from a developmental perspective.
9. Describe roles and communication patterns within families.
10. Describe adaptive and maladaptive mechanisms that families use to cope with various stressors.
11. Describe the role of the nurse in dealing with families experiencing various stresses.
12. Identify community resources that may help meet the family's needs.

Key Terms

dysfunctional communication
functional communication
primary prevention
secondary prevention
tertiary prevention

Chapter 2 described the varied settings in which medical-surgical nurses practice. This chapter explores the diverse patient populations that they serve: individuals, families, and communities; the sick and the well; from diverse cultures; across the adult life span. Medical-surgical patients include individuals at every point on the health-illness continuum. Their nurses engage in health promotion, prevention of disease and injury, management of acute and chronic health deviations, prevention of complications, and support at end of life. Regardless of the employment setting, medical-surgical nurses encounter patients and families from all corners of the earth. They must be sensitive to cultural differences, seeking to provide optimal care to all. Medical-surgical nurses work with the entire spectrum of adult patients, from late adolescents to centenarians. Some settings such as long-term care serve a limited age cohort, whereas others offer practice with young, middle, and older adults. Medical-surgical nurses in acute care settings work primarily with individual patients. Interactions with families often are limited even though the role they play in the patient's life is significant. In community and home settings, however, the nurse enters the patient's social network and has much greater opportunity to care for the family as a unit.

HEALTH-ILLNESS CONTINUUM

Despite the perception that medical-surgical nurses work primarily in acute care, opportunities abound for them to care for patients all along the health-illness continuum. Much care that once was provided only in hospital settings is now available in outpatient clinics, urgent care clinics, and day surgery facilities. In part, this is possible because home health nurses can follow up during convalescence, monitoring and documenting recovery, teaching, and communicating with the health care team about the patient's status. Care of these patients requires expert medical-surgical skills and judgment.

Nursing and residential care facilities employ the largest percentage of licensed vocational nurses/licensed practical nurses (LVNs/LPNs) in the United States. Patients in long-term care are at various points on the health-illness continuum. About 20% of long-term care residents are admitted for rehabilitation or recovery

from acute events that no longer require hospitalization. The medical-surgical nurse is well prepared to manage convalescing and chronically ill residents, but the focus is not just on health deviations. Their nurses promote safety and the highest level of functioning possible. Chronically ill patients are at risk for acute events and require monitoring for physiologic and behavioral changes suggestive of disease processes, as well as adverse responses to treatments.

Residents in retirement centers range from highly functioning to very frail. The medical-surgical nurse aims to keep these patients as independent as possible for as long as possible. That requires skillful health teaching, helping the patient to manage existing health deviations, and monitoring for changes from the patient's usual state.

Home health care gives the medical-surgical nurse exposure to a broad range of patients. They may be recovering from joint replacement surgery, learning to manage an ostomy, or dealing with a slow-healing wound. Some patients will return to complete independence; others may be hoping to spend their final days in the home setting. Family teaching is a vital part of the nurse's role in home health. With adequate instruction and support, some families care for patients who are completely dependent. Home-based hospice is specifically for individuals who have a limited life expectancy. The focus is on comfort and support for the patient and the family. Nursing care at end of life is covered in Chapter 19.

Physician's offices and outpatient clinics, which employ about 13% of LVNs/LPNs, treat patients of all ages whose conditions can be managed outside the hospital. The medical-surgical nurse may assist with data collection for the assessment, reinforce physician or nurse practitioner orders, administer parenteral medications, provide comfort and reassurance, and document data collected and care provided.

HEALTH PROMOTION, DISEASE PREVENTION, AND HEALTH MAINTENANCE

Health promotion activities are directed toward maintaining or enhancing well-being as a protection against illness. Through public education, Americans have become increasingly health conscious and many are beginning to take more responsibility for maintaining healthy lifestyles.

LEVELS OF PREVENTION

Disease or illness prevention behavior is action taken by individuals to decrease the threat of illness and its harmful consequences. The three levels of prevention are primary, secondary, and tertiary. **Primary prevention** seeks to prevent illness and injuries. **Secondary prevention** occurs when an illness or injury has occurred and is directed to minimizing complications and promoting maximum possible return to health. **Tertiary prevention** addresses the long-term effects of the health problem and helps the patient learn to manage them (Box 3.1).

Box 3.1 Examples of Activities at Each Level of Prevention

Primary: Teaching healthy lifestyle, encouraging preventive measures, promoting a safe care environment
Secondary: Providing direct care to patients; implementing plans of care in collaboration with the registered nurse
Tertiary: Providing direct care to convalescing patients and patients living with the effects of illness or injury

CULTURAL AWARENESS AND COMPETENCY

As an LVN/LPN, you must be able to accept a wide diversity of beliefs, practices, and ideas about health and illness, including many that are different from your own. The more sensitive you are to cultural differences, the more effective your nursing care will be. Failure to provide culturally sensitive care can cause additional stress and could prolong the patient's recovery time.

To contribute to the plan of care, you need to collect data to help you understand the patient's needs. A complete cultural assessment of each patient would be very time consuming and therefore impractical. All nurses should have a ready resource that provides information about various cultures. Several nursing guides are available that provide essential information such as health care beliefs, sick-care practices, relationship with health care providers, food practices, family roles, birth and death rites, and pain reactions. Accessing this information prepares you for what you may find when working with the patient and family. You can then collect data specific to that patient and family. Most of us have contact with a limited number of cultures, so it is imperative to acquire more in-depth knowledge of those cultures.

