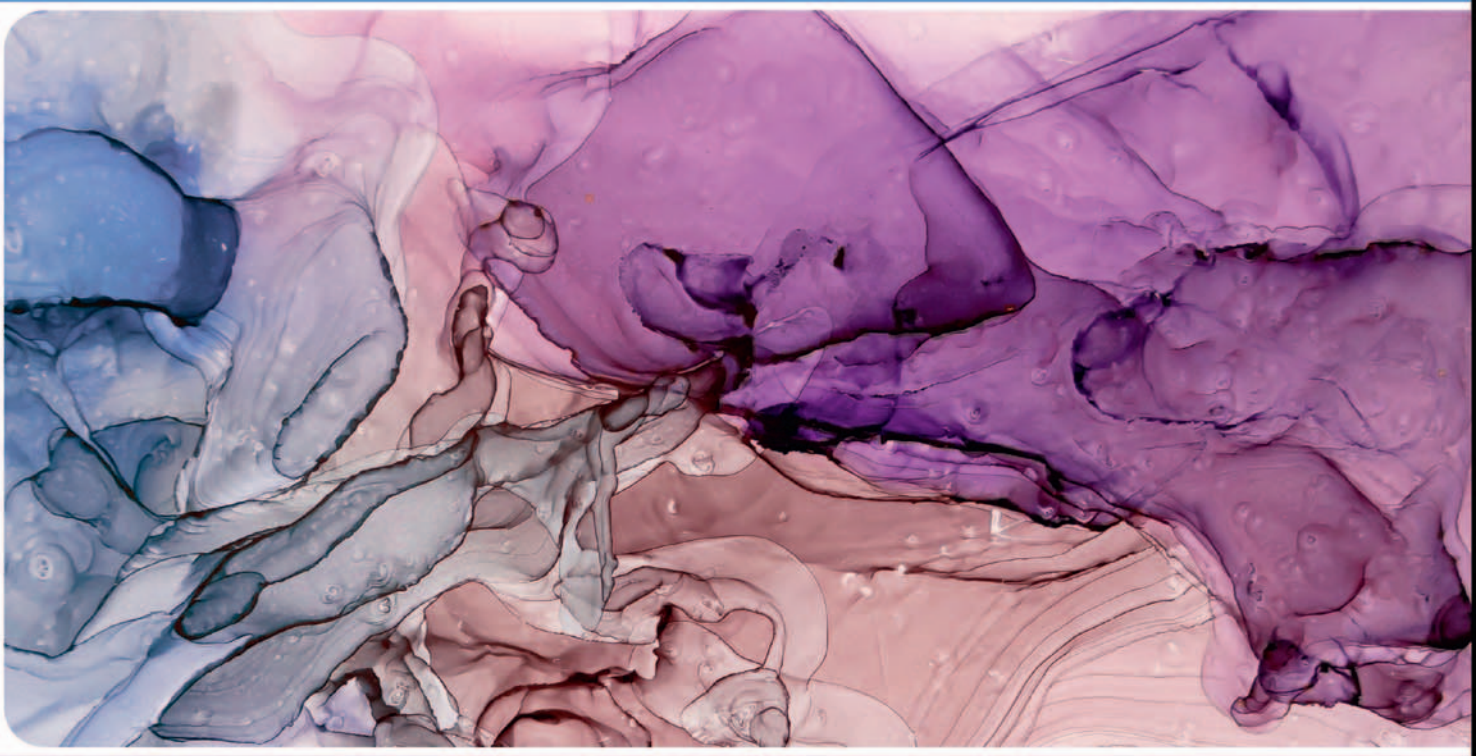
EDITION 5

Medical-Surgical Nursing

Concepts and Practice

Stromberg



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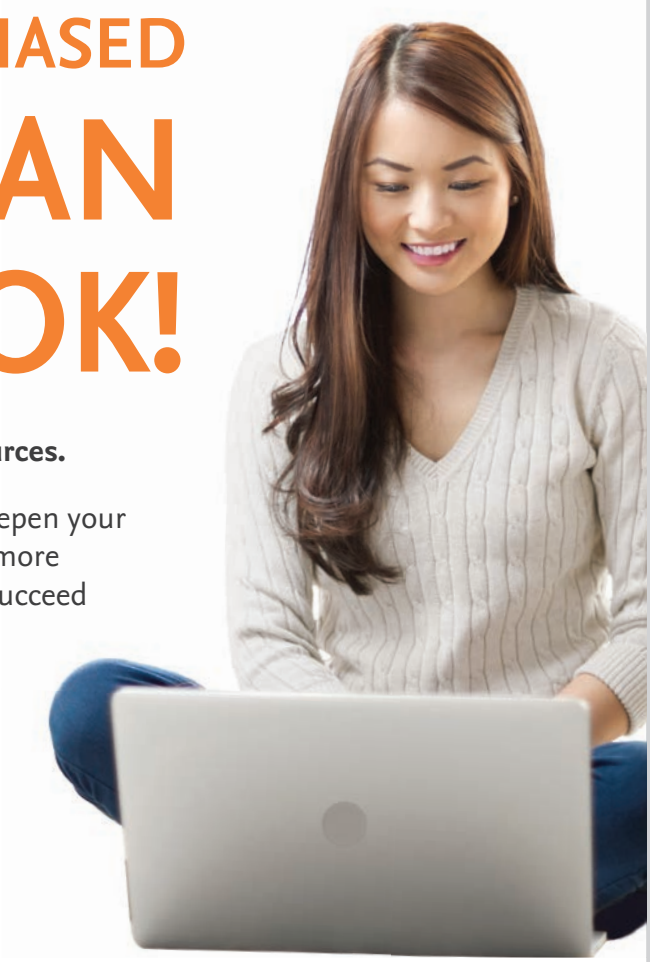

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EDITION
5

Medical-Surgical Nursing

Concepts and Practice

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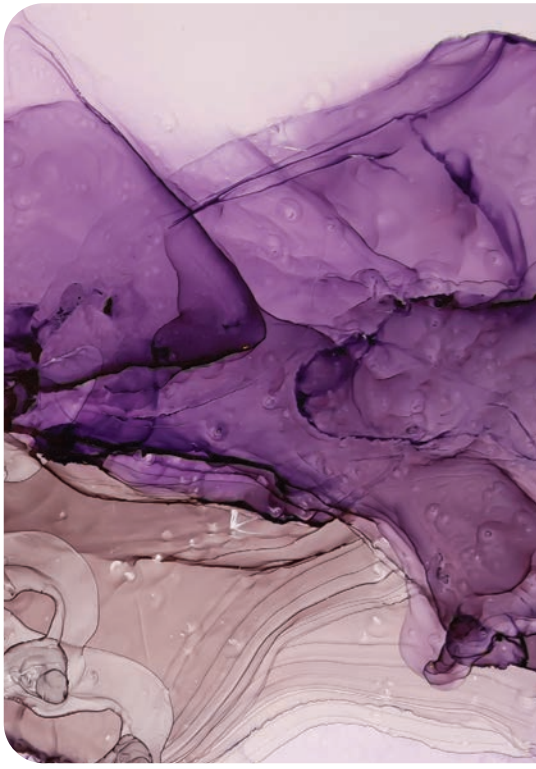

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To my husband, who has been a continuous source of encouragement and support in all of life's endeavors.

To Aunt Kay and the rest of my family for giving me purpose.

To all of the students and colleagues from whom I continue to learn and who are outstanding examples of why I love the nursing profession.

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To the Instructor

ABOUT THE TEXT

Medical-Surgical Nursing: Concepts and Practice is written specifically for the licensed practical/vocational nurse (LPN/LVN) student, who must be educated to work within various settings, including hospitals, long-term care facilities, rehabilitation institutes, ambulatory clinics, psychiatric agencies, health care providers' offices, and home care agencies. All of the most common adult medical-surgical disorders are covered, but particular attention is devoted to disorders most prevalent in our society. Special consideration is given to the older adult population, those with chronic illnesses, and others in long-term care settings.

This text builds on—but does not repeat—the concepts and skills presented in a fundamentals of nursing course. Many states are expanding LPN/LVN scope of practice, via certification, to include administration of intravenous (IV) fluids and medications, but others do not. Information on IV therapy is included within this text so that schools in states in which such certification is possible will have the necessary educational materials.

With the expanding and changing role of the LPN/LVN there is an even greater need for **critical thinking** and the development of **clinical judgment.** These crucial skills are stressed throughout the clinical chapters and again in the *Study Guide.* The text is geared to prompt thinking and develop skills in clinical judgment for application to the clinical setting and the provision of safe and effective patient care. **Evidence-based practice** is designated with a special icon ( ) so that students come to understand that the foundation of nursing care is in research. **Best practices** are highlighted throughout the narrative with an icon ( ) to emphasize cutting-edge information related to interventions.

The nursing process and its application to nursing care is an organizing principle throughout, and patients' needs are presented as the focus of nursing care. There is an emphasis on practical **assessment—including data collection**—to determine problems, monitor for the onset of complications, and evaluate the effectiveness of care. Data collection from the older adult patient requires greater ability to elicit pertinent information from the patient and family, and the achievement of this skill is a major focus of this text. The text emphasizes the role of LPN/LVNs in data collection to assist the registered nurse (RN) in choosing appropriate **nursing diagnoses** or formulating problem statements for each patient. Many health care agencies are not using NANDA-I nursing diagnoses and are using problem statements instead. Agencies that use a collaborative care plan do not use nursing diagnoses at all. The NCLEX-PN® Examination no longer uses NANDA-I nursing diagnoses. For these reasons, this text provides problem statements on the inside back cover. NANDA-I nursing diagnoses are discussed but not listed in the text.

Planning holistic care must include consideration of the patient's cultural background and its effect on the perception of health, illness, and health practices. **Implementation of nursing actions** is the heart of patient care and LPN/LVN practice. The nursing actions presented are specific, comprehensive, and organized by common care problems to decrease repetition of information within a chapter. This helps the student master concepts rather than memorize facts. The concepts covered are listed at the beginning of the chapter. Further interventions are discussed with each disorder as appropriate, and ***safe practice*** is emphasized throughout the text. Additional focal points are using **expected outcomes** and **evaluating** nursing care to ensure that those outcomes and goals have been met.

Patient teaching for health promotion and self-care is a basic function of the LPN/LVN. Each clinical chapter points out ways in which nurses can teach the public how to prevent many of the problems discussed.

LPN/LVN nurse practice acts do not encompass **delegation** as a function. With a few exceptions, only RNs can delegate, although in many situations LPN/LVNs can **assign** tasks. Collaboration with other health care workers and the use of basic management skills to provide coordinated, cost-effective patient care is essential. In this text we particularly speak to the LPN/LVN management role in working with nursing assistants and assigning tasks appropriately.

PEDAGOGICAL FEATURES

Special pedagogical features throughout the text help you teach your students to understand the chapter content and apply it in practice:

- The text has been thoroughly updated with the **Next-Generation NCLEX-PN® Test Plan** in mind.
- Overreaching **concepts** that are addressed in the chapter are listed at the beginning of each chapter. These concepts help fit together ideas and

information to aid in formation of a holistic understanding of the patient situation.
- Competencies identified through the **Quality and Safety Education for Nurses (QSEN) initiative**—and the associated knowledge, skills, and attitudes (KSAs)—have been integrated into the content and were a continual focus during the writing of this text and its ancillaries.
- The Joint Commission's **National Patient Safety Goals** are highlighted to help students integrate safety measures and quality controls into their practice, and **Safety Alerts** remind students of specific safety concerns.
- The Joint Commission's **National Quality Core Measures** and the Institute for Healthcare Improvement's (IHI) **bundles** are described as additional measures for providing safe, effective, and quality care.
- The purpose of ***Healthy People 2030*** as a nationwide health improvement agenda is explained. Goals related to specific patient problems are available on the healthypeople.gov website. Other **Health Promotion** boxes throughout the text also emphasize the importance of health promotion, disease prevention, and reduction of health care costs.
- **Evidence-based practice** is designated with a special icon so that the student will see the thrust of nursing toward a foundation based in research.
- **Overview of Anatomy and Physiology** at the beginning of each system introduction chapter provides basic information for understanding the body system and its disorders. Normal physiologic changes associated with aging are presented for each body system.
- **The Nursing Process** provides a consistent framework for the disorders chapters.
- Separate **Theory** and **Clinical Practice objectives** highlight the chapter's main learning goals.
- **Concept Maps** found in disorders chapters are designed to help students visualize difficult material and to illustrate how a disorder's multiple symptoms, treatments, and side effects relate to each other.
- End-of-chapter **Review Questions for the Next-Generation NCLEX® Examination** include **multiple-choice and alternate-format questions,** and an extensive set of Interactive Review questions for the NCLEX® Examination is located on the Evolve website for students.
- The easily understandable **writing style** is aimed at gaining and retaining student attention to reading assignments.
- The term *patient* rather than *client* is used because *patient* is the term still used in hospitals. *Resident* is used for those in long-term care facilities.
- A section in each chapter of the *Study Guide* has been designed to assist the student to more easily master the chapter content and to enhance English skills.
- **Bolded text** throughout the narrative emphasizes key concepts and practice.

ORGANIZATION OF THE TEXT

Unit I addresses medical-surgical nursing settings, nursing roles and issues, health care trends, assignment considerations, the nursing process, measures related to safe and effective care, and critical thinking. **Unit II** covers key medical-surgical nursing topics, including fluids and electrolytes, surgical patient care, infections, pain, cancer, and palliative care, and contains a separate chapter on chronic illness, rehabilitation, and the interprofessional health care team. **Units III through XIV** cover all of the body systems and their most common disorders; each unit begins with a system overview, followed by specific disorders chapters. **Unit XV** addresses emergency and disaster management—including bioterrorism—as well as trauma and shock. **Unit XVI** is devoted entirely to mental health nursing and includes information on anxiety and mood disorders, eating disorders, cognitive disorders, thought and personality disorders, and substance use disorders.

Content on legal and ethical issues, nutrition considerations, care of the older adult, communication, cultural diversity, complementary and alternative therapies, patient teaching, home care, health promotion, and assignment and delegation has been integrated as appropriate rather than including individual chapters on these subjects. End-of-life issues and palliative care are presented at the end of Chapter 8: *Care of Patients With Cancer.* **Chronic illness** and **rehabilitation care** are growing areas, and Chapter 9 addresses the differences in care approaches and nursing care for these individuals as well as the interaction of the interprofessional health care team. Based on reviewer feedback, multiple sections of content have been resequenced to provide a better flow of information. Care of the LGBTQIA+ patient has been added to Chapter 38: *The Reproductive System.*

LPN THREADS

The fifth edition of *Medical-Surgical Nursing: Concepts and Practice* shares some features and design elements with other Elsevier LPN/LVN textbooks. The purpose of these *LPN Threads* is to make it easier for students and instructors to use the various books required by the relatively brief and demanding LPN/LVN curriculum. The following features are included in the *LPN Threads*.
- The **full-color design, cover, photos,** and **illustrations** are visually appealing and pedagogically useful.
- **Objectives** (numbered) begin each chapter, provide a framework for content, and are especially

important in providing the structure for the TEACH Lesson Plans for the textbook.
- **Key Terms** with phonetic pronunciations and page number references are listed at the beginning of each chapter. Key terms appear in color in the chapter and are defined briefly, with full definitions in the **Glossary.** The goal is to help the student reader with limited proficiency in English to develop a greater command of the pronunciation of scientific and nonscientific English terminology.
- A wide variety of **special features** relate to critical thinking, clinical practice, health promotion, safety, patient teaching, complementary and alternative therapies, communication, home health care, delegation and assignment, and more. The To the Student section of this introduction shows the icons used and descriptions of the features.
- **Think Critically Questions** presented throughout each chapter prompt application of learned content. The **Nursing Care Plans** found in most chapters give students opportunities to practice critical thinking, clinical judgment, and clinical decision-making skills with realistic patient scenarios. Answers are provided in the Student Resources section on the Evolve website.
- **Key Points** at the end of each chapter correlate to the objectives and serve as a useful chapter review.
- A full suite of **Instructor Resources** is available, including TEACH Lesson Plans and Pre-Tests, PowerPoint Slides and Student Handouts, Test Bank, Image Collection, and the Answer Key to the *Study Guide.*
- In addition to consistent content, design, and support resources, these textbooks benefit from the advice and input of the **Elsevier LPN/LVN Advisory Board** (see p. viii).

