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ELEVENTH EDITION

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We would like to dedicate this 11th edition of *Fundamentals of Nursing* to three awe-inspiring groups of people—working nurses, nurse educators, and nursing students. Hardworking, caring nurses have provided and will continue to provide care to hundreds of thousands of patients hospitalized with COVID-19 during the pandemic. It has been a challenging time to deliver care for patients, and all of you have stepped up to the challenge and continued to provide safe, competent, high-quality care to all patients. You have provided patients with support and comfort during the hardest times in their lives. Nurse educators, you have been challenged during the pandemic to continue providing education to nursing students who often were not in your classroom. You have been thoughtful and creative in your approaches and have embraced online and nontraditional delivery of nursing content, determined to prepare future nurses entering the profession. Nursing students, you have embraced these nontraditional styles of learning and have continued to move forward with your education so that you can join the nursing workforce.

Thank you to all the nurses, nurse educators, and nursing students for continuing to excel and meet the unforeseen challenges of the COVID-19 pandemic. We are proud to be a part of the nursing profession with all of you!

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PREFACE TO THE INSTRUCTOR

The nursing profession is always responding to dynamic change and continual challenges. Today, nurses need a broad knowledge base to know how to use sound clinical judgment by applying critical thinking and best evidence in practice to ensure the best outcomes for their patients. The role of the nurse includes assuming the lead in preserving nursing practice and demonstrating its contribution to the health care of our nation. Nurses of tomorrow, therefore, need to become competent clinicians using sound clinical judgment, critical thinkers, patient advocates, and patient educators within a broad spectrum of care services.

The eleventh edition of ***Fundamentals of Nursing*** was revised to prepare today's students for the challenges of tomorrow. This textbook is designed for beginning students in all types of professional nursing programs. The comprehensive coverage provides fundamental nursing concepts, skills, and techniques of nursing practice and a firm foundation for more advanced areas of study.

Fundamentals of Nursing provides a contemporary approach to nursing practice, discussing the entire scope of primary, acute, and restorative care. In an effort to continue to inform and build students' knowledge of the complexities of nursing practice, the authors have developed a new Critical Thinking and Clinical Judgment model that incorporates the major themes and constructs of the National Council of State Boards of Nursing Clinical Judgment Measurement Model (NCSBN-CJMM). The model has been integrated into all clinical chapters of the text along with case studies and more examples of clinical applications. The student is shown throughout the text how clinical judgment is unique to each patient and the patient's clinical condition.

This new edition continues to address a number of key practice issues, including an emphasis on patient-centered care, cultural sensitivity and diversity, evidence-based practice, and globalization of health care. Evidence-based practice is one of the most important initiatives in health care today. The increased focus on applying current evidence in patient care helps students understand how the latest research findings should guide their clinical decision making. Current evidence is reflected in each chapter's references.

KEY FEATURES

We have carefully developed this eleventh edition with the student in mind. We have designed this text to welcome the new student to nursing, communicate our own love for the profession, and promote learning and understanding. Key features of the text include the following:

- **Clinical examples** that assist students in understanding how clinical judgment is practiced.
- Students will appreciate the **clear, engaging writing style.** The narrative actually addresses the reader, making this textbook more of an active instructional tool than a passive reference. Students will find that even complex technical and theoretical concepts are presented in a language that is easy to understand.
- **Comprehensive** coverage and readability of all fundamental nursing content.
- The **attractive, functional design** will appeal to today's visual learner. The clear, readable type and boldface headings make the content easy to read and follow. Each special element is consistently color-keyed so students can readily identify important information.
- Hundreds of **large, clear, full-color photographs and drawings** reinforce and clarify key concepts and techniques.
- The **nursing process** format provides a consistent organizational framework for clinical chapters.
- **Learning aids** to help students identify, review, and apply important content in each chapter include Objectives, Key Terms, Key Points, QSEN activities, Next-Generation NCLEX®–based Reflective Learning Questions, and Review Questions.
- **Reflect Now** boxes interspersed throughout the chapters prompt students to consider a recent clinical experience based on the topic being discussed in the text.
- **Review Questions** have been updated in each chapter and include several alternate-item–type questions. Answers are provided at the end of the chapter, with rationales provided in the Evolve Student Resources.
- **Health promotion and acute and continuing care** are covered to address today's practice in various settings.
- A **health promotion/wellness** thread is used consistently throughout the text.
- **Cultural competence,** care of the **older adult,** and **patient teaching** are stressed throughout chapter narratives, as well as highlighted in special boxes.
- **Evidence-Based Practice** is consistently used within the chapters, including an Evidence-Based Practice box relevant to the content of the chapter. This box includes a brief summary of the evidence related to a PICOT question and appropriate nursing actions.
- **Procedural Guidelines** boxes provide more streamlined, step-by-step instructions for performing very basic skills.
- **Concept Maps** included in clinical chapters show you the association between multiple nursing diagnoses for a patient with a selected medical diagnosis and the relationships among nursing interventions.
- **Nursing Care Plans** guide students on how to conduct an assessment, analyze the defining characteristics in order to select nursing diagnoses, and then determine the expected outcomes of care. The plans include NIC and NOC classifications to familiarize students with this important nomenclature. The evaluation section of the plans shows students how to evaluate whether the identified outcomes of care were achieved.
- Information related to the **Quality and Safety Education for Nurses (QSEN)** initiative is highlighted by headings that coordinate with the key competencies. Building Competency scenarios in each chapter incorporate one of the six key competencies in QSEN. Answers to these activities can be found online in the Evolve Student Resources.
- **More than 55 nursing skills** are presented in a clear two-column format with steps and supporting rationales that are supported with current evidenced-based research.
- **Delegation Considerations** guide when it is appropriate to delegate tasks to assistive personnel.
- **Teach-back** is included in the evaluation section of each skill and in the Patient Teaching boxes.
- **Unexpected Outcomes and Related Interventions** are highlighted within nursing skills to help students anticipate and appropriately respond to possible problems faced while performing skills.
- **Evolve Resources** lists at the beginning of every chapter detail the electronic resources available for the student.
- **Video Icons** indicate video clips associated with specific skills that are available on the Evolve Student Resources.
- **Printed endpapers** on the inside back cover provide information on locating specific assets in the book, including Skills, Procedure Guidelines, Nursing Care Plans, and Concept Maps.

NEW TO THIS EDITION

- Revised unit on Clinical Judgment in Nursing Practice. This unit integrates a model for Clinical Judgment that incorporates elements and constructs from the National Council of State Boards of Nursing Clinical Judgment Measurement Model (NCSBN-CJMM) and Next-Generation NCLEX® to prepare students to know how to make the right clinical decisions for their patients. The model provides a foundation for the nursing process chapters and is applied in all clinical chapters.
- New to the clinical chapters is the inclusion of an **evolving case study** throughout the chapter. Within the nursing process sections of the chapters, these case studies demonstrate how nursing assessment reveals relevant data cues and how the nurse analyzes the data to identify accurate and appropriate nursing diagnoses, identify and prioritize outcomes of care, and select individualized nursing interventions. Last, these case studies demonstrate how the nurse evaluates the outcomes of patient care.
- Increased emphasis on **delegation considerations**. The goal is to help the student understand the professional importance of correctly delegating a skill to the right assistive personnel and of completing any related nursing actions prior to or following delegation.
- **Clinical Judgment points** are included within the Skills and Procedural Guidelines boxes to alert the student to current research or appropriate patient-specific adaptations to a certain skill or technique.
- **Evidence-Based Practice** boxes in each chapter have been updated to reflect current research topics and trends.
- The **Reflective Learning** section uses the chapter case study to help students better understand and think about their clinical and simulation experiences as they progress through their first nursing courses.
- **Teach-Back** has been incorporated into the Evaluation section of the Patient Teaching boxes.

LEARNING SUPPLEMENTS FOR STUDENTS

- The **Evolve Student Resources** are available online at http://evolve.elsevier.com/Potter/fundamentals/ and include the following valuable learning aids organized by chapter:
  - Chapter Review Questions with Answers and Rationales
  - Answers and rationales to Building Competency scenario questions
  - Video clips highlight common skills
  - Concept Map Creator included in each clinical chapter
  - Conceptual Care Map included in each clinical chapter
  - Case Study with questions
  - Audio glossary
  - Fluids & Electrolytes Tutorial
  - Calculation Tutorial
  - Printable versions of chapter Key Points
  - Printable Skills Performance Checklists for each skill in the text
- A thorough ***Study Guide*** by Geralyn Ochs provides an ideal supplement to help students understand and apply the content of the text. Each chapter includes multiple sections:
  - Preliminary Reading includes a chapter assignment from the text.
  - Case Study includes related questions.
  - Comprehensive Understanding provides a variety of activities to reinforce the topics and main ideas from the text.
  - Review Questions include multiple-choice, matching, and fill-in-the-blank questions. Answers and rationales are provided in the answer key.
  - Clinical chapters include a discussion of the Clinical Judgment Measurement Model that expands the case study from the chapter's Nursing Care Plan and asks students to develop a step in the synthesis model based on the nurse and patient in the scenario. This helps students learn to apply both content learned and the critical thinking synthesis model.
  - Twenty chapters include a new Next-Generation NCLEX® question to help prepare students for practice.
- The handy ***Clinical Companion*** complements, rather than abbreviates, the textbook. Content is presented in tabular, list, and outline format that equips your students with a concise, portable guide to all the facts and figures they will need to know in their early clinical experiences.

TEACHING SUPPLEMENTS FOR INSTRUCTORS

The **Evolve Instructor Resources** (available online at http://evolve.elsevier.com/Potter/fundamentals) are a comprehensive collection of the most important tools instructors need, including the following:

- **TEACH for Nurses** ties together every chapter resource you need for the most effective class presentations, with sections dedicated to objectives, teaching focus, nursing curriculum standards (including QSEN, BSN Essentials, and Concepts), instructor chapter resources, student chapter resources, answers to chapter questions, and an in-class case study discussion. Teaching Strategies include relations between the textbook content and discussion items. Examples of student activities, online activities, new health promotion–focused activities, and large group activities are provided for more "hands-on" learning.
- The **Test Bank** contains 1100 questions with answers coded for the NCLEX® Client Needs category, nursing process, and cognitive level. The ExamView software allows instructors to create new tests; edit, add, and delete test questions; sort questions by NCLEX® category, cognitive level, nursing process step, and question type; and administer/grade online tests.
- Updated **PowerPoint Presentations** include over 1500 slides for use in lectures. Art is included within the slides and progressive case studies include discussion questions and answers.
- The **Image Collection** contains more than 1150 illustrations from the text for use in lectures.
- **Simulation Learning System** is an online toolkit that helps instructors and facilitators effectively incorporate medium- to high-fidelity simulation into their nursing curriculum. Detailed patient scenarios promote and enhance the clinical decision-making skills of students at all levels. The system provides detailed instructions for preparation and implementation of the simulation experience, debriefing questions that encourage critical thinking, and learning resources to reinforce student comprehension. Each scenario in *Simulation Learning System* complements the textbook content and helps bridge the gap between lectures and clinicals. This system provides the perfect environment for students to practice what they are learning in the text for a true-to-life, hands-on learning experience.

MULTIMEDIA SUPPLEMENTS FOR INSTRUCTORS AND STUDENTS

- **Nursing Skills Online 4.0** contains 19 modules rich with animations, videos, interactive activities, and exercises to help students prepare for their clinical lab experience. The instructionally designed lessons focus on topics that are difficult to master and pose

a high risk to the patient if done incorrectly. Lesson quizzes allow students to check their learning curve and review as needed, and the module exams feed out to an instructor grade book. Modules cover Airway Management, Blood Therapy, Bowel Elimination/Ostomy Care, Cardiac Care, Cardiac Care, Closed Chest Drainage Systems, Enteral Nutrition, Infection Control, Maintenance of IV Fluid Therapy, IV Fluid Therapy, Administration of Parenteral Medications: Injections and IV Medications, Nonparenteral Medication Administration, Safe Medication Preparation, Safety, Specimen Collection, Urinary Catheterization, Caring for Central Vascular Access Devices (CVAD), Vital Signs, and Wound Care. Available alone or packaged with the text.

ACKNOWLEDGMENTS

The eleventh edition of *Fundamentals of Nursing* is one that we believe continues to prepare the nursing student to be able to practice in the challenging health care environment. Collaboration on this project allows us to be creative, visionary, and thoughtful regarding students' learning needs. Each edition is a new adventure for all of us on the author team as we try to create the very best textbook for beginning nurses. Each of us wishes to acknowledge the professionalism, support, and commitment to detail from the following individuals:

- To the editorial and production professionals at Elsevier, including:
  - Tamara Myers, Director, Traditional Education, for her vision, organization, professionalism, energy, and support in assisting us to develop a text that offers a state-of-the-art approach to the design, organization, and presentation of *Fundamentals of Nursing.* Her skill is in motivating and supporting a writing team so it can be creative and innovative while retaining the characteristics of a high-quality textbook.
  - Tina Kaemmerer as our Senior Content Development Specialist for *Fundamentals of Nursing* for her dedication to keeping the writing team organized and focused and for performing considerable behind-the-scenes work to ensure accuracy and consistency in how we present content within the textbook. She has limitless energy and is always willing to go the extra mile.
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- To our contributors and clinician and educator reviewers, who share their expertise and knowledge about nursing practice and the trends within health care today, helping us to create informative, accurate, and current information. Their contributions allow us to develop a text that embodies high standards for professional nursing practice through the printed word.
- And special recognition to our professional colleagues at Barnes-Jewish Hospital, Southern Illinois University—Edwardsville, Saint Francis Medical Center College of Nursing, and Franciscan Missionaries of Our Lady University.

We believe that *Fundamentals of Nursing*, now in its eleventh edition, is a textbook that informs and helps to shape the standards for excellence in nursing practice. Nursing excellence belongs to all of us, and we are happy to have the opportunity to continue the work we love.

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Any updates to this textbook can be found in the Content Updates folder on Evolve at http://evolve.elsevier.com/Potter/fundamentals/.

UNIT 1 Nursing and the Health Care Environment

UNIT 2 Caring Throughout the Life Span

1

Nursing Today

OBJECTIVES

- Explain how nursing standards affect nursing care.
- Discuss the development of professional nursing roles.
- Discuss the roles and career opportunities for professional nurses.
- Discuss the influence of social, historical, political, and economic changes on nursing practices.
- Discuss how advances in nursing science and evidence-based practice improve patient care.
- Compare and contrast the educational programs available for professional registered nurse (RN) education.
- Explain how professional nursing organizations affect both the profession and the standards of care.

KEY TERMS

Advanced practice registered nurse (APRN)
American Nurses Association (ANA)
Caregiver
Certified nurse-midwife (CNM)
Certified registered nurse anesthetist (CRNA)
Clinical nurse specialist (CNS)
Code of ethics
Continuing education
Genomics
In-service education
International Council of Nurses (ICN)
Nurse administrator
Nurse educator
Nurse practitioner (NP)
Nurse researcher
Nursing
Patient advocate
Professional organization
Quality and Safety Education for Nurses (QSEN)
Registered nurse (RN)

MEDIA RESOURCES

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- Review Questions
- Audio Glossary
- Case Study with Questions
- Content Updates
- Answers to QSEN Activity and Review Questions

Nursing is an art and a science. As an art, nursing involves learning to deliver care with compassion, caring, and respect for each patient's dignity and individuality. It evolves as you gain more experience and witness how patients respond to your actions. As a science, nursing practice is based on a body of knowledge and evidence-based practices that are continually changing with new discoveries and innovations. Through integration of the art and science of nursing, the quality of care you provide meets the highest standards and benefits patients and their families. Your care reflects your patients' multidimensional needs as well as the needs and values of society and professional standards of care.

Nursing offers personal and professional rewards every day. This chapter presents a contemporary view of the evolution of nursing and nursing practice and the historical, practical, social, and political influences on the discipline of nursing.

NURSING AS A PROFESSION

The patient is the center of your practice. Depending on the setting and situation, your patients may include individuals, families, and/or communities. Patients have a wide variety of health care needs, knowledge, experiences, vulnerabilities, and expectations, but this is what makes nursing both challenging and rewarding. Making a difference in your patients' lives is fulfilling (e.g., helping a young mother learn parenting skills, finding ways for older adults to remain independent in their homes, assisting family care givers with end-of-life care and symptom management).

Nursing is not simply a collection of specific skills, and you are not simply a person trained to perform specific tasks. Nursing is a profession. No one factor absolutely differentiates a job from a profession, but the difference is important in terms of how you practice. To act

professionally, you will use critical thinking (see Chapter 15) to administer high-quality evidence-based patient-centered care in a safe, prudent, and knowledgeable manner. You are responsible and accountable to yourself, your patients, and your peers.

A variety of career opportunities are available in nursing, including clinical practice, education, research, management, administration, and even entrepreneurship. As a student it is important for you to understand the scope of professional nursing practice and how nursing influences the lives of your patients, their families, and their communities.

Health care advocacy groups recognize the importance of the role high-quality professional nursing plays in a nation's health care. One such program was the Robert Wood Johnson Foundation (RWJF) *Future of Nursing: Campaign for Action* (RWJF, 2014). This program was a multifaceted campaign to transform health care through nursing, and was a response to the Institute of Medicine (IOM) publication *The Future of Nursing* (IOM, 2010). A new RWJF (2017) initiative, *Catalysts for Change: Harnessing the Power of Nurses to Build Population Health in the 21st Century,* reinforces the fact that nurses are educated to consider health care issues within a broader context, and as a result nurses identify factors outside of health care that affect a person's level of health. These initiatives prepare a professional workforce to meet health promotion, illness prevention, and complex care needs of the population in a changing health care system.

Science and Art of Nursing Practice

Because nursing is both an art and a science, nursing practice requires a blend of current knowledge and practice standards with an insightful and compassionate approach to your patients' health care needs. Your care must reflect the needs and values of society and professional standards of care and performance, meet the needs of each patient, and integrate evidence-based findings to provide the highest level of care. For example, when caring for a patient with a pressure injury, you use evidence-based practice guidelines from professional organizations, such as the Wound, Ostomy, and Continence Nurses Society (WOCN) to individualize wound care interventions.

Clinical expertise takes time and commitment. According to Benner (1984), an expert nurse passes through five levels of proficiency when acquiring and developing generalist or specialized nursing skills (Box 1.1). Expert clinical nursing practice is a commitment to sound clinical judgment involving application of knowledge, ethics, evidence-based practices, and clinical experience. Your ability to interpret clinical situations and make complex decisions is the foundation for your nursing care and the basis for the advancement of nursing practice and the development of nursing science (Benner et al., 1997; Benner et al., 2010).

Critical thinking applied with clinical judgment helps you acquire and interpret scientific knowledge, integrate knowledge from clinical experiences, and become a lifelong learner (Chapter 15). Integrate the competencies of critical thinking in your practice. This includes incorporating knowledge from the basic sciences and nursing, applying knowledge from past and present experiences, considering environmental factors, applying critical thinking attitudes, and implementing intellectual and professional standards. When you provide well–thought-out care with compassion and caring, you provide each patient the best of the science and art of nursing care (see Chapter 7).

Scope and Standards of Practice

When giving care, it is essential to provide a specified service according to standards of practice and to follow a code of ethics. Professional practice includes knowledge from social and behavioral sciences, biological and physiological sciences, and nursing theories. In addition, nursing practice incorporates ethical and social values, professional autonomy, and a sense of commitment and community

BOX 1.1 Benner: From Novice to Expert

- **Novice:** Beginning nursing student or any nurse entering a situation in which there is no previous level of experience (e.g., an experienced operating room nurse chooses to now practice in home health). The learner learns via a specific set of rules or procedures, which are usually stepwise and linear.
- **Advanced Beginner:** A nurse who has had some level of experience with the situation. This experience may be only observational in nature, but the nurse is able to identify meaningful aspects or principles of nursing care.
- **Competent:** A nurse who has been in the same clinical position for 2 to 3 years. This nurse understands the organization and specific care required by the type of patients (e.g., surgical, oncology, or orthopedic patients). This nurse is a competent practitioner who is able to anticipate nursing care and establish long-range goals. In this phase the nurse has usually had experience with all types of psychomotor skills required by this specific group of patients.
- **Proficient:** A nurse with more than 2 to 3 years of experience in the same clinical position. This nurse perceives a patient's clinical situation as a whole, is able to assess an entire situation, and can readily transfer knowledge gained from multiple previous experiences to a situation. This nurse focuses on managing care as opposed to managing and performing skills.
- **Expert:** A nurse with diverse experience who has an intuitive grasp of an existing or potential clinical problem. This nurse is able to zero in on the problem and focus on multiple dimensions of the situation. This nurse is skilled at identifying both patient-centered problems and problems related to the health care system or perhaps the needs of the novice nurse.