CULTURAL INFLUENCES ON INTERACTIONS WITH THE AMERICAN HEALTH CARE SYSTEM

In all health care settings, patients of different cultures may exhibit behaviors that are not understood by health care providers in the dominant culture. Culturally different patients may be labeled complaining, difficult, uncooperative, or noncompliant when, in reality, they are struggling to adapt to a culture that is foreign to them. Culturally congruent care that is in harmony with the patient's values, beliefs, and practices is urgently needed.

MEDICAL-SURGICAL PATIENTS FROM VARIOUS CULTURES

Working in a variety of settings from acute care to community clinics and patient homes provides the

medical surgical nurse the opportunity to work with many diverse cultures. Culture can influence the patient's attitudes, beliefs, and practices in relation to health care. For example, many cultures have strong extended family units and family ties. When a person is hospitalized, family members visit frequently. Some cultures have traditionally cared for their elders in a home setting rather than placing them in residential facilities. Nurses should understand how one's cultural background influences behavior. A nursing fundamentals text often provides more detail about specific cultures. The biggest risk in learning "typical" behavior of people of different cultures is stereotyping. With increased worldwide travel and immigration, many countries have become very diverse. Whereas some immigrants assimilate readily into a new society, others do not. It is easy to make assumptions about a person's beliefs and practices based on appearance or surname. The best way to provide culturally appropriate nursing care is to collect data from the individual and adapt care accordingly.

RELIGION

Religious beliefs and practices can influence perceptions of health and illness, hospitalization, and death and dying. Some patients may observe specific dietary rules and others may have particular practices regarding dress, modesty, daily living habits, or medical interventions. Religious differences also occur in relation to observation of the Sabbath, baptism, the sacrament of the sick, and last rites.

COMMUNICATION

Certain cultural or ethnic groups speak different languages, making communication almost impossible. The speed at which people speak and their tone and inflections vary according to cultural background. Even within the United States, regional accents, words, and slang can affect communication. Anatomic and medical terms may be "foreign" to patients regardless of their language skills.

Nonverbal communication is also culturally based. Personal space, eye contact, gestures, displays of emotions, and the amount and meaning of touch that are acceptable are culturally determined. Some cultures find emotional display more acceptable than others. Some are more comfortable with silence than others.

Subtle forms of miscommunication may occur because of differences between and within groups. Communication should take place in language that patients understand, without talking down to them. Federal regulations require health care providers who receive federal funding to provide appropriate services to persons with limited English proficiency and those who are deaf or hard of hearing.

EDUCATIONAL BACKGROUND AND ECONOMIC STATUS

Patient teaching is a critical nursing skill. However, regardless of the care setting, the nurse must recognize the impact of education, experience, and economic status on a patient's comprehension of health teaching. Large differences in educational backgrounds exist in the United States. Millions of Americans have literacy skills below the eighth-grade level, meaning that they have difficulty with reading and writing. One aspect of literacy is health literacy, which refers to the ability to obtain and understand basic information needed to make health decisions. Health literacy has been found to be highest among women, Caucasians and Pacific Islander adults, and adults under 65 years of age. The nurse can collect data about a person's health literacy by asking the patient what they know about their condition. Start where the patient "is" and build on that knowledge to fill in the gaps and correct misconceptions.

Educational level attained is strongly tied to economic background. School dropout rates appear to be higher among adolescents living in poverty areas. Ethnic groups that are found in large numbers in poverty areas tend to have high dropout rates.

Educational background and economic levels affect the ways in which people perceive the world, health and illness, and the health care system. Teaching about health becomes a challenge because many people with low literacy levels have difficulty reading the materials presented and understanding health care jargon. In addition, people from economically deprived backgrounds may live in crowded, unsafe housing and have inadequate diets. Such conditions make health promotion and disease prevention difficult.

As mentioned in relation to culture, be careful not to stereotype patients based on their education or economic status. Many people are very knowledgeable about their health status as a result of self-study and experience. It is not uncommon for older adults to have limited formal education but a lifetime of informal learning.

HEALTH AND ILLNESS BELIEFS

Of great concern to the nurse is the impact of patient beliefs related to health and illness. Some groups believe illness is expected as part of life and is beyond one's control. Different belief systems attribute illness to punishment for sins, imbalance between the hot and cold parts of the body, or lack of harmony with nature. Western cultures generally approach illness as being treatable once the cause is identified. They also believe the risk of illness can be reduced by a healthy lifestyle. It is easy to see how these varied beliefs affect the approach a person takes toward health and illness management.

Many ethnic groups use healers who practice health care outside of the formal health care delivery system. Patients may visit a folk healer or use folk remedies, such as potions and plants, along with or in place of conventional treatment. When individuals perceive mainstream health care to be too expensive, inconvenient, or when it fails to meet their psychosocial needs, they may turn to traditional healers.

