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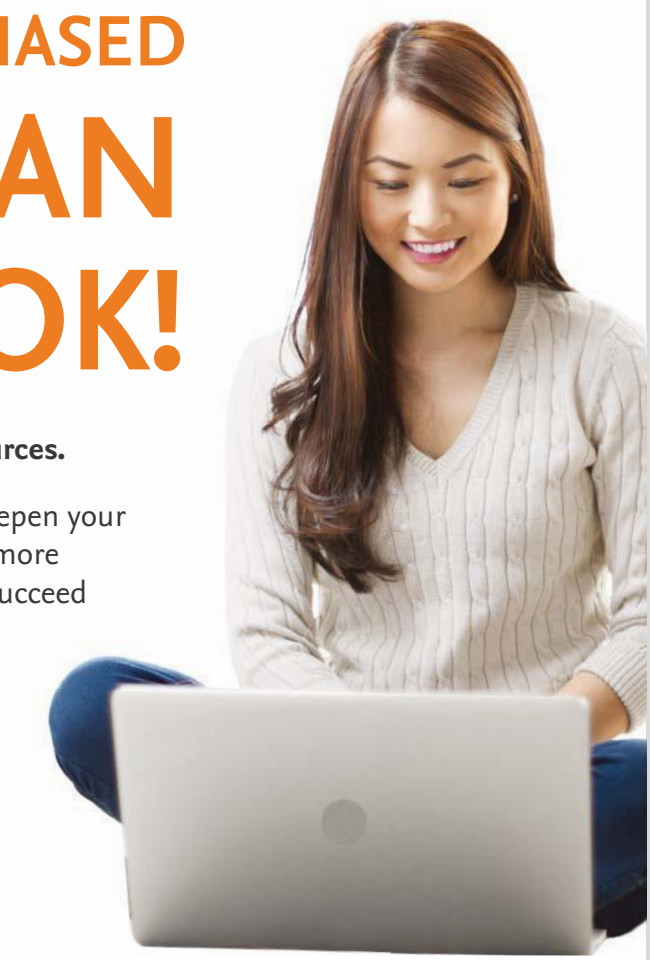

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12TH EDITION

# Lewis's Medical-Surgical Nursing

## ASSESSMENT AND MANAGEMENT OF CLINICAL PROBLEMS


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# PREFACE

The twelfth edition of *Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems* incorporates the most current medical-surgical nursing information in an easy-to-use format. This textbook is a comprehensive resource describing standards of nursing clinical practice for providing safe and comprehensive patient care. The text and accompanying resources include many features to help students learn key medical-surgical nursing content, including patient and caregiver teaching, gerontology, interprofessional care, diversity, patient safety, nutrition and drug therapy, evidence-based practice, and much more.

This edition features several important changes. Chapter 2, Social Determinants of Health, focuses on nursing awareness of patient circumstances on health outcomes. The discussion includes health status differences among groups of people related to access to care, economic aspects of health care, gender and cultural issues, and the nurse's role in promoting health equity.

New to this edition, Chapter 6, Caring for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Gender Diverse Patients, addresses the unique health care needs of the LGBTQ+ population with the goal of promoting high-quality care.

Another new chapter to this edition is Chapter 28, Supporting Ventilation. Promoting a concept-based approach to optimizing ventilation, this chapter focuses on various strategies used use to promote optimal ventilation and oxygenation. Covered content includes $O_2$ therapy, chest tubes, respiratory therapy, chest surgeries, and mechanical ventilation. Textbook reorganization to support a concept-based approach includes adding Acute Respiratory Failure and ARDS to the Ventilation Section and Shock, Sepsis, and MODS to the Perfusion Section.

Chapter 12, Inflammation and Healing, and Chapter 15, Infection, have been revised to include more concept-based care for the patient with an infection or experiencing inflammation. New tables addressing the nursing management of the patient with a fever and infection and antibiotic, antiviral, and antifungal Drug Therapy tables enhance the content. Care of the patient with COVID-19 infection is included.

Critical care nursing is now addressed throughout the textbook, an approach that reflects the needs of patients in various care environments. Varying levels of hemodynamic monitoring now occur outside the critical care unit and are included in the enhanced Cardiovascular System Assessment chapter. Similarly, advanced techniques to assess oxygenation are included in the new Supporting Ventilation chapter. Care of the patient experiencing problems such as pain, difficulty sleeping, and delirium are addressed in the respective textbook chapters.

Special content has been added to assist with NCLEX® preparation and the development of clinical judgment based on NCSBN's Clinical Judgment Measurement Model (CJMM). At the end of each unit, the reader will find Applying Clinical Judgment With Multiple Patients, featuring traditional and Next-Generation NCLEX® (NGN)–style questions. Discussion questions in the management chapters' Case Studies focus on the 6 cognitive skills identified in the CJMM: Recognize Cues, Analyze Cues, Prioritize Hypotheses, Generate Solutions, Take Actions, and Evaluate Outcomes.

Great effort has been put into continuing to improve readability and lower the reading level. Readers will find clearer and easier-to-read language, with an engaging conversational style. The narrative addresses the reader, helping make the text more personal and an active learning tool.

## ORGANIZATION

Content is organized into 2 major divisions. The first division, Sections 1 through 3 (Chapters 1 through 17), discusses general concepts related to the care of adult patients. The second division, Sections 4 through 13 (Chapters 18 through 68), presents nursing assessment and nursing management of medical-surgical problems. At the beginning of each chapter, the Conceptual Focus helps students focus on the key concepts and integrate concepts with exemplars affecting different body systems. Learning Outcomes and Key Terms assist students in identifying the key content for that chapter.

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

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

Management chapters focus on the pathophysiology, clinical manifestations, diagnostic studies, interprofessional care, and nursing management of various problems. The conceptual focus at the beginning of each chapter helps students focus on the key concepts and integrate concepts with exemplars affecting different body systems. The nursing management sections are organized into assessment, clinical problem, planning, implementation, and evaluation. To emphasize the importance of patient care in and across various clinical settings, nursing implementation is organized by the following levels of care:

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

## SPECIAL FEATURES

- Features that are focused on developing clinical judgment include:
  - **Applying Clinical Judgment With Multiple Patients**, featuring traditional and **Next-Generation NCLEX® (NGN)–style** questions at the end of each unit
  - Prioritization questions in case studies and Bridge to NCLEX® Examination Questions.
  - ***Enhanced!* Case Studies** help students learn how to prioritize care and manage patients in the clinical setting. Discussion questions focus on the 6 cognitive skills identified in the CJMM, with a special focus on patient safety. For clarity, they are identified as Recognize, Analyze, Prioritize, Plan, Act, and Evaluate. Answer guidelines are provided on the Evolve website.
- ***Expanded!* Nursing Management** tables focus on the actions nurses need to take to deliver safe, quality, effective patient care. Multiple new tables throughout the text focus on problems such as infection, fever, pressure injury, and inflammation.
- ***Expanded!* Drug Therapy** tables provide more detailed information on associated nursing considerations. Concise **Drug Alerts** highlight important safety considerations for key drugs.
- ***Enhanced!* Evidence-Based Practice** boxes use a case study approach to help students learn to use evidence in making decisions at the patient and systems levels.
- Interprofessional care delivered by physicians, nurses, and other health care team members is highlighted in **Interprofessional Care** tables throughout the text.
- **Safety Alert** boxes highlight important patient safety issues and focus on the US National Patient Safety Goals.
- **Bridge to NCLEX® Examination** questions at the end of each chapter match the Learning Outcomes and help students learn the important points in the chapter. Answers are provided just below the questions for immediate feedback, and rationales are provided on the Evolve website.
- Teaching is an ongoing theme and highlighted in **Patient & Caregiver Teaching** tables.
- Gerontology is addressed throughout the text under Gerontologic Considerations headings and in **Gerontologic Assessment Differences** tables.
- Nutrition is highlighted throughout the textbook. **Nutrition Therapy** tables summarize nutrition interventions and promote healthy lifestyles.
- **Promoting Population Health** boxes address strategies to improve health outcomes as they relate to specific disorders, such as diabetes and cancer, and to health promotion, such as preserving hearing and maintaining a healthy weight.
- **Check Your Practice** boxes challenge students to think critically, analyze patient assessment data, and implement the appropriate intervention. Scenarios and discussion questions are provided to promote active learning.
- **Ethical/Legal Dilemmas** boxes promote critical thinking for timely and sensitive issues that nursing students may deal with in clinical practice—topics such as informed consent, advance directives, and confidentiality.
- **Emergency Management** tables outline the emergency treatment of health problems most likely to require emergency intervention.
- **Nursing Care Plans** on the Evolve website focus on common problems. These care plans incorporate clinical problems, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) in a way that clearly shows the linkages among NIC, NOC, and clinical problems and applies them to nursing practice.
- **Nursing Assessment** and **Health History** tables summarize key subjective and objective data related to common problems. Subjective data are organized by functional health patterns.
- **Assessment Abnormalities** tables in assessment chapters alert the nurse to commonly encountered abnormalities and their possible etiologies.
- **Focused Assessment** boxes in all assessment chapters provide brief checklists that help students conduct a more practical "assessment on the run" or bedside approach to assessment. They can be used to evaluate the status of previously identified health problems and monitor for signs of new problems.
- Genetics content includes:
  - **Genetics in Clinical Practice** boxes that summarize the genetic basis, genetic testing, and clinical implications for genetic disorders that affect adults.
  - A genetics chapter that focuses on practical application of nursing care, as it relates to this important topic.
  - **Genetic Risk Alerts** in the assessment chapters, which highlight key genetic risks
  - **Genetic Link** headings in the management chapters, which highlight the specific genetic bases of many disorders.
- **Biologic Sex Considerations** boxes discuss how biologic women and men are affected differently by conditions such as pain and hypertension.