Data from Benner P: *From novice to expert: excellence and power in clinical nursing practice,* Menlo Park, CA, 1984, Addison-Wesley.

(**American Nurses Association [ANA]**, 2021). The following definition from the ANA illustrates the consistent commitment of nurses to provide care that promotes the well-being of their patients and communities (ANA, 2021):

> ***Nursing*** *incorporates the art and science of caring and focuses on the protection, promotion, and optimization of health and abilities; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity.*

The **International Council of Nurses (ICN)** has another definition (ICN, 2021):

> *Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health; prevention of illness; and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*

Both of these definitions support the prominence and importance that nursing holds in providing safe, patient-centered health care to the global community.

The ANA develops, revises, and maintains the scope of practice statement and standards that apply to the practice of all professional nurses (ANA, 2021). It is important that you know and apply these

BOX 1.2 American Nurses Association (ANA) Standards of Nursing Practice

1. **Assessment:** The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.
2. **Diagnosis:** The registered nurse analyzes the assessment data to determine the actual or potential diagnoses, problems, and issues.
3. **Outcomes Identification:** The registered nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.
4. **Planning:** The registered nurse develops a plan encompassing strategies to achieve expected outcomes.
5. **Implementation:** The registered nurse implements the identified plan.
   - 5a. **Coordination of Care:** The registered nurse coordinates care delivery.
   - 5b. **Health Teaching and Health Promotion:** The registered nurse employs strategies to teach and promote health and wellness.
6. **Evaluation:** The registered nurse evaluates progress toward attainment of goals and outcomes.

BOX 1.3 American Nurses Association (ANA) Standards of Professional Performance

7. **Ethics:** The registered nurse integrates ethics in all aspect of practice.
8. **Advocacy:** The registered nurse demonstrates advocacy in all roles and settings.
9. **Respectful and Equitable Practice:** The registered nurse practices with cultural humility and inclusiveness.
10. **Communication:** The registered nurse communicates effectively in all areas of professional practice.
11. **Collaboration:** The registered nurse collaborates with health care consumers and other key stakeholders.
12. **Leadership:** The registered nurse leads within the professional practice setting and the profession.
13. **Education:** The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.
14. **Scholarly Inquiry:** The registered nurse integrates scholarship, evidence, and research findings into practice.
15. **Quality of Practice:** The registered nurse contributes to quality nursing practice.
16. **Professional Practice Evaluation:** The registered nurse evaluates one's own and others' nursing practice.
17. **Resource Stewardship:** The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible and avoid waste.
18. **Environmental Health:** The registered nurse practices in a manner that advances environmental safety and health.

standards in your practice (Box 1.2). Most schools of nursing and practice settings have published copies of the scope and standards of nursing practice. The scope and standards of practice guide nurses to make significant and visible contributions that improve the health and well-being of all individuals, communities, and populations (ANA, 2021).

Standards of Professional Nursing Practice. The Standards of Professional Nursing Practice contain authoritative statements of the duties that all registered nurses (RNs), regardless of role, population, specialty, setting, or APRN foci, are expected to competently perform (ANA, 2021). The Standards of Professional Nursing Practice describe a competent level of nursing care demonstrated by a critical thinking model known as the nursing process: assessment, diagnosis, outcomes identification and planning, implementation, and evaluation (ANA, 2021). The nursing process is the model for clinical decision making and includes all significant actions taken by nurses in providing care to patients (see Unit 3).

Standards of Professional Performance. The ANA Standards of Professional Performance (Box 1.3) describe a competent level of behavior in the professional nursing role. All RNs are expected to engage in professional role activities reflective of their education, experience, and position (ANA, 2021). The standards set a level of performance to assure patients that they are receiving high-quality care. This assumes that nurses know exactly what is necessary to provide nursing care. The standards are used as a measure to determine whether nursing care meets the standards.

Code of Ethics. The nursing **code of ethics** is a statement of philosophical ideals of right and wrong that define the principles you will use to provide care to your patients. It is important for you to also incorporate your own values and ethics into your practice. As you incorporate these values, explore what type of nurse you will be and how you will function within the discipline (ANA, 2021; Fowler, 2015). Ask yourself how your ethics, values, and practice compare with established standards. The ANA has a number of publications that address ethics and human rights in nursing. *The Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015) lists the nine succinct provisions and interpretive statements that establish the ethical framework for RNs' practice across all roles, levels, and settings. Chapter 22 provides a review of the nursing code of ethics and ethical principles for everyday practice.

Professional Responsibilities and Roles

Nurses provide care and comfort for patients in all health care settings. Their concern for meeting patients' needs remains the same whether care focuses on health promotion and illness prevention, disease and symptom management, family support, or end-of-life care. As a nurse, you are responsible for obtaining and maintaining specific knowledge and skills for a variety of professional roles and responsibilities.

Autonomy and Accountability. Autonomy is an essential element of professional nursing that involves the initiation of independent nursing interventions without medical orders. Although the nursing profession regulates accountability through nursing audits and standards of practice, you also need to develop a commitment to personal professional accountability. For example, you independently implement coughing and deep-breathing exercises to clear the lungs of secretions and promote oxygenation in a patient who recently had major surgery. As you continue to care for this patient, a complication arises. You note that the patient has a fever and the surgical wound has a yellow-green discharge. You collaborate with other health care professionals to develop the best treatment plan for this patient's surgical wound infection. With increased autonomy comes greater responsibility and accountability.

Accountability means that you are responsible professionally and legally for the type and quality of nursing care provided. This includes dependent, independent, and interdependent nursing actions (see Chapter 18). You must remain current and competent in nursing and scientific knowledge and technical skills.

Caregiver. As a **caregiver** you help patients maintain and regain health, manage disease and symptoms, and attain a maximal level of function and independence through the healing process. You provide evidence-based nursing care to promote healing through both physical and interpersonal skills. Healing involves more than achieving improved physical well-being. You support patients by providing measures that restore their emotional, spiritual, and social well-being. As a caregiver you help the patient and family set outcomes and assist them with meeting those outcomes with minimal financial cost, time, and energy.

Advocate. As a **patient advocate** you protect your patient's human and legal rights and provide assistance in asserting those rights if the need arises. As an advocate you act on behalf of your patient, such as safeguarding their care against errors, suggesting alternatives to care, securing your patient's health care rights, and facilitating personal and cultural preferences (Abbasinia et al., 2019; Kowalski, 2016). For example, you provide additional information to help a patient decide whether to accept a treatment, or you find an interpreter to help family members communicate their concerns. Sometimes you need to defend patients' rights to make health care decisions in a general way by speaking out against policies or actions that put patients in danger or conflict with their rights (Takenouchi, 2018). Furthermore, advocates ensure that patients' autonomy and self-determination are respected (Gerber, 2018). Patient advocacy is hard and often provides unique emotional challenges to health care providers, especially when providing high-quality palliative or end-of-life care or caring for patients with debilitating chronic illnesses (Takenouchi, 2018; O'Mahony et al., 2017). As an advocate, it is important to be mindful of your own personal stressors and to identify ways to cope with these stressors (see Chapter 37).

Educator. Your value as a patient educator is important to your patients' health and recovery. Your ability to teach effectively improves patients' knowledge, skills, self-care activities, and ability to make informed decisions (Flanders, 2018). As an educator you identify patients' willingness and ability to learn, explain concepts and facts about their health, describe the reason for care activities, demonstrate procedures such as self-care activities, reinforce learning or patient behavior, and evaluate the patient's progress in learning. Some of your patient teaching is unplanned and informal. For example, during a casual conversation you respond to questions about the reason for an intravenous infusion, a health issue such as smoking cessation, or necessary lifestyle changes. Other teaching activities are planned, more formal, and individualized, such as when you teach your patient how to self-administer insulin injections. Assess your patient's and family caregiver's learning styles and needs and develop a teaching plan that meets your patients' self-management objectives and includes teaching methods that match your patient's and family's needs (Pinchera et al., 2018) (see Chapter 25).

Communicator. An effective communicator is central to the nurse-patient relationship. It allows you to know your patients, including their preferences, strengths, weaknesses, and needs. High-quality communication is essential for all nursing roles and activities (see Chapter 24). You routinely communicate with patients and families, other nurses and health care professionals, resource people, and the community. Effective communication strategies are fundamental to providing high-quality care, coordinating and managing patient care, assisting patients in rehabilitation, advocating for patients, assisting patients and families in decision making, and providing patient education (Christian, 2017).

Manager. Today's health care environment is fast-paced and complex. Nurse managers direct groups of nurses by establishing an environment for collaborative patient-centered care and safe, evidence-based quality care with positive patient outcomes. A manager coordinates the activities of members of a nursing staff in delivering nursing care and has personnel, policy, and budgetary responsibility for a specific nursing unit or agency. A manager uses appropriate leadership styles to create a nursing environment for patients and staff that reflects the mission and values of the health care organization (see Chapter 21).

Career Development

Innovations in health care, expanding health care systems and practice settings, and the increasing needs of patients have created new nursing roles. Today the majority of nurses practice in hospital settings, followed by community-based care, ambulatory care, home care, and nursing homes/extended care settings.

Nursing provides an opportunity for you to commit to lifelong learning and career development. Because of increasing educational opportunities for nurses, the growth of nursing as a profession, and a greater concern for job enrichment, the nursing profession offers different career opportunities. Your career path is limitless. You will probably switch career roles more than once. Take advantage of the different clinical practice and professional opportunities. Examples of these career opportunities include advanced practice registered nurses (APRNs), nurse researchers, nurse risk managers, quality improvement nurses, consultants, and entrepreneurs.

Clinician. Most nurses provide direct (hands-on) patient care in acute care settings. However, as changes in health care services and reimbursement continue, there will be an increase in direct care activities provided in the home care setting and an increased need for community-based health promotion activities, restorative care, and end-of-life care.

In the hospital you may choose to practice in a medical-surgical setting or concentrate on a specific area of specialty practice such as pediatrics, critical care, or emergency care. Most specialty care areas require some experience as a medical-surgical nurse and additional continuing or in-service education. Many intensive care unit and emergency department nurses are required to have certification in advanced cardiac life support and critical care, emergency nursing, or trauma nursing. When developing as a clinician in acute care, you will learn a variety of hands-on technical procedures, the rationale for those procedures, and how to ensure safe implementation. Career advancement promotes a maturing of clinical skills and clinical decision making.

In community and home care settings, nurses' clinical abilities will include technical skills. However, because nurses in these settings usually have more contact with patients and family members over time, expertise in communication and assessment skills is crucial for clinical development. Community and home care nurses have an advantage of gaining a greater insight into how patients live and work daily and to thus apply clinical skills for promotion of long-term improvement in health.

Advanced Practice Registered Nurses. The **advanced practice registered nurse (APRN)** is the most independently functioning nurse. An APRN has a master's degree or Doctor of Nursing Practice (DNP) degree in nursing; advanced education in pathophysiology, pharmacology, and physical assessment; and certification and expertise in a specialized area of practice (American Association of Colleges of Nursing [AACN], 2021a). The APRN Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education provides guidance for states to adopt uniformity in the regulation of APRN roles (National Council of State Boards of Nursing [NCSBN], 2021). The model addresses inconsistent standards in APRN education, regulation, and practice, which had limited APRN mobility from one state to another

(Doherty et al., 2018). The consensus model identified that the title of APRN is for nurses with advanced graduate-level knowledge prepared in one of four roles: clinical nurse specialist (CNS), nurse practitioner (NP), certified nurse-midwife (CNM), and certified registered nurse anesthetist (CRNA). The educational preparation for the four roles is in at least one of the following six populations: adult-gerontology, pediatrics, neonatology, women's health/gender related, family/individual across life span, and psychiatric mental health (NCSBN, 2021).

These advanced practice roles provide additional career opportunities for nurses and expand the professional health care opportunities for patients, many of whom are underserved. However, prior to progressing to an advanced practice role, it is important for the new graduate nurse to obtain solid bedside clinical practice. This clinical practice helps the new graduate increase knowledge about disease processes and how the body responds to illnesses. The nurse gains expertise and confidence in basic and complex skills. As a result, new graduates refine their critical thinking and have opportunities to make sound clinical judgments. The knowledge and skill acquisition, refinement of critical thinking, and opportunities for clinical judgment are essential preparation for the education and practice in an advanced role (Faraz, 2017).

Clinical nurse specialist. A **clinical nurse specialist (CNS)** is an APRN who has graduate preparation (master's degree or doctorate) in nursing and is an expert clinician in a specialized area of practice (National Association of Clinical Nurse Specialists [NACNS], 2019). The specialty may be identified by a population (e.g., geriatrics), setting (e.g., critical care), disease specialty (e.g., oncology, diabetes), type of care (e.g., rehabilitation), or type of problem (e.g., pain) (NACNS, 2019). Clinical nurse specialists provide diagnosis, treatment, and ongoing management of patients in all health care settings (Fig. 1.1). They also provide expertise and support to nurses caring for patients at the bedside, help drive practice changes throughout an organization, and ensure the use of evidence-based practices and evidence-based care to achieve the best possible patient outcomes (Wallace et al., 2019; NACNS, 2019).

Nurse practitioner. A **nurse practitioner (NP)** is an APRN who has graduate preparation (master's degree or doctorate) in nursing. NPs provide primary, acute, and specialty health care to patients of all ages and in all types of health care settings. This care includes assessment, diagnosis, planning, and treatment; monitoring ongoing health status; evaluation of therapies; and health education (American Association of Nurse Practitioners [AANP], 2021). Some NPs provide care to acutely ill patients in hospital settings, including critical care units. Other NPs provide comprehensive care in outpatient settings, directly managing the nursing and medical care of patients who are healthy or who have chronic conditions. It is important to review state regulations for advanced practice. Some states require the NP to have a collaborative provider agreement with an agency or physician/physician group to treat a specific group of patients; other states do not.

FIG. 1.1 Clinical nurse specialist consults on a complex patient case. (iStock.com/Sturti.)

Certified nurse-midwife. A **certified nurse-midwife (CNM)** is an APRN who has graduate preparation (master's degree or doctorate) in nursing, is also educated in midwifery, and is certified by the American College of Nurse-Midwives (ACNM). The scope of practice of nurse-midwifery has been defined by the ACNM (2012) as encompassing a full range of primary health care services for women from adolescence beyond menopause. These services include primary care; gynecological and family planning services; preconception care; care during pregnancy, childbirth, and the postpartum period; care of the normal newborn during the first 28 days of life; and treatment of male partners for sexually transmitted infections (ACNM, 2012). The nurse-midwife conducts physical examinations; prescribes medications, including controlled substances and contraceptive methods; admits, manages, and discharges patients; orders and interprets laboratory and diagnostic tests; and orders the use of medical devices.

Certified registered nurse anesthetist. A **certified registered nurse anesthetist (CRNA)** is an APRN with advanced education from an accredited nurse anesthesia program. Before applying to a nurse anesthesia program, a nurse must have at least 1 year of critical care or emergency experience. Nurse anesthetists practice both autonomously and in collaboration with a variety of health care providers on the interprofessional team to deliver high-quality, holistic, evidence-based anesthesia and pain care services (American Association of Nurse Anesthetists [AANA], 2020). CRNAs practice under the guidance and supervision of an anesthesiologist, a physician with advanced knowledge of surgical anesthesia.

Nurse Educator. A **nurse educator** works primarily in schools of nursing, staff development departments of health care agencies, and patient education departments. Nurse educators need experience in clinical practice to provide them with practical skills and theoretical knowledge.

A faculty member in a nursing program educates students to become professional nurses. Nursing faculty members are responsible for teaching current nursing practice; trends; theory; and necessary skills in classroom, laboratories, and clinical settings. Faculty development is essential to improve and maintain a faculty member's clinical skills in addition to preparing faculty to adapt to new teaching and learning methods (Monsivais and Robbins, 2020). Nursing faculty have graduate degrees such as a master's degree in nursing or an earned doctorate in nursing or a related field. In general, they have a specific clinical, administrative, or research specialty and advanced clinical experience.

Nurse educators in staff development departments of health care agencies provide educational programs for nurses within their agencies. These programs include orientation of new personnel, critical care nursing courses, assisting with clinical skill competency, safety training, and instruction about new equipment or procedures. These nursing educators often participate in the development of nursing policies and procedures.

The primary focus of the nurse educator in a patient education department of an agency such as a wound treatment clinic is to teach and coach patients and their families how to self-manage their illness or disability, make positive choices or change their behaviors to promote their health, and improve their health outcomes (Flanders, 2018). These nurse educators are usually specialized and hold a certification and see only a specific population of patients. One example is a certified diabetic nurse

educator (CDE), who partners with patients and their caregivers to improve diabetic self-management and reduce the rate of hospitalizations or disease-related complications (Wilson et al., 2019).

Nurse Administrator. A **nurse administrator** is responsible for management of the nursing staff in a health care agency. Nursing administration begins with positions such as clinical care coordinators and assistant nurse managers. Experience and additional education sometimes lead to a middle-management position such as nurse manager of a specific patient care area or house supervisor or to an administrative position such as an associate director or director of nursing services. The American Organization of Nurse Executives (AONE) (2015) has outlined five competencies detailing the skills, knowledge, and abilities that guide the practice of nurse leaders in administrative or executive practice. These include communication and relationship management; knowledge of the health care environment; leadership; professionalism; and business skills and principles.

Nurse manager positions usually require at least a bachelor's degree in nursing, and director and nurse executive positions generally require a master's degree. Requirements will vary by agency. Chief nurse executive and vice president positions in large health care organizations often require preparation at the doctoral level. Nurse administrators often have advanced degrees such as a master's degree in nursing administration, hospital administration (MHA), public health (MPH), or business administration (MBA).

In today's health care organizations, directors have responsibility for more than one nursing unit. They often manage a particular service or product line, such as medicine or cardiology. Vice presidents of nursing or chief nurse executives often have responsibilities for all clinical functions within the hospital (e.g., pharmacy, respiratory care, and rehabilitation). This may include all ancillary personnel who provide and support patient care services. The nurse administrator needs to be skilled in business and management and understand all aspects of nursing and patient care. Functions of administrators include budgeting, staffing, strategic planning of programs and services, employee evaluation, and employee development.

Nurse Researcher. The **nurse researcher** conducts evidence-based practice, performance improvement, and research to improve nursing care and further define and expand the scope of nursing practice (see Chapter 5). She or he often works in an academic setting, hospital, or independent professional or community service agency. Academic researchers generally pursue a specific area of research that they have identified and developed over the course of their experiences. Researchers for hospitals often pursue research on topics of priority or interest to the agency. Researchers within community service agencies conduct research based on the service focus of that agency. The preferred educational requirement is a doctoral degree, with at least a master's degree in nursing.

REFLECT NOW

In reviewing the roles and responsibilities of the professional nurse and career options, think about your personal academic and career goals. Design a plan that you can modify as you progress through your academic nursing program.

HISTORICAL INFLUENCES

Nurses have responded and will always respond to the needs of their patients. In times of war they have responded by meeting the needs of the wounded in combat zones and military hospitals in the United States and abroad. When communities face health care crises such as natural disasters, disease outbreaks, or insufficient public health resources, nurses establish community-based immunization and screening programs, treatment clinics, and health promotion activities. Our patients are most vulnerable when they are injured, sick, or dying.

Today nurses are active in determining best practices in a variety of areas such as pressure injury prevention, wound care management, pain control, nutritional management, and care of individuals across the life span. Nurse researchers are leaders in expanding knowledge in nursing and other health care disciplines. Their work ensures that nurses have the best available evidence to support their practices (see Chapter 5).

Knowledge of the history of the nursing profession increases your understanding of the social and intellectual origins of the discipline. Although it is not practical to describe all the historical aspects of professional nursing, some of the more significant nursing leaders and milestones are described in the following paragraphs.

Florence Nightingale

In *Notes on Nursing: What It Is and What It Is Not,* Florence Nightingale established the first nursing philosophy based on health maintenance and restoration (Nightingale, 1860). She saw the role of nursing as having "charge of somebody's health" based on the knowledge of "how to put the body in such a state to be free of disease or to recover from disease" (Nightingale, 1860). During the same year she developed the first organized program for training nurses, the Nightingale Training School for Nurses at St. Thomas' Hospital in London.

Nightingale was the first practicing nurse epidemiologist. Her statistical analyses connected poor sanitation with the incidence of cholera and dysentery. She volunteered during the Crimean War in 1853 and traveled the battlefield hospitals at night, carrying her lamp; thus, she was known as the "lady with the lamp." The sanitary, nutritional, and basic conditions in the battlefield hospitals were poor, and she was asked to ensure the quality of sanitation facilities. As a result of her actions, the mortality rate at the Barracks Hospital in Scutari, Turkey, was reduced from 42.7% to 2.2% in 6 months (Donahue, 2011).