FOR THE INSTRUCTOR

The comprehensive and free Evolve Instructor Resources with TEACH Instructor Resource include the following:
- **Test Bank** with approximately 1400 multiple-choice and alternate-format questions with correct answer, rationale, textbook page reference, topic, step of the nursing process, objective, cognitive level, and NCLEX® category of client needs
- **TEACH Instructor Resource** with Lesson Plans, Pre-Tests, PowerPoint Slides, and Student Handouts
- **Next-Generation NCLEX® (NGN) Examination–Style Case Studies** that include scenarios, activities, answers, and rationales
- **Image Collection** that contains all illustrations and photographs in the textbook and some supplemental images
- **Answer Key** for the *Study Guide*
- **Suggestions for Working With English as a Second Language (ESL) Students**

FOR THE STUDENT

The Evolve Student Resources include the following assets:
- **Animations** depicting anatomy, physiology, and pathophysiology
- **Answers and Rationales** for end-of-chapter Review Questions for the Next-Generation NCLEX® Examination
- **Answer Guidelines** for Think Critically boxes and the Nursing Care Plan Applying Clinical Judgment Questions
- **Audio Clips** of heart and lung sounds
- **Audio Glossary** with pronunciations in English and Spanish
- **Calculators** for determining body mass index (BMI), body surface area, fluid deficit, Glasgow Coma Scale score, IV dosages, and conversion of units
- **Clinical References,** including forms, checklists, and assessment tools
- **Fluids and Electrolytes Tutorial**
- **Helpful Phrases for Communicating in Spanish**
- **Interactive Review Questions**
- **Video clips** of patient assessment

The ***Study Guide*** (sold separately) is a valuable supplement to help students understand and apply the textbook content. There is an emphasis on **priority setting and decision making** throughout the chapters. Varied question and activity types provide students with learning tools for reinforcement and exploration of text material. Terminology, short-answer, multiple-choice, and alternate-format Review Questions for the Next-Generation NCLEX® Examination; Critical Thinking Activities; and a special section called *Steps Toward Better Communication*—written by an ESL specialist—appear in most chapters. Other activity types include Completion, Identification, Review of Structure and Function, Priority Setting, and Application of Nursing Process. All learning activities are geared toward understanding and application of content for the development of clinical judgment skills. The *Study Guide* Answer Key is provided for instructors on the Evolve website.

To The Student

READING AND REVIEW TOOLS

- **Objectives** introduce the chapter topics.
- **Key Terms** are listed with page number references, and difficult medical, nursing, or scientific terms are accompanied by simple phonetic pronunciations. Key terms are considered essential to understanding chapter content and are defined within the chapter. Key terms are in color the first time they appear in the narrative and are briefly defined in the text, with complete definitions in the Glossary.
- Each chapter ends with a ***Get Ready for the Next-Generation NCLEX® Examination!*** **section,** which includes (1) **Key Points** that reiterate the chapter objectives and serve as a useful review of concepts; (2) a list of **Additional Resources,** including the *Study Guide* and Evolve Resources; and (3) an extensive set of **Clinical Judgment and Next-Generation NCLEX® Examination–Style Questions,** with Answers and Rationales on Evolve.
- **References** in the back of the text cite evidence-based information. A **Bibliography** in the back of the text provides resources for enhancing knowledge.

CHAPTER FEATURES

 **Assignment Considerations** address situations in which either the RN delegates tasks to the LPN/LVN or the LPN/LVN assigns tasks to nurse assistants as allowed by each state's nurse practice act.

 **Clinical Cues** provide guidance and advice related to the application of nursing care.

 **Communication** boxes provide guidance in therapeutic communication skills in realistic patient care situations.

 **Complementary and Alternative Therapies** boxes contain information on how nontraditional treatments for medical-surgical conditions may be used to complement traditional treatment.

 **Cultural Considerations** explore select specific cultural preferences and how to address the needs of culturally diverse patients and families.

 **Focused Assessment** boxes are located in each body system overview chapter and include history taking and psychosocial assessment, physical assessment, and guidance on how to collect data and information for specific disorders.

 **Health Promotion** boxes emphasize healthy lifestyle choices, preventive behaviors, and screening tests.

 **Home Care Considerations** focus on postdischarge adaptations of medical-surgical nursing care to the home environment.

 **Legal and Ethical Considerations** present pertinent information about the legal issues and ethical dilemmas that may face the practicing nurse.

 **Medication tables** provide quick access to information about medications commonly used in medical-surgical nursing care.

 **Nursing Care Plans,** developed around specific case studies, include nursing diagnoses with an emphasis on patient goals and outcomes and questions to promote **critical thinking.** Additional nursing care plans are available on the Evolve site.

 **Nutrition Considerations** related to nursing care for specific disorders address the need for holistic care.

 **Older Adult Care Points** address the unique medical-surgical care issues that affect older adults and provide suggestions for assessment (data collection) and particular interventions for the long-term and home care patient.

 **Patient Teaching** boxes include step-by-step instructions and self-care guidelines.

 **Safety Alerts** emphasize the importance of maintaining safety in patient care to protect patients, family, health care providers, and the public from accidents, spread of disease, and medication-related issues.

 **Think Critically** boxes encourage students to synthesize information and apply concepts beyond the scope of the chapter.

Animations depicting anatomy, physiology, and pathophysiology and available on Evolve are referenced with icons in the margins where applicable.

Best Practice icons highlight current information related to interventions.

Evidence-Based Practice icons highlight current references to research in nursing and medical practice.

Video clips of patient assessment available on Evolve are referenced with icons in the margins where applicable.

Acknowledgments

This textbook would not exist without the efforts of Susan C. deWit—author, educator, and mentor. Her tenacity and insight developed the *Medical Surgical Textbook* as well as the *Fundamentals* text, which have become a solid foundation for LPN/LVN nursing programs. Her vision and clarity in writing have been a pleasure to build on.

In addition to Susan's work, multiple writers have been contributors to or coauthors of previous editions. Their foundational work is appreciated.

In previous editions of the work, Thomas Sadowski has done a phenomenal job with the ESL review and suggestions. He also evaluated every chapter in the text and *Study Guide* and provided recommendations for making information more understandable for ESL students. Likewise, Southwestern Washington Medical Center graciously allowed photography within their facility. Their patients, staff, and administration were so willing to help with whatever they could for the education of nursing students. Jack Sanders is a talented, creative, professional photographer whose beautiful photos continue to be seen throughout this book. Ginger Navarro is a wonderful and efficient photo coordinator, and her help was invaluable.

Marian Regional Medical Center welcomed the use of their facility for real-world photographs to help illustrate concepts and equipment. Their cooperation and collaboration are very much appreciated.

Thank you to the team working on the Test Bank, PowerPoint slides, and TEACH materials. Thanks also to the behind-the-scenes people who keep things moving but never have their names appear in publications.

Thanks to the Elsevier team: Nancy O'Brien, Senior Content Strategist, who has been a joy to work with over many years, and best wishes for an enjoyable retirement; Brandi Graham, Senior Content Strategist, taking over Nancy's assignments; Laura Selkirk, Senior Content Development Specialist, for excellent attention to detail; and Jodi Willard, Senior Project Manager, who has brought this project to fruition. Their dedication, professionalism, and collegiality have kept the project on track. Their continued encouragement, direction, and expertise have greatly improved the work. Thank you.

Teaching nursing has been one of the most exciting and gratifying phases of my career. I hope this textbook and its ancillaries make your job as an instructor easier and your class preparation more time efficient. May your students find excitement and joy in learning and in applying the classroom knowledge to clinical practice, touching and changing lives.

Holly K. Stromberg

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Caring for Medical-Surgical Patients

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

Objectives

Theory

1. Compare the roles and functions of the licensed practical/vocational nurse (LPN/LVN) with those of the registered nurse (RN).
2. Identify sites of employment for LPN/LVNs in medical-surgical nursing.
3. Correlate the nurse practice act (NPA) and the standards of practice for the LPN/LVN that guide the practice of each nurse.
4. Relate how Quality and Safety Education for Nurses (QSEN) applies to LPN/LVN practice.
5. Demonstrate knowledge of how evidence-based practice is formulated.
6. Explain the importance of National Patient Safety Goals and how they relate to patient safety.
7. Predict how *Healthy People 2030* can help decrease health care costs.
8. Determine how the current health care system attempts to provide health care for all.
9. Describe how hospitals are reimbursed under the diagnosis-related group (DRG) system of Medicare, including care excluded from reimbursement.

Clinical Practice

10. Demonstrate ways to provide holistic care.
11. Take part in delegation of tasks to unlicensed assistive personnel (UAP).

Key Terms

active listening (ĂK-tĭv LĪ-sĕn-ĭng, p. 2)
acuity (ă-KŪ-ĭ-tē, p. 4)
advocate (ĂD-vō-kăt, p. 2)
capitation (kă-pĭ-TĀ-shŭn, p. 9)
coinsurance (kō-ĭn-SHŪ-rĕnz, p. 7)
complementary and alternative medicine (CAM) (KŎM-plĕ-MĔN-tĕ-rē ănd ăl-TŪR-nă-tĭv MĔD-ĭ-sĭn, p. 6)
copayment (kō-PĀY-mĕnt, p. 7)
cost containment (kŏst kŏn-TĀN-mĕnt, p. 7)
deductible (dē-DŬK-tĭ-bŭl, p. 7)
delegation (DĔL-ĭ-GĀ-shŭn, p. 3)
dependent (dē-PĔN-dĕnt, p. 10)
diagnosis-related groups (DRGs) (dī-ăg-NŌ-sĭs rē-LĀ-tĕd grūpz, p. 8)
empathy (ĔM-pă-thē, p. 10)
fee-for-service (fē fŏr SĔR-vĭs, p. 7)
health maintenance organizations (HMOs) (hĕlth MĀN-tĕ-nĕnz ōr-gă-nĭ-ZĀ-shŭnz, p. 9)
Healthy People 2030 (HĔLTH-ē PĒ-pl, p. 7)
holistic care (hō-LĬS-tĭk kār, p. 6)
managed care (MĂN-ăjd kār, p. 7)
Medicaid (mĕd-ĭ-KĀD, p. 7)
Medicare (mĕd-ĭ-KĀR, p. 7)
nonjudgmental (NŎN-jŭj-MĔN-tăl, p. 11)
nurse practice acts (NPAs) (nŭrz PRĂK-tĭs ăkts, p. 3)
preferred provider organizations (PPOs) (prĕ-FŬRD prō-vī-dĕr ōr-gă-nĭ-ZĀ-shŭnz, p. 9)
prospective payment system (PPS) (prŏs-PĔK-tĭv pā-mĕnt sĭs-tĕm, p. 8)
provider (prō-VĪ-dĕr, p. 2)
stereotypes (STĔR-ē-ō-tīps, p. 11)
unlicensed assistive personnel (UAP) (un-LĪ-sĕnst ă-SĬS-tĭv pĕr-sŏ-NĔL, p. 3)

Concepts Covered in This Chapter

- Professional Identity
- Safety
- Health Care Quality
- Health Care Economics
- Health Care Law
- Communication
- Culture
- Spirituality

CARING FOR MEDICAL-SURGICAL PATIENTS

Licensed practical/vocational nurses (LPN/LVNs), along with other health care team members, promote and maintain health, prevent disease and disability, care for individuals during rehabilitation, and assist dying patients to maintain the best quality of life possible. Patients can have a single diagnosis of a medical or surgical condition or a combination of medical and/or surgical diagnoses (comorbidity). The nursing

process is used to plan and deliver safe, competent care to patients (or clients). LPN/LVNs carry out prescribed therapeutic regimens and protocols by acting in various roles.

ROLES OF THE LPN/LVN

Today you have an exciting, evolving role as an LPN/LVN. Roles include caregiver, educator, collaborator, **advocate**, leader, and delegator. As a caregiver, you perform treatments, give medications, and provide care to meet patients' basic needs. You gather data to assist in planning and evaluating care. You assist patients with exercise and help them obtain sufficient rest, all while keeping their environment neat, clean, and orderly. Therapeutic communication and **active listening** (listening with concentration and focused energy) are incorporated into your care. You give objective and thorough end-of-shift reports and document objectively about the care given and the status of patients.

Clinical Cues

If a patient declines morning care (bath, brushing teeth, etc.), you can be flexible and fit it in elsewhere in your day, as time allows. Leaving care to be performed by the next shift is not acceptable practice because it burdens the oncoming staff. Listen to the patient's reasons for not wanting care. If it appears that care really is being refused for a complete day, talk with the staff nurse or charge nurse about it. Although the patient does have the right to refuse care, you can often gain the patient's cooperation if the benefits of care are explained. Conferring with more experienced team members can help a new nurse determine when the routine can be altered in the patient's best interests.

As an educator, you provide health teaching to patients and their significant others to maintain wellness or promote healing. An important aspect of nursing care is to show patients and families how to care for themselves or for loved ones to prevent complications, restore health, and prevent further illness. You teach basic hygiene and nutrition to promote good health. Examples of teaching include reinforcing what the registered nurse (RN) or **provider** advises regarding scheduled diagnostic tests, upcoming surgery, how to treat a wound, or how to change a dressing, while also addressing the patient's questions and concerns. Other teaching activities concern how to take prescribed medication, what side effects to report, and the self-care activities and lifestyle changes required to promote rehabilitation and independence. You contribute to the discharge plan by reinforcing discharge instructions and providing information to patients about community resources and self-help groups.

Fig. 1.1 A nurse, social worker, and nurse manager collaborate on finding resources for a patient.

Think Critically

How could you reinforce dietary teaching for a patient newly diagnosed with diabetes?

As a collaborator, you interact with other members of the health care team to provide the patient with an integrated, comprehensive plan of care (Fig. 1.1). You work closely with the RNs and nursing assistants to ensure that all aspects of the patient's basic needs are met. When you share information with the team members, the team can best use the expertise and experience of the various team members. You assist in recognizing when a patient is experiencing complications and intervene to maintain patient safety. You assist with the discharge plan and deliver discharge instructions and teaching.

Facility and unit routine can lead to an impersonal health care system that loses its focus on patients' rights. The American Hospital Association (AHA) published *The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities* in 2003, and this is still the document in use. As an advocate, you stand up for patients' rights and ensure that their needs are met. Advocating for a patient could be as simple as arranging for special food or meals at times other than those within the facility's routine, or it may entail informing the health care provider of a patient concern.

Think Critically

What other situations might require you to be an advocate for your patient?

The most common leadership role for the LPN/LVN is in a long-term care facility (nursing home). In this setting, the LPN/LVN commonly assumes the role of charge nurse. Many **nurse practice acts (NPAs)** specifically state that the LPN/LVN charge nurse in a nursing home functions under the general supervision of an RN, who is either on-site or available by phone.

Think Critically

What (if any) restrictions does your state's NPA place on the charge nurse position?

As a leader and delegator, you must know when and which tasks to delegate and which to assign to nursing assistants when acting as the charge nurse (Fig. 1.2). The charge nurse assigns tasks within the job description and capability of **unlicensed assistive personnel (UAP)** to distribute the workload among available staff. To **delegate** is to transfer authority. In the LPN/LVN leadership context, **delegation** involves transferring to qualified UAP the responsibility to perform a selected nursing task or activity in a selected patient situation that is within the job description of the one delegating. You must be knowledgeable about the skills and judgment capabilities of those to whom you delegate. Not all state NPAs include delegation of nursing tasks or activities as an LPN/LVN role, and state NPAs vary greatly on protocol for delegation (Box 1.1). Appropriate tasks to delegate include the following:

- Those that frequently reoccur in the daily care of patients
- Those that do not require the UAP to exercise nursing judgment
- Those that do not require complex application of the nursing process
- Those for which results are predictable and potential risk is minimal
- Those for which a standard procedure is to be used

Fig. 1.2 A charge nurse is assigning tasks to nursing assistants.

