chapter 1

Caring for Medical-Surgical Patients

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Objectives

1. Describe each of the roles of the licensed practical/vocational nurse (LPN/LVN).
2. Identify 10 sites of employment for LPN/LVNs in medical-surgical nursing.
3. Explain the difference between a health maintenance organization (HMO) and a preferred provider organization (PPO).
4. Differentiate between Medicare and Medicaid in the areas of eligibility and services provided.
5. Describe how hospitals are reimbursed under the diagnosis-related group (DRG) system of Medicare, including care excluded from reimbursement.
6. Discuss four factors that contribute to rising health care costs.
7. Explain how *Healthy People 2020*—as a health promotion and prevention of illness strategy—could decrease health care costs.
8. Define and explain the importance of holistic care.
9. Explain how the nurse-patient relationship is established.
10. Discuss how psychological, social, cultural, and spiritual needs are incorporated in the LPN/LVN's plan of care.
11. Identify the relationship of unmet needs to withdrawn, dependent, hostile, and manipulative behavior.

Key Terms

acuity (ă-KŪ-ĭ-tē, p. 3)
advocate (ĂD-vō-kăt, p. 3)
biomedicine (BĪ-ō-MĔD-ĭ-sĭn, p. 10)
capitation (kă-pĭ-TĀ-shŭn, p. 4)
co-insurance (kō-ĭn-SHŪ-rĕnz, p. 4)
complementary and alternative medicine (CAM) (KŎM-plĕ-MĔN-tĕ-rē ănd ăl-TŬR-nă-tĭv MĔD-ĭ-sĭn, p. 10)
copayment (kō-PĀY-mĕnt, p. 4)
cost containment (kŏst kŏn-TĀN-mĕnt, p. 6)
deductible (dē-DŬK-tĭ-bŭl, p. 4)
delegation (DĔL-ĭ-GĀ-shŭn, p. 3)
dependent (dē-PĔN-dĕnt, p. 9)
diagnosis-related groups (DRGs) (dī-ăg-NŌ-sĭs rē-LĀ-tĕd grūpz, p. 5)
empathy (ĔM-pă-thē, p. 7)
fee-for-service (fē fŏr SĔR-vĭs, p. 4)
health maintenance organizations (HMOs) (hĕlth MĀN-tĕ-nĕnz ōr-gă-nĭ-ZĀ-shŭnz, p. 5)
Healthy People 2020 (HĔLTH-ē PĒ-pl, p. 6)
holistic care (hō-LĬS-tĭk kār, p. 7)
managed care (MĂN-ăjd kār, p. 5)
Medicaid (mĕd-ĭ-KĀD, p. 6)
Medicare (mĕd-ĭ-KĀR, p. 5)
nonjudgmental (NŎN-jŭj-MĔN-tăl, p. 9)
nurse practice act (NPA) (nŭrz PRĂK-tĭs ăct, p. 1)
preferred provider organizations (PPOs) (prē-FŬRD prō-vī-dĕr ōr-gă-nĭ-ZĀ-shŭnz, p. 5)
prospective payment system (PPS) (prŏs-PĔK-tĭv pā-mĕnt sĭs-tĕm, p. 5)
provider (prō-VĪ-dĕr, p. 4)
retrospective payment system (rĕt-rōs-PĔK-tĭv pā-mĕnt sĭs-tĕm, p. 5)
stereotypes (STĔR-ē-ō-tīps, p. 10)
unlicensed assistive personnel (UAP) (un-LĪ-sĕnst ă-SĬS-tĭv pĕr-sō-NĔL, p. 3)

Medical-surgical nursing involves care for adult patients with medical and/or surgical conditions that affect single or multiple body systems. Medical patients have diseases that require a variety of treatments, including medication and diet therapy. Surgical patients require operative procedures to treat diseases and/or trauma. Patients can have a single diagnosis of a medical or surgical condition or a combination of medical and surgical diagnoses.

ROLES OF LICENSED PRACTICAL/VOCATIONAL NURSES

Each state's **nurse practice act (NPA)** defines the role and scope of practice of licensed practical/vocational nurses (LPN/LVNs). Administrative rules and regulations and interpretations of the state's board of nursing provide more *specific* details and clarification. Some NPAs list specifically what LPN/LVNs can do, but

the wording allows for changes in the roles of the LPN/LVN. This eliminates the need for state legislators to reopen the nurse practice act and revise it each time a change is required to accommodate evolving nursing roles. It is your responsibility to be aware of the law of the state in which you are employed. The LPN/LVN cares for patients within the scope of the state's NPA, and upholds clinical standards, provides safe patient care, serves as a patient advocate, teaches patients, and communicates effectively—all while functioning as a collaborative member of the health care team.

Think Critically

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

UPHOLD CLINICAL STANDARDS

Check your institution for guidelines and policies. The facility might restrict the LPN/LVN's role to less than the NPA allows, but **no employer can give nurses permission to do what their license says they cannot do.**

The National Association for Practical Nurse Education and Service, Inc. (NAPNES) and the National Federation of Licensed Practical Nurses, Inc. (NFLPN) are practical/vocational nursing organizations that provide standards to guide the role of the LPN/LVN (see Appendices E and F on Evolve and the Online Resources at the end of this chapter). These standards of practice—which echo the values and priorities of the profession and provide guidelines for safe and competent nursing care—may be used as a basis of prosecution or defense in a court of law.

PROVIDE SAFE PATIENT CARE

In the hospital acute care setting, the LPN/LVN may be engaged in total care for assigned patients, under the supervision of a registered nurse (RN). Total care duties involve being responsible for meeting patients' basic needs, with the goal of making patients as independent as possible to preserve their ability to care for themselves. LPN/LVNs cannot assume the role of the professional (registered) nurse, but they do participate in the nursing process by assisting the RN to assess (gather data on) patients and to plan and evaluate patient care. The LPN/LVN assists with personal hygiene, performs ordered treatments, initiates nursing interventions, and administers drugs. In other situations, the LPN/LVN might be used as a medication and treatment nurse for all patients on a team. If asked to do a procedure or treatment that was not taught in the educational program but is allowed by the NPA (e.g., monitoring blood transfusions), LPN/LVNs can obtain further training and have their new proficiency recorded in their personnel file.

