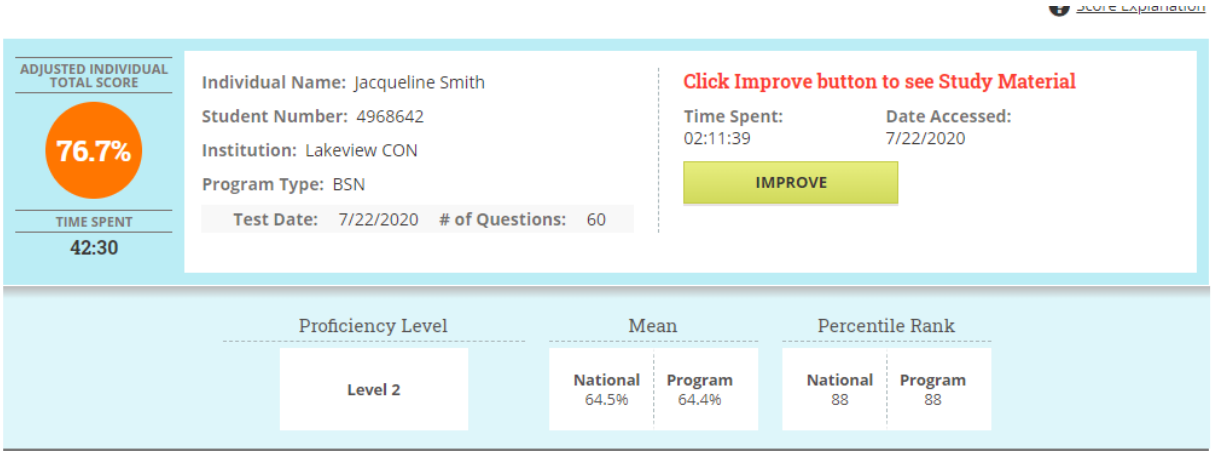

Legal Responsibilities: Nursing Role While Observing Client Care

- Nurses are accountable for protecting the rights of clients. Examples include informed consent, refusal of treatment, advance directives, confidentiality, and information security. Nurses are accountable for practicing nursing within the confines of the law to shield themselves from liability; advocate for clients' rights; provide care that is within the nurse's scope of practice; discern the responsibilities of other members of the health care team; and provide safe, proficient care consistent with standards of care.

Information Technology: Commonly Used Abbreviations

- Only abbreviations and symbols approved by The Joint Commission and the facility are acceptable. The Joint Commission mandates the use of computerized databases to expedite the accreditation process. Health care facilities use the computerized data for budget management, quality improvement programs, research, and many other endeavors.

Information Technology: Documenting in a Client's Medical Record

- Document facts and information precisely (what the nurse sees, hears, feels, smells) without any interpretations of the situation. Unnecessary words and irrelevant detail are avoided. Exact measurements establish accuracy.

Admissions, Transfers, and Discharge: Dispossession of Valuables

- Examples are clothing, jewelry, money, credit cards, assistive devices (eyeglasses, contacts, hearing aids, cane, dentures), medications, cell phones and other technology devices, and religious articles. Discourage keeping valuables at the bedside. Document communication with client related to items left within the room, and valuables locked in the facility's safe.

Legal Responsibilities: Identifying Negligence

- Professional negligence is the failure of a person who has professional training to act in a reasonable and prudent manner. The terms reasonable and prudent generally describe a person who has the average judgement, intelligence, foresight, and skill that a person with similar training and experience would have. Negligence issues that prompt most malpractice suits include failure to: follow professional and facility-established standards of care. Use equipment in a responsible and knowledgeable manner. Communicate effectively and thoroughly with patients. Document care the nurse provided. Notify the provider of a change in the patient's condition. Complete a prescribed procedure.

Infection Control: Caring for a Client Who is Immunocompromised

- Protective environment is an intervention to protect patients who are immunocompromised. A protective environment requires: a private room, positive airflow 12 or more air exchanges/hr, HEPA filtration for incoming air, and mask for the patient when out of the room.

