Exam 4 Study Guide – Spring 2021

While this exam is over the content in DHW Chapters 12, 22, 23, 24, & 25 and ATI Chapter 5 & 9 (pp 81-83), it utilizesd material you have already been tested over as we now look at implementing nursing practice in the community and with special populations. So some of the topics on this study guide will require that you utilize the knowledge/material covered previously e.g. social determinants of health, health disparities, health promotion, levels of prevention, nursing diagnosis process, Health People 2020, data sources, epidemiology.

DHW: Ch.12	Care management, case management, :& Home healthcare-PPT/Lecture/Discussion	ATI: Ch. 5 & Ch 9 pp 81-83

1. What is case management indicated for?

- Care management and case management can be used across the continuum of health from acute care to care within community.
- The development and coordination of care for a selected client and family.
- An integrated collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.
- Case management nursing is indicated for a variety of health care settings, and includes the following:
  - Promoting interprofessional services and increased client/family involvement.
  - Decreasing cost by improving client outcomes.
  - Providing education to optimize health participation.
  - Reducing gaps and errors in care.
  - Applying evidence-based protocols and pathways.
  - Advocating for quality services and client rights.

2. What are the roles of the case manager? What are the limits of the roles?

- Advocacy and education
  - Ensuring that the client has a representative who can speak up and represent their needs for needed services and education.
- Clinical care coordination/facilitation
  - Coordinating multiple aspects of care to ensure that the client progresses.
- Continuity/transition management
  - Transitioning of the client to the appropriate level of care needed.
- Utilization/financial management
  - Managing resource utilization and reimbursement for services.
- Performance and outcomes management
  - Monitoring and, if needed, intervening to achieve desired goals and outcomes for both the client and the hospital.
- Psychosocial management
  - Assessing and addressing psychosocial needs, including individual, familial, and environmental.
- Research and practice development
  - Identifying practice improvements and using evidence-based data to influence needed practice changes.

3. **What are the actions of the discharge planning process?**
   - **Discharge planning is an essential component of the continuum of care and is an ongoing assessment that anticipates the future needs of the client.**
   - **Discharge planning requires ongoing communication between the client, nurse, providers, family, and other members of the interprofessional team.**
     - **The goal of discharge planning is to enhance the well-being of the client by establishing appropriate options for meeting the health care needs of the client.**
   - **Discharge planning begins at admission.**

4. **What does the home health nurse assess for regarding safety in a home?**
   - **Medication Errors**
     - **The risk of errors associated with medications are inherently high.**
     - **Medications may be taken incorrectly (wrong medication, wrong route, wrong dose) and may have adverse effects or interactions.**
     - **These negative side effects include hypotension/bradycardia/syncope, dizziness, ataxia, adverse bleeding, confusion/sedation, and urinary urgency.**
     - **Taking the wrong medication/wrong dose/wrong route can occur because of errors in prescribing, errors in transcribing during the referral phase of the home care visit process, and errors in hearing the medication order; patient and family confusion; pharmacy errors; and cultural beliefs.**
     - **Although all of the various kinds of medication errors can occur in hospitals as well as homes, there are some unique circumstances that make home care medication safety particularly challenging.**
     - **Sometimes, in the freedom of their own home, patients refuse to take medications, forget to take medications, do not fill prescriptions because of cost, lack of knowledge about how to renew a prescription, or lack of access to a pharmacy.**
     - **Sometimes, medication errors occur because of multiple physician involvement in care, transitions from hospital to home, patient or family error, or the use of over-the-counter (OTC) drugs in addition to prescribed medication that may cause adverse reactions.**
     - **On average, community-dwelling elders use 4.5 prescription medications at any giving time in addition to OTC drugs.**
     - **A mean of 10.4 medications prescribed to patients at time of hospital discharge, supporting the frequency with which polypharmacy is occurring at time of hospital discharge.**
     - **Adverse reactions included death, falls/confusion/sedation, adverse bleeding, inappropriate/ineffective treatment, disease exacerbation, emergency department visits and/or rehospitalizations, and ineffective pain control.**
     - **At the initial home visit, it is important for the home care nurse to develop a medication profile that is accurate and will be reviewed at each visit.**
     - **It is critical to talk about the use of prescribed medications with OTCs and herbal supplements, and develop a plan that includes the patient and family being vigilant about medication safety.**

   - **Falls**
     - **Falls are a major health problem in home care.**
     - **One-third of older adults fall every year with serious consequences that include**

death, fractures, and head injuries.