The Civil War to the Beginning of the Twentieth Century

The Civil War (1860–65) stimulated the growth of nursing in the United States. Clara Barton, founder of the American Red Cross, cared for soldiers on the battlefields, cleansing their wounds, meeting their basic needs, and comforting them at end of life. Dorothea Lynde Dix, Mary Ann Ball (Mother Bickerdyke), and Harriet Tubman also influenced nursing during the Civil War (Donahue, 2011). Dix and Bickerdyke organized hospitals and ambulances, appointed nurses, cared for the wounded soldiers, and oversaw and regulated supplies to the troops. Tubman was active in the Underground Railroad movement and assisted in leading more than 300 slaves to freedom (Donahue, 2011).

The first professionally educated African-American nurse was Mary Mahoney. She was concerned with relationships between cultures and races. As a noted nursing leader, she brought forth an awareness of cultural diversity and respect for the individual, regardless of background, race, color, or religion.

Isabel Hampton Robb helped found the Nurses' Associated Alumnae of the United States and Canada in 1896. This organization became the ANA in 1911. She authored many nursing textbooks and was one of the original founders of the *American Journal of Nursing.*

Nursing in hospitals expanded in the late nineteenth century. However, nursing in the community did not increase significantly until 1893, when Lillian Wald and Mary Brewster opened the Henry Street Settlement, which focused on the health needs of poor people who lived in tenements in New York City (Donahue, 2011).

Twentieth Century

In the early twentieth century a movement toward developing a scientific, research-based defined body of nursing knowledge and practice evolved. Nurses began to assume expanded roles. Mary Adelaide Nutting, who became the first nursing professor at Columbia Teachers College in 1906, was instrumental in moving nursing education into universities (Donahue, 2011).

The Magnet Recognition Program® designates organizations worldwide in which nursing leaders successfully align their nursing strategic goals to improve the organization's patient outcomes. The Magnet Recognition Program® provides a roadmap to nursing excellence, which benefits the whole of an organization. To nurses, Magnet Recognition means education and development through every career stage, which leads to greater autonomy at the bedside. To patients, it means the very best care, delivered by nurses who are supported to be the very best that they can be. In 1994 the University of Washington Medical Center in Seattle, Washington was the first American Nurses Credentialing Center (ANCC) Magnet®-designated organization (ANCC, n.d.).

As nursing education developed, nursing practice also expanded, and the Army and Navy Nurse Corps were established. By the 1920s nursing specialization started to develop. The last half of the century saw the creation of specialty-nursing organizations such as the American Association of Critical Care Nurses, Association of periOperating Room Nurses (AORN), Infusion Nurses Society (INS), and Emergency Nurses Association (ENA). In 1990 the ANA established the Center for Ethics and Human Rights, which provides a forum to address the complex ethical and human rights issues confronting nurses and designs activities and programs to increase ethical competence in nurses (Fowler, 2015).

Twenty-First Century

Today the profession faces multiple challenges. Nurses are revising nursing practice and school curricula to meet the ever-changing needs of society, including an aging population, cultural diversity, bioterrorism, emerging infections, and disaster management. Advances in technology and informatics (see Chapter 26), the high acuity level of care of hospitalized patients, and early discharge from health care institutions require nurses in all settings to have a strong and current knowledge base from which to practice. In addition, nursing and the RWJF are taking a leadership role in developing standards and policies for end-of-life care through the *Last Acts Campaign* (see Chapter 36). The End-of-Life Nursing Education Consortium (ELNEC) is a national and international education initiative to improve palliative care offered collaboratively by the AACN and the City of Hope Medical Center. The educational programs focus on end-of-life care and practices in nursing curricula and professional continuing education programs for practicing nurses (AACN, 2021b).

CONTEMPORARY INFLUENCES

Multiple external forces affect nursing, including the need for nurses' self-care, health care reform and rising health care costs, demographic changes of the population, human rights, and increasing numbers of the medically underserved.

Importance of Nurses' Self-Care

Nursing is a dynamic and gratifying career. However, it also has both physical and emotional demands and challenges. You cannot give fully engaged, compassionate care to others when you feel depleted or do not feel cared for yourself. You and your colleagues will have many self-care needs that must be met to function as healthy professionals.

In your educational experience and in your career, you will experience grief and loss. Many times, even before you have a chance to recover from an emotionally draining situation, you will encounter another difficult human story. Nurses in acute care settings frequently witness prolonged, concentrated suffering, leading to feelings of frustration, anger, guilt, sadness, or anxiety (Hairong et al., 2021). The 2020 outbreak of coronavirus disease 2019 (COVID-19) demonstrated the psychological stress experienced by nurses on the front lines. Nursing students are not immune. They report feeling initially hesitant and uncomfortable with their first encounters with a dying patient and identify feelings of sadness and anxiety.

Frequent, intense, or prolonged exposure to grief and loss places nurses at risk for developing compassion fatigue. *Compassion fatigue* is a term used to describe a state of burnout and secondary traumatic stress (Graystone, 2020; Potter et al., 2013a). It occurs without warning and often results from giving high levels of energy and compassion over a prolonged period to those who are suffering, often without experiencing improved patient outcomes (Hairong et al., 2021). *Secondary traumatic stress* is the trauma that health care providers experience when witnessing and caring for others suffering trauma. Examples include an oncology nurse who cares for patients undergoing surgery and chemotherapy over the long term for their cancer or a spouse who witnesses his wife deteriorating over the years from Alzheimer disease.

Burnout is the condition that occurs when perceived demands outweigh perceived resources (Graystone, 2020; Potter et al., 2013a; Potter et al., 2013b). It is a state of physical and mental exhaustion that often affects health care providers because of the nature of their work environment. Over time, giving of oneself in often intense caring environments sometimes results in emotional exhaustion, leaving a nurse feeling irritable, restless, and unable to focus and engage with patients. This often occurs in situations in which there is a lack of social support, organizational pressures influencing staffing, and the inability of the nurse to practice self-care.

Compassion fatigue typically results in feelings of hopelessness, a decrease in the ability to take pleasure from previously enjoyable activities, a state of hypervigilance, and anxiety. Compassion fatigue negatively affects the health and wellness of nurses and the quality of care provided to patients. It also affects health care agencies as nurses experience changes in job performance and in their personal lives; it can result in nurses' desire to leave the profession or their specialty. High nurse turnover can result. In addition, these factors affect patient satisfaction and an agency's ability to maintain a caring, competent staff (Graystone, 2020).

There is a need for health care agencies to identify programs for the early recognition of compassion fatigue and to develop interventions to help nurses manage it. Prompt interventions and creating work environments in which nurses feel supported by co-workers and management improve nurse retention and job satisfaction rates (Graystone, 2020.) Agency-based programs that provide opportunities for nurses to validate their experiences and to talk about the challenges of the type of care they give help nurses cope with compassion fatigue and its implications for professional nursing care (Wenzel and Brysiewicz, 2017).

Compassion fatigue may contribute to what is described as *lateral violence* (see Chapter 24). Lateral violence sometimes occurs in nurse-nurse interactions and includes behaviors such as withholding information, making snide remarks, and demonstrating nonverbal expressions of disapproval, such as raising eyebrows or making faces. New graduates and nurses new to a unit are most likely to face problems with lateral or horizontal violence (Sanner-Stiehr and Ward-Smith, 2017).

All nurses require resiliency skills to better manage the stressors that contribute to compassion fatigue and lateral violence. Managing

stress and conflict, building connections with colleagues to share difficult stories, practicing self-care, and maintaining an appropriate work-life balance are helpful stress-management techniques in dealing with difficult situations and contribute to safe and effective care (see Chapter 37) (Cooper et al., 2020).

Health Care Reform and Costs

Health care reform affects not only how health care is paid for but also how it is delivered. There will be greater emphasis on health promotion, disease prevention, and illness management in the future. More services will be in community-based care settings. However, hospitals will continue to manage the care of very seriously ill patients. As a result, more nurses will be needed to practice in community care centers, patients' homes, schools, and senior centers. This will require nurses to be skilled at assessing for resources, service gaps, and how patients adapt to return to their communities. Nursing needs to respond to such changes by assessing for resources, improving staffing and management models in hospitals, changing nursing education, helping patients adapt to new health care delivery methods, and providing care to safely return patients to their homes.

Skyrocketing health care costs present challenges to the profession, the consumer, and the health care delivery system. As a nurse you are responsible for providing patients with the best-quality care in an efficient and economically sound manner, including following established protocols, exercising timely well-planned patient discharge from a care setting, and judiciously using supplies and equipment. The challenge is to use health care and patient resources wisely. Chapter 2 summarizes reasons for the rise in health care costs and its implications for nursing.

Demographic Changes

The U.S. Census Bureau (2015) predicts that the 2030s will be a transformative decade, with the population expected to grow at a slower pace, age considerably, and become more racially and ethnically diverse. These changes will require expanded health care resources. The U.S. Census Bureau's population projections predict that by 2030, all baby boomers will be older than 65 years of age. This will expand the size of the older population such that one of every five residents will be of retirement age. It is also predicted that by 2044 more than half of the U.S. population will be part of a minority group (U.S. Census Bureau, 2015). To effectively meet all the health care needs of the expanding minority and aging populations, changes need to occur as to how care is provided, especially in public health. The population is still shifting from rural areas to urban centers, and more people are living with chronic and long-term illnesses. Not only are outpatient settings expanding, but more and more people want to receive outpatient and community-based care and remain in their homes or community (see Chapters 2 and 3).

Medically Underserved

Nursing has a strong history in advocating for and meeting the needs of the medically underserved (Porter-O'Grady, 2018). Unemployment, underemployment and low-paying jobs, mental illness, homelessness, and rising health care costs all contribute to increases in the medically underserved population. Caring for this population is a global challenge; social, political, economic, and health literacy factors affect both access to care and access to health care–related resources (Kaphingst et al., 2016).

In addition, the number of underserved patients who require home-based palliative care services is increasing. This is a group of patients whose physical status does not improve and whose health care needs increase. People with low health literacy are less likely to participate in decision making regarding their care because they do not understand the medical information provided, nor do they understand the consequences of indecision (Seo et al., 2016).

TRENDS IN NURSING

Nursing is a dynamic profession that grows and evolves as society and lifestyles change, as health care priorities and technologies change, and as nurses themselves change. The current philosophies and definitions of nursing have a holistic focus, which addresses the needs of the whole person in all dimensions, in health and illness, and in interaction with the family and community. In addition, there continues to be an increasing awareness of patient safety in all care settings.

Evidence-Based Practice

A core responsibility of an RN is to make sound clinical judgments. This applies to acquiring a view of each patient (what you can learn about the patient), identifying the patient's health problems, and knowing what actions to take. Clinical judgment is influenced by the critical thinking element of knowledge (see Chapter 15). Knowledge helps shape clinical judgment. Evidence-based knowledge is a critical element of that knowledge.

Today the general public is more informed about their health care needs, the cost of health care, best practices, and the incidence of medical errors within health care institutions. Your current and future practice needs to be based on current evidence. This means you do not rely solely on information gained during your education, experiential knowledge, or policies and procedures of health care agencies (see Chapter 5). It means you always need to search for the best scientific evidence to apply to recurrent patient health care problems. Delivery of and reimbursement for evidence-based nursing care is essential (Melnyk and Gallagher-Ford, 2018). Health care agencies must show their commitment to each health care stakeholder (e.g., patients, insurance companies, and governmental agencies) to control health care costs, reduce health care errors, and improve patient safety by implementing evidence-based practices (National Quality Forum [NQF], 2021). In addition, many hospitals are achieving Magnet Recognition®, which is an extensive hospital certification program that recognizes excellence in nursing practice and the implementation and dissemination of successful evidence-based nursing practices and strategies (ANCC, n.d.).

Quality and Safety Education for Nurses

The overall goal of the **Quality and Safety Education for Nurses (QSEN)** project is to meet the challenge of preparing future nurses and advanced practice nurses to have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the health care systems within which they work (QSEN, 2020a). To achieve this goal, the IOM and QSEN faculty defined quality and safety competencies for nurses and proposed targets for the KSAs developed for prelicensure programs (Table 1.1). For each competency there are targeted KSAs for prelicensure programs and graduate programs (QSEN, 2020a; QSEN, 2020b).

As you gain experience in clinical practice, you will face situations in which your critical thinking and knowledge will help you to make a difference in improving patient care. Whether that difference is to provide evidence for implementing care at the bedside, identify a safety issue, or study patient data to identify trends in outcomes, each of these situations requires competence in patient-centered care, safety, or informatics. Although it is not within the scope of this textbook to present the QSEN initiative in its entirety, subsequent clinical chapters will provide you an opportunity to address how to build competencies in one or more of these areas.

TABLE 1.1 Quality and Safety Education for Nurses

Competency	Definition With Examples
Patient-centered care	Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs. *Examples: Involve family and friends in care. Integrate an understanding of patient, family, community preferences, values. Provide patient-centered care with sensitivity and respect for the diversity of the human experience.*
Teamwork and collaboration	Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve high-quality patient care. *Examples: Recognize the contributions of other individuals and groups helping patient/family achieve health goals. Discuss effective strategies for communicating and resolving conflict. Participate in designing systems to support effective teamwork.*
Evidence-based practice	Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care. *Examples: Demonstrate knowledge of basic scientific methods. Appreciate strengths and weaknesses of scientific bases for practice. Appreciate the importance of regularly reading relevant journals.*
Quality improvement	Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems. *Examples: Use tools such as flow charts and diagrams to make process of care explicit. Appreciate how unwanted variation in outcomes affects care. Identify gaps between local and best practice.*
Safety	Minimize risk of harm to patients and providers through both system effectiveness and individual performance. *Examples: Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as work-arounds and dangerous abbreviations). Value own role in preventing errors.*
Informatics	Use information and technology to communicate, manage knowledge, mitigate error, and support decision making. *Examples: Navigate an electronic health record. Protect confidentiality of protected health information in electronic health records.*

Adapted from QSEN Institute: *QSEN competencies,* 2020a. https://qsen.org/competencies/pre-licensure-ksas/. Accessed April 2021.

QSEN Building Competency in Patient-Centered Care You are caring for Kitty, a 10-year-old with severe delayed development. Kitty, an only child, lives with her parents and goes to a school that is able to meet her needs. Her mom gives her seizure medicine each day, and her seizures are well controlled. Kitty has very little independent function. She needs assistance with all of her activities of daily living (e.g., bathing, toileting, eating, and hygiene). Up to now Kitty's parents have been able to provide all of her care and meet her needs. As a patient advocate, what do you need to know about Kitty's parents' goals for her future care? Think about how you can use this information to advocate for Kitty and her parents to achieve these goals.

Answers to QSEN Activities can be found on the Evolve website.

Impact of Emerging Information Technologies

Emerging information technologies directly affect nursing practice. These technologies provide more accurate, noninvasive assessment tools; help you to implement evidence-based practices automatically; collect and trend patient outcome data; and use clinical decision support systems. The electronic health record (EHR) is an efficient method for documenting and managing patient health care information (see Chapter 26.) Computerized physician/provider order entry (CPOE), allowing health care providers to directly enter medical orders, is a critical patient safety initiative especially in the area of medication ordering and administration (Crespo et al., 2018).

Emerging information technologies will help you to communicate with, provide care for, and build relationships with your patients. Telehealth, e-visits, and devices that allow your patients to phone in pertinent health information are examples of technology that open new venues for providing care. Learn how these electronic tools work so that you can teach patients how to use them. Evidence-based practice, clinical decision support systems, and case-based reasoning are all methods to increase information acquisition and distribution.

Technological innovations help family caregivers monitor and manage home environments of older adults, enable older adults to stay in their homes but stay connected to their support systems, and help with decision support and care coordination (Andruszkiewicz and Fike, 2015–2016). In addition, there is an increase in the availability and use of telehealth and telemedicine functions for providing patient-centered care to urban and rural populations, in all age-groups, to patients with acute and chronic illness, and to patients and families for end-of-life care and support (Smaradottir and Fensli, 2018).

Genomics

Genetics is the study of inheritance, or the way traits are passed down from one generation to another. Genes carry the instructions for making proteins, which in turn direct the activities of cells and functions of the body that influence traits such as hair and eye color, and susceptibility to disease. **Genomics** is a newer term that describes the study of all the genes in a person and interactions of these genes with one another and with that person's environment (Centers for Disease Control and Prevention [CDC], 2021). Genomic information combined with technology can potentially improve health outcomes, quality, and safety and reduce health care costs (McCormick and Calzone, 2016). This information allows health care providers to determine how genomic changes contribute to patient conditions and influence treatment decisions (Sharoff, 2016). For example, when a family member has colon cancer before the age of 50, it is likely that other family members are at risk for developing this cancer. Genomics counseling and testing can determine family status. Knowing this information is important for family members who will need a colonoscopy before the age of 50 and repeat colonoscopies more often than the patient who is not at risk. Nurses help to assess and interpret genomic test results, identify patients' risk factors, and counsel patients about what this genomic finding means to them personally and to their families. As you use and understand genomics, remember to use genomic test information in a confidential, ethical, and culturally appropriate manner

to help health care providers and patients and their families make informed care decisions (Tluczek et al., 2019).

Public Perception of Nursing

Nursing is a pivotal health care profession. As frontline health care providers, nurses practice in all health care settings and constitute the largest number of health care professionals. They are essential to providing skilled, specialized, knowledgeable care; improving the health status of the public; and ensuring safe, effective, high-quality care (ANA, 2021).

Consumers of health care are more informed than ever; with the Internet, consumers have access to more health care and treatment information. For example, *Hospital Compare* is a consumer-oriented website that allows people to select multiple hospitals and directly compare performance measure information on specific diseases and procedures such as heart attack, heart failure, pneumonia, and surgery (Centers for Medicare and Medicaid Services [CMS], n.d.). This information can help consumers make informed decisions about health care.

Consumers can also access the *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) website to obtain information about patients' perspectives on hospital care. CMS and the Agency for Healthcare Research and Quality (AHRQ) developed the HCAHPS Survey, also known as Hospital CAHPS®, to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care (CMS, 2020). Most hospitals collect information on patient satisfaction; HCAHPS offers a survey that helps consumers obtain valid comparisons about patient perspectives across all hospitals. This information is intended to allow consumers to make "apples to apples" comparisons to support their choice (HCAHPS, 2021).

REFLECT NOW

A nurse is often the first health care professional a patient sees when in the emergency department or following admission to a hospital. Think about the type of impression you want to make in terms of compassion, competency, and professionalism.

Impact of Nursing on Politics and Health Policy

Political power or influence is the ability to influence or persuade an individual holding a governmental office to exert the power of that office to effect a desired outcome. Nurses' involvement in politics is receiving greater emphasis in nursing curricula, professional organizations, public health policy, and health care settings. Professional nursing organizations and State Boards of Nursing employ lobbyists to urge state legislatures and the U.S. Congress to pass legislation that will improve the quality of health care (Mason et al., 2020).

The ANA works for the improvement of health standards and the availability of health care services for all people, fosters high standards of nursing, stimulates and promotes the professional development of nurses, and advances their economic and general welfare. The ANA's purposes are unrestricted by considerations of nationality, race, creed, lifestyle, color, gender, or age.

You can influence policy decisions at all governmental levels. One way to get involved is by participating in local and national efforts (Mason et al., 2020). This effort is critical to exerting nurses' influence early in the political process. Nurses can help make the future bright by becoming serious students of social needs, activists in influencing policy to meet those needs, and generous contributors of time and money to nursing organizations and to candidates working for universal good health care (Mason et al., 2020).

PROFESSIONAL REGISTERED NURSE EDUCATION

A significant amount of formal education is necessary to become a professional RN. The issues of standardization of nursing education and entry into practice remain a major controversy, making it sometimes difficult for individuals to choose nursing programs. Various prelicensure educational programs are available for individuals intending to become an RN. In addition, graduate nurse education and continuing and in-service education are available for practicing nurses.

Prelicensure

Currently in the United States the most frequent way to become a **registered nurse (RN)** is through completion of either an associate or bachelor's degree program. Graduates of both types of programs are eligible to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) to become RNs in the state in which they will practice.

The associate degree program in the United States is a 2-year program that is usually offered by a university or community college. This program focuses on the basic sciences and theoretical and clinical courses related to the practice of nursing. A nurse with an associate degree can later progress to earn a bachelor's degree. Each university determines the additional coursework, and an RN Bachelor of Science in Nursing (BSN) program may take 12 to 18 months depending on a student's associate degree transcript.