TEACH PATIENTS

An important aspect of nursing care is to teach patients and families to care for themselves or loved ones to prevent complications, restore health, and prevent further illness. LPN/LVNs also teach basic hygiene and nutrition in the context of health promotion. Examples of teaching include reinforcing what the registered nurse or physician advises regarding scheduled diagnostic tests, upcoming surgery, how to treat a wound, or how to change a dressing. Other teaching activities concern how to take prescribed medication, what side effects to report, and the self-care activities and lifestyle changes required to promote rehabilitation and independence. LPN/LVNs contribute to the discharge plan by reinforcing discharge instructions and providing information to patients about community resources and self-help groups.

Think Critically

Recall a time when you *reinforced* patient teaching, and rank your teaching effectiveness on a scale of 1 to 10. How would you improve your performance in another patient teaching situation? Do the same for other patient situations in which you *initiated* health teaching.

COMMUNICATE EFFECTIVELY

Therapeutic communication from the medical professional helps the patient develop trust in the quality of care and decreases anxiety about the medical situation. Therapeutic communication is also used when communicating with staff, especially when making requests. Call staff by name, to ensure their attention, and explain the purpose of the communication. Present requirements of a request and give a time line for completion. Obtain feedback that the request was understood, and provide appreciation for cooperation. Loudspeaker noise from paging systems is annoying to patients. Some agencies try to cut down on noise with wireless communication devices that clip on clothing and allow staff to contact each other, other departments, and physicians.

LPN/LVNs give objective and thorough end-of-shift reports and maintain objective documentation about the care given and the status of patients. Nursing documentation is used to receive approval for length of stay, and reimbursement of facility charges from insuring agencies.

WORK AS A COLLABORATIVE MEMBER OF THE HEALTH CARE TEAM

LPN/LVNs work with other members of the health care team (e.g., physician, RN, physical therapist, respiratory therapist, dietitian, pastoral care team, pharmacy personnel, and unlicensed assistive personnel [UAP]) to provide the patient with an integrated, comprehensive plan of care.

Think Critically

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

ADVOCATE FOR THE PATIENT

Facility and unit routine can lead to an impersonal health care system that loses its focus on patients' rights. The American Hospital Association (AHA) has published *The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities* (2003) (Appendix G). LPN/LVNs **advocate** for patients by standing up for patients' rights and ensuring that their needs are met.

Clinical Cues

If a patient declines A.M. care (bath, brushing teeth, etc.), you can postpone it for a while, as your work schedule allows. You should fit it in before your shift is over. Leaving care to be done on the next shift burdens the oncoming staff, and is not considered acceptable practice. Listen to the patient's reasons for not wanting care. If it appears that care really is being refused for that complete day, talk with the staff nurse or charge nurse about it. The patient has the right to refuse care. Most often, if the benefits of care are explained, you can gain the patient's cooperation. Conferring with more experienced team members can help a new nurse determine when routine can be altered in the patient's best interests.

Advocating for a patient could be as simple as making arrangements for special food or meals at times other than those within the facility routine, or it may entail informing the physician of a patient concern.

Think Critically

If you have had the opportunity to advocate for a patient, briefly describe what happened and how you felt about the effectiveness of your action.

EMPLOYMENT OPPORTUNITIES

Hospital employment involves very ill patients with complex needs (high **acuity** patients) and a fast-paced environment. Employment opportunities vary considerably geographically. The majority of graduate practical/vocational nurses are employed in long-term care, and many nursing jobs continue to move to community-based settings. Other sites of employment are listed in Box 1-1.

Think Critically

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

Box 1-1 Various Sites of Employment for LPN/LVNs

AREAS WITHIN THE HOSPITAL

- Outpatient surgery
- Intermediate care unit (step-down unit)
- Intravenous (IV) therapy team*
- Emergency department

ADDITIONAL SITES FOR EMPLOYMENT OPPORTUNITIES

- Long-term care facility (nursing home)
- Ambulatory care
- Rehabilitation services (extended care, postacute care, subacute care)
- Hospice care
- Adult group homes
- Assisted living facilities
- Homes for developmentally disabled
- Home health care
- Ambulatory clinics
- Medical offices
- Hospice care agency
- Military service
- Dialysis center
- Jails and prisons

*Requires postgraduate education and certification.

EXPANDED ROLES

CHARGE NURSE/MANAGER OF CARE

The most common site of employment for the LPN/LVN is the nursing home or long-term care unit. In this setting, LPN/LVNs frequently assume the role of charge nurse. Many NPAs specifically state that the LPN/LVN charge nurse functions in a nursing home under the general supervision of an RN, who is either on site or is available by phone.

Think Critically

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

Delegation and Assignment

To *delegate* is to transfer authority and to assign is to distribute work. In the LPN/LVN context, **delegation** involves transferring to qualified **unlicensed assistive personnel (UAP)** the authority to perform a selected nursing task or activity in a selected patient situation that is within the job description of the LPN/LVN. **Assignment** involves assigning nursing tasks or activities within the job description of the UAP to a particular individual (National Council of State Boards of Nursing [NCSBN], 2005).

Delegation. Not all states allow LPN/LVNs to delegate nursing tasks or activities, and state NPAs vary greatly concerning protocol for delegation (Box 1-2). Check your state's NPA to determine whether you

Box 1-2 Comparison of Assigning and Delegating by the LPN/LVN Charge Nurse

Ask yourself the following questions:

1. Are tasks/activities in nursing assistant's job description?
   When assigning: Yes.
   When delegating: No. The tasks/activities delegated are in the job description of the LPN/LVN. Specific tasks/activities are not listed. Delegated tasks/activities depend on the nurse practice act and patient situation.
2. May nursing assistant refuse nursing task/activity?
   When assigning: No, unless staff person thinks he or she is unqualified for the task/activity assignment.
   When delegating: Yes. In addition, the nursing assistant must voluntarily accept the task/activity.
3. What accountability is held for nursing task/activity?
   When assigning: The nursing assistant is accountable for completing the task/activity and in a safe manner.
   When delegating: The LPN/LVN is accountable for delegating the right task/activity to the right person.