- **For the elderly, there are even more consequences when a fall is sustained.**
- **These include an ongoing fear of falling, loss of function and mobility, disability, restriction of activity, decreased independence, increased social isolation, depression, and nursing home placement.**
- **Fifty-five percent of fall-related injuries occur inside the home.**
- **The most common rooms where people fall include the living room (31%), bedroom (30%), kitchen (19%), bathroom (13%), and hallway (10%).**
- **Fall rates for the elderly are related to intrinsic and extrinsic factors.**
- **In the context of the first home visit, many of these factors are modifiable.**
- **For example, the home care nurse can make plans with the family or home care agency to make environmental modifications that can decrease the chance of a fall.**
- **For example, this may involve having handrails installed in the bathroom and removing scatter rugs or putting nonskid pads under them.**
- **The initiation of an exercise program, medication adjustments, and the management of pain, orthostatic hypotension, and corrected vision all can begin at this first visit.**

➢ **Abuse and Neglect**

- **Unfortunately, in community settings, there can be instances when patients and family members can be victims of abuse and neglect.**
- **This is often hidden until home care nurses or other home care personnel enter the home and observe the potential, or actual, abuse, or neglect.**
- **In thinking about the difference between abuse and neglect, there are not only subtle differences between the two conditions but also differences in motivating factors behind the situations.**
- **Some authors define *abuse* as blatant disregard for the safety and welfare of a patient versus neglect as a chronic, eroding lack of physical, psychosocial, and spiritual support of another.**
- **Abuse can be physical, emotional (often in the form of verbal abuse), and, especially with the elderly, financial.**
- **This is often true when caregivers are responsible for the financial management of the household.**
- **Neglect is not always the responsibility of others.**
- **Some patients, for a variety of reasons that include diagnosed and undiagnosed depression, can be victims of self-neglect.**
- **Self-neglect can take the form of not taking care of personal hygiene, refusing to take medications that may improve their physical or mental condition(s), and refusing to eat.**
- **Abuse and neglect are sometimes motivated intentionally, but more often they can be unintentionally present as issues for patients.**
- **This is the case particularly with neglect and self-neglect.**
- **Extenuating circumstances may involve a lack of knowledge (not being aware of the resources in the community that are available to help with a situation).**
- **One important cautionary note is that home care nurses need to be careful about making judgments related to identifying abuse and neglect involving patients and families.**
- **Consideration must be given to cultural beliefs, lack of caregiver knowledge and/or**

skill, caregiver burden or lack of support, well-intended but misguided care, and patient autonomy and the right to self-determination.

5. How does the home health nurse increase compliance by the client(s)?
   - ➢

6. Which areas of a home have the highest safety concerns?
   - ➢ The most common rooms where people fall include the living room (31%), bedroom (30%), kitchen (19%), bathroom (13%), and hallway (10%).

7. What key factors influenced the development of current home healthcare?
   - ➢

8. Where do regulations for home health care come from?
   - ➢ Home healthcare is regulated by the state and federal government.
   - ➢ Insurance companies generally align themselves with the regulations stipulated by these governments but may have their own rules and regulations.
   - ➢ Home health agencies are certified through a process in which stipulated conditions must be present for the agency to give services to the public and receive payment for those services.