## LEARNING SUPPLEMENTS FOR STUDENTS

- The **Clinical Companion** presents more than 200 common medical-surgical problems and procedures in a concise, alphabetical format for quick clinical reference. Designed for portability, this popular reference includes the essential, need-to-know information for treatments and procedures in which nurses play a major role. An attractive and functional full-color design highlights key information for quick, easy reference.
- The revised **Study Guide** contains more than 500 pages of review material that reflects the content found in the textbook. It features a wide variety of clinically relevant exercises and activities, including NCLEX®-format multiple choice and alternate format questions, anatomy review, critical thinking activities, and much more. The revised case studies mirror the NCLEX® examination, with NGN-style case studies and questions reflecting the cognitive skills of the CJMM. It features an attractive full-color design and many alternate-item format questions to better prepare students for the NCLEX® examination. An answer key is included to provide students with immediate feedback as they study.

- The **Evolve Student Resources** are available online at http://evolve.elsevier.com/Lewis/medsurg. They include the following valuable learning aids organized by chapter:
  - Printable **Key Points** summaries for each chapter.
  - 1000 NCLEX® examination **Review Questions.**
  - **Answer Guidelines** to the case studies in the textbook.
  - **Rationales for the Bridge to NCLEX® Examination Questions** in the textbook.
  - 55 **Interactive Case Studies** with state-of-the-art animations and a variety of learning activities, which provide students with immediate feedback. Ten of the case studies are enhanced with photos and narration of the clinical scenarios.
  - Customizable **Nursing Care Plans** for more than 60 common patient problems.
  - **Conceptual Care Map Creator.**
  - **Audio Glossary** of key terms, available as a comprehensive alphabetical glossary and organized by chapter.
  - **Content Updates.**

## TEACHING SUPPLEMENTS FOR INSTRUCTORS

- The **Evolve Instructor Resources** (available online at http://evolve.elsevier.com/Lewis/medsurg) remain the most comprehensive set of instructor's materials available, containing the following:
  - **TEACH for Nurses Lesson Plans** with electronic resources organized by chapter help instructors develop and manage the course curriculum. This exciting resource includes:
    - Objectives
    - Pre-class activities
    - Nursing curriculum standards
    - Student and instructor chapter resource listings
    - Teaching strategies, with learning activities and assessment methods tied to learning outcomes
    - Case studies with answer guidelines.
  - The **Test Bank** features more than 2000 NCLEX® test questions with text page references and answers coded for NCLEX® Client Needs category, nursing process, and cognitive level. The test bank includes hundreds of prioritization, delegation, and multiple patient questions. Alternate-item format questions are included. The ExamView software allows instructors to create new tests; edit, add, and delete test questions; sort questions by NCLEX® category, cognitive level, nursing process step, and question type; and administer and grade online tests.
  - Unfolding and Standalone **Next-Generation NCLEX® (NGN) Examination–Style Case Studies** can be used to help strengthen students' clinical judgment and prepare them for NGN success.
  - The **Image Collection** contains more than 800 full-color images for use in lectures.
  - The **PowerPoint Presentations** include more than 125 different presentations focused on the most common patient problems. They feature unfolding case studies and NCLEX® examination questions for use with classroom response media.

## ACKNOWLEDGMENTS

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

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# Lewis's Medical-Surgical Nursing

## ASSESSMENT AND MANAGEMENT OF CLINICAL PROBLEMS

1

# Professional Nursing

*Mariann M. Harding*

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

## CONCEPTUAL FOCUS

**Care Competencies**
**Leadership**
**Clinical Judgment**
**Professional Identity**

## LEARNING OUTCOMES

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

## KEY TERMS

**advanced practice registered nurse (APRN)**
**clinical pathways**
**clinical judgment**
**delegation**
**electronic health records (EHRs)**
**evidence-based practice (EBP)**
**failure to rescue**
**interprofessional team**
**nursing**
**nursing process**
**patient handoff**
**SBAR (Situation-Background-Assessment-Recommendation)**
**serious reportable event (SRE)**
**telehealth**

This chapter presents an overview of professional nursing practice, discussing the wide variety of roles and responsibilities nurses fulfill to meet society's health care needs. This overview includes the core abilities that are part of competent nursing practice. These include providing safe, patient-centered care and collaborating with others.

## PROFESSIONAL NURSING PRACTICE

### Domain of Nursing Practice

Today, nursing practice consists of a wide variety of roles and responsibilities necessary to meet society's health care needs. You have never been more important to health care than you are today. As a nurse, you are at the forefront of patient care (Fig. 1.1). Beyond nursing's reputation for compassion and dedication lies a highly specialized profession.[1] Nursing continues to evolve to meet society's health care needs.

As a nurse, you (1) offer skilled care to those recovering from illness or injury, (2) advocate for patients' rights, (3) teach patients to manage their health, (4) support patients and their caregivers at critical times, and (5) help them navigate the complex health care system. You can practice in virtually all health care settings and communities. Although many nurses

**Fig. 1.1** Nurses are frontline professionals of health care. (© LightFieldStudios/iStock/Thinkstock.)

work in acute care facilities, nurses may practice in long-term care, home care, community health, public health centers, schools, and ambulatory or outpatient clinics. Wherever you practice, recipients of your care include individuals, families, groups, or communities. Nurses work collaboratively with other health care providers to manage the needs of persons and groups.

## Definitions of Nursing

Nursing is described as both an art and a science; a heart and a mind.[1] Well-known definitions of nursing show that the basic themes of caring, health, and illness have existed since Florence Nightingale first described nursing. Here are 2 such examples:

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

In 2010, the American Nursing Association (ANA) provided a new definition of nursing that reflects the ongoing evolution of nursing practice:

> **Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.**[4]

## Nursing's View of Humanity

In this book, we believe 7 dimensions of wellness contribute to health and quality of life: Physical, psychologic, social, spiritual, intellectual, career, and environmental. These dimensions are interrelated and not separate entities. Thus, a problem in one dimension may affect one or more of the other dimensions. A person is in constant interaction with a changing environment. A person's behavior is meaningful and oriented toward fulfilling needs, coping with stress, and developing oneself. However, at times a person needs help to meet these needs, cope successfully, or develop their unique potential.