Adapted from Hill, S., & Howlett, H. (2009). *Success in Practical/Vocational Nursing: From Student to Leader* (6th ed.). Philadelphia: Saunders, p. 288.

may delegate as an LPN/LVN charge nurse in your state. If your state gives you permission to delegate as an LPN/LVN, check if your place of employment gives permission for delegation in the facility's written policies. Delegation is a *voluntary* function. You do not *have* to delegate simply because the NPA and the facility allow it.

Your nursing program might include class material on delegation. However, a position paper from the NCSBN (the group that develops your licensing examination) states that delegation is a complex skill that new graduates are not prepared to carry out. The skill for delegation must be developed in the clinical area after graduation, usually by working with an experienced licensed nurse who serves as a role model and who provides advice and support on delegation (NCSBN, 2005).

During the LPN/LVN program, students learn the activities and procedures they will perform when licensed, and the reasons for performing them. Each patient situation determines which task/activity can be delegated; there is no specific list of tasks that can be delegated. Because a patient's condition can change so rapidly, judgment must be developed with experience as to what and when it is wise to delegate.

The NCSBN's position paper, *Delegation: Concepts and Decision-Making Process* (1995), provides a decision-making process to be used by licensed persons in clinical settings as a guide for delegation of nursing duties. The NCSBN identifies "Five Rights" to include when delegating:

1. *Right Task*—a task that can legally be delegated for a specific patient.
2. *Right Circumstances*—the patient is stable, independent nursing judgment is not required for the task, and resources to perform task are available.
3. *Right Person*—the person asked to perform the task is competent and qualified to do so.
4. *Right Direction/Communication*—objective and specific explanation of what should be done and when, what to report to the delegating nurse and when to make the report.
5. *Right Supervision*—the delegating nurse needs to monitor the performance of the task, to intervene when needed, to evaluate the results of the task, and to provide feedback to the unlicensed person.

Assignment. With heavy LPN/LVN workloads, many tasks may need to be assigned to nursing assistants or other UAP. Such tasks must be within the job description of the person to whom they are being assigned. The LPN/LVN should always consider the advisability of assigning the task; consider carefully another person's ability to carry out the task; and provide information about how the assigned task should be done, what should be recorded or reported, and to whom it should be reported.

TYPES OF HEALTH CARE FINANCING

HEALTH INSURANCE

Health insurance, like any type of insurance, spreads risk among the whole group of insureds. The young and the healthy generally do not claim as much as the elderly for health care, and (if the fee structure is equivalent for all) the young and healthy subsidize (support) the sick and older persons covered by the insurance provider.

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

Capitation, an alternative for fee-for-service payment, involves a set monthly fee charged by the provider of health care services for each member of the insurance group for a specific set of health care

services. If services cost more than the monthly fee, the provider absorbs the cost of those services. At the end of the year, if any money is left over from the unused portions of monthly fees, the health care provider keeps this remainder as a profit.

Group Health Insurance

Group health insurance is a private insurance method of pooling individual contributions with the goal of protecting group members from financial disaster because of health care bills. When insured under a group health plan, an individual is said to have third-party coverage (a middleman), which pays a percentage of the individual's health care bills while the individual pays the balance. Employers offer most group health insurance in the United States (e.g., BlueCross BlueShield).

Managed Care. **Managed care** is a type of group health insurance developed to provide quality health care with cost and care utilization controls. This is accomplished by paying physicians to care for groups of patients for a set fee, and by limiting services. Medical necessity and the appropriateness of health care services are monitored by a utilization review system. Types of managed care systems include **health maintenance organizations (HMOs)** and **preferred provider organizations (PPOs).**

Government-Sponsored Health Insurance

Medicare. **Medicare** is a federal public insurance program that helps to partially finance health care for all persons over age 65 years (and their spouses), who have at least a 10-year (40 quarters) record in Medicare-covered employment, and who are citizens or permanent residents of the United States. Coverage is also given to persons under age 65 who are victims of end-stage renal disease or are permanently and totally disabled. Those eligible because of age or disability are entitled, by law, to the benefits of Medicare programs. In November 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, which is the largest expansion of Medicare since it began in 1965 (Box 1-3).

Before 1983, hospitals submitted a bill to the government for the total charges they incurred for Medicare patients and were reimbursed for the billed amount. Payment was based on actual costs and was called a **retrospective payment system.** The federal government was the first group to try to stop the skyrocketing cost of health care. In 1983, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services [CMS]) adopted a system called **diagnosis-related groups (DRGs)** or illness groups. This system pays hospitals a flat rate for Medicare services, and hospitals now know in advance how much they will be reimbursed by this **prospective payment system (PPS).**

Box 1-3 Basic Components of Medicare

MEDICARE PART A

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

MEDICARE PART B

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

MEDICARE PART C

- Refers to Medicare Advantage plans, such as HMOs or regional PPOs.
- Provides Part A, B, and D benefits to persons who elect this type of coverage instead of the original fee-for-service program.

MEDICARE PART D

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

Under the DRG system, the fee the government will pay for hospitalization depends on the DRG category (illness). Hospitals receive a flat fee for each patient's DRG category, *regardless of length of stay in the hospital;* thus hospitals have an incentive to treat patients and discharge them as quickly as possible. If the hospital keeps the patient longer than the government's fee will cover, and the patient cannot be reclassified in the DRG system, the hospital must absorb the difference in costs. However, if the acute care facility can treat the patient for less than the guaranteed reimbursement amount, *the facility can keep the difference in payment as*

profit. Because Medicare patients, as all patients, are discharged sooner from hospitals than they were in the past, extended care units or skilled care facilities and home care are frequently used to continue convalescence. With the goal of improving quality of care and saving millions of taxpayer dollars each year, Medicare no longer covers specific preventable conditions of hospitalized patients (Box 1-4).

