OPEN RN

Ernstmeyer & Christman

NURSING FUNDAMENTALS

SECOND EDITION

Expert-authored, peer reviewed.

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Nursing Fundamentals 2e

Nursing Fundamentals 2e

ERNSTMEYER & CHRISTMAN - OPEN RESOURCES FOR NURSING (OPEN RN)

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Contents

Part II. Communication

Part III. Diverse Patients

Part VII. Sensory Impairments

Part VIII. Oxygenation

Part IX. Infection

Part X. Integumentary

Part XI. Comfort

Part XII. Sleep and Rest

Part XIII. Mobility

Part XIV. Nutrition

Part XV. Fluids and Electrolytes

Part XVI. Elimination

Part XVII. Grief and Loss

Part XVIII. Spirituality

Part XIX. Care of the Older Adult

Part XX. Answer Key

Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

This is the second edition of the *Nursing Fundamentals* OER nursing textbook with CC-BY 4.0 licensing. It has been developed for entry-level nursing students based on the Wisconsin Technical College System (WTCS) statewide nursing curriculum for the Nursing Fundamentals course (543-101), the 2023 NCLEX-RN and NCLEX-PN Test Plans,[1] and the Wisconsin Nurse Practice Act.[2] Here is a summary of updates made to the second edition.

This book introduces the scope of nursing practice, various communication techniques, and caring for diverse clients. The nursing process is used as a framework for providing nursing care for the following concepts: safety, oxygenation, comfort, spiritual well-being, grief and loss, sleep and rest, mobility, nutrition, fluid and electrolyte imbalance, and elimination. Nursing care for clients with integumentary disorders and cognitive or sensory impairments is also discussed. Learning activities have been incorporated into each chapter, including case studies and NCLEX Next Generation-style questions to encourage students to develop clinical judgment while applying content to client-care situations.

This book is available for free online and can also be downloaded in multiple formats for offline use. The online version is required for interaction with adaptive learning activities included in each chapter.

The following video provides a quick overview of how to navigate the online version.

1. NCSBN. (n.d.) *Test plans*. https://www.nclex.com/test-plans.page
2. Wisconsin State Legislature. (2024). *Chapter 6: Standards of practice for registered nurses and licensed practical nurses*. Board of Nursing. https://docs.legis.wisconsin.gov/statutes/statutes/441

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=4#oembed-1

This book is part of the Open RN© Nursing OER textbook series, originally funded by a $2.5 million Open Textbook Pilot grant from the Department of Education with sustainability funded by WisTech Open. This book was written by subject matter experts and is based on reliable scholarly research and evidence. It has been carefully peer reviewed to ensure its accuracy and quality. The content was developed without relying on large language models or AI tools, ensuring that the information is grounded in expert analysis and trusted sources. Read about other OER textbooks available on the Open RN and the WisTech Open websites.

Preface

About this Book

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This second edition of this textbook was developed based on feedback received from WTCS nursing faculty, the 2023 NCLEX-RN and NCLEX-PN Test Plans, the updated WTCS statewide nursing curriculum, new evidence-based guidelines, and current industry practices. The developing author for the second edition was Tami Davis, MSN, RN, from Chippewa Valley Technical College.

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Standards & Conceptual Approach

The Open RN *Nursing Fundamentals, 2e* textbook is based on several external standards and uses a conceptual approach.

External Standards

American Nurses Association (ANA)

The ANA provides standards for professional nursing practice including nursing standards and a code of ethics for nurses.

- https://www.nursingworld.org/ana/about-ana/standards/

The National Council Licensure Examination for Registered Nurses: NCLEX-PN and NCLEX-RN Test Plans

The NCLEX-RN and NCLEX-PN test plans are updated every three years to reflect fair, comprehensive, current, and entry-level nursing competency.

- https://www.nclex.com/test-plans.page

The National League of Nursing (NLN): Competencies for Graduates of Nursing Programs

NLN competencies for practical nursing programs guide nursing curricula to position graduates in a dynamic health care arena with practice that is informed by a body of knowledge and ensures that all members of the public receive safe, quality care.

- https://www.nln.org/education/nursing-education-competencies/practical-nursing-program-outcomes

National Patient Safety Goals

National Patient Safety Goals are established annually by The Joint Commission and focus on significant problems in health care safety and specific actions to prevent them.

- https://www.jointcommission.org/standards/national-patient-safety-goals/

American Association of Colleges of Nursing (AACN): The Essentials: Competencies for Professional Nursing Education

A framework for preparing individuals as members of the discipline of nursing, reflecting expectations across the trajectory of nursing education and applied experience.

- https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Quality and Safety Education for Nurses (QSEN) Institute: Prelicensure Competencies

Quality and safety competencies include knowledge, skills, and attitudes to be developed in nursing prelicensure programs. QSEN competencies include client-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

- https://qsen.org/competencies/

Wisconsin State Legislature, Administrative Code Chapter N6

The Wisconsin Administrative Code governs the Registered Nursing and Practical Nursing professions in Wisconsin.

- https://docs.legis.wisconsin.gov/code/admin_code/n/6

Healthy People 2030

Healthy People 2030 envisions a society in which all people can achieve their full potential for health and well-being across the life span. Healthy People provides objectives based on national data and includes social determinants of health.

- https://health.gov/healthypeople

Conceptual Approach

The Open RN *Nursing Fundamentals* textbook incorporates the following concepts across all chapters:

- **Holism.** Florence Nightingale taught nurses to focus on the principles of holism, including wellness and the interrelationship of human beings and their environment. This textbook encourages the application of holism by assessing the impact of developmental, emotional, cultural, religious, and spiritual influences on a client's health status.
- **Evidence-Based Practice (EBP).** Textbook content is based on current, evidence-based practices that are referenced by footnotes. To promote digital literacy, hyperlinks are provided to credible, free online resources that supplement content. The Open RN textbooks are updated after the release of new NCLEX Test Plans every three years.
- **Cultural Competency.** Nurses have an ethical and moral obligation to provide culturally competent care to the clients they serve based on the ANA Code of Ethics.[1] Cultural considerations are included throughout this textbook.
- **Care Across the Life Span.** Developmental stages are addressed in content describing nursing assessments and interventions.
- **Health Promotion.** Focused interview questions and client education topics are included to promote client well-being and encourage self-care behaviors.
- **Scope of Practice.** Assessment techniques are included that have been identified as frequently performed by entry-level nurse generalists.[2,3,4,5]
- **Patient Safety.** Expected and unexpected findings on assessment are

1. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

highlighted in tables to promote client safety by encouraging notification of health care providers when changes in condition occur.

- **Clear and Inclusive Language.** Content is written using clear language preferred by entry-level prelicensure nursing students to enhance understanding of complex concepts.[6] "They" is used as a singular pronoun to refer to a person whose gender is unknown or irrelevant to the context of the usage, as endorsed by APA style. It is inclusive of all people and helps writers avoid making assumptions about gender.[7]
- **Open Source Images and Fair Use.** Images are included to promote

2. Anderson, B., Nix, E., Norman, B., & McPike, H. D. (2014). An evidence based approach to undergraduate physical assessment practicum course development. *Nurse Education in Practice, 14*(3), 242–246. https://doi.org/10.1016/j.nepr.2013.08.007

3. Giddens, J., & Eddy, L. (2009). A survey of physical examination skills taught in undergraduate nursing programs: Are we teaching too much? *Journal of Nursing Education, 48*(1), 24–29. https://doi.org/10.3928/01484834-20090101-05

4. Giddens, J. (2007). A survey of physical assessment techniques performed by RNs: Lessons for nursing education. *Journal of Nursing Education, 46*(2), 83–87. https://doi.org/10.3928/01484834-20070201-09

5. Morrell, S., Ralph, J., Giannotti, N., Dayus, D., Dennison, S., & Bornais, J. (2019). Physical assessment skills in nursing curricula: A scoping review protocol. *JBI Database System Rev Implement Rep., 17*(6), 1086-1091. https://doi.org/10.11124/jbisrir-2017-003981.