Clinical Cues

The LPN/LVN always works under the supervision of an RN or a licensed health care provider.

Because a patient's condition can change so rapidly, judgment must be developed through experience as to what and when it is wise to delegate. The position paper of the National Council of State Boards of Nursing (NCSBN), originally published in 2006 updated in 2016, with an effective date of 2019, titled *ANA and NCSBN Joint Statement on Delegation* provides a decision-making algorithm to be used by licensed individuals in clinical settings as a guide for delegating nursing duties. The position statement identifies "Five Rights" to ensure when delegating:

1. **Right Task:** The task can legally be delegated for a specific patient.
2. **Right Circumstances:** The patient is stable, independent nursing judgment is not required for the task, and resources to perform the task are available.

Box 1.1 Comparison of Assigning and Delegating by the LPN/LVN Charge Nurse

Ask yourself the following questions:

1. Are the tasks or activities within a nursing assistant's job description?
   - **When assigning:** Yes.
   - **When delegating:** No. The tasks or activities delegated are in the job description of the LPN/LVN. Specific tasks and activities are not listed. Permitted delegated tasks or activities depend on the NPA, patient situation, and documented expertise of the nursing assistant.
2. May the nursing assistant refuse the nursing task or activity?
   - **When assigning:** No, unless staff person thinks they are unqualified for the task or activity assignment.
   - **When delegating:** Yes. In addition, the nursing assistant must voluntarily accept the task or activity.
3. Who holds accountability for the nursing task or activity?
   - **When assigning:** The nursing assistant is accountable for completing the task or activity and doing so in a safe manner.
   - **When delegating:** The LPN/LVN is accountable for delegating the right task or activity to the right person.

Adapted from Knecht P: *Success in practical/vocational nursing: from student to leader,* ed 9, Philadelphia, 2021, Elsevier.

3. **Right Person:** The person asked to perform the task is competent and qualified to do so.
4. **Right Direction and Communication:** The objective and specifically what should be done and when, what to report to the delegating nurse, and when to make the report are explained.
5. **Right Supervision and Evaluation:** The delegating nurse needs to monitor the performance of the task, to intervene when needed, to evaluate the results of the task, to ensure proper documentation, and to provide feedback to the unlicensed person.

Working with others in this supervisory capacity requires tact and effective communication skills. Therapeutic communication should be used when communicating with staff, especially when making requests. Address staff by name to gain their attention and explain the purpose of the communication. Explain the requirements of a request and offer a timeline for completion. Obtain feedback that the request was understood and again when it is carried out, and express appreciation for cooperation and the work completed. You are responsible for care given by others to whom you have delegated. Tasks assigned must be verified to have been completed and to have been accomplished properly, and the care given must be documented.

Think Critically

What is your role as a member of the team when in the clinical area? List three examples. To whom on staff do you communicate the care you give? To whom do you go with questions? What is your instructor's role?

EMPLOYMENT OPPORTUNITIES

In today's medical atmosphere, hospital care involves high-**acuity** patients (very ill patients with complex needs) who require a high level of nursing care. Hospitals are using more and more RNs because of the complexity of care. Employment opportunities for LPN/LVNs vary considerably geographically, with most graduates of practical/vocational nursing programs being employed in long-term care, extended care, or community-based settings. Some sites of employment are listed in Box 1.2.

Think Critically

What are the current medical-surgical opportunities for employment where you live? List two agencies you can contact for this information.

ETHICAL AND LEGAL PRACTICE

Each state's NPA defines the role and scope of practice of LPN/LVNs. It is always your responsibility to be aware of the scope of the practice act of the state in which you are employed. Ethical practice means that the LPN/LVN abides by the *Code for Nurses* learned in the Fundamentals of Nursing course, adheres to the National Patient Safety Goals, and honors privacy according to the Health Insurance Portability and Accountability Act (HIPAA). National Patient Safety Goals evolve from year to year (Table 1.1).

Box 1.2 Sites of Possible Employment for LPN/LVNs

AREAS WITHIN A HOSPITAL
- General patient units
- Outpatient surgery
- Intermediate care unit (step-down unit)
- Intravenous (IV) therapy team[a]
- Emergency department

ADDITIONAL SITES FOR EMPLOYMENT OPPORTUNITIES
- Long-term care facility (nursing home)
- Ambulatory care (clinics and health care provider offices)
- Rehabilitation services (extended care, postacute care, subacute care)
- Hospice care
- Adult group homes
- Assisted living facilities
- Homes for individuals with developmental disabilities
- Home health care
- Hospice care agency
- Military service
- Jails and prisons

[a]Requires postgraduate education and certification.

Think Critically

Nurse practice acts vary considerably from state to state. Where can you obtain a copy of your state's NPA?

Follow your institution's guidelines and policies. The facility might more strictly limit the LPN/LVN's role than does the state's NPA, but **no employer can give nurses permission to do more than their license allows.** The National Association for Practical Nurse Education and Service (NAPNES) and the National Federation of Licensed Practical Nurses (NFLPN) are practical/vocational nursing organizations that provide standards to guide the role of the LPN/LVN. These standards of practice echo the values and priorities of the profession, provide guidelines for safe and competent nursing care, and may also be used as legal standards in court.

QUALITY AND SAFETY

In *Health Professions Education: A Bridge to Quality,* the Institute of Medicine (IOM, 2003) identified the following five competencies:

1. Provide patient-centered care.
2. Collaborate with the interdisciplinary health care team.
3. Implement evidence-based practice.

Table 1.1 National Patient Safety Goals 2021 (Hospital)

Identify patients correctly	Use two ways to identify patients. This is done to ensure that each patient gets the correct medication or treatment. Make sure that the correct patient gets the correct blood when they get a blood transfusion.
Improve staff communication	Get important test results and data to the right staff person in a timely manner.
Use medicines safely	Before a procedure, label medicines that are not labeled. Do this in the area where medicines and supplies are set up. Be very careful with anticoagulant medications. Do a medication reconciliation for each patient as they are admitted, after surgery, and when being discharged. Explain to the patient the importance of taking a medication list to each health care provider visit.
Use alarms safely	Ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	Use hand-cleaning guidelines from the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO). Use proven guidelines to prevent infections that are difficult to treat, of the blood from central lines, after surgery, and of the urinary tract caused by catheters.
Identify patient safety risks	Identify patients at risk for suicide. Applies to nonpsychiatric settings in the patient population being treated for emotional or behavioral disorders.
Prevent mistakes in surgery	Make certain that the correct surgery is done on the correct patient and at the correct site on the patient's body. Mark the correct place where surgery is to be done. Pause before the surgery to make certain that a mistake is not being made.

Data from The Joint Commission: *2021 National Patient Safety Goals*, Oakbrook Terrace, IL, 2021, The Commission. https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2021/simplified-2021-hap-npsg-goals-final-11420.pdf.

4. Use quality improvement in patient care.
5. Use informatics in patient care.

Multiple interdisciplinary agencies published *Core Competencies for Interprofessional Collaborative Practice* (Schmidt et al., 2011), which further developed these five competencies. The Leapfrog Hospital Safety Grade (2020) organization states, "As many as 440,000 people die every year from hospital errors, injuries, accidents and infections."

The Quality and Safety Education for Nurses (QSEN) initiative added *safety* as a separate competency to the IOM set. Specific knowledge, skills, and attitudes have been identified to assist with the development of the competencies incorporated into nursing curriculum.

Patient-centered care means that the patient is a full partner in decisions about their care. Compassionate and coordinated care should be planned and delivered with respect and consideration for the patient's preferences, values, and needs. Collaboration with the interdisciplinary (ID) team requires open communication, mutual respect, and shared decision making. An important member of the ID team is the care manager, who may be a designated nurse or a social worker within the hospital. The case manager strives to work with the ID team to provide quality and cost-effective services and resources so that positive patient outcomes are achieved.

EVIDENCE-BASED PRACTICE (EBP)

Evidence-based practice uses the best current evidence from research findings to make decisions about patient care. Evidence data are drawn from quality improvement (QI) practices, management initiatives such as those from The Joint Commission (TJC), and professional organization standards. Formulation of guidelines involves reviewing current research (evidence), testing the findings in clinical settings, distributing the guidelines, and then keeping them current. Nurses are expected to provide care based on scientific studies to ensure best practice. Nurses must continually seek scientific evidence that supports best patient outcomes.

QUALITY IMPROVEMENT

Nurses use data from completed interventions to monitor the outcomes of the care delivered by various processes and then use the resulting data to design methods of quality improvement. Each accredited health care agency has a QI program in place that sets standards for care (Fig. 1.3). These standards are based on standards for nursing practice set by the American Nurses Association, the AHA, and TJC. Various models may be used for monitoring and improving quality, including total quality management (TQM), continuous quality improvement (CQI), and Focus, Analyze, Develop, Execute (FADE). Nursing units may have a QI committee or delegate nursing staff to do periodic audits of charts to determine whether standards of care are being upheld and to what extent compliance is occurring. The goal is to find discrepancies and continually improve the safety and quality of patient care systems (QSEN Competencies, 2020). Medical-surgical nurses are expected to do the following:

- Identify indicators to monitor the quality and effectiveness of care delivered.
- Gather and evaluate data to monitor the effectiveness of care.

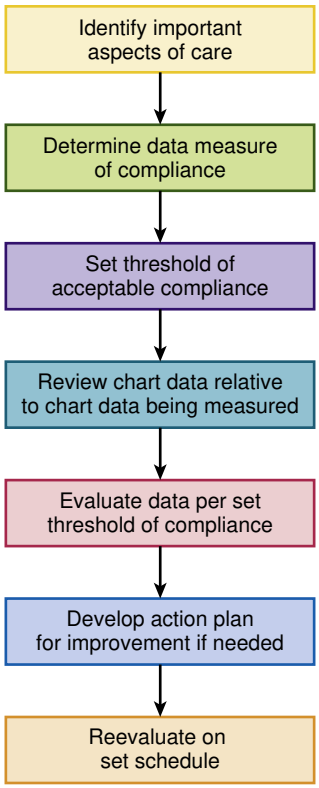

Fig. 1.3 Continuous quality improvement process.

- Recommend ways to improve care.
- Implement activities to improve care.

INFORMATICS

Using information and technology to communicate, manage knowledge, prevent or mitigate error, and support decision making comprises informatics (QSEN Competencies, 2020). The key components of informatics are communication, documentation, electronic data access, and data use. The electronic health record (EHR), or electronic medical record (EMR), is at the heart of informatics. The EHR is central to documenting nursing and interdisciplinary care and patient health data.

Central hospital or agency computers store all data and connect to the internet to allow searches for information on disease processes, medications, diagnostic tests, current care guidelines, and evidence-based practice research. Mobile devices are also used by health care professionals for data access and team communication through text or email. Many health professionals use tablets or smartphones to access data and to communicate with other team members. Devices used for communication of patient information must be approved by the facility to ensure secure data transfer.

SAFETY

Every nurse should consider safety during every patient interaction. Patients are vulnerable to injury when they are ill or incapacitated in the hospital. The NCSBN has identified areas in which nursing practice can improve safety. Clear communication of patient data and clinical assessments is one area. Using the SBAR (Situation, Background, Assessment, and Recommendation) technique when communicating with other members of the team is one way to promote clarity and safety. The Joint Commission Sentinel Event Report (TJC, 2017) identified the hand-off report as a major point of miscommunication. The website for The Joint Commission Center for Transforming Healthcare has several suggested techniques to improve hand-off communication (Joint Commission Center for Transforming Healthcare, 2020).

Be attentive to the National Patient Safety Goals (see Table 1.1). It is vital that you prepare medications in a quiet atmosphere and use the Six Rights of medication administration and nursing responsibilities when administering medications to patients. You must know the purpose, action, side effects, and nursing implications of each medication to be given. Evaluation of the medication's effect is often given insufficient attention. Always check orders carefully before performing a procedure. To ensure patient safety as well as your own, rigorously adhere to infection control guidelines at all times and use proper equipment and methods to lift and turn patients to avoid injuries. Always check electrical equipment before use. Report unsafe practices and self-report errors to promote a safer environment. Follow core measures that are in place to prevent infection to promote better patient outcomes.

HEALTH CARE TODAY

BIOMEDICINE

Biomedicine is the dominant health system in the United States and focuses on symptoms. The goal of biomedicine is to find the cause of disease and to eliminate or correct the problem; it does not emphasize prevention. However, many Americans use methods that focus on the whole body—and not exclusively on symptoms—when treating disease. Holistic medicine, or **holistic care**, incorporates a variety of measures and techniques to treat the whole person including the mind, not just the body.

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)/INTEGRATIVE MEDICINE

Complementary (used in conjunction with biomedical treatments) **and alternative** (substituted for biomedical medicine) **medicine (CAM)** focuses on assisting the body's own healing powers and restoring body balance. The National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) researches and evaluates the effectiveness and safety of CAM therapies. Natural medicines often have not undergone scientific studies to determine correct doses, side effects, or risk of interactions with other medicines or foods. Patients need to be reminded that all herbals and supplements need to be included when they are asked for a list of drugs taken.

Integrative medicine is a specialty that melds biomedical, complementary, and alternative approaches in treatment. The foundational principles include (1) consideration of all factors that influence health, wellness, and disease, including mind, body, and spirit; (2) use of conventional and alternative methods to facilitate the body's innate healing response; (3) appropriate consideration given to use of less invasive and less harmful interventions, when possible, while addressing the whole person in addition to the disease; (4) the concept that medicine is based on good science, is inquiry-driven, and is open to critical consideration of new paradigms; and (5) health care is best provided as a partnership between physician and patient (American Board of Physician Specialties, 2020).

HEALTHY PEOPLE 2030

Healthy People 2030 is a health promotion and disease prevention initiative by the U.S. Department of Health and Human Services (HHS) aimed at improving the health of people in the United States by promoting longer, healthier lives. The four overarching goals are as follows:

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity, eliminate disparities, and improve the health of all groups.
3. Create social and physical environments that promote good health for all.
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

Individuals, groups, and organizations must work together to incorporate the goals of *Healthy People 2030* into current programs, education, special events, publications, and meetings. Every LPN/LVN has the responsibility to educate patients about healthy lifestyles and to work with their communities through education for health promotion. You can also model healthier lifestyles for your patients by not smoking, maintaining healthy eating habits, and exercising.

FINANCING OF HEALTH CARE

HEALTH INSURANCE: GOVERNMENT AND PRIVATE FUNDING

It is helpful to understand a little about payment methods because it is important to keep **cost containment** in mind when delivering nursing care. Health insurance, like any type of insurance, spreads risk among a group of insured individuals. The young and the healthy generally do not have claims for as many health care services as older adults. When the fee structure is equivalent for all, the young and healthy subsidize (support) the sick and older people covered by the insurance provider. Most full-time employees can obtain private health insurance through their employers. People of working age who are healthy enough to continue full-time employment are not the biggest consumers of health care dollars. Retirees with chronic health problems and younger people not able to work traditionally had difficulty obtaining health insurance, so in 1965 Medicare and Medicaid were created by the federal government to cover the needs of these groups. Today, Medicare and Medicaid fund the care for 58% of hospitalized patients.

At the time of this writing, the federal government is again making changes to the health care financing laws and options.

The traditional method of financing health care services, **fee-for-service**, involves direct reimbursement by an insurance company to a provider (a licensed health care professional such as a health care provider, dentist, or nurse practitioner) whose health care services are covered by a health insurance plan. To improve coverage of costs, insurance providers charge a **deductible** (the yearly amount an insured person must spend out-of-pocket for health care services *before* the insurance provider will begin to pay for services), a **copayment** (the amount an insured person must pay at the time of an office visit, for a prescription, or for hospital service), and **coinsurance** (once a deductible is met, the percentage of the total bill the insured person must pay). The insurance company subtracts the amount the patient must pay from the total bill and then pays the remainder to the provider.