? Think Critically

Should Medicare pay for new, expensive, technological procedures that are developed to treat common medical problems of the elderly? Should cost-effectiveness enter the picture for treating Medicare patients? Explain the reasoning behind your answer.

Medicaid. The **Medicaid** program, which is funded jointly by the federal and state governments, provides medical assistance for eligible families and individuals with low incomes and few resources. The federal government establishes broad national guidelines for the program. Each state establishes its own program services and requirements, including eligibility. Proportionally, Medicaid is the second largest item in state budgets (Box 1-5).

GOALS FOR HEALTH CARE

The United States spends more on health care than any other country, yet approximately 47 million persons in the United States are uninsured. The increase in the elderly population taxes the Medicare system, because chronic illness incidence requires more frequent health care. The impending retirement of "baby boomers" (persons born in the period immediately following World War II) will tax the Medicare system even more. As strains on government support for health care increase, Medicare and Medicaid reimbursements to providers continue to decline.

Many persons are unable to afford health insurance premiums and some covered by a health insurance plan are unable to pay the plan's deductibles and copayments. Some retirees who received health insurance as part of their retirement benefits have had these benefits reduced or eliminated. Advances in technology make noninvasive diagnosis of some diseases possible, and technology helps treat these diseases with fewer complications and side effects, but these technologies are very expensive. The continually increasing costs of medications means that some patients cannot afford prescribed drugs.

Box 1-4 Health Care–Associated Conditions Not Paid for by Medicare/Medicaid

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

Data from *www.cms.hhs.gov/apps/media/press/release.asp?Counter=3041*. Retrieved 29 October 2010.

Box 1-5 The Medicaid Program

- Medicaid is the second largest item in state budgets and covers over 39 million low-income children and parents, many in working families.
- Medicaid is the largest source of health insurance for children in the United States. The State Children's Health Insurance Program (SCHIP) supplements Medicaid by providing coverage for low-income children who are not covered by health insurance and do not qualify for Medicaid.
- Medicaid is the primary source of health and long-term care coverage for low-income individuals with disabilities or chronic illnesses and those who need mental health services and substance abuse treatment.
- Medicaid covers services that Medicare does not cover for low-income Medicare beneficiaries, including long-term care and vision and dental care. Medicare beneficiaries who are also enrolled in Medicaid are known as "dual eligibles."

COST CONTAINMENT

The driving force today in all health care facilities is **cost containment** (holding costs to within fixed limits, while remaining competitive in the health care marketplace). Health care agencies are interested in improving their agency's "bottom line" with business principles that reduce waste and inefficiency. Consumers would like the cost of health care to be reduced while high-quality care and service are maintained. Service, quality, and cost control are attributes of health care that need to be understood and considered in all clinical situations, and the LPN/LVN has the opportunity to identify wasteful practices and inefficient routines in the work setting (Box 1-6).

HEALTH PROMOTION AND *HEALTHY PEOPLE 2020*

Healthy People 2020 is a health promotion and disease prevention agenda by the U.S. Department of Health and Human Services to improve the health of all

Box 1-6 LPN/LVN Role in Containing Health Care Costs in the Work Setting

1. Follow facility policy for charging patients for all supplies used in their care.
2. Follow facility policy for documenting patient care for reimbursement.
3. Organize patient care for effective and efficient use of time. If some aspect of care needs to be "redone," it would have been better and more time-efficient to do it right the first time.
4. Decrease patient length of stay by implementing nursing care to help prevent complications.
5. Meet the patient's needs, not your needs.

From Hill, S., & Howlett, H. (2009). *Success in Practical/Vocational Nursing: From Student to Leader* (6th ed.). Philadelphia: Saunders, p. 325.

people in the United States. It includes a set of health objectives based on the best available scientific knowledge. *Healthy People 2020* has the potential to affect the health of all U.S. citizens and reduce health care costs, but individuals, groups, and organizations must work together to incorporate *Healthy People 2020* into current programs, special events, publications, and meetings. Every LPN/LVN has the responsibility to educate patients about healthy lifestyles and assist the health of their communities through educational health promotion. Nurses can also model healthier lifestyles for their patients by not smoking, maintaining healthy eating habits, and exercising to manage weight.

Health Promotion

***Healthy People 2020* Overarching Goals**

- Attain high-quality, longer lives free of preventable disease and disability, and full of opportunities for progress.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

HOLISTIC CARE OF PATIENTS

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

Focused Assessment

Data Collection for Holistic Assessment

PHYSICAL ASSESSMENT
- List and prioritize assessments/data to be collected for specific medical and/or surgical diagnoses and treatments for the patient.

PSYCHOLOGICAL ASSESSMENT
- What is your greatest concern about this hospitalization?
- Is there anyone you do not want to visit you while in the hospital?
- Who are the significant persons in your life?
- Who is your source of support, for help with problems?
- Do you have any fears that may get in the way of diagnosis and treatment? Closed spaces, darkness, needles, etc.?
- Do you experience problems with eating? Too much? Too little? If so, how much of a weight gain or loss have you had in the past 2 months?
- Do you smoke? How much every day?
- Do you drink alcohol? What and how often?
- What do you do to relieve stressful feelings?
- Do you experience feeling hopeless or very sad? How often and what triggers the feeling?
- Is there anyone in your life who abuses you? Verbally? Physically? If so, describe how.
- Are you sexually active? If yes, are you satisfied with your sex life?

SOCIAL ASSESSMENT
- With whom do you live? How will your admission affect those with whom you live?
- Do you have a personal relationship with someone? If so, are you satisfied with this relationship?
- Do you have children? If so, who will care for your children while you are in the hospital?
- Are you employed? If so, how will your illness/accident/hospitalization affect your job? Do you have sick leave at work?
- Do you have health insurance?
- Who are the persons in your life who can be of help at this time?
- Will you be able to manage at home with bathing, meals, cleaning, laundry, errands, and obtaining your medications and/or needed equipment for your treatments?
- Are there any physical impediments (stairs, tub but no shower, etc.) that will make it difficult at home?