6. Verkuyl, M., Lapum, J., St-Amant, O., Bregstein, J., & Hughes, M. (2020). Healthcare students' use of an e-textbook open educational resource on vital sign measurement: A qualitative study. *Open Learning: The Journal of Open, Distance and e-Learning.* https://doi.org/10.1080/02680513.2020.1835623

7. American Psychological Association (2021). *Singular*

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- **Open Pedagogy.** Students are encouraged to contribute to the Open RN textbooks in meaningful ways. In this textbook, students assisted in reviewing content for clarity for an entry-level learner and also assisted in creating open source images.[8]

Terminology

The following terminology is used throughout this book in alignment with the 2023 NCLEX-RN Test Plan[9]:

- **Client:** Individual, family or group, which includes significant others and populations.
- **Order:** Intervention, remedy or treatment as directed by an authorized primary health care provider.
- **Prescription:** Intervention as it relates to medication specifically as directed by an authorized primary health care provider.
- **Primary Health Care Provider:** Members of the health care team who are licensed and authorized to formulate prescriptions and orders on behalf of the client, as well as

"They." https://apastyle.apa.org/style-grammar-guidelines/grammar/singular-they

8. Wagstaff, S. (n.d.). *Open Pedagogy Notebook*. https://openpedagogy.org/

9. National Council of State Boards of Nursing. (2022). 2023 NCLEX-RN Test Plan. https://www.ncsbn.org/publications/2023-nclex-rn-test-plan

receive notifications of client status, are referred as primary health care provider, medical physician (or other specialty, e.g., surgeon, nephrologist) or an advanced practice nurse.

- **Unlicensed Assistive Personnel (UAP):** Any unlicensed personnel trained to function in a supportive role,
  regardless of title, to whom a nursing responsibility may be delegated.

Supplementary Material Provided

Several supplementary resources are provided with this textbook.

- Free supplementary videos to promote student understanding
- Free, online, interactive learning activities with formative feedback, including NCLEX Next Generation-style case studies
- Free downloadable versions for offline use

PART I

SCOPE OF PRACTICE

1.1. Scope of Practice Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Objectives

- Distinguish among the different levels of nursing education
- Specify the ethical and legal boundaries of the student nurse as presented in the Code of Ethics and the Nurse Practice Act
- Detail responsibility for maintaining client confidentiality
- Describe the contribution of all members of the health care team
- Identify the role of evidence-based practice in nursing
- Identify the concept of quality in client care
- Discuss nursing scope of practice and standards of care
- Compare various settings in which nurses work
- Outline professional nursing organizations

Scope of practice refers to services a trained health professional is deemed competent to perform and permitted to undertake according to the terms of

their professional nursing license.[1] Nursing scope of practice provides a legal framework and structured guidance for activities that practical nurses and registered nurses can perform based on their nursing license. As a nursing student, and in the future as a nurse, it is always important to consider if you can perform a task you are requested to do based on your legal scope of practice – or are you putting your nursing education or nursing license at risk?

Nurses must also follow standards when providing nursing care. Standards are set by several organizations, including your state's Nurse Practice Act, the American Nurses Association (ANA), agency policies and procedures, and federal regulators. These standards help guide nursing actions with the intent that safe, competent care is provided to the public.

This chapter will provide an overview of basic concepts related to nursing scope of practice and standards of care.

1. American Nurses Association. (n.d.). *Scope of practice*. https://www.nursingworld.org/practice-policy/scope-of-practice/

1.2 History and Foundation

OPEN RESOURCES FOR NURSING (OPEN RN)

Brief History of Nursing

Before discussing scope and standards of nursing care, it is helpful to briefly review a history of the nursing profession. The nursing tradition began during the 5th and 6th centuries as a charitable means of caring for the sick, feeding and clothing the hungry and the poor, and offering care to widows and orphans. As such, nursing's earliest foundations were based on religious principles, with nuns often providing care. During the Middle Ages, medical and surgical treatments advanced, with formal training beginning for medical practitioners. Care of clients shifted from a religious perspective to a more medical perspective.[1]

In the mid-19th century, Florence Nightingale, answering a religious calling, was determined to enter the field of nursing, much to the chagrin of her family. At the time, nurses generally came from lower socioeconomic class families, and the focus of nursing was changing linens and performing other menial tasks in hospitals. Florence recognized a need for trained nurses, persisted in her calling, and ultimately helped lead nursing into a holistic, spiritual practice. Florence Nightingale is considered to be the founder of

1. University of Pennsylvania. (n.d.). *Barbara Bates center for the study of the history of Nursing*. Penn Nursing: University of Pennsylvania. https://www.nursing.upenn.edu/history/

modern nursing practice.[2,3] In 1860, Florence Nightingale established the first nursing school in the world and promoted the concept of nurses as a professional, educated workforce of caregivers for the sick.[4] See Figure 1.1[5] for a portrait of Florence Nightingale.

Florence Nightingale's contributions to health care started during the Crimean War in 1854. Her team discovered that poor health care for wounded soldiers was being delivered by overworked medical staff in a dirty environment. Florence documented the mortality rate in the hospital and created statistical models that demonstrated that 600 out of every 1,000 injured soldiers died because of preventable communicable and infectious diseases. This statistical analysis was the early foundation of evidence-based practice that nurses use today. Florence's nursing interventions were simple and focused on providing a clean environment, clean water, and good nutrition to promote healing. For example, she provided fruit as part of the care for the wounded soldiers to promote good nutrition and healing. With

2. Aravind, M., & Chung, K. C. (2010). Evidence-based medicine and hospital reform: Tracing origins back to Florence Nightingale. *Plastic Reconstructive Surgery, 125(1),* 403-409. https://doi.org/ 10.1097/PRS.0b013e3181c2bb89.

3. Murdarasi, K. (2020). *The Christian faith of Florence Nightingale: The founder of Modern Nursing*. Premier Christianity. https://www.premierchristianity.com/home/the-christian-faith-of-florence-nightingale-the-founder-of-modern-nursing/2827.article

4. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557413/

5. "Florence Nightingale (H Hering NPG x82368).jpg" by Henry Hering (1814-1893) is in the Public Domain

these simple actions, the mortality rate of the soldiers decreased from 60% to 2.2%.[6]

In 1859, Nightingale wrote a book titled *Notes on Nursing* that served as the cornerstone of the Nightingale School of Nursing curriculum. Nightingale believed in the importance of placing a patient in an environment that promoted healing where they could recover from disease. She promoted this knowledge as distinct from medical knowledge. Her emphasis on the value of the environment formed many of the foundational principles that are still used to promote healing in health care settings today. She also insisted on the importance of building trusting relationships with patients and believed in the therapeutic healing that resulted from nurses' presence with patients. She promoted the concept of confidentiality, stating a nurse "should never answer questions about her sick except to those who have a right to ask them."[7] These nursing concepts formed the foundation of nursing practice as we know it today.

6. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557413/

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Figure 1.1 Florence Nightingale

Modern nursing has reinvented itself a number of times as health care has advanced and changed over the past 160 years. With more than four million members, the nursing profession represents the largest segment of the United States' health care workforce. Nursing practice covers a broad continuum, including health promotion, disease prevention, coordination of care, and palliative care when cure is not possible. Nurses directly affect client care and provide the majority of client assessments, evaluations, and care in hospitals, nursing homes, clinics, schools, workplaces, and ambulatory

settings. They are at the front lines in ensuring that client care is delivered safely, effectively, and compassionately. Additionally, nurses attend to patients and their families in a holistic way that often goes beyond physical health needs and recognize social, mental, emotional, and spiritual needs.[8]

8. Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK209880/57413/

1.3 Licensure, Regulations & Standards

OPEN RESOURCES FOR NURSING (OPEN RN)

Standards for nursing care are set by several organizations, including state Nurse Practice Acts, the American Nurses Association (ANA), agency policies and procedures, federal regulators, and other professional nursing organizations. These standards promote guidelines for safe, competent care to be provided to the public.