## Scope of Nursing Practice

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

The extent that nurses engage in their scope of practice depends on their educational preparation, experience, role, and state law. To enter practice, a nurse must complete an accredited program and pass the NCLEX-RN, a test that verifies the nurse has the basic knowledge needed to provide safe care. Entry-level nurses with associate or baccalaureate degrees are prepared to function as generalists. At this level, nurses provide direct health care and focus on ensuring coordinated, comprehensive care to patients in a variety of settings.

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

More education and experience can prepare nurses for advanced practice. An **advanced practice registered nurse (APRN)** is a nurse educated at the master's or doctoral level. They have advanced education in pathophysiology, pharmacology, and health assessment and expertise in a specialized area of practice. APRNs include clinical nurse specialists, nurse practitioners, nurse midwives, and nurse anesthetists. APRNs play a vital role in the health care delivery system. Besides managing and delivering expert direct patient care, APRNs have roles in patient and staff education, leadership, quality improvement, research, and consulting.

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

## Standards of Professional Nursing Practice

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

practice. Communicating effectively and staying competent in practice are essential. You must be able to work in collaboration with other health care team members, patients, and caregivers.

## INFLUENCES ON PROFESSIONAL NURSING PRACTICE

### Expanding Knowledge and Technology

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

### Diverse Populations

Patient populations are more diverse than ever. People are living longer, with the number of people with chronic illnesses and multiple comorbidities increasing. Unlike those who receive acute, episodic care, patients with chronic illnesses have complex needs. They see different health care providers over an extended period and often move among health care settings. You need to be able to manage and coordinate care when patients transition among different settings.

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

### Consumerism

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

### Health Care Financing

High health care costs are a growing problem. There are many reasons for the continued increase in costs. These include the aging population, increased prescription medication use, administrative costs, and more expensive products and treatments. Many changes in health care systems that influence nursing care delivery are usually in an effort to contain spending and provide more cost-effective health care delivery.

The U.S. health system is a mix of public and private, for-profit and nonprofit insurers, and health care providers. Public and private insurers set their own cost-sharing structures within federal and state regulations. Historically, the most noted event related to reimbursement was the establishment of the Medicare prospective payment system (PPS). With PPS, payment for care for Medicare patients is based on flat fees determined by the diseases and problems treated during the admission. For example, if a patient had a total hip replacement, the hospital receives a set sum of money, such as $45,000, for the patient's care.

Other managed care systems also use PPS. In health maintenance organizations (HMOs) and preferred provider organizations (PPOs), charges are negotiated before delivering care using fixed reimbursement rates or capitation fees for medical care, hospitalization, and other health care services.

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

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

### Health Policy

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

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

### Professional Nursing Organizations

The ANA is the primary professional nursing organization. There are many professional specialty organizations, such as the American Association of Critical-Care Nurses (AACN), National Association of Orthopedic Nurses (NAON), and Oncology Nursing Society (ONS). Professional organizations

**Fig. 1.2** The patient, caregiver, and nurse collaborate as part of coordinating care. (© monkeybusinessimages/iStock/Thinkstock.)

play a role in promoting quality patient care and professional nursing practice. These roles include developing standards of practice and codes of ethics, supporting research, and lobbying for legislation and regulations. Major nursing organizations research the causes of errors, develop strategies to prevent errors, and address nursing issues that affect the nurse's ability to deliver patient care safely. Nurses join a professional organization to keep current in their practice and network with others interested in a specific practice area.

A program that supports nurses is the American Nurses Credentialing Center's Magnet Recognition Program. Health care agencies that achieve Magnet designation have created environments in which high-quality nursing care is provided.[6] Magnet agencies provide a positive practice environment for nurses. Nurses who work in Magnet agencies have low turnover and burnout rates and more professional and personal growth opportunities. This leads to better patient outcomes and greater career satisfaction.

### Nursing Core Competencies

Several high-profile reports over the past 25 years have highlighted problems with health care quality. One report, *The Future of Nursing: Leading Change, Advancing Health,* discussed how health care providers, including nurses, were not being prepared to provide the highest quality care possible in today's health care systems. The report recommended making changes so that nurses would have the skills to advance health care and play leadership roles in health care.[7]

The Robert Wood Johnson Foundation funded the *Quality and Safety Education for Nurses (QSEN) Institute* to address nursing's role in solving these problems. QSEN made a major contribution to nursing by defining specific competencies that nurses need to practice safely and effectively in today's complex health care system. These competencies have been integrated into prelicensure and graduate nursing education. The rest of this chapter describes 6 common nursing competencies and the knowledge, skills, and attitudes (KSAs) associated with each: (1) patient-centered care, (2) interprofessional partnerships, (3) safety, (4) quality improvement, (5) informatics, and (6) evidence-based practice (Table 1.1).[8] When you are licensed as a registered nurse, you accept responsibility to base your practice on these competencies.

## PATIENT-CENTERED CARE

Nurses have long shown that they deliver compassionate and coordinated care based on each patient's unique needs and respect for their preferences and values. We build relationships that make the patient a full partner in their care. Patients and caregivers are involved in making decisions and coordinating care. Patient-centered care is interrelated with quality and safety. With patient-centered care, patients and caregivers seek and receive care from competent and knowledgeable health care professionals.

### Clinical Judgment

Complex health care environments require that you use clinical judgment to make decisions that lead to the best patient outcomes. **Clinical judgment** is your ability to make decisions and solve problems by making sense of information in a situation. It is not memorizing a list of facts or the steps of a procedure. Instead, you use nursing knowledge to assess situations, identify priority problems, and generate the best possible solutions to deliver safe patient care.[9] It involves understanding the medical and nursing implications of a patient's situation when making decisions about patient care. You use clinical judgment when you identify a change in a patient's status, consider the context and patient and caregiver concerns, and decide what to do.

Because of the diversity and complexity of patient care, there may not be a right solution in each situation. Therefore, you need to learn and implement clinical judgment skills through experience. Various experiences in nursing school help you to learn to make decisions about patient care. Learning activities, including unfolding case studies and simulation, help you practice using clinical judgment. Throughout this book, case studies and practice questions promote your use of clinical judgment.

### Clinical Practice Frameworks

Depending on the situation, nurses use different scientific models when providing patient care. Many use the nursing process. The **nursing process** is a problem-solving approach to the identification and treatment of patient problems. It is the foundation of nursing practice. The nursing process framework provides a structure for delivering nursing care and the knowledge, judgments, and actions that nurses use to achieve the best patient outcomes.

The nursing process consists of 5 phases: assessment, diagnosis, planning, implementation, and evaluation (ADPIE) (Fig. 1.3). The nursing process begins with assessment. *Assessment* is the collection of subjective and objective patient information on which you will base your care plan. *Diagnosing* is the act of analyzing the assessment data and making conclusions. During *planning,* you develop patient outcomes or goals and identify nursing interventions to accomplish the outcomes. Identifying the right expected outcomes provides criteria you can use to

## TABLE 1.1 Core Nursing Competencies

| Competency | Examples of Knowledge, Skills, and Attitudes |
|---|---|
| **Patient-Centered Care** | |
| Provide holistic, compassionate, and coordinated care based on respect for patient's preferences, values, and needs and guided by a scientific body of knowledge | • Provide care with sensitivity and respect<br>• Consider the patient's perspectives, beliefs, and culture<br>• Communicate effectively<br>• Engage the patient in an active partnership that promotes health, well-being, and self-care management<br>• Use assessment skills, diagnose health problems, and develop and deliver a plan of care |
| **Interprofessional Partnerships** | |
| Function effectively within nursing and interprofessional teams | • Value the expertise of each team member<br>• Delegate work to team members based on their roles and competency<br>• Initiate appropriate referrals<br>• Follow communication practices that minimize risks associated with hand-offs and care transitions<br>• Take part in interprofessional rounds<br>• Manage conflict among team members |
| **Safety** | |
| Minimize risk of harm to patients and providers | • Follow national safety recommendations<br>• Appropriately communicate concerns about hazards and errors<br>• Contribute to designing systems to improve safety<br>• Be accountable for reporting unsafe conditions and near misses<br>• Promote policies to reduce workplace violence |
| **Quality Improvement** | |
| Use data to monitor the outcomes of care and to improve the quality and safety of health care systems | • Use outcome data to understand performance<br>• Participate in implementing practice changes<br>• Take part in investigating the circumstances surrounding a sentinel event or SRE |
| **Informatics and Health Care Technology** | |
| Use information and technology to communicate, manage knowledge, reduce errors, and support decision making | • Protect confidentiality of protected health information<br>• Document appropriately in electronic health records<br>• Use technology to coordinate patient care<br>• Respond correctly to clinical decision-making alerts |
| **Evidence-Based Practice** | |
| Integrate best current evidence with clinical expertise and the patient/caregiver preferences and values for delivery of optimal health care | • Read research, clinical practice guidelines, and evidence reports related to area of practice<br>• Base patient care plan on patient's values, clinical expertise, and evidence<br>• Continuously improve clinical practice based on new knowledge |