Medicare is a federal public insurance program that helps to partially finance health care for everyone older than 65 years (and their spouses) who have at least a 10-year (40 quarters) record in Medicare-covered employment and who are citizens or permanent residents of the United States. Coverage is also given to people younger than 65 years who have end-stage renal disease or are permanently and totally disabled. Those eligible because of age or disability are entitled, by law, to the benefits of Medicare programs. In November 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, the largest expansion of Medicare since it was enacted in 1965 (Box 1.3). Medicare A covers hospital and durable medical equipment expenses. Part B of Medicare covers out-of-hospital expenses. Medicare Part C involves **managed care** providers. Part D is the Medicare drug program that covers a portion of prescription expenses. There are monthly premiums for Parts B, C, and D, as well as deductibles and copayment amounts. Many patients with Medicare purchase a private supplemental health insurance policy to help pay for expenses not covered by Medicare.

The **Medicaid** program, which is funded jointly by the federal and state governments, provides medical assistance for eligible families and individuals with low incomes and few resources. Each state establishes its own program services and requirements, including eligibility. Proportionally, Medicaid is the second largest item in state budgets (Box 1.4). The program is meant to cover the population of people considered to be living below the federal poverty level (FPL). Many people just above the FPL are working families who do not have insurance.

Box 1.3 Basic Components of Medicare

MEDICARE PART A
- Is available without cost to those eligible for the program.
- Helps pay for inpatient hospital care, including drugs, supplies, laboratory tests, radiology, and the intensive care unit.
- Covers 20 days after hospitalization at a skilled nursing facility for rehabilitation services, home health care services under certain conditions, and hospice care.
- Does not pay for nursing home custodial services (e.g., patients needing help only with activities of daily living or feeding), private rooms, telephones, or televisions provided by hospitals or skilled nursing facilities.

MEDICARE PART B
- Is similar to a major medical insurance plan and is funded by monthly premiums based on income.
- Requires a deductible and pays 80% of most covered charges. The remaining 20% of charges are the patient's responsibility.
- Helps pay for medically necessary providers' services; outpatient hospital services (including emergency department visits); ambulance transportation; diagnostic tests, including laboratory services and mammography and Pap smear screenings; and physical therapy, occupational therapy, and speech therapy in a hospital outpatient department or Medicare-certified rehabilitation agency.
- Does not pay for most prescription drugs, routine physicals, services not related to treatment of illness or injury, dental care, dentures, cosmetic surgery, routine foot care, hearing aids, eye examinations, or glasses.

MEDICARE PART C
- Refers to Medicare Advantage plans, such as health maintenance organizations (HMOs) or regional preferred provider organizations (PPOs).
- Provides Parts A, B, and D benefits to people who elect this type of coverage instead of the original fee-for-service program.

MEDICARE PART D
- Refers to the outpatient prescription drug benefit.
- Is available to all Medicare enrollees in the original fee-for-service program for an additional monthly fee.

The federal government has been attempting to set up a system of insurance that will allow health care coverage for all. The role of the government in health care and the components of the plan have been the topics of much discussion and disagreement. The Affordable Care Act (ACA) was implemented in 2010 by the Obama administration, and the American Health Care Act (AHCA) was proposed by the Trump administration in 2017, passing in the House but not the Senate. Despite challenges, the ACA was upheld for the third time by the Supreme Court in June 2021. The goal is to have a mechanism for affordable insurance for those not covered by employers or not able to purchase private insurance due to health circumstances or income. The HHS has identified multiple strategic goals, the first being to strengthen health care (Box 1.5).

Box 1.4 The Medicaid Program

- Medicaid is the second largest item in state budgets and covers more than 50 million low-income children and individuals, many in working families.
- Medicaid is the largest source of health insurance for children in the United States. The Children's Health Insurance Program (CHIP) supplements Medicaid in some states by providing coverage for children from lower-income families who do not qualify for Medicaid.
- Medicaid is the primary source of health and long-term care coverage for low-income individuals with disabilities or chronic illnesses and those who need mental health services and substance abuse treatment.
- Medicaid covers services that Medicare does not cover for low-income Medicare beneficiaries, including long-term care and vision and dental care. Medicare beneficiaries who are also enrolled in Medicaid are known as *dual eligibles.*

Box 1.5 HHS Strategic Goal: Strengthen Health Care

- Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured.
- Improve health care quality and patient safety.
- Emphasize primary and preventive care, linked with community prevention services.
- Reduce the growth of health care costs while promoting high-value, effective care.
- Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.
- Improve health care and population health through meaningful use of health information technology.

COST CONTAINMENT

The driving force today in all health care facilities is cost containment (holding costs to within fixed limits while remaining competitive in the health care marketplace). Health care agencies are interested in improving their "bottom line" with business principles that reduce waste and inefficiency. Consumers want the cost of health care to be reduced while high-quality care and service are maintained. Service, quality, and cost control are attributes of health care that need to be understood and considered in all clinical situations (Box 1.6).

The federal government was the first group to try to stop the skyrocketing cost of health care. In 1983 the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services [CMS]) adopted a system called **diagnosis-related groups (DRGs)**, or illness groups. This system pays hospitals a flat rate for Medicare services, and hospitals know in advance how much they will be reimbursed by this **prospective payment system (PPS)**. Under the DRG system, the fee the government will pay for hospitalization depends on the DRG category (illness). Hospitals receive a flat fee for each patient's DRG category, **regardless of length**

Box 1.6 LPN/LVN Role in Containing Health Care Costs in the Work Setting

1. Only take linens and supplies that will be used immediately into the patient's room. Supplies not used for the patient must be put in the trash and unused linens must be rewashed.
2. Follow facility policy for documenting all patient care for reimbursement.
3. Organize patient care for effective and efficient use of time. It is less expensive to do something right the first time.
4. Implement nursing care to help prevent complications and catch signs of complications.

of stay in the hospital; thus hospitals have an incentive to treat patients and discharge them as quickly as possible. If the hospital keeps the patient longer than the government's fee will cover, and the patient cannot be reclassified in the DRG system, the hospital must absorb the difference in costs. However, if the acute care facility can treat the patient for less than the guaranteed reimbursement amount, **the facility can keep the difference in payment as profit.** Because Medicare patients, like all patients, are discharged sooner from hospitals than they were in the past, extended care units or skilled care facilities and home care are commonly used to continue convalescence. With the goal of improving quality of care and saving millions of taxpayer dollars each year, Medicare will not cover specific *preventable* conditions of hospitalized patients (Box 1.7). To prevent premature discharge, Medicare will either not cover the hospitalization or levy a fine if readmission occurs within a defined period.

When Medicare and Medicaid adopted DRGs, the private insurance companies followed their lead. The organization that is the largest health care insurance system thereby provides the most funding to health care providers and sets the standards for reimbursement. Guidelines and methods used by Medicare and Medicaid have become the standard for insurance payment to health care facilities and providers.

? Think Critically

Should Medicare pay for new, expensive technological procedures developed to treat common medical problems of older adults? Should cost-effectiveness be a factor in treating Medicare patients? Explain the reasoning behind your answer.

Another measure aimed at cost containment is **capitation**, an alternative to fee-for-service payment. It involves a set monthly fee charged by the provider of health care services for each member of the insurance group for a specific set of health care services. If services cost more than the monthly fee, the provider absorbs the cost of those services. At the end of the year, if any money is left over from the unused portions of monthly fees, the health care provider keeps this remainder as a profit.

Managed care is a type of group health insurance developed to provide quality health care with cost and care use controls. This is accomplished by paying providers to care for groups of patients for a set capitation fee and by limiting services. Medical necessity and the appropriateness of health care services are monitored by a use review system. Types of managed care systems include **health maintenance organizations (HMOs)** and **preferred provider organizations (PPOs)**. This option is used by both Medicare and private insurance companies.

Box 1.7 Health Care–Associated Conditions Not Paid for by Medicare or Medicaid

The conditions listed are those that are acquired during hospitalization and considered preventable.

- Foreign object left in the patient after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, electrical shocks)
- Poor glycemic control (diabetic ketoacidosis, hyperosmolar hyperglycemic state, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Catheter-related urinary tract infection
- Vascular catheter–associated infection
- Surgical site infection after coronary artery bypass graft, particularly mediastinitis (infection in the chest), or after bariatric surgery, gastroenterostomy, laparoscopic gastric restrictive surgery, or orthopedic procedures
- Deep vein thrombosis or pulmonary embolism after total knee replacement or hip replacement
- Surgical site infection after cardiac implantable electronic device insertion
- Iatrogenic pneumothorax with venous catheterization

Data from Centers for Medicare and Medicaid Services (CMS): Medicare program: general information, 2020. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.

PROVIDING HOLISTIC CARE

Holistic nursing care involves being aware of and attending to the physiologic, psychological, social, cultural, and spiritual needs of patients. Data for many of these needs can be collected and interventions carried out while care and treatments are administered. Assisting with bathing, feeding, ambulating, and other physical care provides an opportunity to find out about dimensions of the patient's life beyond physical problems. Use time with the patient constructively. Data gathering guidelines are presented in Chapter 2.

PROMOTING A THERAPEUTIC NURSE-PATIENT RELATIONSHIP

The focus of the nurse-patient relationship is on the patient's problems and needs. The relationship is therapeutic because it provides the patient with the help needed for healing or for a return to wellness. In comparison, a social relationship lacks goals, exists primarily for pleasure, and meets the needs of each person in the relationship. You need to maintain a therapeutic

relationship when working with patients and avoid using patient contact to meet personal needs (e.g., the need to be liked, for friendship, or for approval). Develop awareness of your own personal needs and separate them from the patient's needs. A therapeutic nurse-patient relationship ends when the patient has completed treatment or therapy.

A patient who is physically ill is also affected emotionally by the illness or injury. It is not unusual for patients to display behavior that is not their usual manner. Patients' emotional needs and the resulting behaviors are usually temporary and related to the stresses of illness. Occasionally patient behavior is related to underlying disorders that will benefit from a psychiatric consultation or treatment (see Chapters 46 to 49). Even patients whose primary illness is physical rather than psychological can sometimes express emotional discomfort through **dependent** (inability or unwillingness to do tasks for oneself), withdrawn, hostile, or manipulative behavior. They may act in ways that are confusing and uncomfortable for a nurse who is not prepared to act therapeutically. It is important to not take statements or behaviors personally but to objectively consider why the patient may be responding in this manner (see the Evolve website for Nursing Interventions for Patients with Difficult Behaviors). It is particularly important to note if this is a change in behavior and may signal a change in condition.

It is easier to deal with patients' behavior if their responses to particular situations are understood. Your task is to recognize that patients' behavior results from their current situation. Appropriate nursing responses require kindness, understanding, and sometimes firmness. People may become childlike and fearful when they are ill, or they may act as if they are unaffected by their illness. Patients appreciate having someone available to guide them through their ordeal in a therapeutic manner.

Think Critically

When assigned to a patient recuperating from major surgery who is displaying very dependent behavior, how can you help promote a return to independence?

Inability to assume personal responsibilities can be a source of worry for patients and may interfere with a positive outcome after illness or surgery. Some patients are caring for aging parents; are grandparents who play an active, daily role in caring for grandchildren; or are single parents with young children. If a patient lives alone, pet care may be a concern. Patients who are employed may have used up available sick leave, may not have health insurance, or may have a high insurance deductible that is a concern. Patients enrolled in an educational program might be concerned about having to drop a course or leave a program because of time lost to hospitalization, diagnostic tests, or restrictions such as not being able to drive. Conversing with these patients in a therapeutic manner may help them identify their concerns and begin problem solving.

Think Critically

What effect would your admission today for an emergency appendectomy have on your life? How could you resolve your concerns? Who could help you in this situation?

Establishing Trust

To develop a therapeutic relationship, trust needs to be established between the patient and the nurse. In today's health care system, time with patients is limited and each patient contact must be used efficiently. Knock before entering the room, give your name, identify yourself as a nursing student or LPN/LVN student, and give the reason for your visit. Explain how long you will be on duty, inform the patient when to expect meals to arrive and the approximate time health care providers may visit, and so on. Explain what care will be given on the shift and when it will be offered. Many older patients are not accustomed to the informality of having strangers address them by their given (first) name. Clarify how the patient would like to be addressed. Put the patient at ease with a pleasant, unhurried approach.

Using Empathy

An important part of the nurse-patient relationship is your ability to demonstrate empathy. No one can know or feel what another experiences. **Empathy** involves accurately perceiving the patient's feelings and understanding their meanings, even though you cannot experience the same emotional effect of these feelings, and displaying appreciation for what the other person is feeling.

An empathetic nurse conveys the interpretation of the patient's feelings back to the patient, for validation of accuracy. In this way, the patient's feelings are valued and accepted as legitimate. An example of an empathetic statement is "You appear to be upset about your surgery tomorrow." In contrast, sympathy involves entering into feelings with patients and is displayed by showing sorrow and pity. An example of a sympathetic statement is "You poor thing. I had that surgery." Patients judge their health care experiences by the nature of the help they receive.

Using Therapeutic Communication

Communicate at the level of the patient's understanding. Active listening helps the patient express needs and feelings. Ask patients what they think and actively listen to their answers, concerns, and fears by rephrasing the message when the patient is finished to verify that you understand. Avoid judging the message or the patient. Make sure that the patient's and your verbal and nonverbal communication are congruent. Avoid forming a response while the patient is speaking. Answer all of the patient's questions, when possible. Admit when you do not know the answer to a question and find out and deliver the

answer as soon as possible. The focus needs to be on the physical and mental well-being of patients. Thank the patient for cooperation and attention as appropriate.

Maintaining Patients' Self-Esteem

A major problem for patients of any age during illness or debilitation is the loss of self-esteem. Avoid referring to a patient by the illness or diagnosis; instead refer to the patient by name. Identify the strengths of patients and find a way to support those strengths and thereby sustain their self-esteem. Allowing patients to perform what self-care they can manage and praising them for any effort with activities of daily living or rehabilitation exercises helps rebuild self-esteem. Nurses and providers are especially important in providing encouragement.

Think Critically

Have you observed a patient being treated in a less-than-respectful manner? How did it make you feel? How would you have treated the patient to preserve or build self-esteem?

Ensuring Pain Control

Many nursing actions help decrease patient stress, but pain control is an especially important action. Anticipate patients' pain control needs before they are expressed—for example, administer prescribed pain medication before painful procedures. After surgery, regularly assess for pain and medicate as needed per orders. Patients with chronic disease often need regular medication for pain relief. Assess the need for further pain medication before the next dose is due and determine whether the medication is effective. If the pain medicine is not doing its job, approach the health care provider and ask for an order change. Use adjunctive measures such as distraction for pain control. Provide whatever comfort measures you can, such as a straightened bed or a massage for added relief. Touch can be reassuring, calming, and encouraging to patients. In this era of awareness of sexual harassment, some nurses may be afraid to touch patients. Ask if touch is okay or touch an arm or a hand and watch the patient's reaction to see if this gesture is acceptable. Be aware of cultural taboos about being touched. Touch that is therapeutic can range from a friendly touch on the shoulder to massage or exercise of joints. Touch has been shown to effectively help manage pain in patients experiencing illness or disease.

MEETING CULTURAL NEEDS

Health care must accommodate patients of many cultural backgrounds. Patients may think and behave differently because of social class, religion, ethnic background, minority group status, marital status, or sexual preference. Avoid making judgments about people who are culturally different from you. You should be open-minded and

Older Adult Care Points

- Treat older adults with respect. Do not assume a mental impairment is present unless one is stated by the health care provider in the chart. Speak at a normal volume, with a medium to low pitch, and enunciate clearly.
- Be certain eyeglasses and/or hearing aids are in place before beginning an interaction.
- Display patience and plan extra time because it may take older adults longer to accomplish usual tasks or to formulate answers to questions.
- Give information slowly and ask for feedback to evaluate understanding. Supply printed material when possible.
- Have the patient answer questions rather than allowing other family members or friends to answer.
- Include the older adult in decision making and care planning.

nonjudgmental, take differences at face value, accept people as they are, and give high-quality care. **Transcultural nursing** involves recognizing cultural diversity and delivering nursing care that is sensitive to the particular needs of the patient and family. To do this you must develop cultural competence through knowledge of various cultures and by being sensitive to issues and preferences related to culture, race, gender, sexual orientation, social class, and economic situation. Cultural competence requires examining your own values, attitudes, beliefs, and prejudices; keeping an open mind; and attempting to look at the world through the perspectives of diverse cultures.