9. What are the criteria an individual needs to meet to receive Medicare or home health services?
   - ➢ Homebound
     - Homebound refers to a condition based upon how difficult it is for a patient to leave the home.
     - To leave home must require a taxing effort and must be related to maintaining health and personal care.
     - Determining a patient's homebound status is primarily a way reimbursement systems qualify the severity level of an illness for which they will pay for services.
   - ➢ A Plan of Care
     - A plan of care is an agency-generated written document that is guided by a lengthy assessment.
     - The accuracy needed to complete this assessment is critical because each assessment item becomes the standard from which patient outcomes are measured.
   - ➢ Skilled Needs
     - Skilled needs refer to the needs of the patient that are accomplished through the professional abilities of registered nurses or their supervised designees.
     - This includes skilled observation, assessment, teaching, management, and evaluation of a variety of conditions and situations.
   - ➢ Intermittent Care Needs
     - Intermittent care refers to a situation in which skilled care is usually provided over several hours during the day several days during the week for a specified time period.
     - Medicare requires the specified time period to be 60 days with appropriate renewals if skilled needs continue to exist.

- **Necessity**
  - **Medical necessity means that the service given by a home care agency is reasonable based on the status of the patient.**
  - **For example, it would be unreasonable to schedule daily visits to the home of patients who have learned to use a glucometer to test their blood glucose levels effectively.**
  - **It would be reasonable to visit twice a week for two weeks to see if the patient is conducting the blood glucose test correctly and accurately.**

10. **What are the standards of care as outlined in the Scope and Standards of Home Health Nursing Practice document?**
    - **Evaluating quality of care.**
    - **Evaluating their performance in the agency or home care work in which they are involved, maintaining current competency.**
    - **Helping develop nursing students and other colleagues who aspire to become home care nurses, as well as collaborating with others in the care of home care patients.**
    - **Being ethical in their practice, as well as using evidence-based practice in their encounters with patients and families.**

11. **What are the 5 phases of a home visit?**
    - **Initiating the visit**
      - **Community health nurses initiate home visits for a variety of reasons.**
      - **Many home care agencies receive referrals from physicians or their designees (discharge planners from other healthcare institutions).**
      - **Referrals can be sent to home health agencies at any time (24/7).**
      - **Generally, home care agencies make sure that an initial visit is made within 24 hours after receiving a referral.**
      - **The patient's situation must satisfy the reimbursement criteria mentioned earlier if Medicare funding is to be used.**
      - **Often, these conditions are validated during the first home visit, and plans or alternatives are discussed if these are not met.**
      - **When receiving a referral, it is particularly important to make sure that the orders and directions for care are clear and accurate.**
      - **If necessary, a clarifying phone call should be made prior to the visit to the person who has referred the patient to the agency.**

    - **Preparation**
      - **Documentation is critical.**
      - **All appropriate paperwork required for the assessment of the patient and family must be available in electronic format if the nurse plans to use a laptop computer for charting, or as hard copy.**
      - **Equipment**
      - **Directions**
      - **Personal Safety**

    - **The Actual Visit**
      - **The actual home visit includes introducing home care services to the patient and**

family, as well as the process of obtaining help from the home care agency when a planned home visit is not occurring.
- Details are given orally and in writing about when, whom, and how to call in an emergency or nonemergency.
- It also includes the application of the standards of care for home care practice, which includes the use of the nursing process with defined initial outcomes.
- The key component of the first in-home visit is assessment.
- The home care nurse is a guest in the patient's home, and must obtain the patient's permission and ask for the patient's guidance about how to carry out the initial assessment in the context of the home.
- It is necessary to carry out an overall assessment of the patient's and family's strengths, weaknesses, and challenges.
- In addition, it is also essential to assess home safety risks—medication errors, falls, and abuse and neglect.

➢ **Termination of the Visit**
- In terminating the initial visit, it is critical to make sure that patients and families know how to reach the home care nurse at any time of the day, and that an emergency plan is understood by the patient and the family.
- This understanding may involve the neighbors.
- It is equally important to establish an initial plan of care, and to make a plan for the next scheduled visit.
- If there are any circumstances that would impede future visits, it is important to address these at this time.
- For example, if the patient or family members smoke, and the home care nurse is allergic to smoke or cannot tolerate smoking, the home care nurse should make a contract related to a "no smoking" visit policy.
- If there are pets that disrupt the visit, the home care nurse needs to make a contract that the pet will be put in another area during future home visits.