DIMENSIONS OF CULTURE IN THE UNITED STATES

Despite the diverse subcultures in the United States, certain characteristics are generally true of the American culture. Americans are very time oriented and value being on time, multitasking, and "time saving" measures. Eager to get tasks done, American health care providers may not take the time to establish rapport with patients. Americans typically embrace change, including the newest technologies and treatments. They are likely to believe that people have control over their own destiny rather than attributing outcomes to fate or karma. Self-sufficiency and individualism are highly valued. Reflecting the value of equality and rejection of a social hierarchy, Americans tend to be informal, even with strangers. Americans are described as direct or low-context communicators, meaning that they rely mostly on words and less on nonverbal messages. Indirect communication assigns equal importance to verbal messages and words. The direct speech used by many Americans may seem abrupt or rude to others. Nurses with traditional American backgrounds need to recognize how their beliefs and behaviors can affect the nurse-patient relationship.

TRADITIONAL HEALTH HABITS AND BELIEFS OF MAJOR ETHNIC GROUPS IN THE UNITED STATES

Although stereotyping individual members of any culture or subculture is inappropriate, various ethnic groups in the United States may retain unique traditional health care beliefs and practices. Great variations in beliefs and practices exist not only between but also within ethnic and subcultural groups. First- and second-generation residents of the United States often have more characteristics associated with their ethnic groups than people who have been in the United States for several generations. Many resources provide information about traditional health care beliefs and practices. Remember that these examples are included to show a range of possible health customs for selected ethnic groups. They cannot be generalized to all members of the ethnic group or subculture.

Put on Your Thinking Cap!

Considering your own race or ethnicity, identify three cultural beliefs related to health that are held by your family. For example, how are you expected to respond to illness or stress? When do you seek medical care and what kind of provider do you see? Do you use any complementary or alternative therapies? What activities are believed to promote health or prevent disease?

HOSPITAL HEALTH CARE

The hospital environment can be frightening, even to people who are familiar with it. For individuals who do not speak English, have different eating preferences, and view health and illness differently, adapting to the hospital environment can be overwhelming. Hospital personnel become authority figures who expect patients to conform to policies and accept directions. Patients may feel stripped of their dignity when told to wear hospital gowns that barely cover private body parts. Modesty may be ignored, causing humiliation and anxiety.

Not only do people find themselves in a totally new environment, but they must also endure separation from family and friends. Their support systems topple when visiting policies are strictly enforced. In some cultures, families expect to advocate for the patient, help with nursing care, or at least sit with sick people to keep them company and provide support. Hospital personnel may be uncomfortable with this infringement on their territory.

Language barriers greatly complicate the provision of care. The patient's language proficiency should be documented at the initial contact by asking what language is spoken at home and how well the person speaks English. Unless the patient reports speaking English very well, an interpreter should be offered. Even though nonmedical personnel and family members may help with everyday conversations, they may not correctly relay information between the nurse and the patient. Therefore an official interpreter should be used to convey health information or obtain informed consent. Even bilingual nursing staff should receive training in the skill and ethics of interpretation. Failure to use interpreters has been identified as one factor in errors that are made in the health care system. Options for oral language assistance include trained staff interpreters, professional contract interpreters, employee language banks of bilingual individuals, community interpreter banks that maintain lists of trained interpreters, telephone interpreter services, and remote simultaneous interpretation in which the nurse's statements are translated by an interpreter who conveys the information to the patient via a headset.

CULTURE SHOCK

Culture shock associated with hospitalization occurs in three phases. During the first phase, the patient asks questions regarding the hospital routine and the hospital's expectations of the patient. In the second phase, the patient becomes disenchanted with the whole situation and is frustrated, hostile, and then depressed and withdrawn. In the final phase, the patient begins to adapt to the new environment and is even able to maintain a sense of humor during interactions with others.

COMMUNITY AND HOME HEALTH CARE

LVNs/LPNs are increasingly visible in community and outpatient settings. Community settings in which culturally different individuals may interact with the health

care system include physicians' offices, outpatient clinics, mental health centers, home health care, hospices, and adult day care centers. People from different cultural backgrounds may use both the formal health care system and traditional healers and practices, as described earlier.

Many people have difficulty navigating the maze of health care services either because of language differences or because of negative attitudes toward health care providers based on previous experiences. Individuals with limited financial resources are frequently clinic patients who must wait hours to see a provider only to receive a cursory assessment from the physician or nurse. Because of language barriers, their questions about their condition may be left unanswered, resulting in failure to follow directions for care.

When entering a patient's home, notice symbolic objects that may indicate cultural identity. Shrines, religious pictures or statues, and special candles are examples of symbols. Remember that many immigrant families fully embrace Western medicine while continuing to find comfort in symbols and traditional practices. Ask about your patient's health beliefs and practices that are affected by culture. Patients and their families may have magical, religious, biomedical, or holistic beliefs. If the patient does not speak English, a family member is sometimes able to interpret. Although this is not ideal, it may be the only option at the time. See the earlier section on interpreters.

HEALTH CARE IN LONG-TERM CARE

The majority of residents in long-term care facilities are Caucasian women. Traditionally, some ethnic groups including African Americans, Latinos, and Asians are reluctant to admit older relatives to residential care and prefer to provide care at home. However, changes in family structure are having an impact on these cultures. Women from all cultures are more likely to work outside the home, so they are not able to provide full-time caregiving. Also extended families are often scattered geographically, so fewer family members may be available to help with the person needing care.