The bachelor's degree program usually includes 4 years of study in a college or university. It focuses on the basic sciences; theoretical and clinical courses; and courses in the social sciences, arts, and humanities to support nursing theory. In Canada the degree of Bachelor of Science in Nursing (BScN) or Bachelor in Nursing (BN) is equivalent to the degree of BSN in the United States. *The Essentials: Core Competencies for Professional Nursing Education* (AACN, 2021a) encompasses 10 Domains for the baccalaureate-prepared nurse and guides faculty on the structure and evaluation of the curriculum (Box 1.4). Standards published by nursing program accrediting organizations specify that core competencies for the professional nurse should be in the nursing curriculum. In addition, one of the IOM recommendations is that 80% of nurses be prepared with a bachelor's degree in nursing by 2020 (IOM, 2010) (see Chapter 2).

BOX 1.4 American Association of Colleges of Nursing (AACN) Essential Domains (2021)

Domain 1: Knowledge for Nursing Practice
Domain 2: Person-Centered Care
Domain 3: Population Health
Domain 4: Scholarship for Nursing Practice
Domain 5: Quality and Safety
Domain 6: Interprofessional Partnerships
Domain 7: Systems-Based Practice
Domain 8: Informatics and Healthcare Technologies
Domain 9: Professionalism
Domain 10: Personal, Professional, and Leadership Development

From American Association of Colleges of Nursing (AACN): *The essentials: core competencies for professional nursing education*, 2021a, https://www.aacnnursing.org/Education-Resources/AACN-Essentials. Accessed April 2021.

Graduate Education

After obtaining a bachelor's degree in nursing, you can pursue graduate education leading to a master's or doctoral degree in any number of graduate fields, including nursing. Other fields include public health, epidemiology, and informatics. *The Essentials: Core Competencies for Professional Nursing Education* (AACN, 2021a) provides direction for structure and evaluation of graduate nursing curricula, to include strong knowledge skills in nursing science and theory; advanced knowledge in the basic sciences; and research-based clinical practice. A master's degree in nursing is important for the roles of nurse educator, nurse administrator, and future nurse researcher, and it is a minimum requirement for an APRN.

Doctoral Preparation. Professional doctoral programs in nursing (Doctor of Nursing Science [DSN or DNSc] degree) prepare graduates to apply research findings to clinical nursing. Other doctoral programs prepare nurses for more rigorous research and theory development and award the research-oriented Doctor of Philosophy (PhD) in nursing. The DNP is the terminal practice degree and provides advanced preparation for APRNs. The DNP is a practice-focused doctorate. *The Essentials: Core Competencies for Professional Nursing Education* (AACN, 2021a) provides direction for structure and evaluation of DNP nursing curricula, to include skills in obtaining expanded knowledge through the formulation and interpretations of evidence-based practice.

The need for nurses with doctoral degrees is increasing. Expanding clinical roles and continuing demand for well-educated nursing faculty and administrators, nurse administrators, and APRNs in the clinical settings and new areas of nursing specialties such as nursing informatics are just a few reasons for increasing the number of doctoral-prepared nurses.

Continuing and In-Service Education

Nursing is a knowledge-based profession, and clinical decision making and technological expertise are qualities that health care consumers demand and expect. Continuing education updates your knowledge about the latest research and practice developments, helps you to specialize in a particular area of practice, and teaches you new skills and techniques, all of which are crucial factors to improving patient care (Wellings et al., 2017). **Continuing education** involves educational programs offered by universities, hospitals, state nurses' associations, professional nursing organizations, and educational and health care institutions. An example is a program on caring for older adults with dementia offered by a university or a program on safe medication practices offered by a hospital. Although many of these programs are conducted on-site as a lecture, seminar, or skills training, there is a growth in virtual learning and mobile simulation programs, especially for those nursing subspecialties, such as oncology, that require continuing nursing education or to meet the educational needs of nurses in rural areas (das Gracas Silva Matsubara and De Domenico, 2016; Smith et al., 2020). Many states require a set number of continuing education hours as part of license renewal. In some cases there are continuing education requirements for specific topics such as bioterrorism and pain management.

In-service education programs are instruction or training programs provided by a health care agency or institution. An in-service program is held in the institution and is designed to increase the knowledge, skills, and competencies of nurses and other health care professionals employed by the institution. Often in-service programs are focused on new technologies such as how to correctly use the newest safety syringes. Many in-service programs are designed to fulfill required competencies of an organization. For example, a hospital might offer an in-service program on safe principles for administering chemotherapy or a program on cultural sensitivity.

NURSING PRACTICE

You will have an opportunity to practice in a variety of settings, in many roles within those settings, and with caregivers in other related health professions. The ANA standards of practice, standards of performance, and code of ethics for nurses are part of the public recognition of the significance of nursing practice to health care and implications for nursing practice regarding trends in health care. State and provincial nurse practice acts (NPAs) establish specific legal regulations for practice, and professional organizations establish standards of practice as criteria for nursing care.

Nurse Practice Acts

In the United States each State Board of Nursing oversees its NPA. The NPA regulates the scope of nursing practice for the state and protects public health, safety, and welfare. This protection includes protecting the public from unqualified and unsafe nurses. Although each state has its own NPA that defines the scope of nursing practice, most NPAs are similar. The definition of nursing practice published by the ANA is representative of the scope of nursing practice as defined in most states. During the last decade, many states have revised their NPAs to reflect the growing autonomy of nursing, minimum education requirements, certification requirements, and the expanded roles and scope of practice of APRNs.

Licensure and Certification

Licensure. In the United States all boards of nursing require RN candidates to pass the NCLEX-RN®. Regardless of educational preparation, the examination for RN licensure is the same in every state in the United States. This provides a standardized minimum knowledge base for nurses. Other requirements for licensure such as criminal background checks vary from state to state.

Certification. After passing the NCLEX-RN®, a nurse may choose to work toward certification in a specific area of nursing practice. Minimum practice and/or educational requirements are set, based on specific certification. National nursing organizations such as the ANA have many types of certification to enhance your career, such as certification in medical-surgical or geriatric nursing. After passing the initial examination, you maintain your certification through ongoing continuing education and by maintaining a set number of hours in clinical or administrative practice.

PROFESSIONAL NURSING ORGANIZATIONS

A **professional organization** deals with issues of concern to those practicing in the profession. In addition to the educational organizations previously discussed, a variety of specialty nursing organizations exist. For example, some professional organizations focus on specific areas such as critical care, advanced practice, maternal-child nursing, oncology, and nursing research. These organizations seek to improve the standards of practice, expand nursing roles, and foster the welfare of nurses within the specialty areas. In addition, professional organizations present educational programs and publish journals.

As a student you need to take part in organizations such as the National Student Nurses' Association (NSNA) in the United States and the Canadian Nursing Students' Association (CNSA) in Canada. These organizations consider issues of importance to nursing students such as career development and preparation for licensing. The NSNA often cooperates in activities and programs with the professional organizations.

KEY POINTS

- Nursing standards provide the guidelines for implementing and evaluating nursing care.
- Changes in society, such as health care reform, changing demographic patterns, increases in the medically underserved population, and increased consumerism, affect the practice of nursing.
- A nurse may take multiple professional career paths, such as advanced practice, nurse educator, research, and administration, to advance within the discipline.
- Nurses are increasingly aware of the role of politics and its influence on the health care system. As a result, nurses are more aware of the profession's influence on health care policy and practice.
- Advances in nursing's scientific knowledge base and the application of evidence-based practice have improved patient care and patient outcomes.
- Although nursing programs are available for professional registered nurse (RN) education, all programs should adhere to educational standards established by a professional nursing organization.
- Professional nursing organizations have an impact on educational standards and certifications, specialty practice, consumerism, and patient advocacy.

REFLECTIVE LEARNING

- Thinking back on a recent clinical experience, which QSEN competencies in knowledge, skills, or attitudes did you use while providing care?
- What impact do evidence-based practice and emerging technologies have on high-quality patient-centered care?
- You are on the patient safety committee at your hospital. Your assignment is to identify two resources related to safety. One resource must relate to the individual nurse, and the second must relate to the practice and work environment.

REVIEW QUESTIONS

1. You are preparing a presentation for your classmates regarding the clinical care coordination conference for a patient with terminal cancer. As part of the preparation, you have your classmates read the Nursing Code of Ethics for Professional Registered Nurses. Your instructor asks the class why this document is important. Which statement best describes this code?
   1. Improves self–health care
   2. Protects the patient's confidentiality
   3. Ensures identical care to all patients
   4. Defines the principles of right and wrong to provide patient care
2. A nurse is caring for a patient with end-stage lung disease. The patient wants to go home on oxygen and be comfortable. The family wants the patient to have a new surgical procedure. The nurse explains the risk and benefits of the operation to the family and discusses the patient's wishes with them. The nurse is acting as the patient's:
   1. Educator
   2. Advocate
   3. Caregiver
   4. Communicator
3. The nurse spends time with a patient and family reviewing a dressing change procedure for the patient's wound. The patient's spouse demonstrates how to change the dressing. The nurse is acting in which professional role?
   1. Educator
   2. Advocate
   3. Caregiver
   4. Communicator
4. The examination for RN licensure is the same in every state in the United States. This examination:
   1. Guarantees safe nursing care for all patients
   2. Ensures standard nursing care for all patients
   3. Provides the minimal standard of knowledge for an RN in practice
   4. Guarantees standardized education across all prelicensure programs
5. Contemporary nursing requires that the nurse have knowledge and skills for a variety of professional roles and responsibilities. Which of the following are examples of these roles and responsibilities? (Select all that apply.)
   1. Caregiver
   2. Autonomy
   3. Patient advocate
   4. Health promotion
   5. Genetic counselor
6. Match the advanced practice nurse specialty with the statement about the role.

   1. Clinical nurse specialist
   2. Nurse anesthetist
   3. Nurse practitioner
   4. Nurse-midwife

   a. Provides independent care, including pregnancy and gynecological services
   b. Expert clinician in a specialized area of practice such as adult diabetes care
   c. Provides comprehensive care, usually in a primary care setting, directly managing the medical care of patients who are healthy or have chronic conditions
   d. Plans and delivers anesthesia and pain management to patients across the life span
7. Health care reform will bring changes in the emphasis of care. Which of these models is expected from health care reform?
   1. Moving from an acute illness to a health promotion, illness prevention model
   2. Moving from an illness prevention to a health promotion model
   3. Moving from hospital-based to community-based care
   4. Moving from an acute illness to a disease management model
8. The nurse manager meets with the registered nursing staff about an increase in urinary tract infections in patients with a Foley catheter. The staff work together to review the literature on catheter-associated urinary tract infections (CAUTIs), identifies at-risk patients, and establishes new catheter care practices. This is an example of which QSEN competency?
   1. Patient-centered care
   2. Safety
   3. Teamwork and collaboration
   4. Quality improvement
9. A critical care nurse is using a new research-based intervention to correctly position patients who are on ventilators to reduce pneumonia caused by accumulated respiratory secretions. This is an example of which QSEN competency?
   1. Patient-centered care
   2. Evidence-based practice
   3. Teamwork and collaboration
   4. Quality improvement

10. The nurses on an acute care medical floor notice an increase in pressure injury formation in their patients. A nurse consultant decides to compare two types of treatment. The first is the procedure currently used to assess for pressure injury risk. The second uses a new assessment instrument to identify at-risk patients. Given this information, the nurse consultant exemplifies which career?

1. Clinical nurse specialist
2. Nurse administrator
3. Nurse educator
4. Nurse researcher

Answers: 1. 4; **2.** 2; **3.** 1; **4.** 3; **5.** 1, 2, 3, 4; **6.** 1b, 2d, 3c, 4a; **7.** 1; **8.** 4; **9.** 2; **10.** 4.

Rationales for Review Questions can be found on the Evolve website.

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2

The Health Care Delivery System

OBJECTIVES

- Discuss the features of an integrated health care system.
- Summarize the scope of the six levels of health care.
- Discuss the role of nurses in various health care settings.
- Explain the relationship between levels of health care and levels of prevention.
- Examine the types of settings in which professionals provide primary, secondary, and tertiary health care.
- Discuss the factors that affect a person's access to health care.
- Summarize the importance of discharge planning.
- Identify barriers to effective discharge planning.
- Explain how the concept of "Pay for Value" is used to reward hospitals financially.
- Explain the approaches nurses can use to improve patient satisfaction.
- Discuss how the nursing shortage is affecting the nursing profession.
- Explain the concept of patient-centered care.
- Explain the effects of health disparities on the health of a community.

KEY TERMS

Acute care
Adult day care centers
Affordable Care Act
Assisted living
Diagnosis-related group (DRG)
Discharge planning
Extended care facility
Health care disparities
Health care equity
Home care
Hospice
Inpatient Prospective Payment System (IPPS)
Medicaid
Medicare
Minimum Data Set (MDS)
Nursing-sensitive outcomes
Palliative care
Patient-centered care
Primary health care
Rehabilitation
Respite care
Restorative care
Secondary health care
Skilled nursing facility
Telehealth
Tertiary health care

MEDIA RESOURCES

http://evolve.elsevier.com/Potter/fundamentals/

- Review Questions
- Audio Glossary
- Case Study with Questions
- Content Updates
- Answers to QSEN Activity and Review Questions

The U.S. health care system is complex and constantly changing. Over the past decade, efforts were focused on reducing the costs of health care while improving access to the health care system and ensuring high-quality outcomes. However, in the first 6 months of 2020, approximately 30 million Americans did not have health insurance (Assistant Secretary for Planning and Evaluation [ASPE], 2021). In 2018, health care expenditures in the United States totaled 17.7% of the gross domestic product, which averaged $11,172 per person (Centers for Medicare and Medicaid Services [CMS], 2019a). A variety of services are available from different disciplines of health care professionals, but gaining access to services is often difficult for those with limited health care insurance and other economic resources. Millions of Americans have health insurance but do not seek preventive or needed health care because of the high cost of shared expenses (Himmelstein et al., 2018). Patients who are uninsured or do not seek health care early present a challenge to health care providers because they are more likely to skip or delay treatment for acute and chronic illnesses and die prematurely (Young and Kroth, 2018).

You will better succeed in your career if you understand the functioning of the health care system and the roles nurses play. Nursing is a caring discipline. The profession's values are rooted in helping people to regain, maintain, or improve their health; prevent illness; and find comfort and dignity at the end of life.

The practice of nursing is changing. The American Nurses Association (ANA) states, "Nursing promotes the health, well-being, comfort, dignity, and humanity of all individuals, families, groups, communities, and populations. Nursing's focus on the healthcare consumer is enhanced by interprofessional collaboration, sharing knowledge, scientific discovery, integrative healthcare approaches, and social justice" (ANA, 2021, p. 5). Buerhaus et al. (2017) identified four challenges facing nursing in the upcoming years. The first is the aging baby boomer generation, which will have increased health care needs and thus require more health services and increasingly more complex nursing care. The second is the shortage and uneven distribution of physicians, particularly primary care physicians, which increases the health care that nurses will need to provide. The third is the accelerating rate of nurses' retirements due to an

aging nursing workforce, which results in loss of experienced nurses' knowledge and skills in all areas of practice. The fourth is the uncertainty of health care reform with each new government administration that is elected, which results in changes in roles for nurses within the health care system. It is critical to prepare nurses to face these and other challenges in the health care system today and to work toward improving access and maintaining quality and safety, while working to lessen health care costs that create a barrier to optimal wellness. Developing clinical judgment through the use of critical thinking is important to deliver safe, high-quality patient care in a changing health care environment.

TRADITIONAL LEVEL OF HEALTH CARE

The U.S. health care system has six levels of care for which health care providers offer services: preventive, primary, secondary, tertiary, restorative, and continuing health care. Levels of care describe the scope of services and settings delivered by health care providers to patients in all stages of health and illness. It is important to understand how the health care industry organizes and delivers services for patients and families within these six levels of care (Box 2.1)

Each level of care presents different requirements and opportunities for a nurse. For example, in your role within a primary care setting, you will be extensively involved in patient assessment. You will be expected to identify changes in chronic conditions or the development of new acute conditions. You will educate patients on how to perform self-care activities (e.g., teaching new mothers how to care for their babies, or young adults how to use inhalers). In a continuing care setting, you will apply gerontological nursing principles to help patients adapt to permanent health changes so that they can remain active and engaged.

Levels of care are not the same as levels of prevention (see Chapter 6). Levels of prevention describe the focus of health-related activities in a care setting. These include health promotion and disease prevention (primary prevention), curing or managing disease (secondary prevention), and reducing complications (tertiary prevention). For example, in a tertiary level of care, such as an intensive care unit (ICU), a nurse practices primary prevention by preventing pneumonia through repositioning a patient frequently, secondary prevention by administering antibiotics on time to treat the pneumonia, and tertiary prevention by assessing the patient frequently for signs of antibiotic intolerance.

At every level of care, nurses and other health care providers offer a variety of prevention services. For example, a nurse working in a specialized acute care (secondary/tertiary) hospital setting monitors the recovery of a patient following open heart surgery while also providing health promotion information to the patient and family caregiver concerning diet and exercise.

Health care reform has led to changes unique to each level of care. For example, the health care industry now places greater emphasis on wellness. Thus, the industry directs more resources toward primary and preventive care. Wellness care focuses on the health of populations and their communities rather than simply curing an individual's disease. In wellness care, nurses can help lead communities and health care systems in coordinating resources to better serve their populations.

INTEGRATED HEALTH CARE DELIVERY

Integrated health care delivery (IHCD) came about as part of the U.S. health care reform movement in response to the fragmented, costly, and varying quality of health care found in the United States at the time. An IHCD system is a network of health care organizations that work together to provide a continuum of health services to a defined population with intended outcomes of better aligning resources, improving quality, and controlling costs (Al-Saddique, 2018). IHCDs were developed with a primary focus on improving health care quality and decreasing overall health care costs. The goal of focusing on population health is to decrease health care costs through effective management of patients with chronic health problems. An example of an IHCD is the Accountable Care Organizations (ACOs) that were developed in response to health care reform, with the intended goals of improving quality and decreasing costs of health care (McWilliams et al., 2016).

There is no single model for an integrated health care system. Basically, two types of IHCDs exist: an organizational structure that follows economic imperatives (such as combining financing with all providers, from hospitals, clinics, and physicians to home care and long-term care facilities) and a structure that supports an organized

BOX 2.1 Examples of Health Care Services

Preventive Care
- Adult screenings for blood pressure, cholesterol, tobacco use, and cancer
- Pediatric screenings for hearing, vision, autism, and developmental disorders
- HIV screening for adults at higher risk
- Wellness visits
- Immunizations
- Diet counseling
- Mental health counseling and crisis prevention
- Community legislation (seat belts, car seats for children, bike helmets)

Primary Care (Health Promotion)
- Diagnosis and treatment of common illnesses
- Ongoing management of chronic health problems
- Prenatal care
- Well-baby care
- Family planning
- Patient-centered medical home care

Secondary (Acute Care)
- Urgent care; hospital emergency care
- Acute medical-surgical care: ambulatory care, outpatient surgery, hospital
- Radiological procedures

Tertiary Care
- Highly specialized: intensive care, inpatient psychiatric facilities
- Specialty care (such as neurology, cardiology, rheumatology, dermatology, oncology)

Restorative Care
- Rehabilitation programs (such as cardiovascular, pulmonary, orthopedic)
- Sports medicine
- Spinal cord injury programs
- Home care

Continuing Care
- Long-term care: assisted living, nursing centers
- Psychiatric and older-adult day care

care delivery approach (coordinating care activities and services into seamless functioning) (Al-Saddique, 2018).

The Patient-Centered Medical Home model is an example of an IHCD. The Patient-Centered Medical Home strengthens the physician-patient relationship with coordinated, goal-oriented, individualized care. In this approach, a patient's primary health care provider is the coordinator/manager who enlists the skills and knowledge of health care professionals from various services. These professionals include nurses, medical assistants, nutritionists, social workers, pharmacists, hospice care providers, and other caregivers. Members of a Patient-Centered Medical Home care team are linked by information technology, electronic health records (EHRs), and system best practices to ensure that patients receive care how they want it and when and where they need it. Patient-centeredness is a unifying principle. It describes an ongoing, active partnership with a personal primary care physician or nurse practitioner who leads a team of professionals dedicated to providing proactive, preventive, and chronic care management through all stages of a patient's life (American Academy of Family Physicians, 2020.)