Infection Control: Planning Transmission-Based Precautions for a Client Who Has Tuberculosis

- Tuberculosis uses airborn precautions. Airborn precautions include: the patient having a private room, use of an N95 mask or high-efficiency particulate air respirator devices for caregivers and visitors, negative pressure airflow exchange in the room of at least 6-12 exchanges per hour, if splashing or spraying is a possibility full face (eyes, nose, mouth) protection needs to be worn, and patients who have tuberculosis should wear a mask while outside of the room/home.

Hygiene: Bathing a Client Who Has Dementia

- Shift the focus of the interaction from the "task of bathing" to the needs and abilities of the patient. Focus on comfort, safety, autonomy, and self-esteem, in addition to cleanliness. Individualize patient care. Consult the patient, the patient's record, family members, and other caregivers to determine patient preferences. Consider what can be learned from the behaviors associated with dementia about the needs and preferences of the patient. A patient's behavior may be an expression of utmost needs; unwillingness to participate may be a response to uncomfortable water temperatures or levels of sound or light in the room. Ensure privacy and warmth. Consider the use of music to soothe anxiety and agitation. Consider other methods for bathing. Showers and tub baths are not the only options in bathing. Towel baths, washing under clothes, and bathing "body sections" one day at a time are other possible options. Maintaining a relaxed demeanor. Use calming language. Use one-step commands. Try to determine phrases and terms the patient understands in relation to bathing and make use of them. Offer frequent reassurance. Encourage independence. Use hand-over-hand or a guided hand technique to cue the patient regarding the purpose of the interaction and allow the patient to perform some of the activities independently. Explore the need for routine analgesia before bathing. Move limbs carefully and be aware of signs of discomfort during bathing. Wash the face and hair at the end of the bath or at a separate time. Water dripping in the face and having a wet head are often the most upsetting parts of the bathing process for people with dementia.

Mobility and Immobility: Teaching About Reducing the Adverse Effects of Immobility

- Elastic (antiembolic) stockings cause external pressure on the muscles of the lower extremities to promote blood return to the heart. SCDs and IPC have plastic or fabric sleeves that wrap around the leg and secure with hook-and-loop closures. The sleeves are then attached to an electric pump that alternately inflates and deflates the sleeve around the leg. These machines are set to cycle, typically a 10-15 second inflation and a 45-60 second deflation. Positioning techniques reduce compression of leg veins. ROM exercises cause skeletal muscle contractions, which promote blood return. Specific exercises that help prevent thrombophlebitis include ankle pumps, foot circles, and knee flexion. Antiembolic stockings, SCDs, and IPC require a prescription. Clients who are immobile should perform leg exercises, increase their fluid intake, and change positions frequently. When suspecting poor venous return or possible thrombus, notify the provider, elevate the leg, and do not apply pressure or massage the thrombus to avoid dislodging it.

Fluid Imbalances: Calculating a Client's Net Fluid Intake

- The patient's fluid intake includes the following: All fluids and foods that are liquid at room temperature (ice cream, gelatin desert [Jell-O], and the like). → Use the facility's designation of specific volumes for common food containers (e.g., juice glass, 90mL; milk carton, 240mL). → Remind the patient that sips of water or other fluids in between meals need to be recorded. Remember that liquid medications or water taken with pills may significantly increase the fluid intake of some patients. → All parenteral fluids. → Other fluids taking into the body: subcutaneous fluids, gastrointestinal tube feedings and flushes; IV flushes.

Nutrition and Oral Hydration: Advancing to a Full Liquid Diet

- Full liquid diets contain all the items on a clear liquid diet (clear broth, coffee, tea, clear fruit juices (apple, cranberry, grape), gelatin, popsicles, and commercially prepared clear liquid supplements). Additional items allowed include milk and milk drinks, puddings, custards, plain frozen desserts, pasteurized eggs, cereal gruels, vegetable juices, and milk and egg substitutes in addition to clear liquids. A full liquid diet contains liquids that can be poured at room temperature. High-calorie, high-protein supplements are recommended if a full liquid diet is used for more than 3 days.