CULTURAL ASSESSMENT
- What are your beliefs or practices for staying well?
- What foods do you have in your diet that help you stay well?
- What foods in your diet help you recover when you are sick?
- Do you use complementary and alternative medicine (CAM)?
- If you use CAM, did you inform your physician of CAM use, including herbals?

SPIRITUAL ASSESSMENT
- How do you cope with problems or difficult situations?
- Do you believe in the power of prayer?
- Do you meditate or read spiritual materials?
- What are your beliefs about a higher power?
- If you have a relationship to a higher power, do you have a religious affiliation? If so, do you want a representative of your religious affiliation notified of your admission?
- Do you have any religious items that you wear on your person?

Meeting Psychological Needs

Use of Empathy. An important part of the nurse-patient relationship is the nurse's ability to display empathy. No one can know or feel what another experiences. **Empathy** involves accurately perceiving the patient's feelings and understanding their meanings, even though the nurse cannot experience the emotional impact of these feelings as the patient does.

No one can know or feel what another experiences, but empathy displays appreciation for what the other person is feeling.

The empathetic nurse conveys the interpretation of the patient's feelings back to the patient, for validation of their accuracy. In this way, the patient's feelings are valued and accepted as legitimate responses. An example of an empathetic statement by the nurse is, "You seem upset about your surgery tomorrow." In contrast, sympathy involves entering into feelings with patients and is displayed by sorrow and concern. An example of a sympathetic statement by the nurse is, "You poor thing. I had that surgery."

Patients judge their health care experiences by the nature of the help they receive. Scores on patient satisfaction surveys drop when care is impersonal.

Promote a Therapeutic Nurse-Patient Relationship. The focus of the nurse-patient relationship is on the patient's problems and needs. The relationship is therapeutic, because it provides the patient with the help needed for healing or for a return to wellness. In comparison, a social relationship is not goal-directed, exists primarily for pleasure, and meets the needs of each person in the relationship. LPN/LVNs need to maintain boundaries when working with patients. Avoid using patient contact to meet personal needs (e.g., the need to be liked, for friendship, or for approval). LPN/LVNs need to develop awareness of their own personal needs, and to realize that those needs are appropriately met outside their professional roles, within their personal lives.

The nurse-patient relationship ends when the patient is discharged. Avoid the temptation to continue the relationship on a social basis, which means not allowing the exchange of addresses, phone/cell numbers, or e-mail addresses. It is not beneficial to patients to stay in contact with their nurses after discharge. Sometimes patients want to present nurses with gifts at the time of discharge. Check facility policy regarding this practice.

Establish trust. To develop a therapeutic relationship, trust needs to be established between patient and nurse. In today's health care system, time with patients is limited and each patient contact must be fully utilized. Knock before entering the room, give your name, identify yourself as a nursing student or LPN/LVN, and give the reason for your visit. Call patients by name and preferred title, explain how long you will be on duty, advise when meals arrive and when to expect physicians to visit, and so on. Explain what care will be given on the shift and when it will be offered.

Many older patients are not accustomed to the informality of having strangers address them by their given (first) name. Clarify how the patient would like to be addressed. Put the patient at ease with a pleasant, unhurried approach. Other behaviors to establish trust follow.

Use therapeutic communication skills. Communicate at the level of the patient's understanding. Active listening helps the patient express needs and feelings. Ask patients what they think and actively listen to their answers, as well as to their concerns and fears. Avoid judging the message or the patient. Avoid forming a response while the patient is speaking. Rephrase the message when the patient is finished, to verify that you understand the message. Make sure the patient's and your verbal and nonverbal communication are congruent. Answer all the patient's questions, when possible. Admit when you do not know the answer to a question, and find out and deliver the answer as soon as possible. The focus needs to be the physical and mental well-being of patients and the development of trust. Thank the patient for cooperation and attention. Avoid gossip, arguments, and complaints within patients' range of hearing. Patients may think that because staff cannot get along with each other, they cannot focus on the patients' needs.

Maintain patients' self-esteem. A major problem for patients of any age is the loss of self-esteem. In a health care setting, patients sometimes may be viewed as problems. Patients are sometimes dealt with as an illness (diagnosis) or as a behavior, instead of as a person who happens to have a particular illness or behavior. How often have you heard a patient referred to as "the hip fracture in 205" or "the depressed woman in 305"? Nurses and physicians are especially guilty of this demeaning practice. Some patients are talked down to, coddled, or treated as though they have no strengths. Identify the strengths of patients and find a way to support those strengths and thereby sustain patients' self-esteem.

? Think Critically

If you have experienced an illness or injury or have a chronic illness, have you ever been treated in a demeaning way? How did it make you feel? How would you have liked to have been treated?

Display competence. A skilled and competent nurse builds a patient's confidence, which decreases a patient's anxiety. Focus on the patient and explain what procedures entail and what to expect before starting treatments. Patients expect nurses to be competent when performing treatments and have necessary equipment at hand before beginning a procedure. Leave the patient's environment clean and orderly after procedures.

Ensure pain control. Many nursing actions help to decrease patient stress, but pain control is an especially important action. Anticipate patients' pain control needs before they are expressed—for example, before painful procedures are administered, and before ambulating after surgery or a long illness. Assess the need for further pain medication before the next dose is due and determine whether the medication is effective. If pain medicine is not doing its job, speak to the physician

and get the order changed. Give a back rub along with pain medication, when appropriate, for added relief.

Display compassion. Displaying compassion is considered "low-tech nursing," because no degree, advanced training, or increase in unit budget is required to display kindness and patience to patients. Treat patients with common courtesy, and see them as unique individuals worthy of respect. All health care workers need to be aware of the rights of the patient (see Appendix G). A good starting point is to view the patient as someone's spouse, relative, friend, or parent.

Use therapeutic touch. Touch can be reassuring, calming, and encouraging to patients. In this era of threats of sexual harassment, some nurses may be afraid to touch patients. Ask if touch is OK or touch an arm or a hand and be aware of the patient's reaction, to see if this gesture is acceptable. Be aware of cultural taboos about being touched.