➢ **Post-Visit Planning**
- After the initial visit, the home care nurse establishes, through the nursing process and the use of the initial assessment protocol, a specific plan of care that may include other healthcare disciplines and home health aide services.
- Outcome goals are established, and a schedule of planned visits is organized.
- The most crucial post-visit activity is the establishment of outcome measures, so that the home health team can plan an intervention approach that allows reasonable time and effort for healthcare providers and the patient and family to achieve these measures.
- This is accomplished through the expert judgment of the home care nurse, who manages the home care effort, and consideration of the constraints of Medicare, Medicaid, and other health insurance policies.

DHW: Ch. 22	School Health- PPT/Lecture/Discussion	ATI: Ch. 5
1. What are Primary and Secondary prevention techniques for school health?		

- **Primary Prevention**
  - **Teach health promotion practices.**
    - **Hand hygiene and tooth-brushing.**
    - **Healthy food choices.**
    - **Injury prevention (seat belt use and bike, fire, and water safety).**
    - **Substance use prevention.**
    - **Disease prevention.**
  - **Maintain current records of required immunizations.**

- **Secondary Prevention**
  - **Provide care to children who have the following:**
    - **Headaches.**
    - **Stomach pain, diarrhea.**
    - **Anxiety over being separated from parents.**
    - **Minor injuries (cuts or bruises) that occur at school.**
  - **Provide emergency care (first aid, early defibrillation with AED, CPR).**
  - **Create emergency plans for children who have a potential for anaphylactic reactions or other health problems that could result in an emergency situation.**
  - **Maintain inventory of emergency supply equipment and secure medications.**
  - **Perform screening for early detection of disease and initiate referrals as appropriate.**
    - **Vision and hearing.**
    - **Height and weight.**
    - **Oral health.**
    - **Scoliosis.**
    - **Infestations (lice).**
    - **General physical examinations.**
  - **Assess children to detect child abuse or neglect.**

2. **Who should be involved in planning the school nutrition program?**
   - **Individual in charge of the school lunch program.**
   - **School nurse.**
   - **School board.**
   - **Community stake holders (resources)**
   - **Teachers (education)**

3. **What are the components of a school health education program on nutrition?**
   - **Providing access to meals that accommodate the health and nutrition needs of all children.**
   - **Provides students with opportunities to learn about and practice healthy eating through available foods and beverages, nutrition education, and messages about food in the cafeteria and throughout the school campus.**

4. **What are the components of a school health education program on safety by level i.e. elementary versus adolescents?**
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5. **School nurses' roles in the school health screening process?**

- **There are no federal laws requiring that periodic screening be provided by the schools, although as a public health concern consistent with EPSDT, these screenings are often a major part of the school health program.**
- **The screenings may be essential to the early detection of, and intervention in, problems that may affect academic success.**
- **In addition, people often ask a school nurse why he or she performs periodic screening and how schools use this information.**
- **Screening programs typically begin when the child enters school and may continue in different forms throughout the child's education.**
- **Before implementing a screening program, schools should address these questions.**
- **For example, it is helpful if the health education curriculum addresses the conditions being assessed in the screening process.**
- **That way everyone, including the school staff, students, and families, is fully informed.**
- **It is necessary to develop clear procedures that evaluate the results of screening tests and stipulate how the results will be reported.**
- **In addition, it is essential to establish what the desired screening outcomes are and to emphasize those that fall outside of the targeted benchmarks.**
- **The school nurse should play a major role in planning these screenings and will need to spend the required time to develop a successful program.**
- **For example, in response to the obesity epidemic, many schools are implementing walking programs or similar exercise programs to encourage the recommended 60 minutes a day of physical activity.**
- **Maintain current records of current immunizations.**
  - **Immunization Screening.**
  - **Vision Screening.**
  - **Hearing Screening.**
  - **Postural Screening.**
  - **Body Mass Index Screening.**

6. Be able to give examples of the school nurse's role as a child advocate.

- **Provide education and communication necessary to ensure that the student's health and educational needs are met.**
- **Implement strategies to reduce disruptions in the student's school activities.**
- **Communicate with families and healthcare providers as authorized.**
- **Ensure the student receives prescribed medications and treatments and that staff who interact with the school on a regular basis are knowledgeable about these needs.**
- **Provide a safe and healthy school environment to promote learning.**