Residents in long-term care facilities typically suffer from one or more functional impairments. Individuals from different cultural groups may have the added strain of communication problems and extreme changes in lifestyle and dietary practices. These differences may contribute to confusion, disability, and incontinence. For example, the resident who speaks little English may have difficulty asking for help with toileting. Because older people tend to have limited time between the urge to void and the actual voiding experience, urinary incontinence can occur.

THERAPEUTIC RELATIONSHIPS

Because all nursing care takes place in the framework of the nurse-patient relationship, an environment of acceptance and respect for the beliefs and behaviors of culturally different patients should be established. For patients to trust the nurse, they must feel safe, respected, and accepted.

Maintain an open and inquiring, respectful attitude regarding cultural differences. Patients of another culture may initially be quiet, polite, conforming, or shy. The behavior may reflect a guarded or cautious response, because patients are not sure what is expected of them and how the interaction will go. A good rule of thumb during an initial encounter is to speak softly and in an unhurried manner to put them at ease. Once you understand the lifestyle of the patient, you can work with the registered nurse (RN) to tailor the care plan as needed. The patient should be involved in the care plan by identifying familiar ways of coping with an illness and adaptations that recognize the person's culture.

Conflicts between the patient's health practices and beliefs and those of the health care system may arise. However, the cultural values of patients and their families must be given full consideration. Changes in health practices often require some major changes in lifestyle. Try to understand what prescribed changes mean from the viewpoint of the patient, family, and community. Only then can effective modifications in health practices take place.

BASIC PHYSIOLOGIC NEEDS

Cultural attitudes may affect patients' perceptions of personal hygiene and the role of the nurse in assisting with basic bodily needs. Some patients do not bathe routinely. Others may be extremely modest about having the body exposed to others. As with all patients, show sensitivity to these feelings by knocking on the door before entering and asking permission before touching or assisting with personal hygiene.

During the bath, do not remove a patient's charms, crosses, medals, or other objects without permission. These objects usually have special meaning to the patient. If the patient wishes, family members may assist with the bath, oral hygiene, bed making, ambulation, and other caregiving. Including significant others helps to alleviate stress and fulfill cultural expectations for both patients and family members. Nutrition is an aspect of care affected by culture. Diet is often culturally based and, to be successful, modifications in diet must take culture into account.

DRUG THERAPY

We are just beginning to understand how ethnicity influences the way people react to drugs. Factors that contribute to the differing responses can be categorized as environmental, cultural, and genetic. Environmental factors related to drug absorption, distribution, metabolism, and elimination include diet, smoking, and alcohol use. For example, diets that are high in sodium may reduce the effectiveness of some antihypertensive drugs.

Cultural factors can affect drug response by influencing the patient's expectations, adherence to prescribed drugs, and willingness to report problems to the prescriber. In

addition, some culturally based traditional remedies can interact with prescribed drugs to increase or decrease their effects.

Perhaps the greatest influence of ethnicity related to drug therapy is that liver enzymes are controlled by genetic factors. Liver enzymes determine the rate and extent of drug metabolism. People who metabolize a particular drug slowly are at greater risk for drug toxicity than those who metabolize that drug rapidly. For example, African Americans with hypertension respond better than Caucasians to diuretic therapy alone. Conversely, African Americans are less responsive to monotherapy with beta blockers or angiotensin-converting enzyme inhibitors than Caucasians. The implication of such differences is that you must monitor patient responses to drugs, knowing that they may be different from the expected response.

PATIENT TEACHING

Teaching patients from different cultures may be difficult. They may not be able to understand health and illness information even if they have some command of the English language. Much of language of health care is confusing and unfamiliar. The nurse needs to develop trust so that people will feel free to ask questions and seek clarification of information they do not understand. Sometimes patients and family members nod their head in agreement even though they have little comprehension of the material.

Using both oral and written communication can help to reinforce what has been taught. Written material in the patient's native language greatly improves understanding. Have them demonstrate skills you have taught to confirm that learning has occurred. Consider requesting a trained interpreter if there is reason to believe the patient is not comprehending essential information.

STAGE OF DEVELOPMENT

Reaching adulthood is a significant milestone; however, it is not the end of the development process. Erik Erikson introduced the idea that each stage of life is associated with specific developmental tasks to be achieved to advance to the next stage. Erikson divided adulthood into young, middle, and older stages. This framework provides a useful way to understand the needs of adult patients at any age. Because medical-surgical nurses work primarily with adults, they need to consider the patient's stage of adulthood, developmental tasks, and related health implications (Table 3.1).

YOUNG ADULTS

According to Erikson, individuals in their 20s, 30s, and 40s are young adults. This is the time when most adults establish their own home, settle into a job, find an intimate partner, and raise a family.

Health Problems

Young adults, especially those in their 20s and early 30s, have relatively few health problems. The four most common causes of death in young adults are unintentional injury, homicide, suicide, and malignant neoplasms. Among the youngest members of this age group, the most common cause of unintentional injury is motor vehicle accidents, followed by poisoning (drug overdose, carbon monoxide, etc.). After 25 years of age, unintentional poisoning causes more deaths than motor vehicle accidents. As young adults progress into their late 40s, the primary causes of death are malignancies and heart disease, followed by accidents and suicide.