Elder Care Points

- Please treat me with respect. Avoid treating me as if I have a mental impairment until you clarify by looking on my chart that I do have one. Avoid shouting at me until you clarify that I have a hearing deficit. Regardless, speak in a normal volume, with a medium to low pitch, and enunciate clearly.
- Be patient with me. It might take me longer to get out of bed, to walk to the bathroom, or to answer your repeated questions. If you need to give me information, give it to me slowly, and ask for feedback to see if I understood. It would help if you gave me printed information to read.
- If my family or friends are with me and you want information about me, ask me and let me speak for myself. Also, I want to be included in decision making and planning for my care. Ask me if I would mind being hugged or touched before you do so. If I don't mind, avoid patting me on the head like a child; that is demeaning. Be patient when I talk too much. I may be lonely. Treat me in a way you would want your mother, grandmother, or grandfather treated, or treat me as you would want to be treated if you were in my situation.

Patients Who Display Difficult Behaviors. A patient who is physically ill is also affected emotionally by the illness or injury. It is not unusual for patients to display behavior that is not their usual manner. Patients' emotional needs and the resulting behaviors are usually temporary and related to the stresses of illness. Occasionally, patient behavior is related to underlying disorders that will benefit from a psychiatric consultation or treatment (see Chapters 46 through 49). Even patients whose primary illness is a physical rather than psychological disorder can sometimes express emotional discomfort through **dependent,** withdrawn, hostile, or manipulative behavior. They may behave in ways that are confusing and are uncomfortable for the nurse who is not prepared to intervene effectively.

It is easier to deal with patients' behaviors if you understand that their responses to a particular situation are the best they are capable of offering at that particular time. The task of the nurse is to recognize that patients' behavior results from the demands being placed on them at the moment. Appropriate nursing responses require kindness, understanding, and sometimes firmness. People may become childlike and fearful when they are ill or act as if they are unaffected by their illness. Patients appreciate having someone available to guide them through their ordeal in a therapeutic manner.

Think Critically

When you were assigned to a patient who had a manipulative pattern of behavior, did the patient remind you of someone you know personally? Ask yourself, did you "hang that person's face" on this patient, and respond to the patient accordingly? What was the result?

Meeting Social Needs

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

Think Critically

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

Meeting Cultural Needs

Health care must accommodate patients of many cultural backgrounds. Patients may think and behave differently because of social class, religion, ethnic background, minority group status, marital status, or sexual preference. Avoid making judgments about people who are culturally different. Nurses should be open-minded and **nonjudgmental,** taking differences at face value, accepting people as they are, and giving high-quality care.

Think Critically

Can you give examples of judgmental behaviors you observed in staff members during your clinical rotation?

The philosophy of individual worth is the belief in the uniqueness and value of each human being. Nurses need to realize that individuals have the right to live according to personal beliefs and values *as long as those beliefs and values do not interfere with the rights of others and are within the law.*

Nursing students sometimes think that somewhere there is a recipe book that will tell them how to care for people who are different from themselves. Applying information to all individuals in a group can lead to assumptions, which are called **stereotypes.** A stereotype is a generic simplification used to describe all members of a group, without exception. Stereotyping provides an expectation that all individuals in a group will act in a particular way in a given situation, simply because these individuals are members of a cultural group. Stereotypes ignore individual differences that each person in every cultural group possesses. Members of any culture may have modified the degree to which they observe the values and practices of their culture. Information about cultural groups can help explain—but cannot predict—individual behavior.

Cultural Considerations

Cultural Preferences

- People from the Philippines may be shy and feel awkward in unfamiliar surroundings. They may give little direct eye contact. A family member should be allowed at the bedside at all times. The patient may be reluctant to venture out of the room to ambulate.
- Many Cambodians believe that the soul resides in the head and it is inappropriate to touch their heads without permission. Ask before touching the head when changing head dressings or applying eyedrops.
- Hmong from Southeast Asia prefer their own relatives as interpreters and may not trust a hospital-employed interpreter. The interpreter should be of the same sex as the patient, as neither Hmong men nor women may discuss or admit to intimate problems to an interpreter of the opposite sex.

When disease strikes, people may blame pathogens (germs), spirits, or an imbalance in the body. Some cultural groups have folk medicine rituals or special procedures to address maladies (e.g., rubbing the skin with the edge of a coin to release the toxins causing illness). Some groups have special persons who are charged with curing disease (physician, herbalist, shaman, or curandero). Some groups believe that special foods, or food combinations ("cold" foods for "hot" illness), or herbs (echinacea, feverfew) can prevent or cure illnesses. Others see no relationship between the diet and health. Some patients consider the prevention of illness as an attempt to control the future; they may wonder about the necessity to see a health care provider for preventive care (e.g., immunizations). Different beliefs of patients need to be respected.

Biomedicine. **Biomedicine** is the dominant health system in the United States and focuses on symptoms. The goal of biomedicine is to find the cause of disease and to eliminate or correct the problem. However, many Americans use methods that focus on the whole body—and not exclusively on symptoms—when treating disease.

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

Meeting Spiritual Needs

Spirituality is an essential part of being human. A person's spirit may be thought to incorporate the beliefs and values that provide strength and hope, awareness of self (including inner strengths), and understanding of life's meaning and purpose. Patients have a spiritual self with spiritual needs, and patients may use spiritual practices to meet those needs. Examples of personal spiritual practices may include gardening, reading inspirational books, listening to music, meditating, praying, communing with nature, practicing breathing techniques, volunteering, expressing gratitude, and counting blessings.

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

Crisis situations frequently surface in acute health care situations. Patients' beliefs and values can profoundly affect their response to these crises, attitude toward treatment, and rate of recovery. The need for spiritual care for patients and families may be intensified by hospitalization, pain experiences, chronic or incurable disease, terminal illness, or the death of a loved one (Box 1-7).