Primary and Preventive Health Care Services

Primary health care focuses on improved health outcomes for an entire population by promoting regular health care visits, health education, proper nutrition, maternal/child health care, family planning, immunizations, and control of diseases. The World Health Organization (WHO) (2021) notes that most of a person's health care needs in their lifetime can be met with primary care services. Primary health care requires collaboration among health professionals, health care leaders, and community members. In settings in which patients receive preventive and primary care, such as schools, physicians' offices, and occupational health clinics, health promotion is a major theme (Table 2.1). Health promotion programs are designed to reduce the incidence of disease, minimizing complications and the need to use more expensive health care resources. As a result, the overall costs of health care are also reduced. In contrast, preventive care is more disease oriented and focused on reducing and controlling risk factors for disease through activities such as immunization and occupational health programs. Chapter 3 provides a more comprehensive discussion of primary health care in the community.

Secondary and Tertiary Care

The traditional reason people use health care services (such as a hospital) is for diagnosis and treatment of illness. When the nature or severity of a condition makes primary care insufficient, secondary and tertiary care may become necessary. The difference between secondary and tertiary care arises from the complexity of a patient's medical needs. **Secondary health care** is provided by a specialist or agency on referral by a primary health care provider. It requires more specialized knowledge, skill, or equipment than the primary care physician or nurse practitioner can provide. For example, an individual sees a cardiologist because of increasing shortness of breath with activity.

Tertiary health care is specialized consultative care, usually provided on referral from secondary medical personnel. For example, the cardiac surgeon sees the patient referred from the cardiologist for possible cardiac bypass surgery. However, changes in medical cost reimbursement, improved technology, and less invasive treatments have often made secondary and tertiary care available at the primary care level. For example, more surgeons are performing simple surgeries in outpatient surgical centers or office suites. However, if a patient develops a problem that the surgeon or primary health care provider is not able to treat and/or if intensive nursing care is needed, the patient needs a medical specialist, often resulting in hospitalization. Secondary and tertiary care (also called **acute care**) typically are expensive, especially if the patient has waited to seek care until after symptoms have developed. Delays in treating or diagnosing chronic illness may cause disability, decreased quality of life, and increased health care costs (Young and Kroth, 2018).

Hospitals. Hospitals provide comprehensive secondary and tertiary health care to patients who are acutely ill. During 2018 more than 36 million patients were admitted to American Hospital Association (AHA)–registered hospitals (AHA, 2020a). Even allowing for the fact that some patients are admitted multiple times during a year, a large percentage of the U.S. population receives health care in a hospital each year.

Hospitals vary in the services they offer. Most small rural hospitals offer general inpatient services but have limited emergency and diagnostic services. The exception is Critical Access Hospitals (CAHs). In comparison, large urban medical centers offer comprehensive, state-of-the-art diagnostic services, trauma and emergency care, surgical intervention, ICUs, inpatient services, and rehabilitation centers. Larger hospitals hire professional staff from a variety of specialties, such as nursing, social services, respiratory therapy, physical and occupational therapy, and speech therapy. Most patients who require these services are having acute episodes of illness. Thinking critically and using clinical judgment are needed to assess patients' changing problems quickly and intervene safely and accurately. This is a challenge when you are assigned multiple patients. Using clinical judgment enables you to better organize patient care to deliver an array of nursing interventions safely and effectively, and recognize when the needs of your patients change and no longer match the level of health care where they are receiving treatment. You also must be able to plan and coordinate care with other health care providers quickly and competently.

Hospitals use evidence-based practice guidelines and clinical protocols (see Chapter 5) in the delivery of care to patients. Current evidence-based practices ensure safe, effective, state-of-the art care. Throughout the nursing process, clinical judgment requires the continual evaluation of whether patients achieve outcomes so plans of care can be revised as needed to meet patient needs.

According to the AHA (2020b), delivering the right care, at the right time, in the right setting is the core mission of hospitals across the country. To fulfill this mission, hospitals fully support quality and safety initiatives. An example of a quality initiative is patient satisfaction. Patient satisfaction is challenging to achieve in a stressful setting, such as an inpatient nursing unit. Patients expect to be treated courteously and respectfully and to be involved in daily care decisions (Santana et al., 2019). Hospitals are adopting models of patient-centered care that focus on care that is responsive to individual patient and family preferences, needs, and values and ensuring that patient values guide clinical decisions (Santana et al., 2019). In a patient-centered care model, nurses partner with patients and families early in the decision-making process to develop an individualized plan of care (Santana et al., 2019). As a nurse, you have a key role in learning patient needs and expectations early to form effective therapeutic partnerships. By treating the nurse-patient relationship with respect and dignity, nursing care delivery is improved, which enhances patient satisfaction.

Intensive Care. An ICU or critical care unit (CCU) is a hospital unit in which patients receive close monitoring and intensive medical and nursing care. The status of a patient who is critically ill can change by the minute, so health care providers must have specialized knowledge and skills. ICUs have advanced technologies such as computerized cardiac monitors and high-tech mechanical ventilators. Although many of these devices are on regular nursing units, patients hospitalized within ICUs are monitored and maintained on multiple devices. An ICU is the most expensive health care delivery site because each

TABLE 2.1 Preventive and Primary Care Services

Type of Service	Purpose	Available Programs and Services
School health	Comprehensive programs integrate health promotion principles into a school curriculum. Services emphasize program management, interprofessional collaboration, and community health principles. Research shows a link between the health outcomes of young people and their academic success (CDC, 2021).	Health education Physical education and physical activity Nutrition environment and services Health services Physical environment Social and emotional climate Counseling, psychological services, and social services Employee wellness Family engagement Community involvement
Occupational health	The workplace is an important setting for delivering comprehensive health protection, health promotion, and disease and accident prevention programs. Americans working full time spend an average of more than one-third of their day, 5 days a week, at the workplace (CDC, 2015). The goal is to increase worker productivity, reduce absenteeism, reduce health risks, and reduce the use of expensive medical care.	Environmental surveillance Create company policies that promote healthy behaviors such as a tobacco-free campus policy Work environment: offer healthy foods through vending machines or cafeterias Physical assessment and health screening Health education classes Communicable disease control Counseling
Physicians' offices	Provide primary health care and diagnose and treat acute and chronic illnesses. Practitioners are beginning to focus more on health promotion practices. Advanced nurse practitioners often partner with a physician in managing a patient population.	Routine physical examination Health screening and risk appraisal Diagnostics Disease management Prevention services: diabetes and osteoporosis screenings, smoking cessation programs, and immunizations Wellness counseling
Nurse-managed clinics	Nurse-managed clinics or centers deliver nursing services with a focus on health promotion and health education, chronic disease assessment and management, and support for self-care and caregivers. Clinics often are associated with a school, college, department of nursing, federally qualified health center, or independent nonprofit health care agency.	Day care Clinical education site for other health care providers in school Prevention services: diabetes screenings, smoking cessation programs, and immunizations Physical examinations, cardiovascular checks Health risk appraisal Wellness counseling Employment readiness Acute and chronic care management
Block and parish nursing	Nurses deliver health care services to patients (e.g., older adults or those unable to leave their homes) within their own religious communities. Provide services that are unavailable in traditional health care system.	Running errands/transportation Respite care Counseling Spiritual health: balancing body and mind health to achieve overall wellness
Community centers	Provide comprehensive and cost-effective primary care and supportive services that promote access to health care. Often deliver services to a specific patient population (such as well-baby care, mental health, patients with diabetes) within underserved communities. Sometimes affiliated with a hospital, medical school, church, or other community organization. The care offered by community centers is culturally appropriate and delivered in languages that many in these communities speak.	Physical assessment and health screening Nutrition education Translation services Dental care Mental health services Care coordination and case management Specialty care (such as orthopedic, cardiac, or podiatric care) Disease management Health education

nurse usually cares for only one or two patients at a time and because of all the treatments and procedures the patients in the ICU require.

Mental Health Facilities. According to the National Alliance on Mental Illness (NAMI) (2021), about one in five adults in the United States experience mental illness in a given year, with 1 in 20 adults experiencing a serious mental illness such as depression, shizophrenia, or bipolar disorder. Perhaps more concerning is the report that only 44.8% of adults in the United States with a mental health condition received mental health services in 2019 (NAMI, 2021). Patients who have emotional and behavioral problems such as depression, mood disorders, violent behavior, and eating disorders require special counseling and treatment in psychiatric facilities.

The massive cuts to non-Medicaid state mental health spending in 2011 resulted in states having to cut vital mental health services for tens of thousands of youth and adults living with the most serious mental illnesses. These services include community- and hospital-based psychiatric care, housing, and access to medications (NAMI, 2011). This reduction in mental health agencies and services continues to have consequences today, such as loss of income due to missed work, high suicide rates, and high education dropout rates (NAMI, 2021). Individuals with serious mental illness are more likely to suffer chronic disease and as a result die earlier than others, largely from treatable medical conditions (NAMI, 2021).

The psychiatric facilities that exist are located in hospitals, independent outpatient clinics, and private mental health hospitals. They offer inpatient and outpatient services, depending on the severity of a patient's problem. Patients enter mental health facilities voluntarily or involuntarily. In voluntary admission, the patient or guardian completes an application requesting admission to the mental health facility with the ability to request release at any time. Involuntary admission is made without patient consent if patients require psychiatric treatment, cannot meet their own basic needs, or are a danger to themselves or others. During an involuntary admission, patients retain their right to informed consent, right to refuse medications, and right to freedom from unreasonable restraint (Varcarolis and Fosbre, 2021). Patients who are hospitalized usually have short stays intended to stabilize them before transfer to outpatient treatment centers. Patients with mental illness receive a comprehensive interprofessional treatment plan that engages patients and their families. Medical, nursing, social work, and activity therapy providers collaborate to develop a plan of care that enables patients to become more functional within their communities. Patients usually receive referrals for follow-up care at clinics or with counselors during discharge from inpatient settings.

Rural Hospitals. Lack of access to health care in rural areas is a serious public health problem. Only about 13% of physicians practice in rural America, but nearly 20% of the U.S. population lives in these areas (National Rural Health Association [NRHA], 2020). Rural Americans face a unique combination of factors that create health care disparities that are not found in urban areas, including (1) economic factors (rural Americans are more likely to live below the poverty level), (2) cultural and social differences, (3) educational shortcomings, (4) lack of recognition by legislators, and (5) isolation from living in remote rural areas (NRHA, 2020).

Many rural hospitals have failed economically and closed. To address this problem, the Balanced Budget Act of 1997 changed the designation of some rural hospitals to Critical Access Hospital (CAH) when certain criteria were met (CMS Medical Learning Network [MLN], 2019). A CAH is located in a state that established a rural health plan as of February 2018, is in a rural area (35 miles from another hospital or CAH), provides 24/7 emergency services with no more than 25 inpatient beds, and reports 96 hours or less as an average length of stay (LOS) for temporary care for patients needing stabilization before transfer to a larger hospital. CAHs may operate a distinct rehabilitation and/or psychiatric care unit, each with up to 10 beds. Physicians, advanced practice nurses, or physician assistants staff a CAH. The CAH provides inpatient care to people who are acutely ill or injured before they are transferred to better-equipped health care centers. Basic radiological and laboratory services are also available. To improve care for patients residing in rural areas, rural hospitals are expected to (HealthIT.gov, 2017):

- Improve access to services, including urgent care services, and to meet unmet health needs in isolated rural communities.
- Engage rural communities in developing rural health care systems.
- Develop collaborative delivery systems in rural communities as the hubs of rural health care.
- Create protocols for coordinating care transition by aligning urban health care systems.
- Be the subject matter experts and coordinators for the health care environment of providers, patients, and staff.

Health care reform enabled urban health care systems to branch out and establish affiliations or mergers with rural hospitals. Rural hospitals and CAHs provide a referral base to the larger tertiary care medical centers. Nurses who work in rural hospitals or clinics often function independently without a physician. These nurses must be competent in physical assessment, clinical judgment and decision making, and emergency care. Advanced practice nurses (such as nurse practitioners and clinical nurse specialists) use medical protocols and establish collaborative agreements with staff physicians.

Health care payers, such as CMS and private insurers, expect patients who are hospitalized to be treated and discharged within a reasonably predictable time period. Reimbursements are affected by the quality and timeliness of care. Nurses must use resources efficiently and effectively to help patients recover and return home. For example, a nurse collaborates with members of the interprofessional health care team, such as case managers, advanced practice providers such as nurse practitioners, physical therapists, physicians, and social workers, to plan a quick yet realistic transition to another level of health care. This process is known as *discharge planning.*

Discharge Planning. **Discharge planning** is a coordinated, interprofessional process that develops a plan for continuing care after a patient leaves a health care agency. Studies have shown that patients tend to be discharged "quicker and sicker" from hospitals. This can result in adverse events during the immediate postdischarge period (Aicher et al., 2019; Meek et al., 2018). Such problems include medication prescribing errors, poor communication between hospital and primary care providers, readmission to health care agency, and lack of coordination with community health care services. The focus of discharge planning is to ensure that a patient transitions to the setting in which health care needs can be appropriately met.

With the emphasis on decreased LOS in hospitals, *discharge planning with coordination of services must begin the moment a patient is admitted to a hospital.* As a nurse you will play a large role in discharge planning by knowing a patient's plan of care (developed by the interprofessional team) as soon as possible, informing the patient and family of that plan, encouraging their participation, acting on the plan, and evaluating progress (Fig. 2.1). Discharge planning for patients and their caregivers involves these elements (CMS, 2019b):

- Determining the appropriate post-hospital destination for a patient. A case manager or social worker usually selects this setting based on a patient's health care needs, self-care capacity, insurance, and place of residence.
- Identifying a patient's needs for a smooth and safe transition from the acute care hospital/post–acute care agency to the patient's discharge destination. Nurses, therapists, health care providers, and dietitians usually identify these needs.
- Beginning the process of meeting a patient's needs while the patient is still hospitalized, with approaches such as early mobility protocols, health education, and new medication regimens.

With a well-developed discharge plan, a patient is less likely to have unavoidable complications or unrelated illnesses or injuries and will be able to continue progressing toward the goals of the plan of care after discharge (CMS, 2019b). As a nurse, participate in discharge planning by anticipating and identifying each patient's continuing needs before

FIG. 2.1 Providing discharge teaching to decrease hospital readmission. (Copyright © FatCamera/iStock/Getty Images.)

the actual time of discharge and coordinating efforts to achieve an appropriate discharge plan.

The CMS does not require discharge planning for outpatients, including those who present to an emergency department and are not admitted as hospital inpatients. At the same time, hospitals may help some outpatients (such as emergency department or same-day surgery patients) by providing some discharge planning services (CMS, 2019b). A nurse-driven discharge planning model that includes discharge teaching and follow-up after discharge can help reduce hospital readmission rates (Dizon and Reinking, 2017; Meek et al., 2018). Box 2.2 describes models of discharge planning that focus on the patient and family caregiver.

BOX 2.2 Discharge Planning Models

Coleman's "Care Transitions Program" (Coleman et al., 2006)
Emphasizes the role of a transition coach in managing/facilitating the discharge of a patient to home or to a rehabilitation center. Model is based on four pillars: (1) medication self-management, (2) patient-centered record, (3) follow-up, and (4) indicators of worsening medical condition. Each pillar has different interventions depending on the stage of the hospitalization.

Naylor's "Transitional Care Model" (Naylor et al., 2009)
Emphasizes comprehensive discharge planning and follow-up for older adults who are chronically ill. Model contains six key components: (1) in-hospital assessment and development of the discharge care plan by a transitional care nurse/advanced practice nurse/gerontological nurse; (2) discharge preparation by an interprofessional care team; (3) patient participation (communication between nursing staff and the patient) regarding the process, the decision making, the discharge planning, and the discharge education; (4) continuity of care and communication among health care providers; (5) predischarge assessment; and (6) postdischarge follow-up.

High-Intensity Care Model (GRACE Model)
The interprofessional team is headed by *both* a nurse practitioner *and* a social worker. Other team members include a pharmacist, geriatric specialist, and mental health provider. This team works in tandem to support the primary care physician and, following best practice protocols, to fully address a patient's health conditions. The focus is to help patients manage their health conditions, coordinate their health care, and achieve optimal health (Blue Cross Blue Shield of Michigan, n.d.; Center for Consumer Engagement in Health Innovation, 2018). This achieves a patient's goal from the convenience and security of the patient's own home (Counsell, 2015).

Some patients are more in need of discharge planning because of their health-related risks. For example, some patients have poor health literacy, limited financial resources, or limited family support; others have long-term disabilities or chronic illness; and older adults sometimes have cognitive and/or hearing impairments affecting their attention to discharge instruction. There are also barriers to effective discharge planning, including ineffective communication (health care provider to provider; health care provider to patient), lack of role clarity among health care team members (responsibility and follow-up), and lack of resources (e.g., rehab and nursing home beds) (Abu et al., 2018; Shinall et al., 2019). You can reduce barriers to discharge planning by clearly communicating about the plan of care with patients, families, and members of the health care team. Change-of-shift, hand-off reporting, and hourly bedside rounds are ways to keep all health care providers and patients informed (see Chapter 24). Communicate clearly both verbally and in the entries you make in the EHR (see Chapter 26). Clarify any role confusion to be sure that elements of the plan are completed.

Discharge instructions prepare patients for transition from a hospital to the next level of care (such as home, rehabilitation, or long-term care). Nurses offer useful and relevant information to prepare patients and their family caregivers for postdischarge care. To develop discharge instructions, you must understand the proper timing for discharge, engage the patient and family caregiver (when allowed by the patient) in the process, and know the health care team's plan of care. Patients cannot learn when they are having pain, nausea, confusion, or other disabling symptoms. Family caregivers can be excellent resources when the patient desires their help. Always involve patients and family caregivers in the decisions about the patient's discharge destination.

Provide discharge instruction as early as possible so that you and other health care team members can reinforce the information several times to improve learning. For example, when a patient is receiving care that follows a standard protocol, you can easily anticipate the treatment and the patient's estimated discharge date. When the patient has multiple complications, the plan of care and estimated discharge date might not be clear. Begin to explain discharge instruction as soon as you know the plan of care. The following are required discharge instruction topics (The Joint Commission [TJC], 2020): discharge medications, follow-up care (if needed), list of all medications changed and/or discontinued, dietary needs, and follow-up tests or procedures.

Some patients assume passive roles when they receive instructions. They might be satisfied when a nurse, physician, or therapist rushes through an explanation and finishes by simply inquiring, "Any questions?" This often leads the patient to automatically answer "no." This patient might never have been invited to actively participate in the health care plan. A patient-centered approach does more. For example, the health care provider *invites* the patient to participate: "I want to make sure that I've helped you understand everything you need to know about your illness. Patients usually have questions because their situations can be complicated. Could you tell me what you do not understand, and then I can help clarify?" or "Do you understand which medications were changed or discontinued?" The teach-back approach (see Chapter 25) helps to ensure that a patient understands instructions. Teach-back is an evidence-based health literacy intervention that promotes patient engagement, patient safety, adherence, and quality (Agency for Healthcare Research and Quality [AHRQ], 2020). Comprehensive discharge instruction ensures that patients know what to do when they get home, how to perform care activities, and what to do when problems develop.

Discharge planning often leads to referrals to other health care providers, especially when specific therapies are planned (such as

physical therapy) (see Chapter 18). Some tips for making a successful referral include the following:

- Engage the patient and family caregiver in the referral process, including selecting the care provider. Explain the reason for the referral, the service to be provided, and how the service will be provided.
- Make the referral as soon as possible.
- Give the care provider receiving the referral as much information as possible about the patient. This can avoid unnecessary duplication of assessment (e.g., current vital signs or pain status) and omission of important information.
- The care provider, such as a physical therapist, social worker, dietitian, or radiologist, will make recommendations for the patient's care. Learn these recommendations and incorporate them into the treatment plan as soon as possible.

Restorative Care

Patients recovering from an acute or chronic illness or disability often require additional services in order to return to their previous level of function or to reach a new level of function limited by their illness or disability. The goals of **restorative care** are to help individuals regain maximal functional status and to enhance quality of life through promotion of independence and self-care. With the emphasis on early discharge from hospitals, patients usually require some level of restorative care. For example, some patients require ongoing wound care and activity and exercise management until they recover enough strength and/or function following surgery to independently resume normal activities of daily living.

The intensity of care has increased in a number of restorative care settings because patients are being discharged from hospitals earlier. Patients in a home or rehabilitation setting often still receive intravenous (IV) fluids (see Chapter 42), aggressive pain control (see Chapter 44), or enteral nutrition (see Chapter 45). The restorative health care team is interprofessional and includes the patient and family or significant others. In restorative settings, nurses recognize that success depends on effective and early collaboration with patients and their families. Patients and families require a clear understanding of goals for physical recovery, the rationale for any physical limitations, and the purpose and potential risks associated with therapies. Patients and families are more likely to follow treatment plans and achieve optimal functioning when they are engaged in their care.