Think Critically

Discuss with your classmates any examples of judgmental behaviors you observed in staff members during your clinical rotation.

The philosophy of **individual worth** is the belief in the uniqueness and value of each human being. Nurses need to realize that individuals have the right to live according to personal beliefs and values **as long as those beliefs and values do not interfere with the rights of others and are within the law.** Applying information to all individuals in a group can lead to assumptions, which are called **stereotypes**. A stereotype is a generic simplification used to describe all members of a group, without exception. Stereotyping is an element of profiling and provides an expectation that all individuals in a group will act in a particular way in a given situation. Profiling ignores individual differences. Members of any group or culture may not wholly observe the values and practices of their culture. Information about cultural groups can help explain—but cannot predict—individual behavior.

MEETING SPIRITUAL NEEDS

Spirituality incorporates the beliefs and values that provide strength and hope, awareness of self (including

Cultural Considerations

Examples of Cultural Preferences

- People from the Philippines are very courteous and are hesitant to say "no" or disagree, particularly with someone they hold in esteem. This may result in an individual giving the impression that they understand instructions from the health care provider or nurse when in fact they do not. They may make little direct eye contact since it is considered rude and confrontational. Avoiding eye contact is considered a sign of respect. Family is important, and a family member should be allowed at the bedside at all times. Due to modesty, the patient may be reluctant to venture out of the room to ambulate.
- Many Cambodians believe that the soul resides in the head, and it is inappropriate to touch their heads without permission. Ask before touching the head when changing head dressings or administering eye drops. Lowering the eyes or looking downward when being spoken to or instructed by someone deemed superior or older is a sign of respect.
- Hmong from Southeast Asia do not traditionally shake hands. Greetings are delivered verbally. Information giving and decision making should be accomplished through the head of the household. Physical marks that are related to home treatments may be seen on the body.
- When disease strikes, people may blame pathogens (germs), spirits, or an imbalance in the body. Some cultural groups have folk medicine rituals or special procedures to address maladies (e.g., rubbing the skin with the edge of a coin to release the toxins causing illness). Some groups have special individuals who are charged with curing disease (health care provider, herbalist, shaman, or curandero). Some groups believe that special foods, food combinations ("cold" foods for "hot" illness), or herbs (echinacea, feverfew) can prevent or cure illnesses. Others see no relationship between the diet and health. Some patients consider the prevention of illness as an attempt to control the future; they may wonder about the need to see a health care provider for preventive care (e.g., immunizations). Different beliefs of patients need to be respected.

inner strengths), and understanding of life's meaning and purpose. Patients have a spiritual self with spiritual needs and may use spiritual practices to meet those needs. Examples of personal spiritual practices may include gardening, reading inspirational books, listening to music, meditating, praying, communing with nature, practicing breathing techniques, volunteering, expressing gratitude, and counting blessings.

Spirituality and *religion* are related terms, but they do not have the same meaning. Religion attempts to formalize and ritualize spiritual beliefs. Some patients fulfill spiritual needs by belonging to a religious denomination. Concrete symbols, such as books, pictures, icons, herb packets, beads, statues, jewelry, and other objects, can affirm patients' connection with their belief in a higher power. The value of patients' rituals and religious practices is determined by their faith and is not subject to scientific evidence. Spirituality, on the other hand, does not necessarily include religion.

Crisis situations often surface in acute health care situations. Patients' beliefs and values can profoundly affect their response to these crises, attitude toward treatment, and rate of recovery. The need for spiritual care for patients and families may be intensified by hospitalization, pain experiences, chronic or incurable disease, terminal illness, or the death of a loved one. The pastoral care team allies with nurses in providing spiritual care for patients. Follow agency policy for arranging visits of patients' clergy or spiritual advisors, when such visits are desired, and provide private time for spiritual or religious practices.

Treating each patient as a unique individual requires you to consider all aspects of the patient's humanity—physiologic, psychological, spiritual, and cultural—and incorporate this understanding in delivering individualized care.

Get Ready for the Next-Generation NCLEX® Examination!

Key Points

- Medical-surgical nursing is a vast nursing specialty that involves several roles for LPN/LVNs.
- Qualities and skills needed by LPN/LVNs for medical-surgical nursing include upholding clinical practice standards, providing safe patient care, teaching patients, communicating effectively, working as a collaborative member of the health care team, advocating for the patient, and displaying leadership.
- Assignment involves allocating tasks to unlicensed personnel—when those tasks are within their job descriptions.
- Delegation involves designating to unlicensed personnel duties that are in the job description of the LPN/LVN, are within the boundaries of the NPA, and are advisable considering the patient situation.
- The most common site of employment for LPN/LVNs as a charge nurse is a nursing home or long-term care facility.
- Each state's NPA defines what the LPN/LVN legally can and cannot do in practice, including delegating from the position of charge nurse. LPN/LVNs use evidence-based practice, quality improvement measures, informatics, and safety practices to enhance the quality and safety of nursing care.

- Health care today includes biomedicine, complementary and alternative medicine practices, and the *Healthy People 2030* initiative.
- The ACA, Medicare, and Medicaid are examples of government-sponsored health insurance in the United States.
- To help curb rising health care costs, the federal government adopted the payment system of DRGs as part of Medicare.
- In another measure to cut costs, preventable hospital-acquired problems will not be reimbursed by Medicare.
- Holistic care includes awareness of the physical, psychological, social, cultural, and spiritual needs of patients when planning and delivering care.

Additional Learning Resources

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

Go to your Evolve website (http://evolve.elsevier.com/Stromberg/medsurg) for the following FREE learning resources:
- Animations, audio, and video
- Answers and rationales for questions and activities
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions and more!

Clinical Judgment and Next-Generation NCLEX® Examination–Style Questions

1. **Which of the following is (are) within the role of the LPN/LVN?** ***(Select all that apply.)***
   1. Admitting a patient on a medical-surgical unit
   2. Changing a dressing on a postoperative patient
   3. Assessing a patient whose condition has deteriorated
   4. Collaborating with the physical therapist on how to motivate the patient to ambulate
   5. Advocating for a patient with a health care provider when prescribed pain medication is insufficient
   6. Teaching the patient about the side effects of a new medication

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

2. **What should be the *first* thing considered before delegating a specific task?** ***(Priority setting.)***
   1. Know whether the task is within the scope of practice of the LPN/LVN.
   2. Be aware of the nursing assistant's competency and experience.
   3. Seek approval from the facility administration.
   4. Provide adequate explanation and oversight of the task.

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

3. **In caring for patients with pressure injuries, which task would be most appropriate to assign to the nursing assistant?**
   1. Providing assistance in making dietary choices, including fluids
   2. Participating in determining the appropriate type of wound care
   3. Repositioning the patient every 2 hours
   4. Describing the condition of the wound and any drainage

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

4. **Which cultural custom would be important to understand when being introduced to a Hmong patient?**
   1. Eye lowering is a sign of respect.
   2. Touching the head is considered honoring.
   3. Verbal greetings, not handshakes, are given.
   4. Out of courtesy, they may agree and nod.

   NCLEX Client Need: Psychosocial Integrity

5. **QSEN prepares you to:** ***(Select all that apply.)***
   1. carry out nursing tasks efficiently for a group of patients.
   2. consider safety factors at all times when delivering care.
   3. apply evidence-based practice to the care of patients.
   4. use informatics to collaborate and communicate with the health care team.
   5. note ways that quality of care might be improved.
   6. assign tasks to UAP on the team in a timely manner.

   NCLEX Client Need: Safe and Effective Care Environment: Safety and Infection Control

6. **In the process of developing evidence-based practice, after reviewing current research studies, the next step is to:**
   1. validate the findings in practice.
   2. use data to improve safety.
   3. evaluate outcomes based on evidence.
   4. search for and collect sources of evidence.

   NCLEX Client Need: Safe and Effective Care Environment: Safety and Infection Control

7. **One way in which nurses apply National Patient Safety Goals to patients is to:**
   1. report signs of infection in a patient's wound immediately.
   2. use two methods to identify patients each time before administering a medication.
   3. educate patients about the purpose and side effects of each medication.
   4. use lift equipment to get patients out of bed and into a chair.

   NCLEX Client Need: Physiological Integrity: Reduction of Risk Potential

8. **The reason that Medicare will not pay for care for a deep vein thrombosis on a patient in the hospital after knee replacement is:**
   1. the patient was considered at risk for this problem.
   2. the deep vein thrombosis is considered preventable.
   3. Medicare is working hard to lower costs of the program.
   4. the patient's private insurance will cover the costs.

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

9. **Which statement, made by an LPN/LVN during a patient interaction, indicates a therapeutic response?**

   1. "I am sorry for your loss. I just lost my mother last year."
   2. "Try putting on some ointment before dressing the wound."
   3. "Are you saying that your cast is uncomfortable? Tell me more about your discomfort."
   4. "I understand. I do not like surgery either."

   NCLEX Client Need: Psychosocial Integrity

10. **You find a confused patient with a history of falls attempting to get out of bed. To maintain the patient's self-esteem and safety, your intervention should be to:**

    1. apply physical restraints to keep the patient in bed.
    2. administer sedatives per the health care provider's order.
    3. activate a bed alarm to notify staff.
    4. ascertain what the patient is searching for.

    NCLEX Client Need: Safe and Effective Care Environment: Safety and Infection Control

An 82-year-old male with known hypertension is hospitalized with shortness of breath. He has chest pain when coughing. The patient states he is tired. His assigned unit is busy, and he is taken to his room by a nursing assistant, who helps him change into a gown before taking his vital signs. While assisting the patient, the nursing assistant notices that he favors his left leg and has a slight limp. His vital signs are temperature 97.2° F (36.2° C), blood pressure 152/98 mm Hg, heart rate 100 bpm, respirations 30 breaths/min, O_2 saturation 86% on room air, pain 4, weight 208 lb (94.5 kg). The nurse who comes to finish his assessment takes a history before performing physical assessment. His wife says he came down with the flu last week and has been a little confused the past couple of days. His orders include oxygen via cannula to maintain O_2 saturation above 92%, blood draw for metabolic and coagulation panels, and a chest radiograph. The nurse documents these findings as part of the shift assessment:

11. **Highlight or place an X next to the assessment findings that require immediate follow-up by the nurse.**

	OPTIONS
	Shortness of breath
	Fatigue
	Decreased temperature
	Elevated blood pressure
	Heart rate 100 bpm
	O_2 saturation 86% on room air
	Weight 208 lb (94.5 kg)
	Confusion
	Left leg limp
	Respirations 30 breaths/min
	Chest pain with coughing

12. **Considering his vital signs, symptoms, and orders, what are the first three priority actions the nurse should implement? Choose the *most likely* options for the information missing from the statements below by selecting from the list of options provided.**

    The nurse should first _____ and then _____. After these actions it is important to _____.

OPTIONS
question him about flu duration
draw ordered blood work
listen to heart and lung sounds
start oxygen by cannula
orient him to the room
check pulse oximeter reading

Critical Thinking, Clinical Judgment, and the Nursing Process

2

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

Objectives

Theory

1. Illustrate how critical thinking affects clinical judgment.
2. Explain what characteristics are necessary to think critically.
3. Explain how problem solving and decision making are a part of critical thinking.
4. Discuss the licensed practical/vocational nurse (LPN/LVN) standards for medical-surgical nursing practice.
5. Explain three fundamental beliefs about human life that are the basis for the nursing process.
6. Distinguish how critical thinking, clinical reasoning, and clinical judgment are applied to the nursing process.

Clinical Practice

7. Identify factors that influence critical thinking during patient care.
8. Provide a clinical example of how the nursing process is used in the care of medical-surgical patients.
9. Demonstrate each of the following techniques of physical examination: inspection and observation, olfaction, auscultation, and percussion.
10. Include the patient in formulation of the nursing care plan.
11. Use clinical reasoning to prioritize care for a specific patient.
12. Prepare a prioritized list for beginning-of-shift assessment of a specific patient.

Key Terms

auscultation (ăw-skŭl-TĀ-shŭn, p. 21)
clinical judgment (KLĬN-ĭ-kăl JŬJ-mĕnt, p. 15)
congruent (kŏn-GRŪ-ĕnt, p. 20)
critical thinking (KRĬ-tĭ-căl THĬNG-kĭng, p. 15)
data collection (DĀ-tă, p. 18)
evaluation (ĭh-văl-ū-Ā-shŭn, p. 27)
expected outcomes (ĕk-SPĔCT-ĕd ŎWt-kŭmz, p. 25)
focused assessment (FŌ-kŭsed ŭ-SĔS-mĕnt, p. 22)
goals (gōlz, p. 25)
implementation (ĭm-plĭ-mĕn-TĀ-shŭn, p. 17)
inspection (ĭn-SPĔK-shŭn, p. 20)
interdisciplinary (collaborative) care plans (kŏ-LĂB-ĕr-ă-tĭv plănz, p. 27)
NANDA-I (NĂN-dă-Ī, p. 23)
nursing diagnosis (NŬRZ-ĭng dī-ĭg-NŌ-sēs, p. 24)
nursing interventions (NŬRZ-ĭng ĭn-tĕr-VĔN-shŭnz, p. 25)
nursing process (NŬRZ-ĭng PRŎ-sĕs, p. 17)
objective data (ŏb-JĔK-tĭv DĀ-tă, p. 18)
observation (ŏb-sĕr-VĀ-shŭn, p. 20)
olfaction (ōl-FĂK-shŭn, p. 21)
palpation (păl-PĀ-shŭn, p. 21)
percussion (pĕr-KŬ-shŭn, p. 22)
planning (PLĀN-ĭng, p. 17)
polypharmacy (PŎL-ē-făr′mă-sē, p. 20)
priority setting (prī-ŌR-ĕ-tē SĔt-ĭng, p. 24)
subjective data (sŭb-JĔK-tĭv DĀ-tă, p. 18)

Concepts Covered in This Chapter

- Clinical Judgment
- Communication
- Collaboration

CRITICAL THINKING AND CLINICAL JUDGMENT

Critical thinking is a method for solving problems. It is directed, purposeful mental activity by which you evaluate ideas, construct plans, and determine desired outcomes. *Reasoning* is a synonym used for critical thinking. In nursing practice, critical thinking incorporates the scientific method and uses clinical reasoning to make reliable observations and to draw sound conclusions from obtained data. Developing critical thinking skills is a lifelong process and improves over time with experience. **Clinical judgment** is critical thinking applied to clinical situations, resulting in evidence-based actions with delivery of safe and effective care.

Clinical judgment in practical/vocational nursing can be described as the following:

- Purposeful, informed, and outcome focused (results oriented), requiring careful identification of patient problems, issues, and risks and making accurate decisions about what is happening, what needs to be done, and what the priorities are for patient care

Box 2.1 Characteristics of the Critical Thinker

- Maintains an open mind and a questioning attitude
- Recognizes own biases and limitations
- Is persistent in seeking solutions
- Separates relevant information from irrelevant information
- Recognizes inconsistencies in data gathered
- Identifies missing information
- Considers all possibilities
- Assumes an empathetic attitude
- Uses an organized and systematic approach to problems
- Verifies accuracy and reliability of data
- Considers all possible solutions before making a decision
- Admits what they do not know
- Reasons logically
- Strives for excellence and improvement
- Draws valid conclusions from the evidence or data
- Sets priorities and makes carefully considered decisions
- Is flexible, realistic, creative, humble, honest, curious, and insightful

- Driven by patient, family, and community health care needs
- Based on principles of the nursing process (Box 2.1) and the scientific method in the context of the patient situation
- Focused on using both logic and intuition and based on knowledge, skills, attitude, and the professional experience of the licensed practical/vocational nurse (LPN/LVN)
- Guided by standards and ethical codes of the following organizations:
  - National Association for Practical Nurse Education and Service (NAPNES) *Standards of Practice for Licensed Practical/Vocational Nurses and Code of Ethics*
  - National Federation of Licensed Practical Nurses (NFLPN) *Nursing Practice Standards for the Licensed Practical/Vocational Nurse and The Code for Licensed Practical/Vocational Nurses*
- Interested in strategies that make the most of human potential (e.g., using individual strengths) and compensate for problems created by human nature (e.g., overcoming the powerful influence of personal beliefs, values, and prejudices)
- Committed to constantly reevaluating, self-correcting, and striving to improve (e.g., practicing skills, learning new skills, attending classes and workshops, and reading nursing journals) (Alfaro-Lefevre, 2020; Knecht, 2021)

? Think Critically

List three examples in which you might use critical thinking in the classroom.