Nurse Practice Act

Nurses must legally follow regulations set by the **Nurse Practice Act (NPA)** in the state in which they work. The Nurse Practice Act is enacted by that state's legislature, defines the scope of practice for nurses in that state, and establishes regulations for nursing practice. If nurses do not follow the standards and scope of practice set forth by the Nurse Practice Act, they can have their nursing license revoked by the state Board of Nursing. The **Board of Nursing** is a licensing and regulatory body that issues nursing licenses to qualified candidates and also provides discipline for nurses who do not follow standards and scope of practice established in the Nurse Practice Act.

Each state has their own Nurse Practice Act. To read more about the the Wisconsin Board of Nursing, Standards of Practice, and Rules of Conduct, use the information provided below.[1]

1. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses.* https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

- Read more details about the Wisconsin Administrative Code and the Board of Nursing.
- Read about Wisconsin Standards of Practice for Nurses in Chapter N 6.
- Read about Wisconsin Rules of Conduct in Chapter N 7.

Nursing students must understand their scope of practice as outlined in the Nurse Practice Act in the state in which they are completing their clinical courses. Nursing students are legally accountable for the quality of care they provide to clients just as nurses are accountable. Students are expected to recognize the limits of their knowledge and experience and appropriately alert faculty or other authority figures regarding situations that are beyond their competency. A violation of the standards of practice constitutes unprofessional conduct and can result in the Board of Nursing denying a license to a nursing graduate.

American Nurses Association (ANA)

The American Nurses Association (ANA) is a national, professional nursing organization that was established in 1896. The ANA represents the interests of nurses in all 50 states of America while also promoting improved health care for everyone. The mission of the ANA is to "lead the profession to shape the future of nursing and health care."[2] The ANA states that it exists to advance the nursing profession by doing the following:

- Fostering high standards of nursing practice
- Promoting a safe and ethical work environment

2. American Nurses Association. (n.d.). *About ANA*. https://www.nursingworld.org/ana/about-ana/

- Bolstering the health and wellness of nurses
- Advocating on health care issues that affect nurses and the public[3]

Read more information about the American Nurses Association.

View the *Discover the American Nurses Association* video.[4]

ANA Scope and Standards of Practice

The American Nurses Association (ANA) publishes two resources that set standards and guide professional nursing practice in the United States: *The Code of Ethics for Nurses* and *Nursing: Scope and Standards of Practice*. *The Code of Ethics for Nurses* establishes an ethical framework for nursing practice across all roles, levels, and settings. It is discussed in greater detail in the "Legal and Ethical Considerations" section of this chapter. The *Nursing: Scope and Standards of Practice* describes a professional nurse's scope of practice and defines the who, what, where, when, why, and how of nursing. It also sets 18 standards of professional practice that all registered nurses are expected to perform competently.[5]

3. American Nurses Association. (n.d.). *About ANA*. https://www.nursingworld.org/ana/about-ana/

4. American Nurses Association. (2010, May 14). *Discover the American Nurses Association (ANA)* [Video]. YouTube. All rights reserved. https://youtu.be/PRwPhOjeqL4

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

The “who” of nursing practice are the nurses who have been educated, titled, and maintain active licensure to practice nursing. The “what” of **nursing** is the recently revised definition of nursing: “Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity.”[6] Simply put, nurses treat human responses to health problems and life processes and advocate for the care of others.

Nursing practice occurs “when” there is a need for nursing knowledge, wisdom, caring, leadership, practice, or education, anytime, anywhere. Nursing practice occurs in any environment “where” there is a health care consumer in need of care, information, or advocacy. The “why” of nursing practice is described as nursing’s response to the changing needs of society to achieve positive health care consumer outcomes in keeping with nursing’s social contract and obligation to society. The “how” of nursing practice is defined as the ways, means, methods, and manners that nurses use to practice professionally.[7] The “how” of nursing is further defined by the standards of practice set by the ANA. There are two sets of standards, the *Standards of Professional Nursing Practice* and the *Standards of Professional Performance*.

The **ANA Standards of Professional Nursing Practice** are “authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform

6. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

competently."[8] These standards define a competent level of nursing practice based on the critical thinking model known as the nursing process. The nursing process includes the components of **assessment, diagnosis, outcomes identification, planning, implementation,** and **evaluation**.[9] Each of these standards is further discussed in the "Nursing Process" chapter of this book.

The **ANA Standards of Professional Performance** are 12 additional standards that describe a nurse's professional behavior, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health. All registered nurses are expected to engage in these professional role activities based on their level of education, position, and role. Registered nurses are accountable for their professional behaviors to themselves, health care consumers, peers, and ultimately to society.[10] The 2021 Standards of Professional Performance are as follows:

- **Ethics.** The registered nurse integrates ethics in all aspects of practice.
- **Advocacy.** The registered nurse demonstrates advocacy in all roles and settings.
- **Respectful and Equitable Practice.** The registered nurse practices with cultural humility and inclusiveness.
- **Communication.** The registered nurse communicates effectively in all areas of professional practice.
- **Collaboration.** The registered nurse collaborates with the health care

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

9. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

consumer and other key stakeholders.

- **Leadership.** The registered nurse leads within the profession and practice setting.
- **Education.** The registered nurse seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking.
- **Scholarly Inquiry.** The registered nurse integrates scholarship, evidence, and research findings into practice.
- **Quality of Practice.** The registered nurse contributes to quality nursing practice.
- **Professional Practice Evaluation.** The registered nurse evaluates one's own and others' nursing practice.
- **Resource Stewardship.** The registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and judiciously used.
- **Environmental Health.** The registered nurse practices in a manner that advances environmental safety and health.[11]

Years ago, nurses were required to recite the Nightingale pledge to publicly confirm their commitment to maintain the profession's high ethical and moral values: "I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and family affairs coming to my knowledge in the practice of my calling, with loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care." Although some of the words are outdated, the meaning is clear: Nursing is a calling, not just a job; to answer that call, nurses must be dedicated to serve their community according to the ANA standards of care and code of ethics.[12]

11. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

12. Bostain, L. (2020). *Nursing professionalism begins with you*. American Nurse.

Employer Policies, Procedures, and Protocols

In addition to professional nursing standards set by the American Nurses Association and the state Nurse Practice Act where they work, nurses and nursing students must also practice according to agency policies, procedures, and protocols. For example, hospitals often set a policy that requires a thorough skin assessment must be completed and documented daily on every client. If a nurse did not follow this policy and a client developed a pressure injury, the nurse could be held liable. In addition, every agency has their own set of procedures and protocols that a nurse and nursing student must follow. For example, each agency has specific procedural steps for performing nursing skills, such as inserting urinary catheters. A **protocol** is defined by the Wisconsin Nurse Practice Act as a "precise and detailed written plan for a regimen of therapy." For example, agencies typically have a hypoglycemia protocol that nurses automatically implement when a client's blood sugar falls below a specific number. The hypoglycemia protocol includes actions such as providing orange juice and rechecking the blood sugar. These agency-specific policies, procedures, and protocols supersede the information taught in nursing school, and nurses and nursing students can be held legally liable if they don't follow them. Therefore, it is vital for nurses and nursing students to always review and follow current agency-specific procedures, policies, and protocols when providing client care.

Nurses and nursing students must continue to follow their scope of practice as defined by the Nurse Practice Act in the state they are practicing when following agency policies, procedures, and protocols. Situations have occurred when a nurse or nursing student was asked by an agency to do something outside their defined scope of practice that impaired their nursing license. It is always up to ***you*** to protect ***your*** nursing license and follow the state's Nurse Practice Act when providing client care.

https://www.myamericannurse.com/nursing-professionalism-begins-with-you/

Federal Regulations

In addition to nursing scope of practice and standards being defined by state Nurse Practice Acts, the American Nurses Association, and employer policies, procedures, and protocols, nursing practice is also influenced by federal regulations enacted by agencies such as The Joint Commission and the Centers for Medicare and Medicaid.