Home Care. **Home care** is the provision of medically related professional and paraprofessional services and equipment to patients and families in their homes for health maintenance, education, illness prevention, diagnosis and treatment of disease, rehabilitation, and palliative care. This care consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is prescribed by a health care provider (CMS, 2020a). A home care service also coordinates the access to and delivery of home health equipment, or durable medical equipment, which is a medical product adapted for home use.

Home care nurses have their own patient caseloads and deliver highly individualized nursing care. They help patients adapt to many permanent or temporary physical limitations so that the patients can assume a daily home routine that is as normal as possible. Home care requires a strong knowledge base in many areas, such as family dynamics (see Chapter 10), cultural competence (see Chapter 9), spiritual values (see Chapter 35), and communication principles (see Chapter 24). Home health nurses must also have expertise in assessment (see Chapter 30). Nurses who work in Medicare-certified home care agencies conduct patient-specific comprehensive assessments at a patient's start of care, at 60-day follow-ups, at discharge, and before and after an inpatient stay (Research Data Assistance Center [ResDac], 2020). This comprehensive assessment, OASIS (the Outcome and Assessment Information Set), includes a group of standardized core assessment items for an adult home care patient. OASIS forms the basis for measuring patient outcomes and improving home health care for the purposes of outcome-based quality. Data items within OASIS include sociodemographic information on the patient's home environment and informal caregivers, support system, health status, functional status, psychosocial status, and health service utilization (e.g., emergent care, hospital admissions) (ResDac, 2020). The OASIS assessment tool was designed to gather the data items needed to measure both outcomes and patient risk factors in the home setting.

Home health care focuses on the goal of helping patients and their family members achieve independence. Home care addresses the recovery from and stabilization of an illness. In addition, home care identifies problems related to lifestyle, safety, environment, family dynamics, and health care practices. Home care agencies provide skilled and intermittent professional services, such as wound care, administration of parenteral and enteral nutrition, administration of medications and blood therapy, and home care aide services. The frequency of these services is based on patient need and may range from a couple of times a week to once or twice a day as often as 7 days a week.

Approved home care agencies usually receive reimbursement for services from governmental programs (such as **Medicare** and **Medicaid** in the United States), private insurance, and private payers. The government strictly regulates reimbursement for home care services. An agency cannot simply charge whatever it wants for a service and expect to receive that amount. Governmental programs set the amount of reimbursement for most professional services.

Rehabilitation. The WHO defines **rehabilitation** as the process aimed at enabling people with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological, and social functional levels. Rehabilitation gives people with disabilities the tools they need to attain independence and self-determination (WHO, 2020). Patients require rehabilitation after a physical or mental illness, surgery affecting musculoskeletal function, injury, or chemical addiction. Rehabilitation was once offered mostly to patients with illnesses or injury to the nervous or musculoskeletal system, but the expanded scope of services now also includes cardiovascular, neurological, pulmonary, and mental health rehabilitation programs. The goal of these specialized rehabilitation services is to help patients and families adjust to necessary changes in lifestyle and learn to function with the limitations of their disease. For example, drug rehabilitation centers help patients become free from drug dependence and return to the community.

Rehabilitation services after acute care include physical, occupational, and speech therapy and social services. Ideally rehabilitation begins the moment a patient enters a health care setting for treatment. For example, some orthopedic programs now have patients perform physical therapy exercises before major joint repair to enhance their recovery after surgery. Initially rehabilitation usually focuses on preventing complications related to an illness or injury, such as promoting early mobility in patients after surgery. As the patient's condition stabilizes, rehabilitation helps to maximize functioning and level of independence, often by examining the need for assistive devices such as walkers or canes or adapting approaches for performing self-care.

Rehabilitation settings include rehabilitation units within acute care centers, freestanding outpatient settings, and the home. Patients who have severe disabilities may not be able to carry out the activities of daily living independently. An example would be a patient who has had a stroke or spinal cord injury. These patients may benefit from long-term rehabilitation to reach their maximum potential.

Patients who use rehabilitation services in an outpatient setting receive treatment at appointments during the week but live in their home. Sometimes, specific rehabilitation services are also used in the home to help the patient.

Extended Care Facilities. An **extended care facility** provides intermediate medical, nursing, or custodial care for patients recovering from acute illness or those with chronic illnesses or disabilities. Extended care facilities include intermediate care and skilled nursing facilities. Some include long-term care and assisted-living facilities. In the past, extended care facilities primarily cared for older adults; now, because of the focus on early discharge from hospitals, there is a greater need for intermediate care settings for patients of all ages. For example, health care providers transfer a young patient who has a traumatic brain injury resulting from a car accident to an extended care facility for rehabilitative or supportive care until discharge to the home becomes a realistic and safe option.

An intermediate care or **skilled nursing facility** offers skilled care from a licensed nursing staff. This often includes administration of IV fluids, wound care, long-term ventilator management, and physical rehabilitation. Patients receive extensive supportive care until they are able to move back into the community or into residential care. Extended care facilities provide around-the-clock nursing coverage. Nurses who work in a skilled nursing facility need nursing expertise similar to that of nurses working in acute care inpatient settings, along with a background in gerontological nursing principles (see Chapter 14).

Continuing Care

Continuing care describes a variety of health, personal, and social services provided over a prolonged period. These services are for people who have disabilities, who were never functionally independent, or who have a terminal disease. The need for continuing health care services is growing in the United States. People are living longer, and many of those with continuing health care needs have no immediate family members to care for them. A decline in the number of children that families choose to have, the aging of care providers, and the increasing rates of divorce and remarriage complicate this problem.

Continuing care is available within institutional settings (e.g., nursing centers or nursing homes, group homes, and retirement communities), communities (e.g., adult day care and senior centers), or the home (e.g., home care, home-delivered meals, and hospice) (Meiner and Yeager, 2019). Another alternative for the patient who does not need nursing care but needs some assistance to stay independent is elder care services. These services offer companionship, assistance with activities of daily living, and food preparation.

Nursing Centers or Facilities. The language of long-term care is confusing and constantly changing. *Nursing home* was formerly the name for the dominant setting for long-term care (Meiner and Yeager, 2019). With the 1987 Omnibus Budget Reconciliation Act, *nursing facility* became the term for nursing homes and other facilities that provided long-term care. Now *nursing center* is the most appropriate term. A nursing center typically provides 24-hour intermediate and custodial care such as nursing, rehabilitation, dietary, recreational, social, and religious services for residents of any age with chronic or debilitating illnesses. Nursing center services provided by Medicaid-certified nursing homes offer:

- Skilled nursing
- Rehabilitation
- Long-term care (Medicaid.gov, n.d.)

These three services include 24-hour licensed nursing, rehabilitation, medically related social services, and pharmaceutical services. In addition there are dietary services individualized to the needs of each resident, a professionally directed program of activities to meet the interests and needs for the well-being of each resident, emergency dental services, room and bed maintenance services, and routine personal hygiene items and services. A skilled nursing facility must care for its residents in a manner and in an environment that will promote maintenance or enhancement of the quality of life of each resident (Legal Information Institute, n.d.).

Most people living in nursing centers are older adults. A nursing center may be a resident's temporary or permanent home with surroundings made as homelike as possible. Residents receive a planned, systematic, and interprofessional approach to care to help them reach and maintain their highest level of function.

Nursing centers must comply with the Omnibus Budget Reconciliation Act of 1987 and its minimum requirements for nursing facilities to receive payment from Medicare and Medicaid. Government regulations require that staff members in nursing centers comprehensively assess each resident and that care planning decisions be made within a prescribed period. A resident's functional ability (such as the ability to perform activities of daily living and instrumental activities of daily living) and long-term physical and psychosocial well-being are the focus.

A nursing facility must complete the Resident Assessment Instrument (RAI) for each resident. The RAI helps nursing facility staff gather definitive information on a resident's strengths and needs, which must then be addressed in an individualized care plan (CMS, 2019). The RAI has three components: the **Minimum Data Set (MDS)** Version 3.0, the Care Area Assessment (CAA) process, and the RAI Utilization Guidelines (Box 2.3). The components of the RAI yield information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified (CMS, 2019). The MDS Version 3.0 is an initial overview of a resident's health care needs. It is a preliminary assessment to identify the resident's potential problems, strengths, and preferences. The CAAs are triggered by individual MDS item responses that reveal the need for additional assessment. These item responses identify problems, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. CAAs enable facilities to identify and use tools that are grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources.

The information gathered using the RAI provides a national database for nursing facilities that enables policy makers to better understand the health care needs of the long-term care population. The MDS and CAAs are a rich resource for nurses in selecting interventions that best meet the health care needs of this growing population.

Assisted Living. Assisted living is one of the fastest-growing industries within the United States. There are almost 30,000 assisted-living facilities with nearly one million licensed beds that house more than 800,000 people in the United States (National Center for Assisted Living [NCAL], 2020). **Assisted living** offers an attractive long-term care setting with an environment more like home and greater resident autonomy. Residents require some assistance with activities of daily living but remain relatively independent within a partially protective setting. A group of residents live together, but residents have their own rooms and share dining and social activity areas. Usually people keep all of their personal possessions in their residences.

Assisted-living residences range from hotel-like buildings with hundreds of units to modest group homes that house a handful of seniors. Assisted living provides independence, security, and privacy all at the same time (Touhy and Jett, 2018). These settings promote physical and psychosocial health (Fig. 2.2). Services in an assisted-living center include laundry, assistance with meals and personal care, 24-hour oversight, and housekeeping (NCAL, 2020). Some centers provide assistance with medication administration. Nursing care services are not always

BOX 2.3 Components of the Resident Assessment Instrument (RAI)

Minimum Data Set (MDS)

A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes that are Medicare or Medicaid certified. Elements include:

- Identification information
- Hearing, speech, and vision
- Cognitive patterns
- Mood
- Behavior
- Preferences for customary routine and activities
- Functional status
- Functional abilities and goals
- Bladder and bowel
- Active diagnoses
- Health conditions
- Swallowing/nutritional status
- Oral/dental status
- Skin conditions
- Medications
- Special treatments, procedures, and programs
- Restraints and alarms
- Participation in assessment and goal setting
- Care Area Assessment (CAA) Summary

Care Area Assessment (CAA) Process

This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine a plan of care for it. The CAA process helps the clinician to focus on key issues.

- Care Area Triggers (CATs) are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
- Care Area Assessment is the further investigation of triggered areas, to determine if the CATs require interventions and care planning.
- CAA Summary provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether to proceed to care planning.

Utilization Guidelines

The Utilization Guidelines provide instructions for when and how to use the RAI.

Adapted from Centers for Medicare and Medicaid Services (CMS): *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1,* 2019. https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf. Accessed July 2021.

directly available, although home care nurses can visit patients in assisted-living residences. Unfortunately, most residents of assisted-living residences pay privately. The national median monthly fee is $4000 for a private unit (NCAL, 2020). With no government fee caps and little regulation, assisted living is not always an option for individuals with limited financial resources.

Respite Care. Caring for family members within the home creates great physical and emotional burdens for adult caregivers. This is especially true when the family member who needs assistance is physically or cognitively limited. The caregiver is usually an adult who not only has the responsibility for providing care to a loved one (such as a spouse, parent, or sibling) but often maintains a full-time job, raises a family, and manages the routines of daily living as well.

FIG. 2.2 Providing nursing services in assisted-living facilities promotes physical and psychosocial health. (Copyright © DGLimages/iStock/Thinkstock.)

Respite care is a service that offers short-term relief by providing a new environment or time to relax for family caregivers who support the ill, disabled, or frail older adult (Alzheimer's Association, 2021). Recommend respite services to the family caregivers of your patient whenever indicated. Respite care can be provided at home by a friend, another family member, or a volunteer; by a paid service; or in a care setting such as adult day care or a residential center (Alzheimer's Association, 2021). Research has shown that family caregivers must have great trust in the respite care service and that they perceive that the major benefits for the recipients of care are social interaction and meaningful activity, with a resulting improvement in well-being (Whitmore and Snethen, 2018).

Adult Day Care Centers. **Adult day care centers** provide a variety of health and social services to specific patient populations who live alone or with family in the community. Services offered during the day allow family members to maintain their lifestyles and employment and still provide home care for their relatives (Meiner and Yeager, 2019). Day care centers are associated with a hospital or nursing home or exist as independent centers. Frequently the patients need continuous health care services but not hospitalization (e.g., physical therapy, meals, recreational activities, or counseling) while their families or support people work. Patients who typically use adult day care are physically frail, cognitively impaired, or both and require some supervision but not continuous care (Meiner and Yeager, 2019).

The centers usually operate weekdays during typical business hours and usually charge on a daily basis. Adult day care centers allow patients to retain more independence by living at home, thus potentially reducing the costs of health care by avoiding or delaying an older adult's admission to a nursing center. Nurses working in day care centers provide continuity between care delivered in the home and the center. For example, nurses ensure that patients continue to take prescribed medication and administer specific treatments. Knowledge of community needs and resources is essential in providing adequate patient support (Touhy and Jett, 2018).

Palliative and Hospice Care. **Palliative care** is a holistic, patient- and family-centered care approach with a goal of improving the quality of life of patients and families who are experiencing problems related to life-threatening illnesses. Palliative care is delivered through the continuum of illness with a focus on early identification and treatment of physical, psychosocial, and spiritual problems; relief of pain and suffering; continuity of care; and helping patients and families make informed decisions (National Hospice and Palliative Care Organization [NHPCO], 2021; Parola et al., 2018). Palliative care can be delivered in any health care setting. Some health care agencies have dedicated palliative care units to care for these patients with complex health problems. Key to palliative care delivery is the nurse-patient and nurse-family relationship. With the patient, the nurse develops a singular relationship, and with the family or a partner, a supportive relationship is formed (Parola et al., 2018).

A **hospice** is a system of family-centered care that allows patients to live with comfort, independence, and dignity while easing the pain of terminal illness. A patient entering into hospice care is in the terminal phase of illness, and the patient, family, and health care provider agree that no further treatment will reverse the disease process. Hospice care is provided in a setting that best meets the needs of each patient and family, such as in a patient's home or in nursing homes, assisted-living facilities, freestanding hospices, and hospitals. The focus of hospice care is supportive care, not curative treatment (see Chapter 36). Hospice benefits families and patients in the terminal phase of any disease, such as cardiomyopathy, multiple sclerosis, acquired immunodeficiency syndrome (AIDS), and cancer. Hospice team members are available 24 hours a day, 7 days a week to answer questions or visit anytime the need for support arises. Team members collaborate to provide care that ensures death with dignity. Services continue without interruption even if a patient's care setting changes.

Palliative and hospice care are similar in that both focus on symptom management and ensuring the patient's comfort. Both care delivery methods are managed by an interprofessional team that works together with the patient's primary health care provider to develop and maintain a patient-directed, individualized plan of care (Pawlow et al., 2018). An essential member of the interprofessional team is the advanced practice registered nurse (APRN). To meet the increasing need for APRNs in palliative and hospice care, integration of core competencies into APRN education, development of clinical education opportunities in palliative and hospice care, and provision of continuing education in palliative and hospice care for practicing APRNs need to occur (Pawlow et al., 2018).

ISSUES IN HEALTH CARE DELIVERY FOR NURSES

The climate in health care today influences both health care professionals and consumers. Because those who provide patient care are the most qualified to make changes in the health care delivery system, you need to participate fully and effectively within all aspects of health care. Health care agencies today are working hard to improve patient experience and engagement while delivering high-quality care, improving outcomes, and controlling costs (Considine, 2018). In today's health care system, the outcomes of patient satisfaction and quality care indicators such as infection rates are tied to health care payments (McCay et al., 2018). As you face challenges in maintaining health care quality while reducing costs, you need to develop clinical judgment, applying the nursing process and thinking critically as you make the clinical decisions needed in each patient situation. It is also more important than ever to collaborate with other health care professionals to design and deliver new approaches for patient care delivery.

Health Care Costs and Quality

It is impossible today to separate two initiatives facing health care institutions: managing costs and achieving high-quality patient care. Health care payers (Table 2.2) (such as Medicare, Medicaid, and private insurers) have been trying to manage and address health care costs for many years. The Social Security Act established a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates (CMS, 2020c). This payment system is referred to as the **Inpatient Prospective Payment System (IPPS)**. Under the IPPS, each patient case is categorized into a **diagnosis-related group (DRG)**. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG (CMS, 2020c). Regardless of the amount a hospital spends to care for a patient, the DRG-established payment is the amount the hospital receives. The DRG payment groups are still used, but many payers now demand that evidence-based standards of care be followed to further reduce the cost of health care.

The U.S. Congress created the CMS Innovation Center to test "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" for those who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits (CMS, 2021). The Innovation Center supports the following priorities: testing new payment and service delivery models, including Quality Payment Program Advanced Alternative Payment Models, evaluating results and advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing. One example of an initiative supported by the Innovation Center is the creation of Medicare ACOs. The ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare fee-for-service (FFS) beneficiaries and reduce unnecessary costs (CMS, 2020d). As of 2015, 424 ACOs participate in the CMS Shared Savings Program (CMS, 2020d).

The **Affordable Care Act** ties payment to organizations offering Medicare Advantage plans to the quality ratings of the coverage they offer. If hospitals perform poorly in quality scores, they receive lower payments for services. Quality outcome measures include patient satisfaction and more effective management of care by reducing complications and readmissions and improving care coordination. Examples of reforms that incent or "Pay for Value," designed to build a health care system that better serves the American population (CMS, 2015), include the following:

- *Hospital Value-Based Purchasing:* This program links a portion of hospitals' Medicare payments (1.5% of base operating DRG payment) for inpatient acute care to their performance in important quality measures. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is the standardized survey instrument and data collection methodology that CMS requires for measuring patients' perceptions of hospital care. HCAHPS is a patient satisfaction measure that sets a national standard for collecting or publicly reporting patients' perceptions that enables users to make valid comparisons across all hospitals (HCAHPS, 2021). Research shows that when hospitals have a higher percentage of hospitalists providing care, services are linked and there is improved coordination of care, resulting in higher performance scores (Spaulding et al., 2018).
- *Hospital Readmissions Reduction Program:* This CMS program reduces Medicare payments to hospitals with excess patient readmissions within 30 days of hospital discharge. It is designed to encourage patient safety and care quality. Heart attack, heart failure, and pneumonia are conditions regulated under this program, and readmissions dropped from 18.4% to 17.5% (National Quality Forum, 2021a). Nurses are a vital part of interprofessional teams. These team

TABLE 2.2 Common Health Care Payers in the United States

Among the current health care payment models, quality is a key component. Most health care cost reimbursement arrangements tie the final payment to the achievement of key quality metrics.	
Fee-for-service	• The most traditional health care payment model. • Requires patients or payers to reimburse the health care provider for each service performed. • No incentive to implement preventive care strategies, prevent hospitalization, or take any other cost-saving measures.
Pay for coordination	• Coordinates care between the primary care provider and specialists. • Coordinating care among multiple providers can help patients and their families manage a unified care plan and can help reduce redundancy in expensive tests and procedures.
Pay for performance (P4P)	• Same as value-based reimbursement. • Health care providers are compensated only if they meet certain metrics for quality and efficiency. • Quality benchmark metrics tie physicians' reimbursement directly to quality of care they provide.
Bundled payment or episode-of-care payment	• Reimburses health care providers for specific episodes of care, such as an inpatient hospital stay. • Encourages efficiency and quality of care because only a set amount of money will pay for the entire episode of care.
Upside shared savings programs (Centers for Medicare and Medicaid Services [CMS] or commercial)	• Provide incentives for providers treating specific patient populations. • A percentage of any net savings realized is given to the provider. • Upside-only shared savings is most common with Medicare Shared Savings Program (MSSP) Accountable Care Organizations, but all MSSP participants must move to a downside model after 3 years.
Downside shared savings programs (CMS or commercial)	• Includes both the gain share potential of an upside model, but also the downside risk of sharing the excess costs of health care delivery between provider and payer. • Because providers are taking on greater risk with this model, the upside opportunity potential is larger in most cases than in an all-upside program.
Partial or full capitation	• Patients are assigned a per-member per-month (PMPM) payment based on their age, race, sex, lifestyle, medical history, and benefit design. • Payment rates are tied to expected usage regardless of whether the patient visits more or less. • As with bundled payment models, health care providers have an incentive to help patients avoid expensive procedures and tests in order to maximize their compensation. • Only certain types or categories of services are paid on a capitation basis.