The pastoral care team allies with nurses in providing spiritual care for patients, but pastoral care workers do not relieve nurses of their responsibility to provide spiritual care. Follow agency policy for arranging visits of patients' clergy or spiritual advisors, when such visits are desired. Agency policies vary, and pastoral care policies are being tested nationwide.

Box 1-7 Spiritual Care Interventions

- Ask open-ended questions—ones that cannot be answered by "yes" or "no."
- Actively listen to the patient. Sit beside the patient. Make eye contact, if culturally appropriate.
- Be nonjudgmental of patients and their responses.
- Avoid giving advice or a lecture to the patient.
- Avoid being a proselytizer (a person who tries to convert another person to his or her own religion).
- Be aware of nonverbal messages from the patient.
- Understand the feelings of the patient but avoid adopting those feelings.
- Expect to learn from patients.
- Stay with the patient after the patient has received an unfavorable diagnosis.
- When patients request help with prayer, offer to pray with them if you are comfortable doing so.
- When the patient requests help with specific readings, offer to read to the patient.
- Assist the patient to participate in desired spiritual/religious rituals.
- Protect the patient's spiritual/religious articles. Do not remove them if they are being worn, unless required by emergency.

Adapted from Hill, S., & Howlett, H. (2009). *Success in Practical/Vocational Nursing: From Student to Leader* (6th ed.). Philadelphia: Saunders, p. 208.

Get Ready for the NCLEX® Examination!

Key Points

- Medical-surgical nursing is a vast nursing specialty that involves care for adult patients with medical and/or surgical conditions that affect one or more body systems.
- The most common site of employment for the LPN/LVN as charge nurse is the nursing home/long-term care facility.
- Qualities and skills needed by LPN/LVNs for medical-surgical nursing include upholding clinical practice standards, providing safe patient care, teaching patients, communicating effectively, working as a collaborative member of the health care team, and advocating for the patient.
- Each state's nurse practice act (NPA) defines what the LPN/LVN can and cannot do in practice, including delegating from the position of charge nurse.
- Assignment involves allocating tasks to unlicensed personnel—when those tasks are within their job descriptions, and once the patient has been declared stable.
- Delegation involves designating duties to unlicensed personnel that are in the job description of the LPN/LVN, are within the boundaries of the nurse practice act, and are advisable considering the patient situation.
- The fee-for-service method of financing health care services has been challenged by the capitation method of financing those services.
- Medicare and Medicaid are examples of government-sponsored health insurance in the United States.
- To help curb rising health care costs, the federal government adopted a payment system called diagnosis-related groups (DRGs) as part of Medicare.
- To help curb costs and increase the quality of care, Medicare will not reimburse for some conditions unless those conditions exist at the time of admission.
- The driving force in health care facilities is cost containment. LPN/LVNs play a role in containing health care costs in the work setting.
- Holistic care includes being aware of the physical, psychological, social, cultural, and spiritual needs of patients.
- The nurse-patient relationship is therapeutic and goal-directed, and ends when the patient is discharged.
- Trust is established with patients by using therapeutic communication skills, maintaining the patient's self-esteem, displaying competence in providing care, and displaying compassion for patients.
- The patient with a physical illness is also affected emotionally and may display dependent, hostile, or manipulative behaviors.

Additional Learning Resources

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

evolve Go to your Evolve website (http://evolve.elsevier.com/deWit/medsurg) for the following FREE learning resources:

- Animations, audio, and video
- Answers and rationales for questions and activities
- Concept Map Creator
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions and Exercises and more!

Online Resources

- *Healthy People 2020,* www.healthypeople.gov
- National Council of State Boards of Nursing (NCSBN), www.ncsbn.org/Joint_statement.pdf
- National Federation of Licensed Practical Nurses (NFLPN), www.nflpn.org/practice-standards4web.pdf

Review Questions for the NCLEX® Examination

1. On initial assessment, the patient is found to be quite interested in asking questions about the nurse, evades personal questions, and is often silent while making no eye contact. These characteristics are more likely to be found in which behaviors?
   1. Withdrawn
   2. Manipulative
   3. Dependent
   4. Hostile

2. Which statement made by a patient strongly indicates dependent behavior?
   1. "I can do this by myself. I do not need help."
   2. "I will try to do this and will ask for help if needed."
   3. "Would you help me if I am not able to do it myself?"
   4. "I'm tired and I'd rather you help me dress."

3. A patient must decide between HMO or PPO health care plans that her employer offers. Which statement best describes coverage of the HMO plan?
   1. "All heath care bills are covered except yearly mammograms, annual physical exams, and routine colonoscopies."
   2. "Patients can only see physicians hired by the HMO whenever a visit or treatment is required—no exceptions."
   3. "I will have to pay a fixed monthly fee and a co-payment for each doctor's visit regardless of treatment needed."
   4. "I will have to pay charges as I leave the doctor's office and send the bills to the HMO for reimbursement."

4. Which condition is not paid for by Medicare if it develops after hospitalization?
   1. Hypokalemia
   2. Heart attack
   3. Hip fracture
   4. Meningitis

5. If the nurse is caring for a patient with an indwelling urinary catheter, which task can be delegated to the nursing assistant?
   1. Providing perineal care each morning and evening
   2. Collecting a urine specimen for laboratory testing
   3. Irrigating the catheter to ensure patency
   4. Instilling antibiotics for a urinary infection

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

7. The nurse finds a confused patient with a history of falls attempting to get out of bed. To maintain the patient's self-esteem and safety, the nurse's intervention should be to:
   1. apply physical restraints to keep the patient in bed.
   2. administer sedatives per doctor's order.
   3. install a bed alarm to notify staff.
   4. discover what the patient is searching for.

8. After providing discharge instructions to a patient following knee replacement, which statement by the patient indicates a need for further teaching?
   1. "I will wash my hands before changing my dressing."
   2. "I will be on strict bed rest to allow my knee to heal."
   3. "I will take analgesics before the pain gets worse."
   4. "I will be able to eat and drink as usual."