Typical health problems are related to stress on the job or in social interactions, lifestyle, and childbearing. These problems include depression; anxiety; complications of pregnancy; cervical and breast cancer; and back, hip, and limb injuries. By 30 years of age, half of adults have gum disease. In the quest for meaningful social relationships and a career that will gain them independence and success, young adults may experience tension and stress and may lack the time to attend to health promotion activities such as a proper diet, exercise, and rest. They may work hard and party enthusiastically. Meals may be eaten on the run and the diet may rely heavily on fast foods. The total number of calories needed is less than during adolescence, given that the young adult has completed physical growth. Smoking and alcohol or drug abuse are common. These practices may have a direct bearing on health in the later years (Table 3.2).

Table 3.1 Erikson's Adult Developmental Tasks

DEVELOPMENTAL STAGE	DEVELOPMENTAL TASK	NURSING ASSESSMENT DATA
Young adulthood	Intimacy versus isolation	Meaningful, intimate relationships now and in the past Support systems
Middle adulthood	Generativity versus self-absorption and stagnation	Employment status Leisure or recreation Typical daily routine if not employed Signs of depression, such as excessive sleeping and decreased appetite
Older adulthood	Ego integrity versus despair	Daily routine Family and other relationships If lonely, note signs of depression

From Ignatavicius DD, Workman, ML, Mishler, M: *Medical-surgical nursing: A nursing process approach,* ed. 3, Philadelphia, 1999, Saunders.

Table 3.2 Harmful Practices, Effects on Health in the Later Years, and Preventive Measures

HARMFUL PRACTICE	POSSIBLE EFFECTS ON HEALTH	PREVENTIVE MEASURES
Lack of physical activity	Diabetes, osteoporosis, heart disease, cancer, obesity, stroke, depression	Increase moderate daily physical activity and reduce sedentary lifestyle
Obesity	Heart disease, hypertension, type 2 diabetes mellitus, degenerative joint disease, cancer, stroke, atherosclerosis	Maintain ideal weight; maintain low-cholesterol, low-fat, nutritious diet with plenty of vegetables, fruits, and grain products
Cigarette smoking	Heart disease; cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, and bladder; chronic bronchitis and emphysema	Stop smoking or do not start smoking
Alcohol and drug abuse	Malnutrition, cirrhosis of the liver, brain damage, mental status changes, homicide, suicide, motor vehicle fatalities	Limit alcohol intake and stop using drugs or do not start; participate in 12-step program for rehabilitation
Stress	Stress-related conditions such as hypertension and heart disease	Recognize and modify stressors; use a stress management program, such as exercise or biofeedback

Modified from U.S. Department of Health and Human Services: *Healthy people 2010, vol 1, With understanding and improving health, vol 2, Objectives for improving health*, ed 2 (Publication No. [PHS] 99-1256), Washington, DC, 1999, U.S. Government Printing Office.

In their 30s and early 40s, young adults typically are focused on raising a family and furthering their careers. This age may be a time to reassess their lives and careers, and often major changes are made. Factors that contribute to health problems are stress related to work, marital problems, and stress related to managing a household. Couples who have postponed childbearing may have difficulties with conception and pregnancy.

Health Care Needs

Health care needs are related to promoting optimal health. Having at least one thorough physical examination during the 20s is recommended. The examination should include tests for sexually transmitted infections, hypertension, and elevated blood lipids. Several types of health screening should be initiated and repeated at regular intervals. See Chapter 7 for American Cancer Society screening guidelines. Note that guidelines are exactly that; more or less frequent screening may be recommended based on a person's personal and family history.

A tetanus booster should be given if persons have not received one in the past 10 years. The hepatitis B vaccine is recommended for adults at risk of exposure to blood and body fluids. Routine dental and eye examinations should be scheduled. Women who wish to perform breast self-examinations (BSE) should be instructed in the proper technique. They should also be informed that BSE does not replace periodic professional examinations or mammograms. Young men should be taught to do testicular self-examinations.

Health counseling in the 20s should focus on health promotion behaviors. Programs may be established to include topics such as nutrition; exercise and leisure; rest and sleep; human sexuality and family planning; stress management; and the effects of smoking, drugs, and alcohol.

In the years between 30 and 45 years of age, especially after 35 years of age, young adults should begin to think about the prevention of chronic illness, particularly cancer and heart disease. Periodic physical examinations should include tests for hypertension, anemia, elevated serum lipids, and a cervical Pap test for women. Experts suggest that people in this age group examine their skin and mouth periodically for precancerous lesions. Preventive dental checkups are usually recommended every 6 months to 2 years.

Health promotion and disease prevention programs have a similar focus as for people in their 20s. Stress management, effective parenting, proper diet and nutrition, exercise, drug and alcohol awareness, and smoking cessation are appropriate topics for health teaching and counseling.

MIDDLE-AGE ADULTS

The years from 45 to 65 years of age are considered middle age. Americans who fall into this category earn most of the money, pay most of the taxes, and have most of the power in business and government. Middle age is a time of relatively good health for most. People experience a new personal freedom and enjoy maximal command of themselves. Many people in their middle years belong to a group called the "sandwich generation" because they still have adolescents and young adults at home and also have older parents who need care. Many women work outside the home and have important careers. Taking on the care of one or more aged parents along with existing responsibilities can create a great deal of conflict and stress.