7. Be able to give examples of the school nurse's role as a case manager.

- **Coordinates comprehensive services for children who have complex health needs.**

8. Identify the common school health issues.

- **Substance Use: Drugs and Alcohol**
- **Substance Use: Smoking**
- **Sexual Behavior and Teenage Pregnancy**

- **Sexually Transmitted Infections**
- **Nutrition**
- **Violence**

9. How does the school nurse utilize the epidemiological process?

- **Epidemiologically we see incidents and prevalence rates, morbidity and even mortality rates, rates specific to age groups, rates specific to a specific disease or disability, and rates specific to some of the other social determinants of health.**

10. What skills are required for school nurse practice?

- **Tube feedings.**
- **Catheterizations.**
- **Suctioning.**
- **Identification of common problems that impact a child's learning, such as infestation with lice, or other communicable diseases.**
- **Physical assessment skills and knowledge of first aid to address issues.**
- **Knowledge and skills to respond to a mass casualty in the School Emergency Triage Training program.**
- **Provide leadership in all phases of emergency preparedness and response.**
- **Health assessment, Health promotion, Skills as a health educator, and the ability to work as a child health advocate.**

11. Identify health education interventions for school nursing.

- **Schools, where children and adolescents spend one-third of their day, present an ideal setting for providing health education.**
- **A health education curriculum is an important part of a comprehensive kindergarten to grade 12 school health program.**
- **Consistent with the WSCC program, evidence-based health education programs may vary in their approach but should be age-appropriate and should focus on developing and enhancing social and emotional strengths.**
- **Programs that serve to increase self-esteem, develop social skills, and increase understanding of issues such as peer influence and decision-making should be considered.**
- **Some professionals have recommended that the school nurse's role in health education should be that of a resource person or consultant and not necessarily that of a teacher.**
- **This opinion is contrary to that of the NASN, which considers health education an important intervention to be implemented as a primary responsibility of the school nurse.**
- **Whether or not the school nurse is in the classroom, health education is a priority.**
- **The school nurse must seek to accomplish health teaching in encounters with students and families, in the classroom, in individual counseling sessions (e.g., teaching a child how and when to use his or her EpiPen), and in group meetings.**
- **Despite the existence of National Health Education Standards, the Society for Public Health Education reports that health education in schools is a low priority.**
- **By adopting the eight National Health Education Standards, schools increase the likelihood that children will adopt lifelong health-promoting behaviors.**

- **It is recommended that the focus of health education be skill-based and address the health promotion concerns identified in the National Health Objectives of *Healthy People 2020*.**
- **This includes focusing on protective factors that support health-enhancing behaviors related to nutrition, physical activity, and safe use of social media, and that promote the avoidance of drug, alcohol and tobacco use, and the prevention of bullying and other forms of violence.**

12. What are common focuses of school-based community assessment?

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13. School-based strategies to reduce the number of adolescent pregnancies.

- **Evidence-based teen pregnancy prevention programs are those that have demonstrated, in at least one program evaluation, a positive effect on preventing teen pregnancies, sexually transmitted infections, or sexual risk behaviors.**
- **The Adolescent Family Life (AFL) program, created in 1981, was the first federal program to focus on adolescents.**
- **From 1998 to 2009, the program relied heavily on abstinence-only education.**
- **In 2010, a new Teen Pregnancy Prevention program was funded to provide "medically accurate and age-appropriate programs that reduce pregnancy."**
- **The Patient Protection and Affordable Care Act (ACA) enables states to operate a new Personal Responsibility Education Program (PREP), which is a comprehensive approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and STDs.**
- **Finally, the Title V Abstinence Education Block Grant is available to states specifically for abstinence-only education. State Abstinence Education Grant Programs continue to provide funds for programs offering mentoring, counseling, or adult supervision programs to promote abstinence.**
- **Since 2009, the U.S. Department of Health and Human Services (USDHHS) has sponsored an independent systematic review of the teen pregnancy prevention literature to identify programs with evidence of effectiveness in reducing teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors.**
- **The American Academy of Pediatricians, the American Academy of Family Physicians, and the American Medical Association all endorse sex and contraceptive counseling performed by healthcare professionals as the model to be used to promote responsible sexual behavior and reduce teen pregnancy.**
- **The most recent YRBSS reports that the prevalence of sexual intercourse among high school students nationwide is 41.2% of students; 30.1% of students are currently sexually active.**
- **The prevalence of having ever had sexual intercourse was higher among males (43.2%) than females (39.2%); of these, 3.9% had had sexual intercourse for the first time before age 13.**
- **The prevalence of not having used any method of birth control to prevent pregnancy ranged from 7.2% to 20.0%.**
- **In previous surveys, the reasons that female students gave for not using contraceptives consistently included the belief that pregnancy will not affect them, the desire to**