The Joint Commission

The Joint Commission is a national organization that accredits and certifies over 20,000 health care organizations in the United States. The mission of The Joint Commission (TJC) is to continuously improve health care for the public by inspiring health care organizations to excel in providing safe and effective care of the highest quality and value.[13] The Joint Commission sets standards for providing safe, high-quality health care. Examples of standards include following National Patient Safety Goals and establishing a Safety Culture in health care agencies.

National Patient Safety Goals

The Joint Commission establishes annual National Patient Safety Goals for various types of agencies based on data regarding current national safety concerns.[14] For example, National Patient Safety Goals for hospitals include the following:

- Identify Patients Correctly
- Improve Staff Communication
- Use Medicines Safely

13. The Joint Commission. (n.d.). https://www.jointcommission.org/

14. The Joint Commission. (n.d.). *National patient safety goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/

- Use Alarms Safely
- Prevent Infection
- Identify Patient Safety Risks
- Prevent Mistakes in Surgery

Nurses, nursing students, and other staff members are expected to incorporate actions related to these safety goals into their daily client care. For example, SBAR (Situation, Background, Assessment, and Recommendation) handoff reporting techniques, barcode scanning equipment, and perioperative team "time-outs" prior to surgery are examples of actions incorporated at agencies based on National Patient Safety Goals. Nursing programs also use National Patient Safety Goals to guide their curriculum and clinical practice expectations. National Patient Safety Goals are further discussed in the "Safety" chapter of this book.

Use the information provided below to read more about The Joint Commission and National Patient Safety Goals.

- The Joint Commission
- The Joint Commissions' National Patient Safety Goals

Safety Culture

A **safety culture** empowers nurses, nursing students, and other staff members to speak up about their concerns about client risks and to report errors and near misses, all of which drive improvement in client care and reduce the incidences of client harm.[15] Many health care agencies have

15. Joint Commission Center for Transforming Healthcare. (n.d.). *Creating a safety culture*. https://www.centerfortransforminghealthcare.org/why-work-with-us/video-resources/creating-a-safety-culture

implemented a safety culture in their workplace and successfully reduced incidences of client harm. An example of a safety culture action is a nurse or nursing student creating an incident report when an error occurs when administering medication. The incident report is used by the agency to investigate system factors that contribute to errors. To read more about how The Joint Commission encourages agencies create a safety culture, use the information provided in the following box.

Read more about Safety Culture from The Joint Commission.

Reimbursement for Health Services and Regulations

Although many individuals pursue nursing careers to help others, it is important to realize that health care is a business. Even non-profit organizations rely on funding to provide services, pay employees, and maintain the facility and equipment. There are several sources of funding for health care, including private health insurance or government-funded programs like Medicare and Medicaid. No matter what type of funding source, agencies must comply with state and federal regulations.

Private Health Insurance

The health insurance industry provides private health insurance that is sponsored by employers or purchased privately by individuals from the Health Insurance Marketplace. Private insurance programs must comply with state and federal regulations even though they are privately owned. Read more about the Affordable Care Act in the following box.

Affordable Care Act

The Affordable Care Act (ACA) of 2010, commonly referred to as "Obamacare," created cost-reduction programs for private insurance through a public insurance marketplace. Insurance premiums are subsidized by taxpayer funds to help reduce the cost of health insurance and make it more affordable. Subsidies are provided for incomes between 100% and 400% of the federal poverty level. For example, in 2023, the income range for a family of four was $30,000 to $120,000.[16] These subsidies have significantly decreased the number of uninsured individuals, but unfortunately, insurance premiums sold through the marketplace can still be high. Approximately 7.7% of individuals and families in the United States remain uninsured, resulting in increased health risks due to lack of participation in preventive services, well child care, dental care, and treatment of chronic disease. As a result, visits to the Emergency Room often increase when clients delay care due to cost concerns, further

16. U.S. Centers for Medicare & Medicaid Services. (n.d.). *Glossary*. HealthCare.gov. https://www.healthcare.gov/glossary/

contributing to the cost of health care as hospitals are often not reimbursed for these visits.[17,18]

Federal and State-Funded Health Care

Medicare is federally funded health care coverage of individuals aged 65 or older, individuals younger than 65 with certain disabilities, or those at any age with end-stage renal disease. Medicaid is a combination of state and federally funded health care coverage of low-income adults, pregnant women, and children. Agencies receiving Medicare or Medicaid reimbursement must comply with state and federal regulations and meet established client outcomes, or their reimbursement rates are decreased or eliminated. Read more about Medicare in the following box.

17. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (2023). *National Uninsured Rate Reaches an All-Time Low in Early 2023 After Close of ACA Open Enrollment Period (Issue Brief No. HP-2023-20).* [PDF]. ASPE: Office of Health Policy. https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf

18. U.S. Department of Health and Human Services. (n.d.). *Access to health services*. OASH: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

Medicare

Medicare uses a system of reimbursement based on diagnosis-related groups (DRGs). DRGs classify clients with similar clinical characteristics, such as age, gender, severity of disease, and comorbidities, with the rationale that these clients have similar care needs. Based on these DRGs, reimbursement occurs at rates set by the Centers for Medicare & Medicaid Services (CMS) for qualifying services. Differences between set reimbursement rates and health care organization charges cannot be passed on to the individual, although the individuals may be required to pay copays for care received. By agreeing to accept clients with Medicare or Medicaid coverage, the health care organization agrees to accept these rates of reimbursement, although they may be less than the actual cost of providing care. For example, in 2017, Medicaid reimbursement was 89% of the cost of providing care.[19,20,21]

19. Chen, Y. J., Zhang, X. Y., Yan, J. Q., Xue-Tang, Qian, M. C., & Ying X. H. (2023) Impact of diagnosis-related groups on inpatient quality of health care: A systematic review and meta-analysis. *Inquiry.2023 Jan-Dec; 60,* 469580231167011. https://doi.org/10.1177/00469580231167011

20. U.S. Centers for Medicare & Medicaid Services. (n.d.). *Home – Centers for Medicare & Medicaid Services*. CMS.gov. https://www.cms.gov/

21. Wisconsin Hospital Association. (2025). *Medicaid*. https://www.wha.org/HealthCareTopics/M/Medicaid

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a federal agency that establishes and enforces regulations to protect client safety in hospitals that receive Medicare and Medicaid funding. For example, one CMS regulation states that a hospital's policies and procedures must require confirmation of specific information before medication is administered to clients. This CMS regulation is often referred to as "checking the rights of medication administration." You can read more information about checking the rights of medication administration in the "Administration of Enteral Medications" chapter of the Open RN *Nursing Skills, 2e* textbook.[22]

CMS also enforces quality standards in health care organizations that receive Medicare and Medicaid funding. These organizations are reimbursed based on the quality of their client outcomes. For example, organizations with high rates of healthcare-associated infections (HAI) receive less reimbursement for services they provide. As a result, many agencies have reexamined their policies, procedures, and protocols to promote optimal client outcomes and maximum reimbursement.

Now that we have discussed various agencies that affect a nurse's scope and standards of practice, let's review various types of health care settings where nurses work and members of the health care team.

22. Ernstmeyer, K., & Christman, E. (Eds.). (2023). *Nursing Skills 2e*. Access for free at https://wtcs.pressbooks.pub/nursingskills/

1.4 Health Care Settings & Team

OPEN RESOURCES FOR NURSING (OPEN RN)

Health Care Settings

There are several levels of health care including primary, secondary, and tertiary care. Each of these levels focuses on different aspects of health care and is typically provided in different settings.