Health Problems

Most people in their middle years continue to be relatively healthy, and the same factors that contribute to

the deterioration of health habits in the young adult apply to those in middle age. The major cause of death is cardiovascular disease, and the most common health problems, in addition to cardiovascular disease, are cancer, pulmonary disease, diabetes, glaucoma, obesity, alcoholism, anxiety, and depression. Respiratory conditions are a frequent cause of absence from work for women; injuries are a frequent cause among men.

Women usually enter a perimenopausal period between 45 and 50 years of age. Bone mass begins to decrease in the middle years. Women lose calcium from bone tissue after menopause, leading to an increased risk of osteoporosis. Muscle mass is reduced as a result of decreased muscle fiber. In the 40s, changes in vision typically begin. Age-related farsightedness (*presbyopia)* develops as a result of decreasing elasticity in the lens. The clue to developing presbyopia is that the individual begins to hold reading material at a distance to focus on it better. *Presbycusis* (i.e., the common loss of hearing acuity associated with aging) may begin to appear.

Put on Your Thinking Cap!

Mrs. J., 55 years of age, is diagnosed with a life-threatening illness. She is married to a dentist and works as a nurse manager on a medical-surgical hospital unit. Her youngest child, 20 years of age, is in college and living at home. She has two young adult children who live independently, and two grandchildren. Her mother, 87 years of age, lives nearby and relies on Mrs. J. for assistance with personal care and transportation. What are the effects of this diagnosis on family, job, and other roles?

Health Care Needs

The health care goals in middle age are the same as for younger adults: health promotion and disease prevention to preserve and prolong the period of maximal energy and optimal mental health and social activity. During the middle years, regular assessment of health status is important for maintaining good health. Good management of existing conditions and early diagnosis of illnesses help to prevent later complications. A complete physical examination every 3 years is recommended. It should include blood pressure screening and tests for serum glucose and cholesterol levels. The patient's dentist should determine the frequency of dental visits based on the oral assessment. Various cancer screening tests may be ordered depending on the patient's history. The recommendations of the American Cancer Society and other specialty organizations are commonly followed. See Table 7.6 in Chapter 7 for recommended screenings and schedules.

During the perimenopausal period, a gradual decrease in estrogen occurs, accompanied by a gradual decrease in menstrual flow. Pregnancy remains a possibility until the menstrual cycle ceases completely—usually between 45 and 55 years of age. Menopausal symptoms (hot flashes, perspiration, fatigue, etc.) may be treated with estrogen, depending on the patient's history. However, estrogen alone increases the risk of endometrial cancer. Therefore a combination of estrogen and progesterone is safer for the postmenopausal woman who still has her uterus. After menopause, any vaginal bleeding should be reported, as it may be a sign of endometrial cancer.

Health promotion activities during middle age are the same as for young adults. The focus is on proper nutrition, exercise, stress management, and the reduction or elimination of smoking, drug use, and alcohol use.

OLDER ADULTS

Age 65 years is commonly considered the beginning of old age. However, many people in their 60s and older do not consider themselves old and continue to live healthy, productive lives. People are entering old age in better health than in the past. In the United States today, 8 in 10 people will live past their 65th birthday. Markers that may be more meaningful than chronologic age to define older age are biologic age, psychologic age, and social age. Biologic age focuses on the functional capabilities of the body systems. Many older people, especially those who engage in exercise and other health promotion activities, continue to function well whereas others seem to be prematurely ill and frail. Psychologic age refers to the capacity of the person to adapt to changing environmental demands. Factors that affect psychologic age include memory and the ability to learn. Social age refers to the roles and habits of a person in relation to other members of society. Individuals of the same chronologic age may differ in biologic, psychologic, and social age. Also the three ages are not necessarily the same in an individual. The important thing for the nurse to know is that older adults are a very heterogeneous group. Nurses must avoid stereotyping based on age and assess each person as a unique individual. Chapter 10 provides detailed descriptions of the changes that occur with aging.

Health Problems

The major causes of death in older age are heart disease, cancer, chronic respiratory disease, cerebrovascular disease, Alzheimer disease, diabetes, influenza and pneumonia, nephritis, and septicemia. Unintentional injuries rank among the top ten causes of death in this age group. The most common conditions are arthritis, heart disease, diabetes, and cancer. Benign or malignant enlargement of the prostate is common in older men; breast cancer is common in older women.

Health Care Needs

The health care goals of the older age group are to manage chronic illnesses and to maintain and prolong the period of optimal physical, mental, and social activity. Helping older adults to maintain their independence for as long as possible in the event of one or more chronic illnesses is important.

Physical examinations should be performed annually and include the same assessment as indicated for middle-aged adults. However, depending on individual risk factors, some screenings can be discontinued after 65 or 70 years of age, or when life expectancy reaches certain limits. Women who have had a total hysterectomy do not require an annual Pap test. Dental examinations and treatment should also continue in older age. Periodic evaluation and treatment by a podiatrist are recommended to promote mobility.

Annual influenza immunizations are recommended. Two forms of the pneumococcal vaccine exist: pneumococcal conjugate vaccine (PCV or PCV13) and pneumococcal polysaccharide vaccine (PPSV or PPSV23). The Centers for Disease Control and Prevention (November 22, 2016) recommends vaccination with PCV13 for all adults 65 years of age or older. Individuals who have never received PCV13 should receive a dose or PCV13 first, followed one year later by a dose of PPSV23. Individuals who have previously received PPSV23 should be given a dose of PCV13 at least one year after the most recent dose of PPSV23.