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

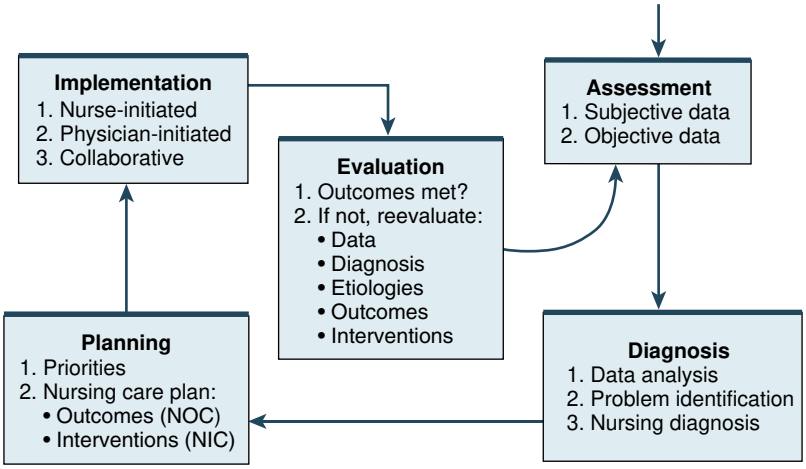


**Fig. 1.3** Nursing process.

| Model/theory | Components | | | | | |
|---|---|---|---|---|---|---|
| NCSBN clinical judgment model | Recognize cues | Analyze cues | Prioritize hypotheses | Generate solutions | Take action | Evaluate outcomes |
| Nursing process (ADPIE or AAPIE) | Assessment | Diagnosis or analysis | | Planning | Implementation | Evaluation |
| Tanner model | Noticing | Interpreting | | Responding | | Reflecting |

**Fig. 1.4** Comparison of the phases of clinical practice frameworks. (From https://evolve.elsevier.com/education/next-generation-nclex/resources/continuing-nursing-education/.)

measure and evaluate the impact of the interventions you provide. *Implementation* is the action phase of the plan with the use of nursing interventions. *Evaluation* is a continual activity of deciding whether the patient outcomes were met. If the outcomes were not met, a review of the process helps to figure out why. You may need to obtain more assessments and revise diagnoses, outcomes, and interventions. Once started, the nursing process is continuous and cyclic.

There are other clinical practice frameworks. These include Tanner's Model of Clinical Judgment Model (with the phases of Noticing, Interpreting, Responding, and Reflecting) and the National Council of State Boards of Nursing's Clinical Judgment Model (CJM) (Fig. 1.4). The CJM was designed to test your clinical judgment on the NCLEX-RN. All 3 models emphasize assessment, making decisions, taking action, and evaluating outcomes. Many clinical facilities use a "shortened version" of the nursing process—Assess, Act, Reassess.[10]

In this book, we use an ADPIE format to help you learn how to care for patients with certain health problems. We use the term "clinical problem" to represent the diagnostic phase of nursing clinical practice (see Appendix B). It is intended to be a synonym for nursing diagnoses, nursing problems, patient problems, or any other label that describes patient problems, conditions, or diagnoses requiring health care.[11] Clinical problems can be diagnosed based on a single clinical finding, such as pain or anxiety, or result from a complex decision about a particular focus, such as impaired nutrition or musculoskeletal problem. Clinical problems are the basis for selecting nursing interventions to achieve patient outcomes for which nursing is accountable.

A nursing intervention is "a single nursing action, treatment, procedure, activity, or service designed to achieve an outcome of a nursing or medical diagnosis for which the nurse is accountable."[12] This includes treatments that you perform and direct or indirect care. When planning care for a patient, choose specific interventions for the patient based on the clinical problem and desired patient outcomes. You collaborate with the patient to decide when and which interventions to use for a specific patient and situation.

## Nursing Care Plans

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

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

The nursing care plans associated with this book list clinical problems, in order of priority, along with outcomes and interventions. When you use these care plans, you will need to customize the plan for your patient. You must use clinical judgment to continually evaluate the situation and revise the clinical problems, outcomes, and interventions to fit each patient's unique care needs.

A *concept map* is another way to record a nursing care plan. A concept map records the nursing process in a visual diagram. The map shows patient problems and interventions and relationships among clinical data. Nurse educators use concept mapping to teach nursing processes and care planning. Concept maps have various formats.

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

## Continuum of Patient Care

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

Decisions about the best setting for obtaining health care often depend on the cost of care and the patient's health insurance plan and personal finances. Although the hospital is the

## NURSING CARE PLAN

***Patient With Heart Failure***

**Clinical Problem**

***Impaired Respiratory Function***

Etiology: Increased preload, alveolar-capillary membrane changes

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

**Patient Goal**

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

**Outcomes (NOC)**

**Respiratory Status: Gas Exchange**

- $O_2$ saturation ___
- Arterial pH ___
- $PaO_2$ ___
- $PaCO_2$ ___
- Chest x-ray findings ___

**Measurement Scale**

1 = Severe deviation from normal range
2 = Substantial deviation from normal range
3 = Moderate deviation from normal range
4 = Mild deviation from normal range
5 = No deviation from normal range

- Dyspnea with exertion ___
- Dyspnea at rest ___
- Restlessness ___
- Impaired cognition ___

**Measurement Scale**

1 = Severe
2 = Substantial
3 = Moderate
4 = Mild
5 = None

**Interventions (NIC) and *Rationales***

**Respiratory Monitoring**

- Monitor pulse oximetry, respiratory rate, rhythm, depth, and effort of respirations *to detect changes in respiratory status.*
- Auscultate breath sounds, noting areas of decreased or absent ventilation and presence of adventitious sounds *to detect presence of pulmonary edema.*
- Monitor for increased restlessness, anxiety, and work of breathing *to detect increasing hypoxemia.*

**Oxygen Therapy**

- Administer supplemental $O_2$ or other noninvasive ventilator support (e.g., bilevel positive airway pressure [BiPAP]) as needed *to maintain adequate $O_2$ levels.*
- Monitor the $O_2$ liter flow rate and placement of $O_2$ delivery device *to ensure $O_2$ is adequately delivered.*
- Change $O_2$ delivery device from mask to nasal prongs during meals as tolerated *to sustain $O_2$ levels while eating.*
- Monitor the effectiveness of $O_2$ therapy *to identify hypoxemia and establish range of $O_2$ saturation.*

**Positioning**

- Position patient to alleviate dyspnea (e.g., semi-Fowler's position), as appropriate, to improve ventilation by decreasing venous return to the heart and increasing thoracic capacity.

mainstay for acute care interventions, community-based settings offer patients the opportunity to live or recover in settings that maximize their independence and preserve human dignity.

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

There is a new emphasis on care coordination when patients transition between care settings. *Transitions of care* refer to patients moving among health care practitioners, settings, and home as their condition and care needs change.[13] As a nurse, you are an essential part of care coordination by stressing actions that meet patients' needs and facilitate safe, quality care. Collaborating with other members of the health care team is critical. A lack of communication can result in an ineffective care transition, leading to drug errors and higher hospital readmission rates. For example, you are a nurse in acute care admitting a long-term care patient who has been receiving propranolol 20 mg/5 mL twice a day. The admitting orders read, "propranolol 20 mg/mL, give 5 mL twice a day." Using communication to reconcile the difference averts a drug error. The patient would have received 100 mg instead of the 20 mg dose ordered.