Primary Care

Primary care promotes wellness and prevents disease. This care includes health promotion, education, protection (such as immunizations), early disease screening, and environmental considerations. Settings providing this type of health care include physician offices, public health clinics, school nursing, and community health nursing.

Secondary care

Secondary care occurs when a person has contracted an illness or injury and requires medical care. Secondary care is often referred to as acute care. Secondary care can range from uncomplicated care to repair a small laceration or treat a strep throat infection to more complicated emergent care such as treating a head injury sustained in an automobile accident. Whatever the problem, the client needs medical and nursing attention to return to a state of health and wellness. Secondary care is provided in settings such as physician offices, clinics, urgent care facilities, or hospitals. Specialized units include areas such as critical care, burn units, neurosurgery, cardiac surgery, and transplant services.

Tertiary Care

Tertiary care addresses the long-term effects from chronic illnesses or conditions with the purpose to restore a client's maximum physical and mental function. The goal of tertiary care is to achieve the highest level of functioning possible while managing the chronic illness. For example, a client who falls and fractures their hip will need secondary care to set the broken bones, but may need tertiary care to regain their strength and ability to walk even after the bones have healed. Clients with incurable diseases, such as dementia, may need specialized tertiary care to provide support they need for daily functioning. Tertiary care settings include rehabilitation units, assisted living facilities, adult day care, skilled nursing units, home care, and hospice centers.

Health Care Team

No matter the setting, quality health care requires a team of health care professionals collaboratively working together to deliver holistic, individualized care. Nursing students must be aware of the roles and contributions of various health care team members. The health care team consists of health care providers, nurses (licensed practical nurses, registered nurses, and advanced practice registered nurses), unlicensed assistive personnel, and a variety of interprofessional team members.

Health Care Providers

The Wisconsin Nurse Practice Act defines a health care **provider** as, "A physician, podiatrist, dentist, optometrist, or advanced practice nurse."[1] Providers are responsible for ordering diagnostic tests such as blood work and X-rays, diagnosing a client's medical condition, developing a medical

1. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses.* https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

treatment plan, and prescribing medications. In a hospital setting, the medical treatment plan developed by a provider is communicated in the "History and Physical" component of the client's medical record with associated prescriptions (otherwise known as "orders"). Prescriptions or "orders" include diagnostic and laboratory tests, medications, and general parameters regarding the care that each client is to receive. Nurses should respectfully clarify prescriptions they have questions or concerns about to ensure safe client care. Providers typically visit hospitalized clients daily in what is referred to as "rounds." It is helpful for nurses and nursing students to attend provider rounds for their assigned clients to be aware of and provide input regarding the current medical treatment plan, seek clarification, or ask questions. This helps to ensure that the provider, nurse, and client have a clear understanding of the goals of care and minimizes the need for follow-up phone calls.

Nurses

There are three levels of nurses as defined by each state's Nurse Practice Act: Licensed Practical Nurse/Vocational Nurse (LPN/LVN), Registered Nurse (RN), and Advanced Practice Registered Nurse (APRN).

LICENSED PRACTICAL/VOCATIONAL NURSES

The National Council of State Boards of Nursing (NCSBN) defines a **licensed practical nurse (LPN)** as, "An individual who has completed a state-approved practical or vocational nursing program, passed the NCLEX-PN examination, and is licensed by a state board of nursing to provide client care."[2] In some states, the term licensed vocational nurse (LVN) is used. LPNs/LVNs typically work under the supervision of a registered nurse, advanced practice

2. NCSBN. https://www.ncsbn.org/index.htm

registered nurse, or physician.[3] LPNs provide "basic nursing care" and work with stable and/or chronically ill populations. **Basic nursing care** is defined by the Wisconsin Nurse Practice Act as "care that can be performed following a defined nursing procedure with minimal modification in which the responses of the client to the nursing care are predictable."[4] LPNs/LVNs typically collect client assessment information, administer medications, and perform nursing procedures according to their scope of practice in that state. The Open RN *Nursing Skills, 2e* textbook discusses the skills and procedures that LPNs frequently perform in Wisconsin. See the following box for additional details about the scope of practice of the Licensed Practical Nurse in Wisconsin.

Scope of Practice for Licensed Practical Nurses in Wisconsin[5]

"The Wisconsin Nurse Practice Act defines the scope of practice for Licensed Practical Nurses as the following: "In the performance of acts in basic patient situations, the LPN shall, under the general supervision of an RN or the direction of a provider:

(a) Accept only patient care assignments which the LPN is competent to perform.

(b) Provide basic nursing care.

3. NCSBN. https://www.ncsbn.org/index.htm

4. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

5. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

(c) Record nursing care given and report to the appropriate person changes in the condition of a patient.

(d) Consult with a provider in cases where an LPN knows or should know a delegated act may harm a patient.

(e) Perform the following other acts when applicable:

1. Assist with the collection of data.
2. Assist with the development and revision of a nursing care plan.
3. Reinforce the teaching provided by an RN provider and provide basic health care instruction.
4. Participate with other health team members in meeting basic patient needs."

REGISTERED NURSES

The NCSBN defines a **Registered Nurse (RN)** as "An individual who has graduated from a state-approved school of nursing, passed the NCLEX-RN examination and is licensed by a state board of nursing to provide client care."[6] Registered Nurses (RNs) use the nursing process as a critical thinking model as they make decisions and use clinical judgment regarding client care. The nursing process is discussed in more detail in the "Nursing Process" chapter of this book. RNs may be delegated tasks from providers or may delegate tasks to LPNs and UAPs with supervision. See the following box for additional details about the scope of practice for Registered Nurses in the state of Wisconsin.

6. NCSBN. https://www.ncsbn.org/index.htm

Scope of Practice for Registered Nurses in Wisconsin[7]

(1) "GENERAL NURSING PROCEDURES. An RN shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:

(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.

(b) Planning. Planning is developing a nursing plan of care for a patient, which includes goals and priorities derived from the nursing diagnosis.

(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to LPNs or less skilled assistants.

(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement, which may lead to modification of the nursing diagnosis.

(2) PERFORMANCE OF DELEGATED ACTS. In the performance of delegated acts, an RN shall do all of the following:

7. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

(a) Accept only those delegated acts for which there are protocols or written or verbal orders.

(b) Accept only those delegated acts for which the RN is competent to perform based on his or her nursing education, training or experience.

(c) Consult with a provider in cases where the RN knows or should know a delegated act may harm a patient.

(d) Perform delegated acts under the general supervision or direction of provider.

(3) SUPERVISION AND DIRECTION OF DELEGATED ACTS. In the supervision and direction of delegated acts, an RN shall do all of the following:

(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.

(b) Provide direction and assistance to those supervised.

(c) Observe and monitor the activities of those supervised.

(d) Evaluate the effectiveness of acts performed under supervision."

ADVANCED PRACTICE REGISTERED NURSES

Advanced Practice Registered Nurses (APRN) are defined by the NCSBN as an RN who has a graduate degree and advanced knowledge. There are four categories of Advanced Practice Registered Nurses: Certified Nurse-Midwife (CNM), Clinical Nurse Specialist (CNS), Certified Nurse Practitioner (CNP), and Certified Registered Nurse Anesthetist (CRNA). APRNs can diagnose illnesses and prescribe treatments and medications. Additional information about advanced nursing degrees and roles is provided in the box below.

Advanced Practice Nursing Roles[8]

Nurse Practitioners: Nurse practitioners (NPs) work in a variety of settings and complete physical examinations, diagnose and treat common acute illness and manage chronic illness, order laboratory and diagnostic tests, prescribe medications and other therapies, provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance, and refer clients to other health professionals and specialists as needed. In many states, NPs can function independently and manage their own clinics, whereas in other states physician supervision is required. NP certifications include, but are not limited to, Family Practice, Adult-Gerontology Primary Care and Acute Care, and Psychiatric/Mental Health.