9. What should the nurse do before delegating a specific task? *(Select all that apply.)*
   1. Know the scope of practice.
   2. Be aware of the staff person's competency and experience.
   3. Seek approval from the facility administration.
   4. Determine stability of the patient's condition.
   5. Provide adequate explanation and oversight of the task.

10. The patients states, "I'm worried about this procedure." Which statement(s) would be therapeutic? *(Select all that apply.)*
    1. "You poor thing. I had a similar surgery."
    2. "You seem upset regarding your procedure."
    3. "Can you tell me what you mean by that?"
    4. "You will be fine. Your doctor is the best."
    5. "I will hold your hand during the entire procedure."

Critical Thinking Questions

Scenario A

During your clinical rotations, your instructors will schedule a clinical evaluation. Thinking about your clinical experience to date, consider the following.

1. What are your strong areas within the roles of the LPN/LVN? Give example corresponding behaviors for each role.
2. What are the roles of the LPN/LVN and corresponding behaviors for areas where you feel you need improvement?
3. What behaviors are necessary to improve the above roles during the rest of the medical-surgical rotation?

Scenario B

The U.S. federal government is faced with budget problems resulting in large deficits and the need to reduce spending. Congress suggests reducing spending by cuts in the Medicare and Medicaid programs. The congressional representative for your district asks for your opinion and your rationale in answer to each of the following questions.

1. Should Medicare pay the cost of coronary bypass surgery for an active 85-year-old person?
2. Should Medicaid pay for care in an extended-care facility for an 88-year-old person who has suffered a stroke and is long-term comatose?
3. Should Medicare or Medicaid pay for lifestyle prescription drugs (e.g., Viagra) for men eligible for these programs?

Scenario C

Bill Boyd, age 72, was surprised at the aloofness of the admission clerk as she "entered" him into the electronic system for a total knee replacement, his first hospital experience. Two personnel who assisted him to his assigned room called him "Bill." Neither introduced themselves or indicated the role they played in his admission. While wearing a patient gown with the opening down the front and waiting for a nurse to interview him, people kept coming into his room without knocking. One asked his wife if he drank coffee or tea with his meals. That night, the sound of TVs, the click and beep of machines, and staff talking in the halls prevented him from getting a good night's sleep before surgery.

1. List the things that went wrong with Mr. Boyd's admission-day experience.
2. Describe how you would have made admission day a better experience.
3. Explain the reasons for the things you chose to do differently.

Scenario D

Mario Villanuevo, a Mexican American, has a fracture of the right femur and is in balanced suspension traction. Neurovascular assessments are indicated every shift. The LPN/LVN documents that Mario moves the toes of his right foot on command and can feel the nurse touch different aspects of each toe. The pulse in the dorsalis pedis artery of the right foot is palpable and the foot is warm to touch. The LPN/LVN is unable to note any color changes because of the patient's dark skin tone.

1. How can the LPN/LVN student assess color of any patient who has dark skin tone?
2. What should the LPN/LVN student do if there is a question about finding the dorsalis pedis pulse?
3. If sensation is diminished, what should the LPN/LVN student do?

chapter 2

Critical Thinking and the Nursing Process

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Objectives

Theory

1. Explain what critical thinking is in your own words.
2. Describe how critical thinking affects clinical judgment.
3. Discuss why nurses in all programs must learn to think critically.
4. Clarify your role in nursing process according to your state's nurse practice act.
5. Explain three fundamental beliefs about human life as the basis for nursing process.
6. Identify the source for LPN/LVN standards for nursing practice.

Clinical Practice

1. Explain how factors that influence critical thinking are experienced by you during patient care.
2. Provide a clinical example of how nursing process is used in the care of medical-surgical patients.
3. Provide an example of each of the following techniques of physical examination: inspection and observation, olfaction, auscultation, and percussion.
4. Prepare a list for beginning-of-shift assessment for a specific patient.
5. Write an example of a patient goal that is realistic, measurable, and time-referenced.
6. Differentiate between nursing orders and medical orders.
7. Explain the value of identifying the patient's actual problems that lead to nursing diagnoses.
8. Provide a clinical example of a bundle used to reduce the incidence of a deadly infection.
9. Explain the purpose of National Patient Safety Goals.
10. Explain how core measures relate to clinical care.

Key Terms

auscultation (ăw-skŭl-TĀ-shŭn, p. 20)
bundles (p. 16)
congruent (kŏn-GRŪ-ĕnt, p. 20)
Core Measures (p. 17)
critical thinking (p. 14)
data collection (DĀ-tă, p. 15)
evaluation (ĭh-văl-ū-Ā-shŭn, p. 15)
expected outcomes (p. 26)
goals (p. 26)
implementation (ĭm-plĭ-mĕn-TĀ-shŭn, p. 15)
inspection (p. 20)
interdisciplinary (collaborative) care plans (kŏ-LĂB-ĕr-ă-tĭv plănz, p. 27)
National Patient Safety Goals (NPSGs) (p. 16)
North American Nursing Diagnosis Association International (NANDA-I) (p. 24)
nursing diagnosis (p. 24)
nursing interventions (p. 26)
nursing process (p. 16)
objective data (ŏb-JĔK-tĭv DĀ-tă, p. 17)
observation (p. 20)
olfaction (ōl-FĂK-shŭn, p. 20)
palpation (păl-PĀ-shŭn, p. 20)
percussion (pĕr-KŬ-shŭn, p. 20)
planning (p. 15)
priority setting (p. 24)
subjective data (sŭb-JĔK-tĭv DĀ-tă, p. 17)

Critical thinking is a method for solving problems. In nursing practice, critical thinking incorporates the scientific method and always asks, "Is there a better way?" Developing critical thinking skills is a lifelong process and, as you practice the knowledge you are gaining, you become more skilled at thinking critically and applying new knowledge to patient care.

CRITICAL THINKING AND CLINICAL JUDGMENT

Critical thinking applied to clinical judgment in practical/vocational nursing can be described as:

- Purposeful, informed, and outcome focused (results oriented), requiring careful identification of patient problems, issues, and risks, and makes accurate