## Delivery of Nursing Care

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

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

**Fig. 1.5** Patient in home quarantine videoconferencing with the nurse. (© valentinrussanov/iStock/Thinkstock.)

members during a work period. In total patient care models, you are responsible for planning and providing all care.

*Case management* involves managing the patient's care with other health care team members and available resources across multiple care settings and levels of care to meet their health needs. It is thought to promote quality, cost-effective outcomes. In nursing case management delivery systems, a registered nurse assumes the role of case manager. In this role, the nurse assesses the needs of patients and/or caregivers, coordinates services for them, makes appropriate referrals, and evaluates the progress toward meeting care goals. For example, a nurse case manager in an outpatient clinic has been working for 3 months with an older male patient with multiple comorbidities, including severe coronary artery disease, diabetes, and osteoarthritis. After he is scheduled for a coronary artery bypass, the nurse manager coordinates his care with other health care team members. She arranges his preoperative appointments and informs the other team members so that everyone understands the patient's unique needs. After the patient has surgery, he develops a deep venous thrombosis in his leg. The case manager then works with the health care team to evaluate the patient's discharge needs and decide whether rehabilitation or home health care is necessary for the patient. With the patient and caregiver, the team decides to discharge the patient to a rehabilitation facility. The case manager helps with the transition, again coordinating care so that the providers at the rehabilitation facility are aware of the patient's needs.

**Telehealth** nursing provides health care and information using telehealth technologies in virtual environments. These include smartphones and watches, kiosks, and Web-based or digital platforms. The type of telehealth visit depends on the setting and patient need.[14] Among the many uses are triaging patients, monitoring patients with chronic or critical conditions, helping patients manage symptoms, providing patient and caregiver education and emotional support, and providing follow-up care. Telehealth can increase access to care. The nurse engaged in telehealth can assess the patient's health status, deliver interventions, and evaluate the outcomes of nursing care while separated geographically from the patient (Fig. 1.5).

### Supporting Caregivers

Caregivers play a valuable role in the patient's health and are members of the health care team. They contribute to the patient's well-being by (1) linking the patient to news from the outside world; (2) facilitating decision making and advising the patient; (3) helping with activities of daily living; (4) acting as liaisons to advise the health care team of the patient's wishes for care; and (5) providing safe, caring, familiar relationships for the patient.

When someone is ill, care extends beyond the patient to the patient's caregivers. Caregivers need your guidance and support. Anxiety and concerns about the patient's condition, prognosis, and pain are common. Caregivers may have a concern about financial issues related to a hospital stay. They often disrupt their daily routines to support the patient. Conduct a family assessment and intervene as needed. Recognize the caregivers' feelings, listen to them openly and without being judgmental, and acknowledge their decisions. Consult other team members, such as a chaplain or social worker, as needed to help caregivers cope.

The key needs of caregivers include information, communication, and access. Lack of information is a major source of anxiety. Assess their understanding of the patient's status, treatment plan, and prognosis and provide them with information. Identify a spokesperson to help coordinate information exchange between the health care team and caregivers. Have them meet team members. Include caregivers in rounds and patient care conferences. It helps caregivers cope when they see that the team is caring and competent, decisions are deliberate, and their input is valued. Invite the caregivers to take part in the patient's care if they want.

Caregivers need access to the patient. Assess the patient's and caregiver's needs and preferences and include these into the plan of care. Caregivers should have the option to be present at the bedside when patients are undergoing invasive procedures (central line insertion) or cardiopulmonary resuscitation (CPR). Even when the outcomes are not favorable, being present helps caregivers to (1) overcome doubts about the patient's condition, (2) reduce their anxiety and fear, (3) meet their need to be together with and to support their loved one, and (4) begin the grief process if death occurs.

## INTERPROFESSIONAL PARTNERSHIPS

### Interprofessional Team

To deliver high-quality care, you need to have effective working relationships with the health care team members. The **interprofessional team** is made up of providers from various disciplines, working together and sharing their expertise to provide customized care. It may consist of physicians, nurses, pharmacists, occupational and physical therapists, and others (Table 1.2). To be competent in interprofessional practice, you must collaborate in many ways by exchanging knowledge, sharing responsibility for problem solving, and making patient care decisions. You may be responsible for coordinating care among the team members, taking part in interprofessional team meetings or rounds, and making referrals when you need expertise in specialized areas to help the patient. To do so, you must be aware of the knowledge and skills of other team members and be able to communicate effectively with them.

To help you develop the competencies necessary to practice within an interprofessional clinical environment, you may take

**TABLE 1.2 Interprofessional Health Care Team Members**

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

**TABLE 1.3 Guidelines for Communicating Using SBAR**

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

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

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

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

part in education activities with students from other disciplines. Throughout this book, case studies and review questions discuss the roles others have in managing patient care.

## Coordinating Care

### Communication

Effective communication is key to fostering teamwork and coordinating care. To provide safe, effective care, team members must exchange information clearly and accurately among team members. Everyone involved in a patient's care should understand the patient's condition and needs. Unfortunately, many issues result from a breakdown in communication.

One model used to improve communication is the **SBAR (Situation-Background-Assessment-Recommendation)** technique (Table 1.3). SBAR offers a structured way to discuss a patient's condition between team members. It allows you to communicate vital patient information that needs immediate attention and action. There will be times when you will be

**TABLE 1.4 Communicating Using CUS**

| CUS: Concerned, Uncomfortable, Safety | |
|---|---|
| "I am **C**oncerned that…" | State your concern about the patient or situation. |
| "I am **U**ncomfortable because…!" | State why you feel uncomfortable with what is occurring. |
| "This is a **S**afety issue because…" | Describe why there is a safety issue and state what actions you think should be taken. |

Example: "I'm concerned that the patient is more confused and having difficulty breathing. I am uncomfortable because of the sudden onset of these symptoms. I believe the patient is not safe; there may be something serious going on, and we need to call the rapid response team."

alarmed about a patient situation and need to alert team members. At those times, you can use another model: Concerned, Uncomfortable, Safety (CUS) (Table 1.4). With CUS you state that you are concerned, feel uncomfortable, or perceive a safety issue to stress important or critical information.

Poor communication can occur during transitions of care. Examples of transitions in care include shift changes and patient transfers. A **patient handoff** is the process of passing patient information to another team member during a transition.[15] The handoff should include information about the patient's condition and any recent or anticipated changes. There should be an opportunity to ask questions and a way to confirm information, such as read-back.

Huddles and rounds promote effective communication among team members. A huddle is a short, daily meeting that often happens at the start of each day.[16] Huddles let team members discuss patient concerns, safety concerns, and updates. They improve care quality by helping to solve problems that are affecting patient care (Box 1.1). Interprofessional rounds allow team members to discuss patient care and discharge plans. Rounding at the bedside involves the patient in planning care.

## Clinical Pathways

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

The exact content and format of clinical pathways vary among agencies and settings. Each agency usually has its own pathways based on evidence-based practice guidelines. Common components include assessment guidelines, laboratory and diagnostic testing, medications, activity, diet, and teaching. In acute care, clinical pathways often describe which patient care components are needed at specific times (Fig. 1.6). The case types that have pathways are usually high volume or high risk and predictable, such as myocardial infarction and surgical procedures, like endoscopy, cholecystectomy, cataract surgery.

**BOX 1.1 EVIDENCE-BASED PRACTICE**

***Participating in Post-Fall Huddles***

You are caring for J.R., a 76-year-old female admitted for acute kidney injury. She has a history of falls at home, none of which have resulted in serious injury to date. Despite correct identification of her fall risk and implementation of the fall prevention bundle, J.R. fell trying to get up to the bedside commode without calling for assistance. Based on recent policy changes on your unit, a post-fall huddle is called after any patient fall to evaluate contributing circumstances and any unidentified patient risk factors. You are taking part in the fall huddle as J.R.'s assigned nurse. J.R. and her 52-year-old daughter are joining the huddle.