Health promotion activities should continue into older age. These activities can increase quality of life and, in many cases, prevent many of the chronic illnesses common in older age. Proper nutrition (low-fat, high-fiber diet with a large amount of complex carbohydrates) helps to promote intestinal motility and decrease susceptibility to some chronic illnesses. Exercise can benefit older adults, even the very old who begin an exercise program for the first time. Walking is the ideal exercise. One hundred and fifty minutes of walking each week can help maintain weight, blood pressure, coordination, and mobility and create a positive outlook on life. Older people can also benefit from counseling for alcohol and drug abuse and smoking cessation.

SOCIAL NETWORK

The importance of a patient's personal support network cannot be overestimated. Family and friends can provide encouragement, advocate for the patient, reinforce health teaching, assist with care, and relieve the patient of some responsibilities. On the other hand, sometimes family or individual issues can add to the patient's stress. Not all members are supportive or helpful. Traditionally, we have considered "legal" relatives to be the patient's family. As the modern family has evolved, we have expanded our definition of the family. Many families today vary from the traditional formula of mother, father, and children. More and more family units are composed of single parents or stepparent families. In addition, friends or partners of the same or opposite sex now are often considered family or extended family.

Therefore it makes sense for patients to define their family according to their own criteria, and to determine how those family members will participate in care and decision making. When patients are admitted for care, they usually are asked who may be given information about their health status. With that in mind, this chapter will use the term *family* to include all of those that the patient views as family. Regardless of the setting, medical-surgical nurses often work closely with their patients' significant others.

FAMILY AND CULTURE

In the United States, many variations in cultural patterns are found among families. Traditional cultural practices were discussed earlier in this chapter. Cultural diversity may occur even within ethnic groups. Immigrants are in varying stages of assimilation and acculturation, especially among various generations. To avoid stereotyping, the best way to determine the specific cultural patterns of a family is to get the information from the family itself.

Cultural Considerations

What Does Culture Have to Do With Families?

Culture influences most aspects of family function, including communication, child rearing, diet, and health practices.

FAMILY DEVELOPMENTAL THEORY

Families go through predictable stages of growth and development, just as individuals do. However, because not all families fit into the traditional nuclear family model, variations among stages are found depending on the makeup of the family. Responsibilities for growth (developmental tasks) must be met at each developmental stage to meet biologic needs, cultural demands, and goals. Table 3.3 summarizes the stages of the family life cycle and developmental tasks of the two-parent nuclear family.

Divorced Family and Step-Parent Family Life Cycle and Developmental Tasks

With approximately half of all marriages in the United States ending in divorce, the single-parent family is common. The stages and developmental tasks in single-parent families are essentially the same as in two-parent families. However, the divorced parent who maintains the home with children shoulders more responsibilities alone. Issues confronting divorced families may include financial problems, lack of a mother or father role model, and the loss of the child's relationship with the absent parent. The introduction of a stepparent or unmarried partner requires a period of adjustment that typically lasts 2 to 3 years. Once the new structure has stabilized, the new family can progress developmentally.

Gay and Lesbian Family Life Cycle and Developmental Tasks

Gay and lesbian marriage was ruled legal in the United States in 2015. With or without legal sanction, gay or lesbian couples who live together and have an intimate

Table 3.3 Stages of the Family Life Cycle of the Two-Parent Nuclear Family

STAGE	DEVELOPMENTAL TASK
Beginning families	Establish mutually satisfying marriage Work out satisfactory relationship with spouse's family Make decisions about parenthood
Families with young children	Set up young family as a stable unit Develop parental roles to meet changing needs of children Maintain satisfying marital relationship Socialize children Maintain and expand relationships with extended family, adding parenting and grandparenting roles Maintain healthy relationships outside the family
Families with adolescents	Balance freedom with responsibility in adolescents Refocus on the marital relationship Communicate openly between parents and children
Launching children and moving on	Expand family circle to include new family members acquired by marriage of children Continue to renew and readjust in the marital relationship Assist aging and ill parents of the husband and wife
Families in later life	Maintain satisfying living arrangement Adjust to reduced income Maintain marital relationship Adjust to loss of a spouse Maintain intergenerational family ties Continue to make sense of one's existence

relationship, with or without children, may consider themselves a family. Same-sex families who fear discrimination and lack of social acceptance may conceal their relationship from others. Like other types of families, same-sex families go through developmental stages.

FAMILY RESPONSE TO PATIENT ILLNESS OR INJURY

Factors that affect the way the family responds to a member's illness depend on many factors including role structure, family interactions, communication patterns, coping skills, and resources.

Family Role Structure

Each member of the family has a role. Through these roles, family functions are carried out. A family member who is ill or injured may be temporarily or permanently unable to perform his or her usual roles. A healthy family may be able to shift roles to other members so that the family can continue to function adequately.