Intravenous Therapy: Promoting Vein Dilation Prior to Inserting a Peripheral IV Catheter

- Place the patient in low-Fowler's position in bed. Place a protective towel or pad under the patient's arm. → Provide emotional support, as needed. → Open the short extension tubing package. Attach the needleless connector or end cap, if not in place. Clean the needleless connector or end cap with alcohol wipe. Insert a syringe with normal saline into the extension tubing. Fill the extension tubing with normal saline and place the extension tubing and syringe back on the package, within easy reach. → Select and palpate for an appropriate vein. If the intended insertion site is visibly soiled, clean the area with soap and water. → If the site is hairy and facility policy permits, clip a 2-in area around the intended entry site. → Put on gloves. → Apply a tourniquet 3 to 4 in above the venipuncture site to obstruct venous blood flow and distend the vein. Direct the ends of the tourniquet away from the entry site. Make sure the radial pulse is still present. → Instruct the patient to hold the arm lower than the heart. → Ask the patient to open and close the fist. Observe and palpate for a suitable vein. Try the following techniques if a vein cannot be felt: Lightly stroke the vein downward, Remove the tourniquet and place warm, dry compresses over intended vein for 10 to 15 minutes. → Cleanse the site with >5% chlorhexidine, or according to facility policy. Press the applicator against the skin and apply chlorohexidine using a gentile back and forth motion. Do not wipe or blot. Allow to dry completely for at least 30 seconds. → Using the nondominant hand placed about 1 or 2 in below the entry site, hold the skin taut against the vein. Avoid touching the prepared site. Ask the patient to remain still while performing the venipuncture. → Align the IV catheter on top of the vein; enter the skin gently, holding the catheter by the hub in your dominant hand, bevel side up, at a 10- to 15-degree angle. Insert the catheter from directly over the vein or from the side of the vein. While following the course of the vein, advance the needle or catheter into the vein. A sensation of "give" can be felt when the needle enters the vein.

Intravenous Therapy: Selection of an Intravenous Site

- Select the vein by using visualization, gravity, fist clenching friction with the cleaning solution, or heat and choose: Distal veins first on the nondominant hand, a site that is not painful or bruised

and will not interfere with activity, a vein that is resilient with a soft, bouncy sensation on palpation. Avoid varicose veins that are permanently dilated and tortuous, veins in the inner wrist with bifurcations, in flexion area, near valves (appearing as bumps), in lower extremities, and in the antecubital fossa (except for emergency access), veins in the back of the hand, veins that are sclerosed or hard, veins in an extremity with impaired sensitivity (scar tissue, paralysis), lymph nodes removed, recent infiltration, a PICC line, or an arteriovenous fistula or graft, and veins that had previous venipunctures.

Airway Management: Performing Chest Physiotherapy

- The use of a set of techniques that loosen respiratory secretions and move them into the central airways where coughing or suctioning can remove them. For patients who have thick secretions and are unable to clear their airways. Contraindicated for patients who are pregnant; have a rib, chest, head, or neck injury; have increased intracranial pressure; have had recent abdominal surgery; have a pulmonary embolism; or have bleeding disorders or osteoporosis. Nursing actions include: Schedule treatments 1 hr before or 2 hr after meals, and at bedtime to decrease the likelihood of vomiting or aspirating. → Administer a bronchodilator medication or nebulizer treatment 30 min to 1 hr prior to postural drainage. → Offer the patient an emesis basin and facial tissues. → Apply manual percussion to the chest wall using cupped hands or a specific device. → Place hands on the affected area, tense hand and arm muscles, and move the heel of the hands to create vibrations as the patient exhales. Have the patient cough after each set of vibrations. → Have the patient remain in each position for 10 to 15 min to allow time for percussion, vibration, and postural drainage. → Discontinue the procedure if the patient reports faintness or dizziness. → Note that older adult patients have decreased respiratory muscle strength and chest wall compliance, which puts them at risk for aspiration. They require more frequent position changes and other interventions to promote mobility of secretions. Percussion: the use of cupped hands to clap rhythmically on the chest to break up secretions. Vibration: the use of a shaking movement during exhalation to help remove secretions. Postural drainage: the use of various positions to allow secretions to drain by gravity.