Critical thinking is most effective when the brain is purposefully engaged—for example, when attentively listening to a report at the beginning of the shift and thinking about how you will apply the information you have gained. Observe the critical thinking activities that take place among the nurses during the report as they collaborate in solving a patient-related problem. Observe the same elements later in the shift as nurses make decisions about patient care issues or about when to notify the health care provider of a problem or a need for a change of orders. Consider the following when receiving a report:

- What will I be expected to do for my assigned patients?
- What are the priorities of nursing care for each patient?
- What areas need further clarification?
- What procedures can be done independently, and which require supervision?

Examine your thinking and the thinking of others and apply the knowledge to patient care. Critical thinking is based on science and scientific principles and includes the following:

- Collecting data in an organized way
- Verifying data
- Looking for gaps in information
- Analyzing the data with recognition of significant clinical cues

As a nurse, you must access, understand, recall, and use information as the basis for critical thinking in the clinical area. A sound knowledge base is essential to critical thinking, and that base will grow throughout your nursing education and practice. Critical thinking allows you to apply learned knowledge and principles to different patient care situations.

FACTORS THAT INFLUENCE CRITICAL THINKING AND NURSING CARE

Attitude

A major factor in learning to apply critical thinking is attitude. The critical thinker is humble and recognizes that they do not have all the answers; they also recognize that their perceptions may be clouded by personal values and beliefs and strive to maintain objectivity. The critical thinker makes an effort to consider evidence that is presented objectively and values and respects the dignity, beliefs, and rights of patients.

Communication Skills

The critical thinker communicates effectively both orally and in writing. Thoughts are reflected on before speaking, and information is presented in a clear, concise manner. The critical thinker listens attentively with the objective to understand rather than respond. Documentation clearly conveys to other health team members what was planned, the patient's reaction to any care offered or provided, and whether expected outcomes were met (Box 2.2).

It is helpful to identify a nurse who is skilled at thinking critically and who can communicate clearly

Box 2.2 Actual Examples of Student Charting (Unclear Communication)

- Vaginal packing out. Dr. Heffle in.
- Dr. Jones in. Had large, formed brown stool.
- On the second day the knee was better, and on the third day it disappeared.
- She is numb from the toes down.
- Patient was alert and nonresponsive.

both verbally and through charting. This person can serve as a mentor as you learn to apply critical thinking and knowledge. The most effective mentor will be one who coaches by asking questions, rather than someone who merely provides answers.

Many other factors influence your critical thinking, such as your personality, age or maturity, prejudices and biases, past experiences, and situational factors such as anxiety, stress, and fatigue.

Think Critically

When listening to the report on a patient, what constitutes attentive listening? How does critical thinking help you obtain all the data you need to care for the patient?

Problem Solving, Decision Making, and Clinical Judgment

The ability to problem solve and make decisions is integral to critical thinking. Incorporating scientific knowledge and research into nursing requires a consistent, logical method to solve problems. Using the scientific method, one first defines the problem, then gathers information, analyzes the information, and develops solutions (Box 2.3). Next a decision is made about which solution to use; then **implementation** of the solution occurs. Evidence-based research findings are considered when choosing actions to implement the solution. Identifying problems based on clinical cues, seeking out significant additional information, and using the information to develop interventions appropriate to the clinical situation demonstrate the use of clinical judgment. Assessment of the effectiveness of the interventions confirms that the correct actions were taken for the patient and validates clinical judgment.

INTEGRATING CRITICAL THINKING AND THE NURSING PROCESS

Critical thinking, clinical reasoning, and clinical judgment are integral to the nursing process. It is essential to know the boundaries of the role of the LPN/LVN in your state. If in doubt about the role of the LPN/LVN in the nursing process, direct your questions to your state's board of nursing. According to National Council of State Boards of Nursing (NCSBN) research, all U.S. states and territories identify a scope of practice for either LPNs or LVNs. However, the scope of practice allowed varies widely. Most LPN/LVN scopes of practice

Box 2.3 Steps in the Problem-Solving Process

1. Define the problem clearly.
2. Consider all possible alternatives as solutions to the problem.
3. Consider the possible outcomes, both positive and negative, for each alternative.
4. Predict the likelihood of each outcome occurring.
5. Choose the alternative with the best chance of success and least chance of undesirable outcomes.

Adapted from Williams P: *Fundamental concepts and skills for nursing,* ed 6, St. Louis, 2022, Elsevier.

stipulate a directed role under the supervision of a registered nurse (RN), but scopes of practice differ from state to state in the areas of care **planning**, assessment, intravenous therapy, teaching, and delegation (Knecht, 2021).

The NCSBN has clearly defined the LPN/LVN role in the nursing process and clinical reasoning. The Next-Generation NCLEX® testing model being used as of 2023 has been designed to evaluate clinical judgment skills. The NCSBN Clinical Judgment Measurement Model (NCJMM) is the basis for the new NCLEX® question formats. It is not a new clinical tool but rather an evidence-based model for measuring if a new graduate meets the national standard in clinical judgment and decision-making ability (NCSBN, 2020).

Legal and Ethical Considerations

What does your state's nurse practice act (NPA) indicate about the role of the LPN/LVN?

Think Critically

What questions do you have regarding clarification of your state's nurse practice act?

Nursing process is critical thinking, clinical reasoning, and clinical judgment in the language of nursing. It is an orderly way to assess a patient's response to current health status and to plan, implement, and evaluate the patient's response to nursing care (see the Evolve website for Nursing Care Plan Form). It is a way to communicate to all nursing personnel what is to be done and who is to do it, during all shifts. The nursing process provides a way to make changes in the patient's plan of care if progress is not being made. It builds on a patient's strengths and creates a partnership between the nurse and patient whenever possible. The goal of the nursing process is to alleviate, minimize, or prevent real or potential health problems (Box 2.4).

APPLYING LPN/LVN STANDARDS IN MEDICAL-SURGICAL NURSING

The five basic steps of the nursing process are (1) assessment (data collection), (2) nursing diagnosis/problem identification, (3) planning, (4) implementation,

Box 2.4 Four Phases of the Nursing Process for LPN/LVNs

1. **Data collection:** Assist the RN by systematically gathering and reviewing information about the patient and communicating it to appropriate members of the health care team.
2. **Planning:** Assist the RN in the development of expected outcomes and interventions for a patient's plan of care.
3. **Implementation:** Provide planned nursing care to accomplish expected outcomes.
4. **Evaluation:** Compare actual outcomes of nursing care to expected outcomes and assist with updating the nursing care plan.

and (5) evaluation. The LPN/LVN assists the RN with steps 1, 3, 4, and 5. The RN is responsible for formulating the problem statements in step 2 from the assessment data obtained from all sources.

ASSESSMENT (DATA COLLECTION)

The purpose of **data collection** is to have a relevant database from which patient problems and potential problems may be identified. Data collection provides the basis for developing a problem list, from which problem statements or nursing diagnoses will be developed. The RN is responsible for the initial admission assessment, but the LPN/LVN may be asked to assist with parts of it. The LPN/LVN is responsible for ongoing assessment for assigned patients.

The LPN/LVN acts in a more independent role when participating in data collection (assessment) and during the implementation phase of the nursing process (see the Evolve website for Admission Data Collection Form and Physical Assessment Form). LPN/LVNs systematically gather and review data about the patient and communicate their findings to appropriate members of the health care team. A complete database includes a thorough health history, physical assessment, psychosocial assessment, and cultural and spiritual assessments. Many sources are used to compile a complete database for the patient. Most health care facilities use a standardized form for the **admission assessment**. Both **subjective data** (data that the patient gives that cannot be seen or felt by another, such as pain) and **objective data** (data that can be verified by sight, smell, touch, or sound) are included.

If there is an immediate life-threatening problem, determine immediately what action must be taken and whether additional expertise is needed to address the problem. Once the patient's physical condition is stabilized, a formal care plan can be developed (Nursing Care Plan 2.1).

Nursing Care Plan 2.1 Care of the Patient With Imbalanced Nutrition

SCENARIO

Mr. Nielson, age 82, was admitted because of dizziness and weakness. He is a frail-looking man who walks slowly and with hesitation. The patient has experienced loss of appetite, loss of weight, and loss of energy since his right lung lobectomy 3 years ago.

PROBLEM STATEMENT/NURSING DIAGNOSIS

Altered nutrition/Imbalanced nutrition: less than body requirements related to loss of appetite and weakness and weight loss.

SUPPORTING ASSESSMENT DATA

Objective: Height 5′9″, weight 128 lb (58 kg), loss of 35 lb (16 kg)

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
Goal: No further weight loss Outcomes Patient will eat 1500 calories of soft diet and drink 2000 mL of liquids each 24-h period.	Serve six small meals at 8 A.M., 10 A.M., noon, 2 P.M., 4 P.M., and 6 P.M.	Small, attractively arranged soft diet of favorite foods will entice patient to eat without feeling too full.	Encouraged to eat until he felt full.
	Assist patient to chair using minimal assistance.	Sitting up encourages proper digestion.	Sitting up for all meals.
	Encourage self-feeding. Assist only if needed. Assess preferred diet.	Encourages independence. Patients eat more when presented with food they prefer.	Feeding self. Prefers chicken, mashed potatoes, gravy, creamed peas, and lemon pie.
	Set up tray for easy reach.	Preserves strength and helps patient overcome weakness.	Trays set up. Continue plan.

Nursing Care Plan 2.1 Care of the Patient With Imbalanced Nutrition—cont'd

Goals/Expected Outcomes	Nursing Interventions	Selected Rationale	Evaluation
By day 2, patient will drink 1000 mL during 24-h period.	Offer 240 mL of liquids at 6 A.M., 9 A.M., 11 A.M., 3 P.M., 5 P.M., 7 P.M., and 9 P.M. Vary choices with apple juice, orange juice, lemon-lime drink, tea, ice cream, water, and gelatin. Record time, amount, and liquids taken.	A variety of favorite liquids in small amounts, alternating between meals, will be easier to consume. Verifies amount of liquid consumed.	Intake: 500 mL this shift.
By day 4, patient will be able to remove lids and cut most of meat.	Day 1: Open packages and milk carton. Cut meat. Encourage patient to remove lids. Day 2: Open milk carton and cut meat. Day 3: Cut meat	Helps conserve energy. Progressive increase in activity will build strength.	Continue plan.
Patient will verbalize increased energy and spend more time awake during the day.	Collect data on amount of hours patient is awake and the length and number of naps. Group activities to allow for rest periods.	Provides objective data as a baseline. Allows for uninterrupted rest.	Patient states that he feels more energetic and will decrease the length of morning and afternoon nap times to 30 min each.

APPLYING CLINICAL JUDGMENT

1. What practical methods can you use to entice the patient to eat, without actually feeding him?
2. What measures can you use to encourage activity, without tiring the patient excessively?

Sources of Information for the Database

Admission forms, history, and physical. An admission form is completed if paper charting is used, and information is charted on the appropriate screens in the EHR for electronic formats. The admission form covers basic information such as the reason for admission, allergies, home medications, and other important information. If the patient has been hospitalized in the past, previous records may be sent to the unit or may be available electronically. The medical diagnosis will guide you in collecting assessment data and in identifying patient problems. Check to see if results of preliminary laboratory work, imaging studies, or other test results have been completed. If available, read the current information before entering the patient's room; knowing current information will enhance your critical thinking and observation skills during your initial patient contact (and will keep you from repeating obvious questions). Obtaining adequate and appropriate information will contribute to arriving at sound clinical judgments.

Think Critically

How many sources can you identify that would provide information for a nursing database on a patient who has been admitted to a long-term care facility?

Interview. Ask the patient what they think is their major problem or "chief complaint." Other questions concern the present level of pain, when the last bowel movement occurred, problems with urination or appetite, difficulty sleeping, and whether they have any additional concerns or complaints. The patient is the primary source of current information and knows more about the problem than anyone else.

Focused Assessment

General Interview Guide

SOCIAL ASSESSMENT

- What is your living situation?
- Who lives with you?
- Who may the health care team discuss your condition with in addition to you?
- What kind of work do you do?
- Do you have spiritual beliefs that we can help support?
- Do you have concerns regarding finances related to this hospitalization?
- How are things at home if you are not there while in the hospital?
- Are there any medical problems that are common in your family?
- Have you had previous surgeries or serious injuries?
- In your life now, who is helpful to you?
- What prescription drugs do you take? What over-the-counter medicines or supplements?
- Do you smoke? How much? What do you smoke?
- Do you drink alcohol? How often do you drink and how much?
- Do you use any other drugs?
- Are you allergic to any drugs? Foods? Other substances? What kind of reaction do you have?
- Are you on a special diet at home?

Continued

Focused Assessment—cont'd

General Interview Guide

PHYSICAL ASSESSMENT

- Why were you admitted here?
- What health problems do you have?
- Do you routinely see doctors? If so, for what?

REVIEW OF SYSTEMS (ASK QUESTIONS ABOUT THE FOLLOWING)

Head and Neck

Frequent headaches; dizziness, ringing of the ears, hearing problems; visual problems, glaucoma, cataracts, glasses or contact lenses; surgery of the brain, eyes, or ears; frequent colds; nasal allergies; sinus infections; frequent sore throats; hoarseness; trouble swallowing; swollen glands; mouth sores; date of last dental examination; history of thyroid problems; use of a hearing aid; difficulty sleeping, napping

Chest

Male and female: Cough, sputum production; asthma, wheezing, frequent bronchitis; history of pneumonia; tuberculosis, exposure to tuberculosis; exposure to occupational respiratory hazards; palpitations, chest pain; shortness of breath; history of heart problems, murmurs, hypertension; anemia; surgery

Female: Frequency of breast examinations; date of last mammogram; nipple discharge; breast lumps

Abdomen (Gastrointestinal Tract)

Indigestion; pain; nausea; vomiting; excessive thirst or hunger; frequency of bowel movements; change in bowel movements; rectal bleeding; black or tarry stools; constipation; diarrhea; excessive gas; hemorrhoids; history of gallbladder or liver problems

Genitourinary (Inquire With Cultural Sensitivity)

Male and female: Problems with urination; up at night to urinate; dribbling of urine; history of urinary tract infection; stones

Female: Sexual activity; sexual problems; menstrual cycle and any problems; last menstrual period; bleeding between periods or after menopause; vaginal discharge; date of last Pap smear; history of sexually transmitted infections or vaginal disorders

Male: Sexual activity; genital problems; penile discharge; history of sexually transmitted infections; sexual problems

Extremities and Musculoskeletal System

Joint pain or stiffness; back problems; muscle pain; limited range of motion; vascular problems in legs or arms; easy bruising; skin lesions; history of phlebitis; thrombophlebitis; gout, osteoarthritis, rheumatoid arthritis, fractures, injury

PSYCHOLOGICAL ASSESSMENT

- Are you experiencing anxiety? Depression?
- Do you have unusual memory problems?
- Do you have difficulty thinking?
- Are you ever confused?

If for some reason the patient is incapacitated, secondary sources of information are useful (e.g., spouse, significant other, relative, friend, or patient advocate). The secondary source can also help verify information that was provided by the patient. Box 2.5 provides suggestions for interviewing. The remainder of the admission form is filled out and includes the status of advance directives, assessments for fall risk, pain level, pressure injury risk, suicide risk, nutrition requirements, and ability to perform activities of daily living. Psychosocial, cultural, and spiritual assessment data are gathered as well.

Older Adult Care Points

Plan extra time for an interview with a patient who is older. An older person who is ill may think and speak more slowly than expected, may have a hearing loss, and often has a longer health history to relate than does a younger person.