Data from American Academy of Pediatrics: *Getting paid: alternative payment models,* 2020. https://www.aap.org/en-us/professional-resources/practice-transformation/getting-paid/Pages/Payment-Models.aspx. Accessed June 2020; American Hospital Association: *Current and emerging payment models,* 2020. https://www.aha.org/advocacy/current-and-emerging-payment-models. Accessed June 2020; and Brookings: *The beginner's guide to new healthcare payment models,* 2014. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2014/07/23/the-beginners-guide-to-new-health-care-payment-models/. Accessed June 2020.
CMS, Centers for Medicare and Medicaid Services; *MSSP*, Medicare Shared Savings Program.

members collaborate to design treatment and discharge instruction protocols to reduce unnecessary patient readmissions.

- *Bundled Payments for Care Improvements:* Certain health care organizations are testing whether bundled payments (single payment for all services performed to treat a patient) for a specific episode of care (inpatient stays in an acute care hospital) can better coordinate care for Medicare patients and reduce Medicare costs. A bundled payment includes payments for services such as medical, radiological, and therapeutic. This initiative focuses on improving care for specific conditions. Bundling payments for services, such as heart bypass surgery, is one way to encourage doctors and hospitals to better coordinate care during hospitalization and after discharge (CMS, 2020b). Health care institutions enter into payment arrangements that include financial and performance accountability for an episode of care
- *Hospital-Acquired Condition (HAC) Reduction Program:* This program was developed by CMS to encourage hospitals to improve health care quality and patient safety. As a component of this program, hospitals that have a high incidence of HACs in patients—such as pressure injury development, catheter-associated urinary tract infections (CAUTIs), central line–associated bloodstream infections (CLABSIs), surgical site infections, and *Clostridium difficile* infection (CDI)—received reduced or no funding from CMS for the treatment of these HACs. This program saves CMS approximately $350 million annually (CMS, 2020e). Because of this reduced funding, hospitals have focused quality improvement efforts on reducing and preventing these HACs.

Patient Satisfaction. Patient satisfaction is the responsibility of all health care providers. It is more important than ever because patient satisfaction measures are linked to hospital reimbursement. Patient perceptions of the quality of their health care have been incorporated into quality assessment. As a result, health care organizations have made the patient experience and patient-centered care major components of their health care missions (Cody and Williams-Reed, 2018; Niederhauser and Wolf, 2018). Hospitals now report patient satisfaction scores for patient care units monthly. All health care staff members help identify satisfaction trends and determine ways to improve quality of care. Hospitals and other health care agencies use a variety of instruments to measure patient satisfaction (NEJM Catalyst, 2018). Instruments are provided by private vendors. They usually are not published, and their reliability and validity are unclear:

- Public and standardized instruments such as patient satisfaction questionnaires (e.g., PSQ-18) and consumer assessment health plans (e.g., HCAHPS) have the advantage of good reliability and validity; however, they have a limited scope of survey questions.
- Internally developed instruments are derived mainly from questions extracted from other instruments.

The HCAHPS is used widely by hospitals to collect and publicly report patient satisfaction data for comparison purposes (HCAHPS, 2021). The HCAHPS survey has 29 items, including 19 that encompass critical aspects of the hospital experience (e.g., communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, transition of care, and willingness to recommend the hospital). The remaining 10 items forward patients to appropriate disease- and procedure-specific questions, adjust for the mix of patients across hospitals, and support congressionally mandated reports (HCAHPS, 2021).

Much research has been conducted to identify the factors that patients perceive affect their satisfaction, including relational communication techniques, hourly rounding, nurse staffing patterns, and bedside shift report (Cody et al., 2018; Persolja, 2018; Dilts Skaggs et al., 2018). One common factor among the studies is interpersonal skills, especially the courtesy and respect of health care providers. This is in addition to the communication skills of providing explanations and clear information, which are more influential in affecting patient perceptions than other technical skills (George et al., 2018; Pattison et al., 2017).

Nursing Shortage

The American Association of Colleges of Nursing (AACN) has warned of a shortage of registered nurses (RNs) that is expected to intensify as baby boomers age and the need for health care grows (AACN, 2020). The problem is complicated by the fact that nursing schools across the country are struggling to expand their capacity to meet the rising demand for RNs. In addition, aging nurses are retiring from the workforce. The AACN noted important shortage indicators:

- The Bureau of Labor Statistics (BLS) Employment Projections for 2018–28 show that RNs are among the top occupations in terms of job growth through 2028 (BLS, n.d.). The RN workforce is expected to grow 12% (increase of 371,500) by 2028. The Bureau also predicted the need for 203,700 replacement nurses in the workforce, bringing the total number of RN job openings to 3.4 million by 2026 (AACN, 2020).
- The Institute of Medicine (IOM) 2010 report *The Future of Nursing: Leading Change, Advancing Health* called for an increase in the percentage of nurses who attain a bachelor's degree to 80% and a doubling in the number of nurses with doctoral degrees. The current nursing workforce falls far short of these recommendations, with only 56% of RNs prepared at the bachelor's or graduate degree level (IOM, 2010; AACN, 2020).

The shortage affects all aspects of nursing, including patient care, administration, and nursing education, but it also represents challenges and opportunities for the profession. Many health care dollars are invested in strategies aimed at recruiting and retaining a well-educated, critically thinking, motivated, and dedicated nursing workforce. There is a positive correlation between direct patient care provided by an RN and positive patient outcomes, reduced complication rates, and a more rapid return of the patient to an optimal functional status (Box 2.4) (Aiken, 2017; Twigg et al., 2019). Research also correlates poor staffing with missed nursing assessments and missed nursing care. In postoperative patients whose status changes rapidly, these missed assessments and care result in poor patient outcomes (Ball et al., 2018).

Professional nursing organizations predict that the number of nurses will continue to diminish (AACN, 2020). With fewer available nurses, it is important for you to learn to use your patient contact time efficiently and professionally. Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and a feeling that they received high-quality care. Your patients should never feel that they received rushed or incomplete care. They need to feel that they are important and are involved in decisions and that their needs are met. If a certain aspect of patient care requires 15 minutes of contact, it takes you the same time to deliver organized and compassionate care as it does if you rush through your nursing care.

The nursing shortage opens great opportunities for every nurse. If you pursue further education and watch trends in health care, you will be able to find employment in any professional position you choose.

Competency

Health care practitioner competencies are an excellent tool for measuring how well a nurse practices nursing and serve as a guide for the development of a professional nursing career. The Quality and Safety

BOX 2.4 EVIDENCE-BASED PRACTICE

Impact of Nurse Staffing and Patient Outcomes

PICOT Question: What is the impact on patient outcomes in hospitals with adequate nurse staffing versus hospitals with lower nurse staffing?

Evidence Summary

There is a growing body of research that shows that nurse staffing affects patient outcomes, patient survival, and the occurrence of adverse events. A systematic quantitative review of the literature found that higher nurse staffing mixes were associated with better patient outcomes. Examples of the outcomes affected by staffing mix included length of stay (LOS), incidence of pressure ulcers, pneumonia, sepsis, catheter-associated urinary tract infections (CAUTIs), 30-day mortality rate, infection, and acute myocardial infarction (Twigg et al., 2019). Patients experiencing an in-hospital cardiac arrest were more likely to survive when there was a decreased patient-to-nurse ratio (Twigg et al., 2019). Combining higher nurse staffing with an evidence-based intervention such as a sepsis bundle results in improved patient outcomes, including decreased mortality and length of stay (Lasater et al., 2021).

Higher nurse staffing was also found to significantly correlate with nursing-sensitive outcomes, such as reduced falls and improved risk assessment for pressure injuries (Burnes Bolton et al., 2017; Brooks Carthon et al., 2018). When there is poor nurse staffing, resulting in larger numbers of patients assigned to a nurse, there is an increase in the occurrence of medication errors, missed care, pressure injury formation, and falls with injuries (ANA, 2019; Griffiths et al., 2018). Studies have found that a higher professional nurse staffing mix results in decreased inpatient mortality, decreased length of stay, decreased patient readmissions, and increased patient satisfaction (Aiken et al., 2021; McHugh et al., 2021). Studies demonstrating the positive impact that increased nurse-to-patient ratios have on outcomes provide nursing administrators with evidence to support the hiring of qualified professional nurses.

Application to Nursing Practice

- Consider the nurse-to-patient ratio and staffing mix when looking at a hospital or unit for employment (Aiken et al., 2017; Lasater et al., 2021).
- Adequate nursing levels help to improve the nursing work environment, resulting in improved patient safety and quality of care (AHRQ, 2019; McHugh et al., 2021; Sloane et al., 2018).
- Patient care units in which there is an increased risk for falls due to the patient population or diseases need increased nurse staffing (Burnes Bolton et al., 2017).
- Although research supports the economic impact of nurse staffing and improved nursing-sensitive outcomes and other patient outcomes, there needs to be continued research on the impact of nurse staffing ratios (Lasater et al., 2021; Twigg et al., 2019).

BOX 2.5 Registered Nurse Competencies

QSEN Competencies

- Patient-Centered Care
- Teamwork and Collaboration
- Evidence-Based Practice (EBP)
- Quality Improvement (QI)
- Safety
- Informatics

Massachusetts Nurse of the Future Nursing Core Competencies

- Patient-Centered Care
- Professionalism
- Leadership
- Systems-Based Practice
- Informatics and Technology
- Communication
- Teamwork and Collaboration
- Safety
- Quality Improvement
- Evidenced-Based Practice (EBP)

Data from Massachusetts Department of Higher Education Nursing Initiative (MDHENI): *Massachusetts Nurse of the Future Nursing Core Competencies© REGISTERED NURSE*, 2016. https://www.mass.edu/nahi/documents/NOFRNCompetencies_updated_ March2016.pdf. Accessed April 2021; and Quality Safety Education for Nursing (QSEN): *QSEN competencies*, 2020. http://qsen.org/competencies/pre-licensure-ksas/. Accessed April 2021.

Education for Nurses (QSEN) project developed quality and safety competencies for nurses so that they would have the knowledge, skills, and attitudes to meet the challenges in today's health care settings (QSEN, 2020). The Massachusetts Nurse of the Future Nursing Core Competencies were developed by the Massachusetts Department of Higher Education and the Massachusetts Organization of Nurse Executives (now part of the Organization of Nurse Leaders) to identify knowledge, attitude, and skills for 10 competencies considered essential for the RN for the future (Box 2.5) (Massachusetts Department of Higher Education Nursing Initiative [MDHENI], 2016). A consumer of health care expects that the standards of nursing care and practice in any health care setting are appropriate, safe, and effective. Health care organizations ensure high-quality care by establishing policies, procedures, and protocols that are evidence based and follow national accrediting standards. Your responsibility is to follow policies and procedures and know the most current practice standards. Ongoing competency is your responsibility. You are also responsible for obtaining necessary continuing education, following an established code of ethics, and earning certifications in specialty areas.

Patient-Centered Care

In a landmark report, *Crossing the Quality Chasm,* the IOM defined **patient-centered care** as "care that is respectful of and responsive to individual patient preferences, needs, and values and [ensures] that patient values guide all clinical decisions" (IOM, 2001). Hospitals across the country have implemented patient-centered care strategies, specifically delivery of care models (see Chapter 21). Patient-centered care is a component of the total patient experience, which includes all interactions that a patient has in a health care setting. The overall patient experience is influenced by the culture of the health care setting and patient perceptions (Wolf, 2017).

Patient-centered care is much more than simply "individualizing" patient care. A critical component of patient-centered care is the partnering of the nurse, patient, and family caregiver to identify the patient's health care needs within the context of the patient's lifestyle and to coordinate the entire health care team so that patient and family are engaged in the care process and associated decisions. This is a major shift in how care is delivered, empowering the patient and family to participate in the plan of care and engaging patients and families in a dialogue about the patient experience (Niederhauser and Wolf, 2018). The following are the Picker Institute's eight principles of person-centered care (Picker, 2021), based on input from patients, families, and health care experts:

1. Fast access to reliable health care advice
2. Effective treatment delivered by trusted professionals
3. Continuity of care and smooth transitions
4. Involvement and support for family and carers
5. Clear information, communication, and support for self-care
6. Involvement in decisions and respect for preferences
7. Emotional support, empathy, and respect
8. Attention to physical and environmental needs

REFLECT NOW

After completing your assigned clinical experience, complete a self-assessment evaluating your use of the principles of patient-centered care. Identify areas that you can improve on for your next clinical assignment.

QSEN **Building Competency in Patient-Centered Care** Nathan, a new graduate nurse, is assigned to care for a patient who had surgery yesterday for cancer. The plan is for the patient to be discharged home in 2 days. Identify strategies that Nathan can use to meet his patient's expectations.

Answers to QSEN Activities can be found on the Evolve website.

Magnet Recognition Program®

The American Nurses Credentialing Center (ANCC) established the Magnet Recognition Program® to recognize health care organizations that achieve excellence in nursing practice (ANCC, 2020). Health care organizations that apply for Magnet® status must demonstrate high-quality patient care, nursing excellence, and innovations in professional practice. The professional work environment needs to allow nurses to practice with a sense of empowerment and autonomy to deliver high-quality nursing care. The Magnet® Model has five components affected by global issues that are challenging nursing today (ANCC, 2020). The five components are (1) Transformational Leadership, (2) Structural Empowerment, (3) Exemplary Professional Practice, (4) New Knowledge, Innovation, and Improvements, and (5) Empirical Quality Results (Box 2.6). In Magnet® hospitals, the organizational culture is focused on nurse engagement, use of evidence-based practices to provide high-quality care, commitment to quality improvement, clear strategic direction, shared governance, and trust in leadership (Fischer and Nichols, 2019; Lavenberg et al., 2019). Peer review is often used as a mechanism to improve accountability and foster professional growth (Roberts and Cronin, 2017). Magnet® status requires nurses to collect data on specific nursing-sensitive quality indicators or outcomes and compare their outcomes against a national, state, or regional database to demonstrate quality of care. Research shows that patient outcomes for nursing-sensitive indicators such as patient falls, CAUTIs, and CLABSIs are

BOX 2.6 Model and Forces of Magnetism

Magnet® Model Components	Forces of Magnetism
Transformational leadership—A vision for the future and the systems and resources to achieve the vision are created by nursing leaders.	• Quality of nursing leadership • Management style
Structural empowerment—Structures and processes provide an innovative environment in which staff are developed and empowered and professional practice flourishes.	• Organizational structure • Personnel policies and programs • Community and the health organization • Image of nursing • Professional development
Exemplary professional practice—Strong professional practice is established, and accomplishments of the practice are demonstrated.	• Professional models of care • Consultation and resources • Autonomy • Nurses as teachers • Interprofessional relationships
New knowledge, innovations, and improvements—Contributions are made to the profession in the form of new models of care, use of existing knowledge, generation of new knowledge, and contributions to the science of nursing.	• Quality improvement
Empirical quality results—Focus is on structure and processes and demonstration of positive clinical, workforce, and patient and organizational outcomes.	• Quality of care

Adapted from American Nurses Credentialing Center (ANCC): *Magnet Model—creating a magnet culture,* 2020. https://www.nursingworld.org/organizational-programs/magnet/magnet-model/. Accessed June 1, 2020.

significantly better in Magnet® organizations than in non-Magnet® organizations (Fischer and Nichols, 2019). One contributing factor to this may be the higher levels of transformational leadership found in nurse managers in Magnet® organizations (Fischer and Nichols, 2019).

Nursing-Sensitive Outcomes. **Nursing-sensitive outcomes** are patient outcomes and nursing workforce characteristics that are directly related to nursing care, such as changes in patients' symptom experiences, functional status, safety, psychological distress, RN job satisfaction, total nursing hours per patient day, and costs. As a nurse you assume accountability and responsibility for achieving and accepting the consequences of these outcomes. Measuring and monitoring nursing-sensitive outcomes reveal the interventions that improve patients' outcomes. Nurses and health care agencies use nursing-sensitive outcomes to improve nurses' workloads, enhance patient safety, and develop sound policies related to nursing practice and health care. The ANA developed the National Database of Nursing Quality Indicators (NDNQI) to measure and evaluate nursing-sensitive outcomes with the purpose of improving patient safety and quality care (NDNQI, n.d.). The NDNQI reports quarterly results on nursing outcomes at the nursing unit level. This provides a database for individual hospitals to compare their performance against national nursing performance. The evaluation of patient outcomes and nursing workforce characteristics remains important to nursing and the health care delivery system. Chapter 5 describes approaches for measuring outcomes.

Technology in Health Care

Technological advances continually affect health care organizations and change the ways in which nurses deliver evidence-based care to patients. Emerging technologies that will change how nurses practice include genetics and genomics, less invasive and more accurate tools for diagnosis and treatment, three-dimensional printing, robotics, biometrics, EHRs (see Chapter 26), and computerized physician/provider order entry and clinical decision support. Technology makes your work easier in many ways, but the technology does not replace your clinical judgment and clinical decision making. For example, when you manage an IV infusion smart pump, you must monitor the infusion to ensure that the device infuses on schedule and without complications despite its numerous automatic settings. An infusion device infuses at a constant rate, but you must confirm that the rate is calculated correctly. An infusion device sets off an alarm if the infusion slows but does not indicate why the infusion slowed. You must assess why the alarm sounded and use clinical judgment to determine the problem and how to resolve it. Technology never replaces a nurse's astute, critical eye and clinical judgment.

Robotics is an emerging technology that will greatly affect how nursing is practiced in the future. It is estimated that robotic use will grow because of workforce shortages, a growing elderly population, and a call for higher-quality care not subject to human limitations (Backonja et al., 2018; Hauser and Shaw, 2020). Most robotic applications are limited to food service, medication distribution, infection control, surgery, and even diagnosing patients. However, one area with huge potential for affecting nursing is the use of robots as direct care providers. Daily care robots provide support to older adults and people with disabilities in such activities as preparing and serving meals and in daily care tasks such as retrieving items (Kyarini et al., 2021; Sefcik et al., 2018). In addition, exoskeleton-powered robots are used to help patients who are paralyzed stand, with the goal of reducing morbidity and augmenting physical therapy for patients with impaired extremities (Kyarini et al., 2021). The implications for nursing are significant. Telenursing robots are a component of a telenursing system in which a robot is physically present with the patient and has an interlink to nurses or other health care providers who are at a different location (Hauser and Shaw, 2020). The telenursing robot provides two-way communication, is mobile to move between patients or rooms, is able to collect diagnostic and assessment data, provides accuracy and precision in data collection, and is able to use human- or robot-developed health care tools and instruments (Hauser and Shaw, 2020; Kyarini et al., 2021). The use of robots in health care and to perform nursing tasks presents challenges (Kyarini et al., 2021). The cost of robots is high for health care systems, and there is still concern about the maturity and readiness of the technology (Kyarini et al., 2021). Concerns for patient privacy have been voiced because of the cameras on the robots. There is also a question about how willing patients will be to accept care from robots (Kyarini et al., 2021). Nursing must be on the front line in deciding how robotics is used in order to advocate for patients and families and to ensure that professional standards of care are delivered.

Telemedicine is a technology that relies on interactive video; it uses medical information gathered and reviewed at one site (such as a hospital, home, clinic, or urgent care center) and transmits treatment recommendations to another site to improve a patient's clinical health status (American Telemedicine Association, 2020). There are a variety of applications and services using two-way video, smartphones, wireless tools, and other forms of telecommunications technology. The benefits of telemedicine include providing services that meet patient demand, increasing access to care, and decreasing cost (American Telemedicine Association, 2020). However, varying federal and state

policies on telemedicine use and reimbursement pose an obstacle to wider adoption of this emerging practice (Young and Kroth, 2018).

Nurses need to play a role in evaluating and implementing new technological advances. You use technology to improve the effectiveness of nursing care, enhance safety, and improve patient outcomes. Most important, it is essential for you to remember that the focus of nursing care is not the machine or the technology; it is the patient. Therefore you need to constantly attend to and connect with your patients and ensure that their dignity and rights are preserved at all levels of care.

Health Care Disparities

Health care disparities are the differences in health care outcomes and dimensions of health care, including access, quality, and equity, among population groups (Almgren, 2018; Kneipp et al., 2018). Disparities can be related to many variables, such as race, ethnicity, gender, location, disability, or social determinants (Artiga et al., 2020). Social determinants greatly affect health disparities. They are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality-of-life outcomes and risks (ODPHP, n.d.). The *Healthy People 2030* initiative identifies five categories of social determinants: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context (Office of Disease Prevention and Health Promotion [ODPHP], n.d.). Disparities in health status, particularly in a community in which the majority have poor health, will affect the productivity and vulnerability of a population. The National Quality Forum (2021b) reported that health care disparities are linked to the following social determinants: inadequate resources, poor patient-provider communication, a lack of culturally competent care (see Chapter 9), and inadequate access to patient language services, among other factors (Box 2.7) (Fig. 2.3). The health care system and the many professionals who serve patients must address these factors and reduce their effect on patients' health so that all patients receive needed care. One strategy is to establish and support policies that positively influence social and economic conditions and support changes in individual behavior (such as pursuing healthful diets and adhering to medication regimens).