In the traditional nuclear family, roles can also be characterized as formal or informal. Formal roles consist of a limited number of positions in the family that are explicitly defined, such as wife-mother, husband-father, son-brother, and daughter-sister. Each of the formal roles has certain role expectations, such as wage earner, homemaker, financial manager, cook, and so on, and these roles are usually given to the person who has the skills necessary to carry them out. Smaller families and single-parent families have fewer people to take on the various roles, so individuals may play several roles at different times. Single parents may engage extended family members to help with role fulfillment. In a nontraditional family, role expectations may be negotiated more based on skills than on typical male-female division of labor.

Whereas formal roles are explicit roles that each family role structure contains, informal roles are often not as apparent and usually meet the emotional needs of individuals or maintain the family's equilibrium. Informal roles have different requirements that are based on the personality attributes of individual members rather than on age or sex. Effective performance of informal roles can strengthen the performance of the formal roles. Some of the roles enhance the well-being of the family whereas others can interfere with family functioning.

Family roles may be classified as performance oriented or emotional. For example, performance-oriented roles could include breadwinner, homemaker, handyman or handywoman, or gardener. Emotional roles could be leader, nurturer, protector, healer, or rebel. Members may fill more than one role, and any member can satisfactorily fill any role in either category.

Common informal roles include encourager (praises others' contributions to the family), harmonizer (mediates differences among other members), initiator-contributor (suggests new ideas and initiates action), blocker (opposes and rejects all ideas), martyr (sacrifices everything for the sake of the family), family scapegoat (family emotional ills blamed on this member; labeled

as "problem" member), family caretaker (nurtures and cares for other members in need), family go-between (the family "switchboard"—transmits and monitors communication within the family), and family coordinator (organizes and plans family activities). The scapegoat usually assumes or is assigned this role to preserve the family and maintain homeostasis. It generally serves to divert attention from family issues such as conflict between the spouses. The go-between is usually the mother, who monitors all communications and is in charge of settling all disputes. When the conflicts are not resolved, the go-between is often blamed. This type of interaction is sometimes considered dysfunctional because it interferes with direct communication among family members.

Family Interaction

Family interaction is a unique form of social interaction based on a set of intimate and continuing relationships. It is the sum of all family roles being actualized within a family at a given time. Family functions and tasks are carried out through the process of interaction. One of the most important influences on family interaction is the self-esteem of each member. Adult members who have adequate self-esteem are able to provide the love and nurturing that children need to develop self-esteem, belonging, and acceptance. Adults who lack self-acceptance and self-respect are unlikely to be loving spouses or parents. In a healthy family, the members love and respect one another.

Family Communication Patterns

Families continually exchange communication to provide information, correct misinformation, solve problems, and resolve misunderstandings. Family communication patterns depend on the family power structure, the closeness of relationships, and the popularity of individual members. As noted earlier, many routes of information may go through one person, who assumes the role of go-between. Communication in the family may be functional or dysfunctional. However, communication patterns are not totally one way or the other. They exist on a continuum from functional to dysfunctional, with the patterns of most families falling somewhere in between the polar extremes.

Functional Communication. **Functional communication** is the clear transmission of a message that enables the receiver to understand the intent of what the sender transmits. Communication in healthy families is a dynamic, two-way process such that both the sender and the receiver are active participants in the communication. Communication patterns in a functional family demonstrate acceptance of individual differences, openness, honesty, acknowledgment of feelings, and recognition of the needs and emotions of one another. A functional family uses communication to create and maintain mutually beneficial relationships.

Functional patterns of communication include emotional and affective communication. Emotional communication deals with the expression of emotions or feelings, such as anger, hurt, sadness, happiness, affection, and tenderness. A healthy, functional family demonstrates a wide range of emotions and feelings. For family members to be able to enjoy one another, their responses to each other should be fresh and spontaneous rather than controlled, repetitious, and predictable. Affective communication involves verbal messages of caring and nonverbal, physical gestures of touching, caressing, holding, and looking. Families with functional communication patterns value openness, spontaneity, self-disclosure, and a mutual respect for each other's feelings, thoughts, and concerns. They usually can discuss most personal issues and concerns and resolve conflicts.

Dysfunctional Communication. **Dysfunctional communication** is the opposite of functional communication. It is the unclear transmission of a message so that the receiver cannot understand the sender's intent. The primary reason for dysfunctional communication is low self-esteem among the family members. Communications become confusing, vague, indirect, secretive, and defensive because the individuals lack the ability to appreciate differences, thoughts, and feelings of other family members and are unable to deal with conflict. Children growing up in this environment are often unable to recognize and interpret a variety of feelings and experiences.

Dysfunctional patterns of communication may be subtle, and the intent of the communication is not clear. For example, individuals in an interaction may constantly restate their own issues without really listening to others' points of view or acknowledging their needs. Another example is the inability to focus on one issue. Each individual in the interaction rambles from one issue to another instead of resolving any one problem. Unwritten rules may specify subjects that are allowed for discussion; dysfunctional families have more forbidden subjects than functional families (see the Cultural Considerations box). Sometimes, dysfunctional families avoid discussing meaningful issues or expressing feelings by using superficial conversation; they talk about unimportant daily occurrences rather than the meaningful issues of family life.

Cultural Considerations

What Does Culture Have to Do With Communication?

Cultural aspects of family communication must be considered when determining whether a family is functional or dysfunctional. Some cultures are more open and communicative whereas others are less likely to discuss various topics or to show feelings or emotions.