### Making Clinical Decisions

#### *Synthesis of Best Available Evidence*

After-action reviews, also called huddles or debriefs, have been implemented in health care after a key event (e.g., a patient fall) to discuss contributing factors, identify lessons learned, and determine how those lessons can be implemented to avoid future incidents. Debriefing increases knowledge and improves patient outcomes. Debriefing is widely used as part of an evidence-based fall prevention program. The team members convened after a patient fall typically includes the assigned nurse, any AP, the charge nurse, as well as physical therapists, respiratory therapists, and pharmacists. A designated family member may be included. In particular, nursing staff and the family provide information about what the patient was doing at the time of the fall, the location of the fall, how it was discovered, the severity of any patient injury, interventions intended to be placed, and changes in the plan of care needed to decrease the risk of another fall.

#### *Clinician Expertise*

Although the research is limited and has not shown that post-fall huddles decrease fall occurrence, you know that the huddle is part of a unit culture of reflection and open communication. You review J.R.'s current medications and discuss with the pharmacist the potential impact on fall risk. The physical therapist and you discuss the potential value of a balance and core strengthening exercise plan for J.R.

#### *Patient Preferences and Values*

J.R. and her daughter express concern about the risk of injury with future falls, but they also want to preserve J.R.'s independence.

### Implications for Nursing Practice

1. How does taking part in post-fall huddles encourage teamwork and a culture of patient safety?
2. How can the results of post-fall huddles be shared for wider learning by all staff?

### Reference for Evidence

Jones KJ, Crowe J, Allen JA, et al.: The impact of post-fall huddles on repeat fall rates and perceptions of safety culture: A quasi-experimental evaluation of a patient safety demonstration project, *BMC Health Serv Res* 19:650, 2019.

## Delegation and Assignment

As a registered nurse (RN), you will delegate nursing care and supervise those who are qualified to deliver care. **Delegation** allows a care provider to perform a specific nursing activity, skill, or procedure beyond their usual role.[17] Delegating and assigning nursing activities is a process that, when used appropriately, results in safe, effective, and efficient patient care. Delegating can allow you more time to focus on complex patient care needs. Delegating care and supervising others will be one of your essential roles as a professional nurse.

Patient Name _____ Date _____

DRG# _____ Expected LOS <23 hours

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

**Fig. 1.6** Clinical pathway for endoscopy. (From Arnold EC, Boggs KU: *Interpersonal relationships,* ed 6, St Louis, 2011, Mosby.)

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

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

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

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

*Assignment* is different from delegation. The term *assign* is used when you direct an LPN/VN or AP to do an activity or procedure that is part of their everyday job.[17] An assignment must be within the authorized scope of practice of the LPN/VN or part of the routine function of the AP. For example, you can assign an LPN/VN to give medications to a patient because this is within the LPN/VN's scope of practice. You cannot assign an LPN/VN to a patient who needs an admission assessment because an RN must perform the initial patient assessment.

Whether you delegate or assign staff tasks, you are responsible for the patient's total care during your work period. You need to decide what patient care tasks must be carried out during the

**TABLE 1.5 The 5 Rights of Delegation**

The registered nurse uses clinical judgment to be sure that the delegation or assignment is:
1. The right task
2. Under the right circumstances
3. To the right person
4. With the right directions and communication
5. Under the right supervision and evaluation

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

Source: National Guidelines for Nursing Delegation. Retrieved from https://www.ncsbn.org/NGND-PosPaper_06.pdf.

given period, identify who will do them, and prioritize the order in which the tasks must be completed. You are responsible for supervising AP and LPN/VNs. Clearly communicate the tasks that need completed and give necessary guidance. Because you are accountable for ensuring that delegated tasks are completed competently, evaluate the care provided, follow up as needed, and make sure no care was missed.

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

## SAFETY

Preventable medical errors are a serious problem and a leading cause of death in the United States. Several groups address this issue by outlining safety goals for health care organizations and identifying safety competencies for health professionals. Implementing procedures and systems that improve patient safety minimizes the risk of harm to patients through effective health care systems and individual accountability.

### Serious Reportable Events

The National Quality Forum (NQF) uses the term **serious reportable event (SRE),** also called a *never event,* to describe serious, largely preventable, and harmful clinical events.[18] The current list of SREs consists of 29 events. These events include a patient acquiring a stage 3 or greater pressure injury after admission and death or injury from a fall or hypoglycemia.

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

### National Patient Safety Goals

The Joint Commission (TJC), an accrediting agency for health care organizations, gathers and reports data on serious errors they call sentinel events. A *sentinel event* is a patient safety event unrelated to the patient's illness or underlying condition that results in death, permanent harm, or severe, temporary harm.[19] Events are "sentinel" because they signal the need for immediate investigation and response. Many sentinel events are also serious reportable events. If the patient has a wrong-site or wrong-procedure surgery, is assaulted in the health care setting, or receives an incompatible blood product, the occurrence is both a sentinel event, reportable to TJC, and a serious reportable event, reportable to NQF.

To address specific patient safety concerns, TJC issues National Patient Safety Goals (NPSGs).[20] NPSGs promote patient safety by giving evidence-based solutions to common safety problems. Table 1.6 lists the current NPSGs.

The latest safety goal, focusing on improving the safety of clinical alarm systems, greatly affects nursing. Patient monitoring systems provide vital information. Alarms that work well

**TABLE 1.6 National Patient Safety Goals**

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

Adapted from The Joint Commission (TJC): National patient safety goals. Retrieved from https://www.jointcommission.org/standards/national-patient-safety-goals/.

improve patient safety and care by telling you when a patient needs your attention. However, so many alarms can go off that *alarm fatigue* occurs, and you can become less sensitive to the sounds. By better managing alarms, we reduce alarm fatigue and improve patient safety.

**Failure to rescue** (FTR) occurs when there is failure or delay in recognizing a patient has developed complications. As a result, the patient worsens and has an adverse outcome. FTR often involves subtle signs and symptoms that are thought to be of no concern or are missed entirely. You can prevent FTR by recognizing changes in a patient's condition, taking the right actions based on the problem, and activating a response team when needed.

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

## QUALITY IMPROVEMENT

Quality care and safety are related: the higher the culture of safety, the better the quality of care. Quality improvement (QI) programs involve systematic actions that monitor, assess, and improve health care quality. Health care systems focused on quality outcomes use practice standards and protocols based on best evidence while considering the patient's unique preferences and needs. QI is an interprofessional team effort that accrediting agencies require.

As part of your nursing practice, you will coordinate the complex aspects of patient care, including monitoring the care delivered by others and looking for and correcting issues associated with poor quality or unsafe care. You need to be able to collect data using QI tools, implement interventions to improve patient care, and monitor patient outcomes. Think to yourself, "How can I do my job better?" Identify where changes can be made and be part of making them.

Patient outcomes are an important indicator of quality in health care. Several public and private groups focusing on improving health care quality have developed standard QI measures. These performance measures assess how well the health care team cares for a patient with a certain condition or receives a specific treatment. They describe what data the team must collect and monitor. Fig. 1.7 shows an example of a QI system for adult patients with asthma. In this example, you would review patient medical records to decide if flu vaccination rates exceed 90%. You would share the results with the team and work as a team to implement measures to correct the problem if the identified standard was not met.