- To read more about NP certification, visit Nursing World's *Our Certifications* web page.

Clinical Nurse Specialists: Clinical Nurse Specialists (CNS) practice in a variety of health care environments and participate in mentoring other nurses, case management, research, designing and conducting quality improvement programs, and serving as educators and consultants. Specialty areas include, but are not limited to, Adult/Gerontology, Pediatrics, and Neonatal.

8. Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. National Academies Press. https://www.nap.edu/catalog/12956/the-future-of-nursing-leading-change-advancing-health

- To read more about CNS certification, visit National Association of Clinical Nurse Specialist's *What is a CNS?* web page.

Certified Registered Nurse Anesthetists: Certified Registered Nurse Anesthetists (CRNAs) administer anesthesia and related care before, during, and after surgical, therapeutic, diagnostic, and obstetrical procedures, as well as provide airway management during medical emergencies. CRNAs deliver more than 65 percent of all anesthetics to clients in the United States. Practice settings include operating rooms, dental offices, and outpatient surgical centers.

- To read more about CRNA certification, visit National Board of Certification & Recertification for Nurse Anesthetist's website.

Certified Nurse Midwives: Certified Nurse Midwives provide gynecological exams, family planning advice, prenatal care, management of low-risk labor and delivery, and neonatal care. Practice settings include hospitals, birthing centers, community clinics, and client homes.

- To read more about CNM certification, visit the American Midwifery Certification Board website.

Unlicensed Assistive Personnel

Unlicensed Assistive Personnel (UAP) are defined by the NCSBN as, "Any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state tested nursing assistants (STNAs), nursing assistants-registered (NA/Rs), or certified

medication aides/assistants (MA-Cs). Certification of UAPs varies between jurisdictions."[9]

CNAs, PCAs, and PCTs in Wisconsin generally work in hospitals and long-term care facilities and assist clients with daily tasks such as bathing, dressing, feeding, and toileting. They may also collect client information such as vital signs, weight, and input/output as delegated by the nurse. The RN remains accountable that delegated tasks have been completed and documented by the UAP.

Interprofessional Team Members

Nurses, as the coordinator of a client's care, continuously review the plan of care to ensure all contributions of the multidisciplinary team are moving the client toward expected outcomes and goals. The roles and contributions of interprofessional health care team members are further described in the following box.

Interprofessional Team Member Roles[10]

Dieticians: Dieticians assess, plan, implement, and evaluate interventions, including those relating to dietary needs of those clients who need regular or therapeutic diets. They also provide dietary education and work with other members of the health

9. NCSBN. https://www.ncsbn.org/index.htm

10. Burke, A. (2020). *Collaboration with interdisciplinary team: NCLEX-RN*. RegisteredNursing.org. https://www.registerednursing.org/nclex/collaboration-interdisciplinary-team/#collaborating-healthcare-members-disciplines-providing-client-care

care team when a client has dietary needs secondary to physical disorders such as difficulty swallowing.

Occupational Therapists (OT): Occupational therapists assess, plan, implement, and evaluate interventions, including those that facilitate the client's ability to achieve their highest possible level of independence in their activities of daily living such as bathing, grooming, eating, and dressing. They also provide clients with adaptive devices such as long shoehorns so the client can put their shoes on, sock pulls so they can independently pull on socks, adaptive silverware to facilitate independent eating, grabbers so the client can pick items up from the floor, and special devices to manipulate buttoning so the person can dress and button their clothing independently. OTs assess the home for safety and the need for assistive devices when the client is discharged home. They may recommend modifications to the home environment such as ramps, grab rails, and handrails to ensure safety and independence. OTs practice in all health care environments, including the home, hospital, and rehabilitation centers.

Pharmacists: Pharmacists ensure the safe prescribing and dispensing of medication and are a vital resource for nurses with questions or concerns about medications they are administering to clients. Pharmacists ensure that clients not only get the correct medication and dosing, but also have the guidance they need to use the medication safely and effectively.

Physical Therapists (PT): Physical therapists are licensed health care professionals who assess, plan, implement, and evaluate interventions, including those related to the client's functional abilities in terms of their strength, mobility, balance, gait, coordination, and joint range of motion. They supervise prescribed exercise activities according to a client's condition

and also provide and teach clients how to use assistive aids like walkers and canes and how to perform exercise regimens. Physical therapists practice in all health care environments, including the home, hospital, and rehabilitation centers.

Podiatrists: Podiatrists provide care and services to clients who have foot problems. They often work with clients who have diabetes to clip toenails and provide foot care to prevent complications.

Prosthetists: Prosthetists design, fit, and supply the client with an artificial body part such as a leg or arm prosthesis. They adjust prosthesis to ensure proper fit, comfort, and functioning.

Psychologists and Psychiatrists: Psychologists and psychiatrists provide mental health and psychiatric services to clients with mental health disorders and provide psychological support to family members and significant others as indicated.

Respiratory Therapists: Respiratory therapists treat respiratory-related conditions in clients. Their specialized respiratory care includes managing oxygen therapy; drawing arterial blood gases; managing clients on specialized oxygenation devices such as mechanical ventilators, CPAP, and Bi-PAP machines; administering respiratory medications like inhalers and nebulizers; intubating clients; assisting with bronchoscopy and other respiratory-related diagnostic tests; performing pulmonary hygiene measures like chest physiotherapy; and serving an integral role in providing respiratory support.

Social Workers: Social workers counsel clients and provide psychological support, help set up community resources according to clients' financial needs, and serve as part of the

team that ensures continuity of care after the person is discharged.

Speech Therapists: Speech therapists assess, diagnose, and treat communication and swallowing disorders. For example, speech therapists help clients with a disorder called **expressive aphasia**. They also assist clients with using word boards and other electronic devices to facilitate communication. They assess clients with swallowing disorders called **dysphagia** and treat them in collaboration with other members of the health care team including nurses, dieticians, and health care providers.

Ancillary Department Members: Nurses also work with ancillary departments such as laboratory and radiology departments.

- **Clinical laboratory departments** provide a wide range of laboratory procedures that aid health care providers to diagnose, treat, and manage clients. These laboratories are staffed by medical technologists who test biological specimens collected from clients. Examples of laboratory tests performed include blood tests, blood banking, cultures, urine tests, and histopathology (changes in tissues caused by disease).[11]
- **Radiology departments** use imaging to assist providers in diagnosing and treating diseases seen within the body. They perform diagnostic tests such as X-rays, CTs, MRIs, nuclear medicine, PET scans, and ultrasound scans.

11. Nguyen, J. D. (2023). *Pursed-Lip Breathing*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK545289/

Chain of Command

Nurses rarely make client decisions in isolation, but instead consult with other nurses and interprofessional team members. Concerns and questions about client care are typically communicated according to that agency's chain of command. In the military, **chain of command** refers to a hierarchy of reporting relationships – from the bottom to the top of an organization – regarding who must answer to whom. The chain of command not only establishes accountability, but also lays out lines of authority and decision-making power. The chain of command also applies to health care. For example, a registered nurse in a hospital may consult a "charge nurse," who may consult the "nurse supervisor," who may consult the "director of nursing," who may consult the "vice president of nursing." In a long-term care facility, a licensed practical/vocational nurse typically consults the registered nurse/charge nurse, who may consult with the director of nursing. Nursing students should always consult with their nursing instructor regarding questions or concerns about client care before "going up the chain of command."

Nurse Specialties

Registered nurses can obtain several types of certifications as a nurse specialist. **Certification** is the formal recognition of specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty. See the following box for descriptions of common nurse specialties.

Common Nurse Specialties

Critical Care Nurses provide care to clients with serious, complex, and acute illnesses or injuries that require very close monitoring and extensive medication protocols and therapies.

Critical care nurses most often work in intensive care units of hospitals.