After obtaining a list of current medications from the patient or transferring facility, a medication reconciliation form to identify and prevent **polypharmacy** (multiple drugs prescribed for the same condition by different health care providers) is filled out (see the Evolve website for Medication Reconciliation Form). Some acute care facilities have pharmacy staff compile this information on paper or in the electronic health record (EHR). Medication reconciliation also reduces the risk of medication order errors and adverse interactions between drugs. Patient allergies and medications—prescription, over-the-counter, and herbal preparations and supplements—are included on the form, which is reviewed by both the provider and the pharmacist. Patients need to know that the information gathered will be recorded and used in planning their care. It also helps prevent neglecting to continue an important home medication that may not be directly related to the reason for admission. Many medications require maintenance of adequate blood levels to be therapeutic.

Physical assessment. Physical data collection usually begins with measuring the patient's blood pressure, pulse, respiration, pulse oximetry, temperature, weight, and height. **Accuracy is essential.** Data collection correlates current readings with the baseline data, with trends of past readings, with the patient's current clinical status, and with any medical care that has been provided. Such data yield significant information about the patient's condition and response to medication and other treatments. Complete assessments are performed daily. Observe the patient for clinical cues that might alert you to the need for immediate interventions or to undiagnosed conditions. Knowing what is normal in the physical assessment will help you to identify anything abnormal.

Inspection and observation. **Inspection** (looking) and **observation** (looking and noting) are important aspects of nursing assessment. Use your eyes to pick up clues about the patient's physical and mental condition. Note the patient's facial expression, posture, grimaces, and movements and whether answers are **congruent** (match the feeling tone of what is said verbally). Inspect the hair, skin, nails, and oral mucous membranes for data about hydration and

Box 2.5 Interview Suggestions

- Introduce yourself to the patient by name and as an LPN/LVN student.
- Be respectful.
- A patient is entitled to be addressed by their surname. Do so, unless the patient asks you to address them differently.
- Pull up a chair so that the patient can see you at eye level and can hear you clearly.
- Speak slowly and clearly.
- Ask your questions without dropping your voice at the end of the sentence. Be alert to any hearing difficulty the patient may have.
- Give time for the patient to respond.
- Attempt to resolve incongruence between body language and responses.
- Ask for clarification if you are unsure what the patient means by a particular statement or response.
- Summarize for the patient what you think you heard during the interview.
- Ask the patient for any corrections or additions.

dental hygiene. Observe the patient's state of personal care. Is the hair combed, and are the nails clean and reasonably trimmed? Is there anything in the room that gives evidence of support systems, family, or friends?

Olfaction. **Olfaction** (smelling) can provide data about a patient's personal hygiene, as well as clues to possible illness. The sweet, fruity odor of acetone can be indicative of diabetic acidosis. The smell of newly mown clover can be present with hepatic coma. The smell of alcohol indicates that the patient has been drinking. Sometimes patients with acute alcoholism may smell like aftershave, mouthwash, vanilla, Sterno, or other substances that contain a high percentage of alcohol. Foul or metallic mouth odors usually indicate poor oral hygiene or periodontal disease. Odor from the nose may be indicative of chronic sinusitis with postnasal drip or an obstruction in the nasal passages.

Patients who have anemia, an endocrine problem, or a central nervous system abnormality may try to cover up unpleasant body odor with bath powder or heavy perfume. An unpleasant genital odor may indicate an infection, poor hygiene, or insufficient fluid intake (commonly found in female patients in long-term care facilities). Without additional attention, body areas that are unattended may become reddened, irritated, and sometimes infected.

Palpation. Palpate (touch) the patient's skin to determine whether it feels healthy or is coarse, dry, swollen, cold, or clammy. Dryness may be related to dehydration, and swelling may indicate edema (fluid in the tissues). If you depress the skin with your fingers and your touch leaves pitting (indentation) on the skin, edema is present. Measure and record the depth of pitting and the length of time the tissue remains indented (see Chapter 3, Fig. 3.5). **Palpation** of the skin can provide additional information.

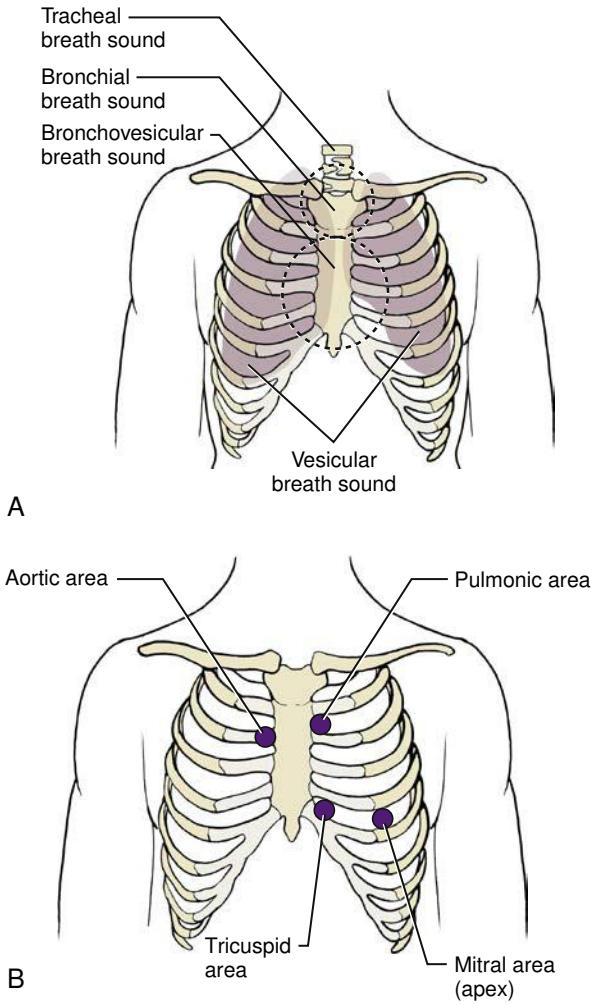

Fig. 2.1 **A,** Locations of normal lung sounds. **B,** Place the stethoscope at the apex of the heart (fifth intercostal space) to listen to the apical pulse.

Cold extremities may indicate poor circulation. Hot tissue may result from localized inflammation, and you will want to examine the area more carefully. Use your fingertips, not your thumb, to palpate the pulses. Use the flat of the hand to palpate the abdomen to determine whether it is soft or hard and whether there are any tender areas. Palpate the breasts for abnormal growths. Premenopausal women may have masses in their breasts, making it difficult to determine which lumps are significant (this is a good time to ask for assistance from your instructor, the staff RN, or the clinical nurse specialist).

Auscultation. **Auscultation** (listening) is an important skill in gathering data. Listen to the sounds of the patient's breathing—with a stethoscope and without a stethoscope. You may hear wheezing from constricted bronchi or stridor caused by a partial airway obstruction. Listening to the quality of a patient's cough will determine whether it is dry or moist. With the stethoscope, the sounds are amplified, and you can auscultate normal, abnormal, or adventitious breath sounds (Fig. 2.1). Listen to the apical pulse at the apex of the heart and on the abdomen for bowel sounds; listen carefully in each quadrant (Fig. 2.2).

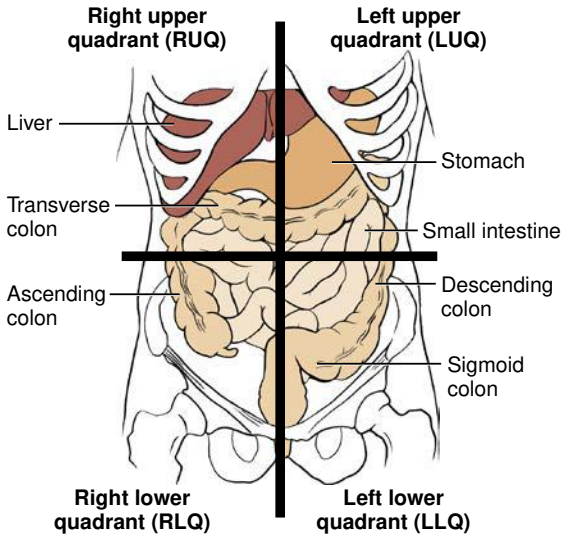

Fig. 2.2 Listen for bowel sounds in all four quadrants of the abdomen.

Percussion. **Percussion** consists of using light, quick tapping on different surfaces of the body to tell the size, location, and density of different organs, especially in the chest, abdomen, and kidney areas. Percussion of the abdomen will reveal areas of excessive gas in the bowel.

Daily Focused Assessment (Data Collection)

A daily **focused assessment**, usually performed at the beginning of the shift, is directed to areas in which the patient is experiencing health problems. This assessment augments the admission assessment of the patient and is based on the identified problems, data from the report, and medical diagnoses and treatment. Many hospitals have standardized assessment forms for collecting head-to-toe data on the patient. Information from the patient's chart and care plan is used to identify areas in which focused assessment data should be collected. Ask for a demonstration of an appropriate head-to-toe assessment.

Focused Assessment

Beginning-of-Shift Assessment

PHYSICAL REVIEW[a]

- Assess the patient's level of consciousness (LOC), including their ability to respond quickly and appropriately and their orientation to person, place, and time. Refer to the Glasgow Coma Scale in Chapter 21 for patients with neurologic problems.
- Check the patient's ability to think (mentate) by asking questions within their capacity (e.g., Who is the president?).
- Observe the skin color and texture and degree of moisture.
- Note the appearance of the eyes.
- Measure the vital signs (temperature, pulse, respiration, pulse oximetry, and blood pressure). Note the rhythm and strength of the pulse, rhythm and depth of respiration, and respiratory effort.
- Ask the patient to describe any pain. Determine the location, severity, quality, and precipitating and alleviating factors.
- Auscultate the chest using the stethoscope. Listen for breath sounds, noting normal, abnormal, and adventitious breath sounds. Listen at the apex of the heart, checking for regularity of rhythm. Auscultate the apical pulse for 60 seconds to count the rate and note the rhythm of the heartbeat. It is difficult for a new nurse to pick up extra heart sounds, but you can determine whether there is an increase or decrease in the heart rate.
- Assess the skin turgor (elasticity) by gently lifting the skin on the upper chest with your thumb and forefinger and observing the speed with which it snaps back when you let go.
- Observe the contour of the abdomen (e.g., flat, round, distended).
- When the patient is in a supine position or low Fowler position, auscultate bowel sounds in all four quadrants.
- Gently palpate the abdomen with the palm side of the fingers, noting whether the abdomen is soft or firm. Also ask the patient whether they are experiencing any pain or discomfort, indicating areas of tenderness. Inquire about appetite and weight changes.
- Assess the patient's bowel and bladder status. Note the time of their last bowel movement (from the chart or by asking the patient) and whether flatus is being passed. Review the intake and output (I&O) for the past 24 hours. Observe and palpate the pubic area to assess bladder distention, especially if there is a discrepancy between the current and previous I&O. If urinary retention is suspected, a bladder scanner may be available for verification. If the patient has an indwelling catheter, observe the characteristics of the urine in the drainage tube and the rate of drainage.
- Ask the patient to move each extremity. Observe their ability to actively move the joints through the range of motion and the coordination of the movements. If the patient is unable to actively move any joints, assist them with passive motion and note the degree of flexibility. Ask the patient to move their extremities against resistance, to determine extremity strength. You can also determine the patient's level of cooperation and ability to follow directions during the exercises.
- Compare the peripheral pulses bilaterally.
- Note the presence of any edema.

TUBES AND EQUIPMENT STATUS

- **Intravenous catheter:** Condition of site; fluid in progress, rate, additives; time next fluid is to be hung
- **Nasogastric tube:** Suction setting; amount and character of drainage; patency of tube; security of tube;

Focused Assessment—cont'd

Beginning-of-Shift Assessment

confirm that tube markings are correct to ensure that the tube has not moved since insertion
- **Urinary catheter:** Character and quantity of drainage; tubing not positioned underneath patient; properly secured
- **Dressings:** Location; drains in place; wound suction devices; amount and character of wound drainage; condition of dressing
- **Patient-controlled analgesia pump:** Properly functioning; correct medication infusing; amount of solution remaining; end-tidal carbon dioxide ($ETCO_2$) monitoring in place (if part of protocol)
- **Oxygen:** Type of delivery device, rate of flow
- **Equipment:** Applied properly; functioning as ordered

[a]The physical review may include a head-to-toe assessment based on the patient's needs.

Chart Review

The face sheet of the chart provides demographic data such as address, marital status, insurance coverage, age, date of birth, occupation, significant others, and emergency contact information. This information may be located in various areas of the EHR. The health care provider's history, physical examination, progress notes, and results of diagnostic tests give an overview of the patient's total health status and provide a summary of current health problems and progress toward resolving them. Allergy information should be identified as part of the admission information and displayed prominently on the front of the chart, on the header of the EHR page, and in other locations as required by the facility's policies and procedures. The current provider's orders provide a clue as to the plan for that day (tests or treatments).

The medication profile sheets, screens, or medication administration record (MAR) lists the routine and as-needed (PRN) medications and provides documentation of medication administration. Consultation notes or nursing documentation includes narrative notes and flow sheets that describe care provided to the patient and the patient's response to that care.

Older Adult Care Points

You walk into your assigned patient's room and find that Mr. Nethers, age 72, has a sitter because he pulled out his oxygen tube, intravenous (IV) line, and urinary catheter earlier that morning. He has also attempted to get out of bed several times. Yesterday he was alert and had a lucid conversation with you. Mr. Nethers had surgery yesterday after you left the unit to go to class, and you see in the documentation that he has been receiving hydrocodone-acetaminophen for pain. You recall that this medication could have a severe behavioral side effect, especially for an older patient. You inform the medication nurse of your observations and ask that the health care provider be consulted before giving additional doses.

Diagnostic Test Results

Review laboratory and test data to identify general concerns and to confirm assessment findings. Particularly note test data related to the patient's problems that indicate improvement or a complication.

Other Resources

Course textbooks are a primary resource; other texts, journal articles, and the internet can provide a wealth of information. Handheld devices with downloaded electronic resources (e.g., medical-surgical, drug, and laboratory texts) and apps provide instant access to clinical resources. Because there is no control over information placed on the internet, resources should be evaluated carefully. Your instructor, pharmacists, dietitians, social workers, occupational therapists, physical therapists, physicians, and other specialists can provide valuable information about specific aspects of the patient. Work to gain a comprehensive picture of the patient's situation, diagnoses, medications, and potential actions for care.

DATA ANALYSIS AND PROBLEM IDENTIFICATION

The LPN/LVN reports data collection findings to the RN and assists in verifying, categorizing, and grouping the collected data in a logical order. The LPN/LVN also assists in analyzing the data to determine significant relationships among data, patient needs, and problems. A *prioritized* list of patient problems is developed. The focus is on actual and potential patient problems that can be addressed with independent nursing interventions. From the analysis, the RN chooses problem statements or uses nursing diagnoses from the **NANDA-I** list or a facility-approved problem statement list. Many facilities do not use NANDA-I nursing diagnoses, but some method of problem identification is used. An interdisciplinary care plan with the medical diagnosis listed may be the preferred method of care planning.

Nursing care is based on the *priority* of patient problems. High-priority problems are dealt with first, and lower-priority problems are dealt with as time permits. The problem statements or nursing diagnoses are based on all available patient data, including—but not limited to—the nursing assessment (subjective and objective) data, the diagnostic test data, and the medical diagnosis. Placing a problem statement or nursing diagnosis in the care plan means that the nurse is accepting accountability for the accuracy of the statement. Permitting a problem to continue without designating a problem statement can lead to patient harm (Alfaro-Lefevre, 2020).

Think Critically

What is important in choosing the correct problem statement for a care plan? How would you determine that a problem statement or nursing diagnosis on a facility care plan is appropriate for the patient?

It is important to differentiate between a problem statement or **nursing diagnosis** and a medical diagnosis. The health care provider is concerned with health problems that can be treated with surgery, medications, and other forms of therapy provided or prescribed by them. Problem statements or nursing diagnoses identify the patient's response to an illness or a health condition. Nursing practice addresses physical, psychological, social, cultural, and spiritual comfort and well-being; the prevention of complications; and patient education. Nursing care focuses on preventing, minimizing, and alleviating specific health problems. Although the provider is responsible for managing medical problems, the RN uses clues from the medical diagnosis to identify patient problems and to develop accurate nursing problem statements or nursing diagnoses.