### National Database of Nursing Quality Indicators

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

## INFORMATICS

Nursing is an information-intense profession. Technology has changed the way nurses plan, deliver, document, and evaluate

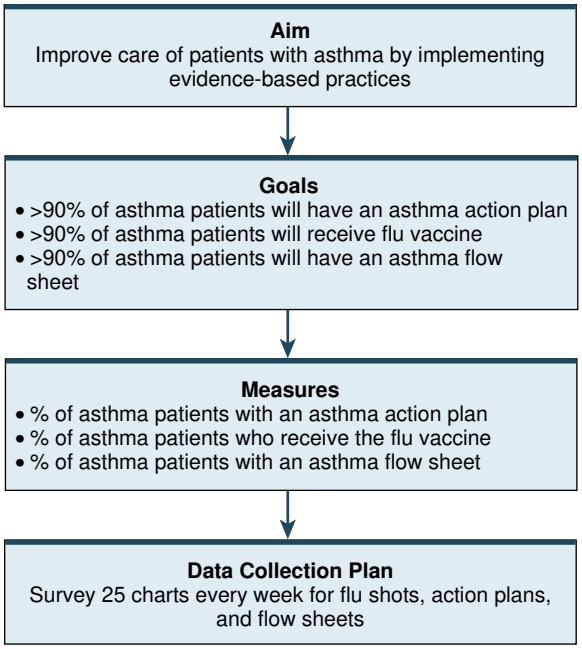


**Fig. 1.7** Quality improvement system. (Adapted from Courtlandt CD, Noonan L, Leonard GF: Model for improvement—part 1: a framework for health care quality, *Pediatr Clin North Am* 56:757, 2009.)

care. All nurses, regardless of their setting or role, use informatics and technology every day in practice. You will use informatics to obtain and review diagnostic information, make clinical decisions, communicate with patients and health care team members, document, and provide care.

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

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

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

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

As a nurse, you have an obligation to ensure the privacy of your patient's health information. To do so, you need to understand your agency's policies about the use of technology. You need to know the rules about accessing patient records and releasing PHI, what to do if information is released accidentally or intentionally, and how to protect all your passwords. If you are using social networking, you must not place PHI online (Box 1.2).

**TABLE 1.7 National Database of Nursing Quality Indicators**

- Structure indicators
  - RN turnover rate
  - Nursing hours per patient day
  - RN education and certification
  - Staff mix: RNs, LPN/VNs, AP, agency staff
- Process and outcome indicators
  - Patient falls and falls with injury
  - Pressure injury rate
  - RN job satisfaction and practice environment survey results
- Outcome indicators
  - Physical/sexual assault rate
  - Restraint use
- Health care–associated infection rate

Source: National Database of Nursing Quality Indicators. Retrieved from https://nursingandndnqi.weebly.com/ndnqi-indicators.html.

### Electronic Health Records

The largest use of informatics is **electronic health records (EHRs)**, also called *electronic medical records.* An EHR is a computerized record of patient information. It is shared among all health care team members involved in a patient's care and moves with the patient—to other providers and across care settings. The ideal EHR is a single place for team members to review and update a patient's health record, document care given, and enter patient care orders, including medications, procedures, diets, and diagnostic and laboratory tests (Fig. 1.8).

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

## EVIDENCE-BASED PRACTICE

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

## BOX 1.2 ETHICAL/LEGAL DILEMMAS

### *Social Networking: HIPAA Violation*

**Situation**

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

**Ethical/Legal Points for Consideration**

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

**Discussion Questions**

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

**Reference**

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

**Fig. 1.8** Members of the interprofessional team review a patient's electronic health record. (© Portra/iStock/Thinkstock.)

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

1. Ask the clinical question using the **PICOT** format:
   **P**atients/population
   **I**ntervention
   **C**omparison or comparison group
   **O**utcome(s)
   **T**ime (as applicable)
2. Search for the best evidence based on the clinical question.
3. Critically appraise and synthesize the evidence.
4. Implement the evidence in practice.
5. Evaluate the practice decision or change.
6. Share the outcomes of the decision or change.

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

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

## Steps of EBP Process

The EBP process has 6 steps (Table 1.8).

### Step 1

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

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

### Step 2

Step 2 is searching for the best evidence that applies to the clinical question. Technology provides you with ready access to data. You can easily search online resources and collect large amounts of information and evidence. It is important to evaluate all data sources for their credibility and reliability. Not all evidence is equal. Fig. 1.9 presents the hierarchy of evidence. As

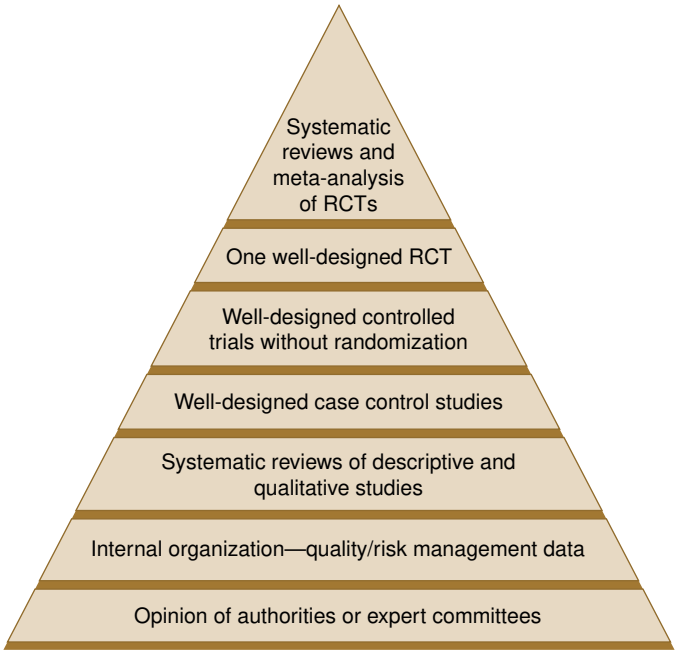


**Fig. 1.9** Hierarchy of evidence. (Modified from Melnyk BM, Fineout-Overholt E: *Evidence-based practice in nursing and healthcare: a guide to best practice,* ed 3, Philadelphia, 2014, Lippincott Williams & Wilkins.)

you go down the pyramid, the strength of the evidence becomes weaker. Systematic reviews and evidence-based clinical practice guidelines save time and effort in the EBP process. However, they are available for only a limited number of clinical topics and may not suit all types of clinical questions. When insufficient research exists to guide practice, recommendations from expert panels and authority figures may be the best evidence available.

### Step 3

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

### Step 4

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

### Step 5

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

### Step 6

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

## Implementing EBP

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

## BRIDGE TO NCLEX EXAMINATION

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

1. An example of a nursing activity that best reflects the American Nurses Association's definition of nursing is
   - **a.** treating dysrhythmias that occur in a patient in the coronary care unit.
   - **b.** diagnosing a patient with a feeding tube as being at risk for aspiration.
   - **c.** setting up protocols for treating patients in the emergency department.
   - **d.** offering antianxiety drugs to a patient with a disturbed sleep pattern.
2. A nurse working on the medical-surgical unit at an urban hospital would like to become certified in medical-surgical nursing. The nurse knows that this process would most likely require
   - **a.** a bachelor's degree in nursing.
   - **b.** formal education in advanced nursing practice.
   - **c.** experience for a specific period in medical-surgical nursing.
   - **d.** membership in a medical-surgical nursing specialty organization.

3. The nurse is assigned to care for a newly admitted patient. Number in order the steps for using the nursing process to prioritize care. (Number 1 is the first step, and number 5 is the last step.)
   ___ Determine whether the plan was effective.
   ___ Identify any clinical problems.
   ___ Collect patient information.
   ___ Carry out the plan.
   ___ Decide a plan of action.
4. Using the SBAR format, number in order the steps for how the nurse would communicate information with the provider. (Number 1 is the first step, and number 4 is the last step.)
   ____ "I would like you to order an IV medication and come evaluate the patient as soon as possible."
   ____ "This is Nurse M.H. I am calling from the unit because your patient, D.R., has a new onset of atrial fibrillation."
   ____ "The atrial fibrillation started about 10 minutes ago. The heart rate is 124; BP 90/60. The patient is reporting dizziness."
   ____ "D.R., who is 2 days postoperative for a bowel resection for an obstruction, has a history of mitral valve disease."
5. The nurse is caring for a patient with diabetes in the ambulatory surgical unit who had a wound debridement. Which task is appropriate for the nurse to delegate to assistive personnel (AP)?
   **a.** Check the patient's vital signs.
   **b.** Assess the patient's pain level.
   **c.** Palpate the patient's pedal pulses.
   **d.** Monitor the patient's IV catheter site.
6. The nurse's role in addressing the National Patient Safety Goals established by The Joint Commission includes *(select all that apply)*
   **a.** answering all patient monitoring alarms promptly.
   **b.** memorizing all the rules published by The Joint Commission.
   **c.** obtaining a correct list of the patient's medications on admission.
   **d.** encouraging patients to be actively involved in their health care.
   **e.** using side rails and alarm systems as necessary to prevent patient falls.
7. Advantages of using informatics in health care delivery are *(select all that apply)*
   **a.** reduced need for nurses in acute care.
   **b.** increased patient anonymity and confidentiality.
   **c.** the ability to deliver high standards of safe, quality care.
   **d.** access to decision-making tools for health care teams members.
   **e.** improved communication of the patient's health status to the health care team.
8. When using evidence-based practice, the nurse
   **a.** must use clinical practice guidelines developed by national health agencies.
   **b.** should use findings from randomized controlled trials to plan care for all patient problems.
   **c.** uses clinical decision making and judgment to decide what evidence is appropriate for a specific clinical situation.
   **d.** analyzes the relationship of nursing interventions to patient outcomes to discover evidence for patient interventions.