Public Health Nurses work to promote and protect the health of populations based on knowledge from nursing, social, and public health sciences. Public health nurses most often work in municipal and state health departments.

Home Health/Hospice Nurses provide a variety of nursing services for chronically ill clients and their caregivers in the home, including end-of-life care.

Occupational/Employee Health Nurses provide health screening, wellness programs and other health teaching, minor treatments, and disease/medication management services to people in the workplace. The focus is on promotion and restoration of health, prevention of illness and injury, and protection from work-related and environmental hazards.

Oncology Nurses care for clients with various types of cancer, administering chemotherapy and providing follow-up care, teaching, and monitoring. Oncology nurses work in hospitals, outpatient clinics, and clients' homes.

Perioperative/Operating Room Nurses provide preoperative and postoperative care to clients undergoing anesthesia or assist with surgical procedures by selecting and handling instruments, controlling bleeding, and suturing incisions. These nurses work in hospitals and outpatient surgical centers.

Rehabilitation Nurses care for clients with temporary and permanent disabilities within inpatient and outpatient settings such as clinics and home health care.

Psychiatric/Mental Health Nurses specialize in mental and behavioral health problems and provide nursing care to

individuals with psychiatric disorders. Psychiatric nurses work in hospitals, outpatient clinics, and private offices.

School Nurses provide health assessment, intervention, and follow-up to maintain school compliance with health care policies and ensure the health and safety of staff and students. They administer medications and refer students for additional services when hearing, vision, and other issues become inhibitors to successful learning.

Telenursing refers to providing nursing care remotely using information and communication technology. Nursing care may include client education, support, health assessment and evaluation, and triage. While telenursing is not a specialty, it is provided in several specialty areas such as Critical Care and Emergency Departments. It is also provided in outpatient environments and encourages increased client interactions, especially in underserved rural areas.[12]

Other common specialty areas include a life span approach across health care settings and include maternal-child, neonatal, pediatric, and gerontological nursing.[13]

12. Khraisat, O. M. A., Al-Bashaireh, A. M., & Alnazly, E. (2023). Telenursing implications for future education and practice: Nursing students' perspectives and knowledge from a course on child health. *PLoS One, 18*(11), e0294711. https://doi.org/10.1371/journal.pone.0294711.

13. Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine. (2011). *The future of nursing: Leading change, advancing*

health. National Academies Press. https://www.nap.edu/catalog/12956/the-future-of-nursing-leading-change-advancing-health

1.5 Nursing Education and the NCLEX

OPEN RESOURCES FOR NURSING (OPEN RN)

Now that we have discussed various settings where nurses work and various nursing roles, let's review levels of nursing education and the national licensure exam (NCLEX).

Nursing Education and the NCLEX

Everyone who wants to become a nurse has a story to tell about why they want to enter the nursing profession. What is your story? Perhaps it has been a lifelong dream to become a Life Flight nurse, or maybe you became interested after watching a nurse help you or a family member through the birth of a baby, heal from a challenging illness, or assist a loved one at the end of life. Whatever the reason, everyone who wants to become a nurse must do two things: graduate from a state-approved nursing program and pass the National Council Licensure Exam (known as the NCLEX).

Nursing Programs

There are several types of nursing programs you can attend to become a nurse. If your goal is to become a **Licensed Practical Nurse/Vocational Nurse (LPN/VN)**, you must successfully complete a one-year nursing program, pass the NCLEX-PN exam, and apply to your state Board of Nursing to receive an LPN license.

If you want to become a **Registered Nurse (RN)**, you can obtain either a two-year associate degree (ADN) or a four-year baccalaureate of science in nursing degree (BSN). Associate degree nursing graduates often enroll into a baccalaureate or higher degree program after they graduate. Many hospitals

hire ADN nurses on a condition they complete their BSN within a specific time frame. A BSN is required for military nursing, case management, public health nursing, and school-based nursing services. Another lesser-known option to become an RN is to complete a three-year hospital-based diploma program, which was historically the most common way to become a nurse. After completing a diploma program, associate degree, or baccalaureate degree, nursing graduates must successfully pass the NCLEX-RN to apply for a registered nursing license from their state's Board of Nursing.

NCLEX

Nursing graduates must successfully pass the National Council Licensure Examination (NCLEX) to receive a nursing license. Registered nurses must successfully pass the NCLEX-RN exam, and Licensed Practical Nurses (LPNs) or Licensed Vocational Nurses (LVNs) must pass the NCLEX-PN exam.

The NCLEX-PN and NCLEX-RN are online, adaptive tests taken at a specialized testing center. The NCLEX tests knowledge, skills, and abilities essential to the safe and effective practice of nursing at the entry level. NCLEX exams are continually reviewed and updated based on surveys of newly graduated nurses every three years.

Both the NCLEX-RN and the NCLEX-PN are variable length tests that adapt as you answer the test items. The NCLEX-RN examination can be anywhere from 75 to 265 items, depending on how quickly you are able to demonstrate your proficiency. Of these items, 15 are unscored test items. The time limit for this examination is six hours. The NCLEX-PN examination can be anywhere from 85 to 205 items. Of these items, 25 are unscored items. The time limit for this examination is five hours.[1]

In April 2023, the Next Generation NCLEX (NGN) went into effect. Examination questions on the NGN use the NCSBN Clinical Judgment Measurement Model as a framework to measure prelicensure nursing graduates' clinical judgment and decision-making. The critical thinking

1. NCSBN. (2024). *NCLEX & other exams*. https://www.ncsbn.org/nclex.htm

model called the “Nursing Process” continues to underlie the NGN, but candidates will notice new terminology used to assess their decision-making. For example, candidates will be asked to “recognize cues,” “analyze cues,” “create a hypothesis,” “prioritize hypotheses,” “generate solutions,” “take actions,” or “evaluate outcomes.”[2] For this reason, many of the case studies and learning activities included in this book will use similar terminology as the NGN.

> The Nursing Process critical thinking model is discussed in the “Nursing Process” chapter.

There are new types of questions on the NGN, including case studies, enhanced hot spots, drag and drop ordering of responses, multiple responses, and embedded answer choices within paragraphs of text. NCSBN’s rationale for including these types of questions is to “measure the nursing clinical judgment and decision-making ability of prospective entry-level nurses to protect the public’s health and welfare by assuring that safe and competent nursing care is provided by licensed nurses.”[3] Similar questions have been incorporated into learning activities throughout this textbook.

Use the information below to read more about the NCLEX and the Next Generation NCLEX.

2. NCSBN. (2024). *Next Generation NCLEX*. https://www.ncsbn.org/next-generation-nclex.htm

3. NCSBN. (2024). *Next Generation NCLEX*. https://www.ncsbn.org/next-generation-nclex.htm

Read more information about the NCLEX & Test Plans.

View sample "Next Generation NCLEX Item Types" on the Elsevier website.

Nurse Licensure Compact

The **Nurse Licensure Compact (NLC)** allows a nurse to have one multistate nursing license with the ability to practice in their home state, as well as in other compact states. As of 2023, 41 states have implemented NLC legislation.

Read additional details about the Nurse Licensure Compact.

Advanced Nursing Degrees

After obtaining an RN license, nurses can receive advanced degrees to expand their opportunities in the nursing profession.

MASTER'S DEGREE IN NURSING

A Master of Science in Nursing Degree (MSN) requires additional credits and years of schooling beyond the BSN. There are a variety of potential focuses in this degree, including Nurse Educator and Advanced Practice Registered Nurse (APRN). Certifications associated with an MSN degree are Certified Nurse Educator (CNE), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS),

Certified Registered Nurse Anesthetist (CRNA), and Certified Nurse Midwife (CNM). Certifications require the successful completion of a certification exam, as well as continuing education requirements to maintain the certification. Scope of practice for advanced practice nursing roles is defined by each state's Nurse Practice Act.