When using NANDA-I diagnoses, NANDA-I–approved stems are based on an analysis of available data. These approved stems label the patient problems that can be treated independently using nursing interventions. Other components of a NANDA-I nursing diagnosis make statements specific to the patient's situation and direct the planning and implementation phases of the nursing process. A complete NANDA-I nursing diagnosis includes the problem (NANDA-I stem), the etiology (related causes of the problem), and the signs and symptoms (evidence of the problem).

The etiology component describes the known or suspected cause or causes of a problem (e.g., a patient's altered breathing patterns could be related to etiologies of reduced lung capacity, anxiety, or pain). The signs and symptoms of the problem describe the subjective and objective evidence of the problem (i.e., the diagnosis is supported [evidenced] by the assessment data). To follow our example, a patient's altered breathing pattern might be evidenced by a statement of shortness of breath or by observation of dyspnea (difficulty breathing), changes in respiratory rate or rhythm, or decreased oxygen saturation levels. The problem statement would be: *Altered breathing pattern related to pneumonia as evidenced by patient complaint of shortness of breath, observed use of accessory muscles, O_2 saturation of 89% on room air.*

Actual problems are problems that the patient currently exhibits, and documentation should include all three components of the diagnosis statement (problem, etiology, signs and symptoms). Sometimes the patient does not currently exhibit evidence of actual problems, but the data demonstrate that a problem could occur; these situations describe potential problems. An example of a potential problem is: *Potential for fluid deficit related to vomiting and diarrhea.* In this example, the patient is not currently showing signs of dehydration but is at risk because of the fluid loss associated with vomiting and diarrhea. Potential problems alert you to take preventive measures rather than wait for a problem to materialize before taking action. Even though many facilities do not use NANDA-I nursing diagnoses, the LPN/LVN may be expected to be familiar with the NANDA-I list of nursing diagnoses or the list of facility-approved problem statements.

Setting Priorities of Care

Priority setting is a method of handling problems and tasks according to the importance (priority) of the patient's problems. Maslow's hierarchy of needs is one way to prioritize patient problems and nursing care (Fig. 2.3). Other factors to consider are safety and involvement of the patient (see Chapter 1). Problem statements or nursing diagnoses may be listed on the care plan in order of priority. The need to sustain life, such as an airway and breathing, must be attended to immediately, even before a formal care plan is developed. Clinical judgment is used to set priorities and recognize the need for prompt nursing action. All possible patient problems might not be included in the initial plan. As problem statements or nursing diagnoses are dealt with successfully, they are modified or discontinued. Other problems are added to the plan as they arise.

PLANNING

LPN/LVN standards of care indicate that the LPN/LVN will use the nursing process in planning nursing care and will assist the RN in the identification of health goals, outcomes, and interventions for a patient's plan of care. For a care plan to be effective, the patient should be involved in determining which problems are most important. Data regarding what the patient is willing and able to do to improve the situation and what education is needed are also gathered for the care plan. Sometimes, something you might consider minor is very important to the patient.

Goals and Expected Outcomes

All goals or expected outcomes, set together by the patient and the nurse, must be patient centered, be realistically achievable, be measurable, and include a time frame within which they will be met. Goals and expected outcomes relate to (1) restoring health when there is a health problem and (2) promoting health when the patient's resources can and should be directed at regaining or maintaining health. For example, the patient is eager to learn how to live with the diagnosis of diabetes. The patient needs to be instructed about the illness, how to monitor the glucose level, what action is needed to stabilize the glucose level, how to administer insulin or oral medication, how to maintain a

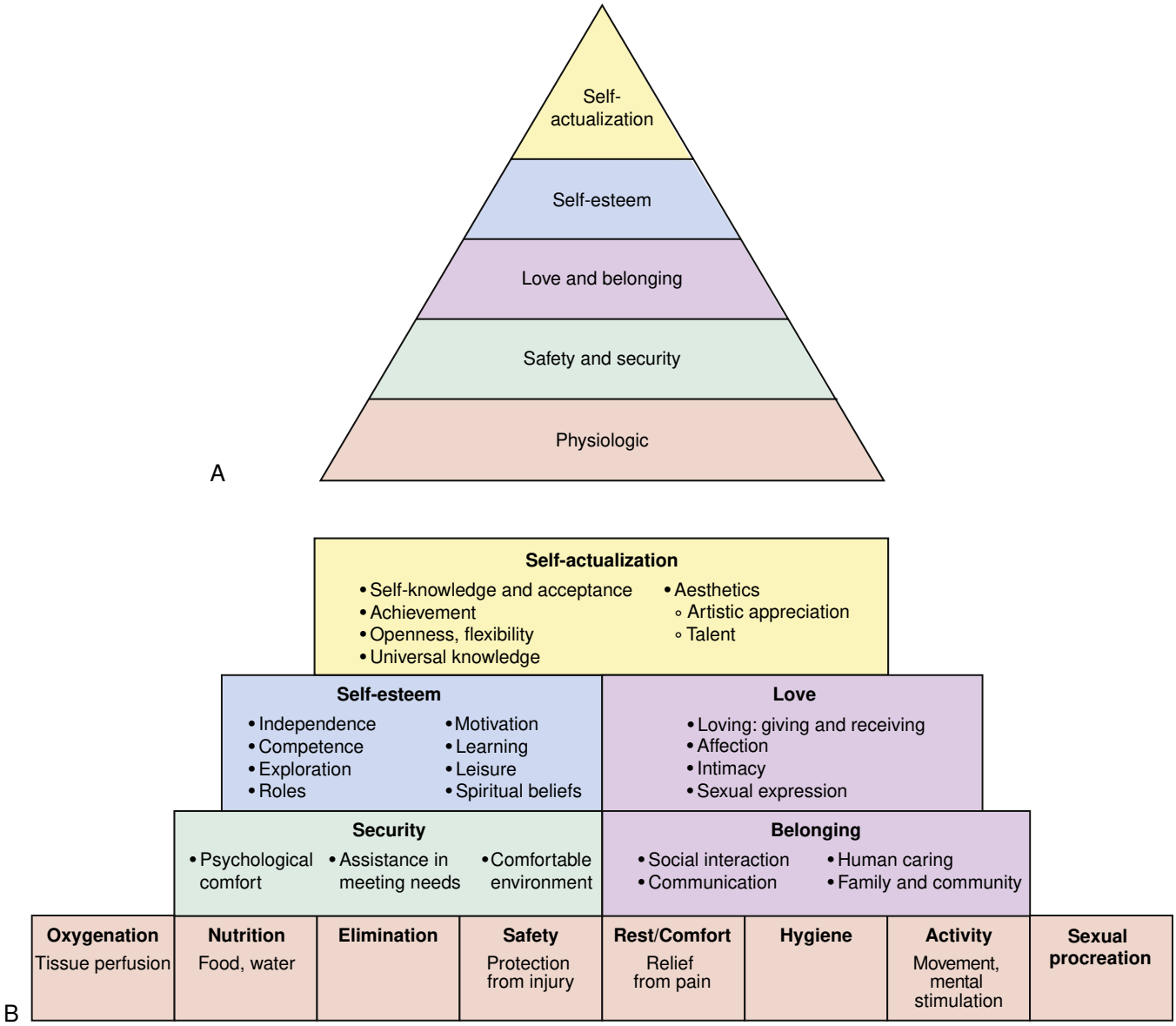

Fig. 2.3 **A,** Maslow's hierarchy of needs. **B,** Evolving hierarchy of needs adapted by nursing to help determine priorities of care. (From Williams P: *Fundamental concepts and skills for nursing*, ed 6, St. Louis, 2022, Elsevier.)

therapeutic diet, what kinds and what frequency of exercise are appropriate, how to prevent infections, and when to seek additional medical help.

Goals state a general intent about what the patient will achieve. **Expected outcomes** describe a specific result expected at a certain point in time. The terms are used interchangeably in some agencies. *Outcome* generally is used to describe what the patient, not the nurse, will do. An outcome is written as *"The patient will …"* Patient input is important to establish motivation to accomplish the outcome. Outcome statements are derived from the signs and symptoms included in the problem statements. The word *patient* is used as the subject of the statement. The outcome statements are written with a subject, an action verb, conditions or modifiers, and the criterion (standard) for desired performance. Expected outcomes should include the following:

- Patient activity that can be observed or patient knowledge that can be assessed. Consider how "the patient will select *[action verb, which can be measured or observed]* low-sodium foods from a list" provides a better indicator of knowledge than "the patient will understand *[passive verb]* a low-sodium diet."
- A description of how the patient's behavior will be measured, including the accuracy and quality of performance and the time frame within which the objective is to be met.

Nursing Interventions

Nursing interventions are nursing actions and patient activities chosen to achieve the goals and expected outcomes. Evidence-based practice research is considered to locate best practices for the types of interventions that are appropriate for each problem statement or

nursing diagnosis. Independent nursing interventions can be initiated and implemented without a health care provider's order. Dependent actions are ordered by the provider. Chosen interventions are listed on the nursing care plan.

Prioritizing Delivery of Care

Prioritizing care is the most important step in planning competent, timely patient care. Prioritizing of care includes when to give medications, measure vital signs, monitor blood glucose, change dressings, check IVs, and so on. Prioritizing also includes identifying which tasks are urgent and which tasks can wait. An urgent task would be administering medication on schedule, whereas a nonurgent task would be ambulating the patient.

Nursing students often have only one or two patients assigned to them for clinical care. After graduation, the norm is four to six patients. During times of low staffing, expect the number of assigned patients to increase. Once you receive your assignments:

- Review the patient's chart, computer printout, or whichever system is used for patient information.
- Look up required drug information for each routine and PRN drug listed, including IV solutions and additives.
- List focused assessments you will make and data you will collect, both at intervals and before you go off duty.
- List procedures that will be performed and a list of equipment for each.
- Attend report, make additional notes, and question what you do not understand.
- Make rounds on all your assigned patients (unless a bedside report was given). Seeing the patient alerts you to changes that need immediate attention.
- Consider a plan for your shift, including when the patient might be out of the unit for a test, when medications are due, when meals are served, when health care providers usually make rounds, what time physical therapy or respiratory therapy might be working with the patient, treatments that are ordered, and when a spouse might arrive to visit. Consider when patient teaching might be worked in and when you might chart and revise the care plan if needed.

Priority setting is a skill that must be developed to work efficiently and safely. During prioritizing, it should become apparent if there is a need to assign some tasks to others.

IMPLEMENTATION

LPN/LVN standards require that you provide care within the scope of practice to accomplish established goals. Standardized care plans are frequently found on medical-surgical units and include generic nursing care for commonly encountered patient problems. The standardized plan is not individualized for a specific patient. However, problems and interventions can be added or deleted if they are not appropriate for the patient. An individualized plan of care is more thorough because it is developed for a specific patient.

Distinguish which activities you need to carry out and which activities the patient must learn to do to gain independence. Sometimes when you are very busy, it seems faster to do an activity for the patient (e.g., feeding a patient who needs to learn to feed themselves). The interventions listed in the care plan should indicate that the caregiver is to sit beside the patient and encourage them verbally, as needed. In this way the patient will gain independence by eventually feeding themselves.

Staff Communication Regarding Care

Communication among staff members occurs in numerous ways throughout the day. Sometimes staff communication must be immediate to communicate urgent and relevant data that were discovered during an assessment of the patient. Urgent data are usually communicated verbally and may require immediate action. Use the SBAR format (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) for communicating information.

Charting occurs on nurses' notes, treatment flow sheets, MARs, and activity flow sheets. Nurses also might chart on common charting forms with other health care providers. Health care facilities are moving to electronic documentation and records management. Most acute care facilities have transitioned to electronic records and many long-term care facilities use computerized charting. An EHR is a computerized comprehensive record of a patient's history and care across all facilities and admissions (Williams, 2022). Security of information is extremely important whether located on paper or a computer.

Think critically about what needs to be documented and be succinct in recording the information. Follow agency policy for the method of documentation to be used (e.g., problem-oriented record, focus charting, or charting by exception).

Legal and Ethical Considerations

Privacy and Protected Health Information

Other clinicians, such as the dietitian, respiratory therapist, and social worker, contribute to the documentation in the patient's chart. Information provided by these clinicians completes the comprehensive picture of the patient.

Any protected health information in a patient's chart must be carefully guarded to avoid violating the confidentiality component of the Health Insurance Portability and Accountability Act (HIPAA). Information retained by a student for educational purposes must be devoid of identifying information. Student preparation paperwork that contains protected health information must be destroyed before

leaving the facility according to the policies and procedures of the facility.

Report is conducted at the change of shifts according to facility protocol to ensure continuity of care for patients. On some medical-surgical units, all staff members listen to report on all patients, the advantage of which is that all nurses and nursing assistants are aware of the needs of every patient. Other units use an individualized report system in which a nurse receives report on assigned patients only. Walking rounds are another method for change-of-shift report in which nurses go to patients' rooms and the departing nurse and the patient describe what happened during the previous shift. They discuss what the departing nurse and the patient see as priorities for the next shift. This is more time consuming than other methods, but walking rounds provide a sense of partnering for the patient, and the arriving nurse has an opportunity to see and hear the patient before beginning care. Having appropriate information available during report facilitates discussion of identified patient priorities.

Think Critically

What information is needed to effectively receive and give report? What are the items to which you will pay greatest attention or that you will emphasize?

EVALUATION

The LPN/LVN standards require comparison of *actual* outcomes of patient care to the *expected* outcomes. This comparison is known as **evaluation**. Evaluation begins as soon as a nursing plan is implemented. To make the comparisons needed for evaluation, collect data with every patient contact, think critically about how the patient is progressing in response to nursing actions, and determine whether there is a way to improve care. Daily evaluation is part of the natural flow of the nursing process, regardless of the time frame established for patient outcomes. The collected and documented data demonstrate a patient's progress toward meeting the expected outcomes. If the data show a lack of progress toward meeting the expected outcomes with planned interventions, the interventions should be reviewed and revised.

INTERDISCIPLINARY (COLLABORATIVE) CARE PLANS

Interdisciplinary (collaborative) care plans require input from all health team members involved in patient care (see the Evolve website for Interdisciplinary [Collaborative] Care Plan). The collaborative care plan is developed using the interdisciplinary focus of each professional (e.g., nurse, social worker, occupational therapist, recreational therapist). A separate care plan for each profession is considered repetitious. The focus of interdisciplinary planning is patient problems rather than nursing diagnoses, making the language used in the plan common to all professions. Interdisciplinary care plans have the following characteristics:

- The patient's medical diagnosis is used, rather than a problem statement or nursing diagnosis.
- Observations (data collected) are shared among all providers involved in the care of the patient.
- A problem list is developed and prioritized. The patient's statement of problems that led to admission is considered. **Priority is given to lifesaving or physiologic needs.**
- A shared care plan is created, identifying specific and shared responsibilities for all professions represented.
- The plan is discussed with the patient (when possible) or patient advocate. The team plays a supportive role during implementation of the plan.
- Documentation of progress is usually made on a common form or computer record to allow easy access for all team members involved with the patient.
- Evaluation is ongoing, with periodic in-depth evaluation by the team on agreed-on dates. Interventions are deleted, added, and changed as needed.

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Key Points

- Critical thinking generates new ideas and judges the worth of those ideas. Critical thinking prompts the LPN/LVN to ask what could be improved and what measures would prevent further harm to the patient.
- Clinical judgment is a proactive reasoning skill that uses critical thinking in the clinical area to determine the appropriate actions to take in specific situations.
- Factors that influence critical thinking and the decisions about nursing care include our culture, personal motivation, attitude, and verbal and written communication ability.
- The nursing process is an advanced problem-solving method used to collect and analyze data to plan, implement, and evaluate patient care in an orderly way.
- Goals and expected outcomes are patient centered and describe what the patient will achieve.
- Receiving a patient assignment and preparing a preliminary care plan before beginning patient care is considered safe practice for student nurses.
- Techniques of physical examination used by the LPN/LVN include inspection and observation, olfaction, palpation, percussion, and auscultation. Nurses need to be aware of