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

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

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Review Questions (Online Only)
Key Points
Answer Key for Questions
- Rationales for Bridge to NCLEX Examination Questions

Conceptual Care Map Creator
Audio Glossary
Content Updates

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2

# Social Determinants of Health

*Andrew Scanlon and Courtney Reinisch*

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

## CONCEPTUAL FOCUS

**Culture**
**Health Disparities**
**Population Health**

## LEARNING OUTCOMES

1. Identify the social determinants of health.
2. Describe the factors that contribute to health disparities and health equity.
3. Define cultural competence and its related terminology.
4. Explain how culture and ethnicity may affect a person's health.
5. Apply strategies for integrating social determinants of health in the nursing process.
6. Describe the role of nursing in promoting health equity.
7. Examine ways that your cultural background may influence nursing care.
8. Describe strategies for successfully communicating with a person who speaks a language that you do not understand.

## KEY TERMS

**acculturation**
**cultural competence**
**culture**
**ethnicity**
**ethnocentrism**
**folk healers**
**health disparities**
**health equity**
**health status**
**place**
**race**
**racism**
**social determinants of health**
**stereotyping**
**values**

This chapter discusses social determinants of health (SDH), health disparities, and culture. The SDH serve as the foundation for how we express our culture. Understanding the SDH is needed to provide patient-centered care. Health is a cultural concept because culture frames and shapes our experiences. Cultural beliefs influence health promotion practices and attitudes about seeking health care. Social and cultural factors influence equity in health care. **Health disparities** are differences in the incidence, prevalence, mortality rate, and burden of diseases that exist among specific population groups. An inability to address the SDH results in health disparities and negatively impacts well-being.

## SOCIAL DETERMINANTS OF HEALTH

Why are there differences in people's health status? How do these differences occur? The **social determinants of health** are nonmedical factors that (1) influence the health of persons and groups and (2) explain why some people have poorer health than others.[1] The SDH can be broken down into 5 groups. These are neighborhood, economic stability, education, health care access, and community context (Fig. 2.1). Where people are born, grow up, live, work, and age helps to determine their health status, behaviors, and care.

**Health status** is a holistic concept that is more than the presence or absence of disease. It encompasses life expectancy and self-assessment of health. Many measures make up the concept of health status. For a person, this means the sum of their current health problems plus their coping resources (e.g., family, financial resources). For a community, health status is the combination of health measures for all people living in the community. Community health measures include birth and death rates, life expectancy, access

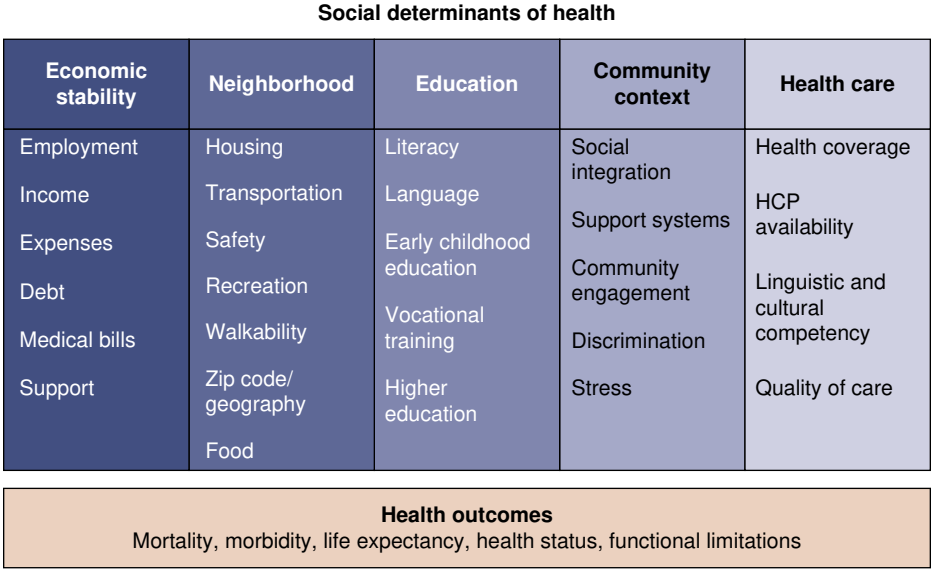


**Fig. 2.1** Social determinants of health.

to care, and morbidity and mortality rates related to disease and injury.

Factors in a person's social and physical environment, including personal relationships, workplace, housing, transportation, and neighborhood violence, contribute to health status.[1] For example, the risk of youth homicide is much higher in neighborhoods with gang activity and high crime rates. The physical environment in which one lives, works, and plays may expose a person to such risks as environmental hazards (workplace injuries), toxic agents (chemical spills, industrial pollution), unsafe traffic patterns (lack of sidewalks), or absence of fresh, healthy food choices.

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

Access to health care contributes to a person's health. Although government initiatives strive to reduce the number of uninsured Americans, millions still are uninsured and have limited access to care. This affects both individual and community health.

## Neighborhood

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

Housing is a basic need. It protects us from environmental harm. Housing can contribute to poor health outcomes. Unsafe or poor-quality housing is associated with exposure to lead, indoor air pollution, and asthma triggers (dust, mold, rodents). Overcrowded living conditions can contribute to the spread of infectious disease. Living close to environmental hazards can affect pregnancy outcomes. It increases the risk of cancer and neurologic problems.

About 20% of Americans live in nonurban or rural areas.[2] Differences in access to health care services between rural and urban settings can create geographic health disparities. People in rural areas may need to travel long distances to receive health care.[2] This can result in inadequate or less-frequent access to health care services. Some parts of the rural United States are "medically underserved" because of low numbers of HCPs.

People in rural areas have higher rates of obesity and chronic disease. They are more likely to have cancer, heart disease, diabetes, depression, and injury-related deaths than people in urban areas. In rural Appalachia, the rates of lung, colon, cervical, and colorectal cancer are higher than average. Rural populations tend to be older than urban populations. The impact of social and physical environment on health choices can be illustrated by the problem of intimate partner violence in rural communities.[3] The decision to seek help is affected by geographic isolation, traditional gender roles, patriarchal attitudes, fear of lack of confidentiality, and economic factors that exist in some small rural communities.

Living in urban centers may predispose a person to other health disparities. People in high crime areas may not visit HCPs. High rates of chronic health problems and premature deaths occur in neighborhoods with social inequalities. These include high poverty rates, high crime rates, and residential segregation.

Among the most obvious health behaviors affected by place are physical activity and nutrition. Safe, walkable neighborhoods with playgrounds promote physical activity. Source and price of healthy foods affect diet intake and weight. Social support positively affects coping with illness. Social networks are more likely in communities where neighbors interact and rely on one another.

## Economic Stability

The main nonmedical factor affecting health is socioeconomic status. Socioeconomic status is related to wealth, education, and occupation. Those living in poverty cannot afford healthy food,