become pregnant, "cultural" beliefs, and fear. ➢ **Despite evidence that supports SBHC and the school nurse as a pivotal access point to contraceptive counseling, barriers continue to exist.** ➢ **The ACA of 2010 that provided significant funding for SBHCs, particularly those that serve Medicaid-eligible populations, expired in 2013.** ➢ **Funding for SBHCs remains an issue.** ➢ **Most available on-site services include abstinence counseling (84%), pregnancy testing (81%), and counseling for birth control (70%); however, about 60% are prohibited from dispensing contraception, thus limiting access.**

DHW: Ch. 23	**Faith-Oriented Communities and Health Ministries in Faith Communities** **-PPT/Lecture/Discussion**	**ATI: Ch. 5**
1. Primary prevention, secondary, & tertiary prevention interventions in faith-based nursing ➢ **Primary: teaching health promotion practices and immunization status** ➢ **Secondary: Assess children, faculty, staff, perform screenings, counseling and responding to crisis** ➢ **Tertiary: Providing care and assessing children who have diseases/disabilities**		
2. Strategies for identifying the needs of a faith community. ➢		
3. Common misconceptions regarding the role of faith community nurse		
4. Nursing duties for the institution-based model – slide 10 & pg 576 ➢ **Serves as a liaison and helps plan and coordinate care, particularly at times of transition.** ➢ **Serve as an ambassador and referral agent for the institution** o **Not direct care but support client in self-care and engaging the healthcare system**		
5. Tasks for the faith community nurse serving several local congregations.		
6. Roles of an advisory board for the faith community nurse.		
7. Use of epidemiology in faith-community nursing. ➢		
8. Examples of the faith-based nurse's role as health advocate. Table 23.4 ➢ **Empowerment of members of the congregation** ➢ **Empowerment of the congregation to improve the health of the community**		
9. Interventions for nurses of faith-based communities. ➢ **Use of the data to plan intervention examples** o **Health education, health-risk appraisals (a type of screening), and support for management of chronic disease processes.**		
10. Seven functions that parish nurses perform in faith community work. Pg. 587 ➢ **Integrator of faith and health** ➢ **Personal health counselor** ➢ **Health educator** ➢ **Health advocate**		

➢ **Referral agent** ➢ **Coordinator of volunteers** ➢ **Accessing and developing support groups**

DHW: Ch. 24	**Palliative and End -of-life Care PPT/Lecture/Discussion -**	**ATI: Ch. 4**
1. Identifying clients who should be recommended for hospice services.		
2. Expected roles of hospice care workers.		
3. Maladaptive behaviors of those with terminal illness.		
4. Identifying behaviors during the stages of the grieving process.		
5. Identify the services of hospice care.		
6. Identifying clients who would be appropriate for palliative care.		
7. What are advanced directives and what are their purposes?		

DHW: Ch. 25	**Occupational Health Nursing PPT/Lecture/Discussion -**	**ATI: Ch. 5**
1. Activities which are done as part of an occupational health needs assessment.		
2. Occupational health risks for farmers and agricultural workers.		
3. Steps of a root cause analysis.		
4. Categories of hazards in the workplace with examples.		
5. Techniques to use for an assessment of the workplace.		
6. Roles of OSHA, FMLA, NORA.		
7. Workplace emergency plans.		

DHW: Ch. 6, 7	**Epidemiology-Rates**	**ATI: Ch. 3**
1. Calculation of rates related to school health, faith communities, occupational health.		
2. Review Incidence, prevalence, proportions		