Healthy People 2030 (ODPHP, n.d.) aims to promote the nation's health and create a society in which all people throughout the life span can achieve their fullest potential for health and well-being. An important goal is to eliminate health disparities, achieve **health care equity**, and attain health literacy to improve the nation's health and well-being. Nurses practice in a wide variety of settings that require an awareness of the social determinants of health that contribute to health disparities (see Chapter 9). Social determinants of health impact a person's health, overall functioning, and quality of life (Kneipp et al., 2018). Nurses play a key role in promoting access to health care and in providing appropriate education to patients and families to promote healthy development, healthy behaviors, and well-being to all individuals across the life span.

BOX 2.7 Examples of Social Determinants of Health

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Adapted from Office of Disease Prevention and Health Promotion. Social determinants of health. *Healthy People 2030,* n.d., U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Accessed July 2021.

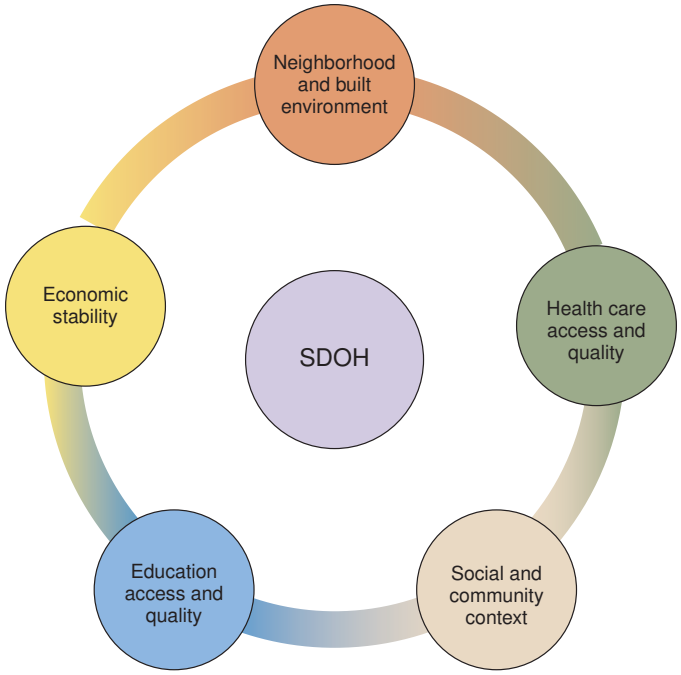

FIG. 2.3 Social determinants of health (SDOH). (From Office of Disease Prevention and Health Promotion [ODPHP]: Social determinants of health. *Healthy People 2030.* n.d., U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.)

REFLECT NOW

Discuss with your clinical group the social determinants of health impacting the community where you are assigned to complete your clinical experiences. How have they created health disparities in the community?

THE FUTURE OF HEALTH CARE

A discussion of the health care delivery system today is incomplete without discussing the issue of change. The current system is in a constant state of change and reform, making it challenging to predict the future but also opening opportunities for improvement (Young and Kroth, 2018). The ultimate issue in redesigning and delivering health care is to ensure the health and welfare of the populations that health care institutions serve. It is predicted that the health care model of the future will have the consumer in the center (Batra et al., 2019). Young and Kroth (2018) reported that the U.S. health care system is a paradox—extreme successes and technological advances offset by limited access, high costs, and quality issues. One example of how the health care landscape is changing is the increasing emergence and reliance on technology and digital health (Batra et al., 2019; Larsen, 2020). Over the last few years, there has been increasing use of telehealth and digital care, with both expected to continue to grow over the next 5 years (Heller, 2019). **Telehealth**, sometimes called telemedicine—is the

use of electronic information and telecommunication technologies (e.g., using cloud-based video conferencing tools) to provide care when a patient and health care provider are not in the same place at the same time (Telehealth.hhs.gov, 2021). All that is needed is access to the internet. Digital technology (e.g., computers and applications using the internet, video cameras, and mobile devices such as smartphones and electronic tablets) is providing patients the first access they will have into health care and with a health care provider, making a "digital front door" (Larsen, 2020). Using digital technology will decrease office visits as they occur today and streamline care for patients (Larsen, 2020). The use of technology will allow health care providers to continually monitor individuals with chronic or major health problems so that interventions can be implemented at the first indication of problems. Artificial intelligence (AI) will be used more to assist in the treatment of diseases through early detection and better understanding of disease progression (Batra et al., 2019). Technology will also help decrease cost of health care and remove the barrier of geography and access to services (Batra et al., 2019). Health care organizations are implementing new and improved technologies that are changing how they provide their services, reducing unnecessary costs, improving access to care, and improving the quality of patient care. Professional nursing is an important player in the future of health care delivery. The solutions necessary to improve the quality of health care depend largely on the active participation of nurses.

KEY POINTS

- An integrated health care system consists of a network of health care organizations that work together to provide a continuum of coordinated health care services to a defined group of people to improve quality of care and control health care costs.
- Each of the six levels of health care describe the types of services and different settings in which health care is delivered to patients in all stages of health and illness.
- Each level of care presents different requirements and opportunities for a nurse. In a primary care setting, nurses are extensively involved in patient assessment, whereas in restorative care settings, nurses know that success depends on their effective and early partnering with patients and their families in planning and care delivery.
- Levels of prevention are not the same as levels of care. Levels of prevention describe the focus of health-related activities in a care setting, such as health promotion and disease prevention (primary prevention) and curing or managing disease (secondary prevention)
- Health care professionals provide patient care in different settings. For example, primary care focuses on health promotion and tends to be provided in community settings, whereas hospitals provide comprehensive secondary and tertiary care to patients who are acutely ill.
- Health care access is influenced by access to hospitals, clinics, and physician offices; availability of transportation; ease in scheduling appointments; availability of appointments when needed; accessibility of specialty services when a referral is made; and clear instructions provided on when and how to get referrals.
- Rural Americans' access to health care is affected by economic factors (rural Americans are more likely to live below the poverty level), cultural and social differences, educational shortcomings, lack of recognition of the problem by legislators, and the isolation of living in remote rural areas.
- Discharge planning begins at admission to a health care agency, helps determine the best place for a patient to go after discharge from the hospital, and creates a smooth transition of a patient's care from the acute care or post–acute care agency to the patient's next environment
- Barriers to effective discharge planning include ineffective communication, lack of role clarity among health care team members, and lack of resources.
- "Pay for Value" ties reimbursement to quality; if hospitals perform poorly in quality scores, they receive lower payments for services from CMS.
- Nurses promote patient satisfaction through providing patient- and family-centered care and applying good interpersonal skills, including courtesy, respect, and good communication skills.
- The nursing shortage is an issue in health care that affects all aspects of nursing (e.g., patient care, nursing administration, nursing education) and opens vast opportunities to nurses. Furthering education and following trends in health care open professional options for nurses.
- Patient-centered care is care that is focused on the patient's preferences, needs, and values and involves the patient in the clinical decision-making process. This type of care is based on the patient's lifestyle and is coordinated with the health care team so that the patient is engaged in the care process.
- Social determinants of health contribute to health disparities, creating differences in the health status of different groups of people in a community. Disparities in health status, particularly in a community in which the majority have poor health, will affect the productivity and vulnerability of a population.

REFLECTIVE LEARNING

- Investigate whether the clinical unit on which you are assigned displays its patient satisfaction data on the unit. If so, review the data and identify areas that, as students, you can work on to help improve patient satisfaction. Discuss with your clinical group.
- Select one of the RN competencies identified in Box 2.5. Develop a plan for improving your knowledge, skills, and attitudes for the competency during your upcoming clinical experience.
- Discuss with your clinical group changes in health care that have occurred in the last 5 years. How have these changes affected how you practice nursing today?

REVIEW QUESTIONS

1. Which activity performed by a nurse is related to maintaining competency in nursing practice?
   1. Asking another nurse about how to change the settings on a medication pump
   2. Regularly attending unit staff meetings
   3. Participating as a member of the professional nursing council
   4. Attending a review course in preparation for a certification examination
2. Which of the following are examples of a nurse participating in primary care activities? (Select all that apply.)
   1. Providing prenatal teaching on nutrition to a pregnant woman during the first trimester
   2. Assessing the nutritional status of older adults who come to the community center for lunch
   3. Working with patients in a cardiac rehabilitation program
   4. Providing home wound care to a patient
   5. Teaching a class to parents at the local elementary school about the importance of immunizations

3. Which of the following statements is true regarding Magnet® status recognition for a hospital?
   1. Nursing is run by a Magnet® manager who makes decisions for the nursing units.
   2. Nurses in Magnet® hospitals make all of the decisions on the clinical units.
   3. Magnet® is a term that is used to describe hospitals that are able to hire the nurses they need.
   4. Magnet® is a special designation for hospitals that achieve excellence in nursing practice.
4. The nurse is working in a tertiary care setting. Which activity does the nurse perform while providing tertiary care?
   1. Conducting blood pressure screenings at a local food bank
   2. Administering influenza vaccines for older adults at the local senior center
   3. Inserting an indwelling catheter for a patient on a medical-surgical unit
   4. Performing endotracheal suctioning for a patient on a ventilator in the medical ICU
5. A nurse is providing restorative care to a patient following an extended hospitalization for an acute illness. Which of the following is the most appropriate outcome for this patient's restorative care?
   1. Patient will be able to walk 200 feet without shortness of breath.
   2. Wound will heal without signs of infection.
   3. Patient will express concerns related to return to home.
   4. Patient will identify strategies to improve sleep habits.
6. Which of the following describe characteristics of an integrated health care system? (Select all that apply.)
   1. The focus is holistic.
   2. Participating hospitals follow the same model of health care delivery.
   3. The system coordinates a continuum of services.
   4. The focus of health care providers is finding a cure for patients.
   5. Members of the health care team link electronically to use the EHR to share the patient's health care record.
7. The school nurse has been following a 9-year-old student who has shown behavioral problems in class. The student acts out and does not follow teacher instructions. The nurse plans to meet with the student's family to learn more about social determinants of health that might be affecting the student. Which of the following potential social determinants should the nurse assess? (Select all that apply.)
   1. The student's seating placement in the classroom
   2. The level of support parents offer when the student completes homework
   3. The level of violence in the family's neighborhood
   4. The age at which the child first began having behavioral problems
   5. The cultural values about education held by the family
8. A nurse is assigned to care for an 82-year-old patient who will be transferred from the hospital to a rehabilitation center. The patient and her husband have selected the rehabilitation center closest to their home. The nurse learns that the patient will be discharged in 3 days and decides to make the referral on the day of discharge. The nurse reviews the recommendations for physical therapy and applies the information to fall prevention strategies in the hospital. What discharge planning action by the nurse has not been addressed correctly?
   1. Patient and family involvement in referral
   2. Timing of referral
   3. Incorporation of referral discipline recommendations into plan of care
   4. Determination of discharge date
9. Which of the following are common barriers to effective discharge planning? (Select all that apply.)
   1. Ineffective communication among providers
   2. Lack of role clarity among health care team members
   3. Number of hospital beds to manage patient volume
   4. Patients' long-term disabilities
   5. The patient's cultural background
10. A nurse newly hired at a community hospital learns about intentional hourly rounding during orientation. Which of the following are known evidence-based outcomes from intentional rounding? (Select all that apply.)
    1. Reduction in nurse staffing requirements
    2. Improved patient satisfaction
    3. Reduction in patient falls
    4. Increased costs
    5. Reduction in patient use of nurse call system

Answers: 1. 4; **2.** 1, 2, 5; **3.** 4; **4.** 4; **5.** 1; **6.** 1, 3, 5; **7.** 2, 3, 5; **8.** 2; **9.** 1, 2; **10.** 2, 3, 5

Rationales for Review Questions can be found on the Evolve website.

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3

Community-Based Nursing Practice

OBJECTIVES

- Explain the relationship between public health and community health nursing.
- Contrast community-oriented nursing with community-based nursing.
- Discuss the role of the community health nurse.
- Discuss the role of the nurse in community-based practice.
- Identify characteristics of patients from vulnerable populations that influence the community-based nurse's approach to care.
- Explain the competencies important for success in community-based nursing practice.
- Discuss how global health impacts the health of a community.
- Identify elements of a community assessment.

KEY TERMS

Community-based nursing center
Community-based nursing
Community health nursing
Community-oriented nursing
Health disparities
Incident rates
Population
Public health nursing
Social determinants of health
Vulnerable populations

MEDIA RESOURCES

http://evolve.elsevier.com/Potter/fundamentals/

- Review Questions
- Case Study with Questions
- Audio Glossary
- Content Updates
- Answers to QSEN Activity and Review Questions

Community-based care focuses on health promotion, disease prevention, and restorative care. Some patients are discharged from acute care settings and require ongoing care outside traditional settings. Patients also require preventive care such as immunizations, screenings, lifestyle teaching, and counseling. Health care delivery has changed greatly over the past few decades, resulting in a growing need to provide health care services where people live, work, socialize, and learn. One way to achieve this goal is through a community-based health care model. Community-based health care is a collaborative, patient-centered approach to provide culturally appropriate health care within a community (Centers for Medicare & Medicaid Services [CMS], 2019). A healthy community includes elements that maintain a high quality of life and productivity, such as access to health services, preventive care, nutrition, safety, physical activity, oral health, and environmental quality (Office of Disease Prevention and Health Promotion [ODPHP], n.d.c). Including interventions that address both mental and physical health is essential for community health programs (CDC, 2018). Nurses directly influence the health and well-being of patients every day and can encourage lifestyle changes within communities (American Nurses Association [ANA], n.d.). As more community health care partnerships develop, nurses are in a strategic position to play an important role in health care delivery and to improve the health of the community.

The focus of health promotion and disease prevention continues to be essential for the holistic practice of professional nursing. Historically, nurses have established and met the public health needs of their patients. Within community health settings, nurses continue to be leaders in making the clinical judgments needed to provide patients public and community health services. Community health nursing and community-based nursing are components of a health care delivery system that improve the health of the general public.

COMMUNITY-BASED HEALTH CARE

Regardless of where you practice nursing, you need to understand the focus of community-based health care. Community-based health care is a model of care that reaches everyone in a community (including the poor and underinsured), focuses on primary rather than institutional or acute care, and provides knowledge about health and health promotion and models of care to the community. Community-based health care occurs outside traditional health care institutions such as hospitals. It provides services to individuals and families in nontraditional settings such as ambulatory care clinics, community hospice centers, senior centers, parishes, and schools. These settings allow those who would not be able to access care in other areas to receive the care they need. Providing necessary care to maintain and restore health decreases vulnerability in at-risk populations.

Today the challenges in community-based health care are numerous. Political policy, social determinants of health, increases in health disparities, and economics all influence public health problems and subsequent health care services. Some of these problems include a lack of adequate health insurance, chronic illnesses (e.g., heart disease and diabetes), substance abuse, an increase in sexually transmitted infections, and underimmunization of infants and children (ODPHP, n.d.c).

Today's leaders in the health care system must commit to reform and bring attention to health promotion and disease prevention and provide health care services to all communities. Many community health programs are trying to decrease disparity by addressing ways to improve quality of care, access to care, and cost (ODPHP, n.d.c).

Achieving Healthy Populations and Communities

The U.S. Department of Health and Human Services Public Health Service designed a program to improve the overall health status of people living in this country. The *Healthy People Initiative* was created to establish ongoing health care goals for the U.S. population (see Chapter 6) to meet the diverse public health needs and to seize opportunities to achieve its goals. Health of the nation is tracked, and goals are updated every 10 years based on data gathered during program evaluation and national health trends. *Healthy People* has become a broad-based public engagement initiative, with thousands of citizens helping to shape it at every step along the way. The overall goals of *Healthy People 2030* are to increase life expectancy and quality of life, attain health literacy, achieve health equity, and eliminate health disparities through improved delivery of health care services (ODPHP, n.d.b). Improved delivery of health care involves three key components: assessment, development and implementation of public health policies, and improved access to care.

Assessment of the health care needs of individuals, families, and communities is the first component. Assessment includes systematic data collection on the population, monitoring of the health status of the population, and accessing available information about the health of the community (Stanhope and Lancaster, 2018). An example of community assessment includes the gathering of information on **incident rates**, such as identifying and reporting new infections or diseases, such as rates for influenza or COVID-19, determining adolescent pregnancy rates, and reporting the number of motor vehicle accidents caused by teenage drivers. A comprehensive community assessment informs the development and maintenance of community health programs aimed at infection control, adolescent sex education, or ways to reduce distractions for teen drivers.

The second component of improved health care delivery is policy. Health professionals provide leadership in developing public policies to support the health of the population (Stanhope and Lancaster, 2018). Strong policies are driven by community assessment. For example, assessing the level of lead poisoning in young children often results in a lead cleanup program to reduce the incidence of lead poisoning. This is the case in Flint, Michigan. Nurses were instrumental as case managers for children exposed to lead but also led public health efforts to lobby for and educate about water filtration and successfully reduced the lead levels (Gomez et al., 2018). Nurses also play an important role in advocating and educating about the nation's opioid epidemic. Strict prescription monitoring programs, as well as referrals and the implementation of evidence-based substance abuse or pain relief treatments, can reduce the abuse of opioids (Becker and Starrels, 2020). Identifying evidence-based practices to help people manage chronic illnesses in the home and the community addresses the needs of nurses and their patients (Coffin, 2020; Croft et al., 2018).

The last component of improved health care delivery is access to care. Improved access to care ensures that essential community-wide health services are available and accessible to all members of a community (Stanhope and Lancaster, 2018). Insurance coverage, geographic availability of care, and the development of relationships with health care providers are essential in establishing access to community-wide health promotion and health maintenance activities (ODPHP, n.d.c). Examples include prenatal care programs and programs focusing on disease prevention, health protection, and health promotion. The five-level health services pyramid is an example of how to provide community-based services within existing health care services in a community (Fig. 3.1). In this population-focused health care services model, the goals of disease prevention, health protection, and health promotion provide a foundation for primary, secondary, and tertiary health care services.

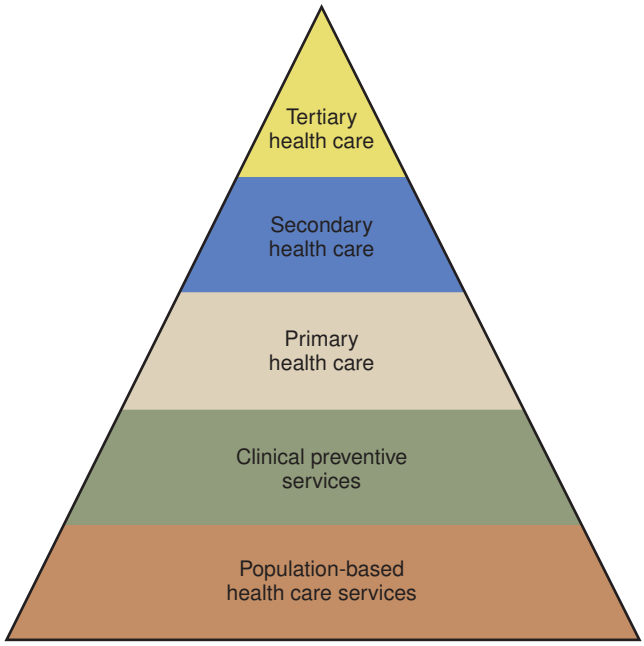

FIG. 3.1 Health services pyramid. (Courtesy U.S. Public Health Service: For a healthy nation: return on investments in public health, Washington DC, 2008, USDHHS.)

A rural community does not always have a hospital to meet the acute care needs of its citizens. However, the community may have the resources for providing childhood immunizations, flu vaccines, and primary preventive care services and is able to focus on child developmental problems and child safety. For example, a nurse completing a community assessment identifies services available to meet the needs of expectant mothers, reduce teenage smoking, and provide nutritional support for older adults. In addition, the nurse also identifies the health care gaps for the community. Community-based programs provide needed services and are effective in improving the health of the community by ensuring that members of the community are aware of the resources that are available.

Public health services aim at achieving a healthy environment for all individuals. Health care providers apply these principles for individuals, families, and the communities in which they live. Nursing plays a role in all levels of the health services pyramid. By using public health principles, you are better able to understand the types of environments in which patients live and the interventions necessary to help keep them healthy.

Social Determinants of Health

Our health is determined in part by access to social and economic opportunities. These include the resources and support systems available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.

Health starts in our homes, schools, workplaces, neighborhoods, and communities. Research shows that taking care of ourselves by eating well and staying active, not smoking, getting recommended immunizations and screening tests, and seeing a health care provider when we are sick all influence our health. However, there are also social determinants of