DOCTORAL DEGREES IN NURSING

Doctoral nursing degrees include the Doctor of Philosophy in Nursing (PhD) and the Doctor of Nursing Practice (DNP). PhD-prepared nurses complete doctoral work that is focused on research. They often teach or conduct research in universities or other settings. DNP-prepared nurses complete doctoral work that is focused on clinical nursing practice. They typically have work roles in advanced nursing practice, clinical leadership, or academic settings.

Lifelong Learning

No matter what nursing role or level of nursing education you choose, nursing practice changes rapidly and is continually updated with new evidence-based practices. Nurses must commit to lifelong learning to continue to provide safe, quality care to their clients. Many states require continuing education credits to renew RN licenses, whereas others rely on health care organizations to set education standards and ongoing educational requirements.

Now that we have discussed nursing roles and education, let's review legal and ethical considerations in nursing.

1.6 Legal & Ethical Considerations

OPEN RESOURCES FOR NURSING (OPEN RN)

Legal Considerations

As discussed earlier in this chapter, nurses can be reprimanded or have their licenses revoked for not appropriately following the Nurse Practice Act in the state they are practicing. Nurses can also be held legally liable for negligence, malpractice, or breach of client confidentiality when providing client care.

Negligence and Malpractice

Negligence is a general term that denotes conduct lacking in due care, carelessness, and a deviation from the standard of care that a reasonable person would use in a particular set of circumstances.[1] **Malpractice** is a more specific term that looks at a standard of care, as well as the professional status of the caregiver.[2]

1. Missouri Department of Health & Senior Services. (n.d.). *Negligence and malpractice*. https://health.mo.gov/living/lpha/phnursing/negligence.php#:~:text=Negligence%20is%3A,a%20particular%20set%20of%20circumstances
2. Missouri Department of Health & Senior Services. (n.d.). *Negligence and malpractice*. https://health.mo.gov/living/lpha/phnursing/negligence.php#:~:text=Negligence%20is%3A,a%20particular%20set%20of%20circumstances

To prove negligence or malpractice, the following elements must be established in a court of law[3]:

- Duty owed the client
- Breach of duty owed the client
- Foreseeability
- Causation
- Injury
- Damages

To avoid being sued for negligence or malpractice, it is essential for nurses and nursing students to follow the scope and standards of practice care set forth by their state's Nurse Practice Act; the American Nurses Association; and employer policies, procedures, and protocols to avoid the risk of losing their nursing license. Examples of a nurse's breach of duty that can be viewed as negligence includes the following:[4]

- Failure to Assess: Nurses should assess for all potential nursing problems/diagnoses, not just those directly affected by the medical disease. For example, all clients should be assessed for fall risk and appropriate fall precautions implemented.
- Insufficient monitoring: Some conditions require frequent monitoring by the nurse, such as risk for falls, suicide risk, confusion, and self-injury.
- Failure to Communicate:

3. Missouri Department of Health & Senior Services. (n.d.). *Negligence and malpractice*. https://health.mo.gov/living/lpha/phnursing/negligence.php#:~:text=Negligence%20is%3A,a%20particular%20set%20of%20circumstances

4. Vera, M. (2020). *Nursing care plan (NCP): Ultimate guide and database*. https://nurseslabs.com/nursing-care-plans/#:~:text=Collaborative%20interventions%20are%20actions%20that,to%20gain%20their%20professional%20viewpoint

    - Lack of documentation: A basic rule of thumb in a court of law is that if an assessment or action was not documented, it is considered not done. Nurses must document all assessments and interventions, in addition to the specific type of client documentation called a nursing care plan.
    - Lack of provider notification: Changes in client condition should be urgently communicated to the health care provider based on client status. Documentation of provider notification should include the date, time, and person notified and follow-up actions taken by the nurse.

- Failure to Follow Protocols: Agencies and states have rules for reporting certain behaviors or concerns. For example, a nurse is considered a mandatory reporter by law and required to report suspicion of abuse or neglect of a child based on data gathered during an assessment.

Patient Self Determination Act

The Patient Self Determination Act (PSDA) of 1990 is an amendment made to the Social Security Act that requires health care facilities to inform clients of their right to be involved in their medical care decisions. This law specifically applies to facilities accepting Medicare or Medicaid funding but is considered a right of all clients regardless of their method of reimbursement.

Under the PSDA, clients must also be asked about their advance directives and care wishes. Clients must be provided with teaching about advance directives, appointment of an agent or surrogate in the event they become incapacitated, and their right to self-determination. Conversations about these topics and clients wishes must be documented in the medical record. It is considered an ethical duty of nurses and other health care professionals to ensure clients are aware and understand these healthcare-associated rights.[5]

5. Teoli, D., & Ghassemzadeh, S. (2023). *Patient Self-Determination Act*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK538297/

Informed Consent

Informed consent is written consent voluntarily signed by a client who is competent and understands the terms of the consent without any form of coercion. In the event the client is a minor or deemed incompetent to make their own decisions, a parent or legal guardian signs the informed consent.[6]

Informed consent is crucial for upholding the client's right for self-determination. Informed consent provides documentation signed by the client of their understanding of health care being provided; its benefits, risks, potential complications; reasonable alternatives to treatment; and the right to withdraw consent. It is the health care provider's responsibility to fully discuss the treatment, procedure, or other health care action being proposed that requires consent. The nurse often signs as a witness to the client's signature on the form, affirming that person signed the form. However, it is not the nurse's responsibility or role to provide information. If the client (or their parent/legal guardian) expresses questions, concerns, or lack of understanding, the nurse has an ethical responsibility to notify the provider and advocate for further discussion before signing the form.[7]

In emergency situations where the delay to obtain consent would cause undue harm to the client, verbal or telephone consent may be temporarily obtained that is valid for no more than ten days. Verbal consent and the

6. Wisconsin State Legislature. (2024). *Chapter DHS 94: Patient Rights and Resolution of Patient Grievances.* https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94/i/02/22

7. Strini, V., Schiavolin, R., & Prendin, A. (2021). The role of the nurse in informed consent to treatments: An observational-descriptive study in the Padua hospital. *Clinics and Practice, 11*(3), 472-483. https://doi.org/ 10.3390/clinpract11030063

reason for verbal consent must be documented in the medical record by the provider.[8]

See the following box for examples of situations requiring informed consent in the state of Wisconsin according to the Wisconsin Department of Health Services.

Examples of Situations Requiring Informed Consent[9]

- Receipt of medications and/or treatment, including psychotropic medications (unless court-ordered)
- Undergoing customary treatment techniques and procedures
- Participation in experimental research
- Undergoing psychosurgery or other psychological treatment procedures
- Release of treatment records
- Videorecording
- Performance of labor beneficial to the facility

Confidentiality

In addition to negligence and malpractice, confidentiality is a major legal

8. Wisconsin State Legislature. (2024). *DHS 94.03 Informed Consent*. https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94/i/03

9. State of Wisconsin. (2022). Client rights: Informed consent. Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/clientrights/informedconsent.htm

consideration for nurses and nursing students. **Patient confidentiality** is the right of an individual to have personal, identifiable medical information, referred to as their protected health information (PHI), protected and known only by those health care team members directly providing care to them. This right is protected by federal regulations called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was enacted in 1996 and was prompted by the need to ensure privacy and protection of personal health records and data in an environment of electronic medical records and third-party insurance payers. There are two main sections of HIPAA law, the Privacy Rule and the Security Rule. The Privacy Rule addresses the use and disclosure of individuals' health information. The Security Rule sets national standards for protecting the confidentiality, integrity, and availability of electronically protected health information. HIPAA regulations extend beyond medical records and apply to client information shared with others. Therefore, all types of client information should only be shared with health care team members who are actively providing care to them.

How do HIPAA regulations affect you as a student nurse? You are required to adhere to HIPAA guidelines from the moment you begin to provide client care. Nursing students may be disciplined or expelled by their nursing program for violating HIPAA. Nurses who violate HIPAA rules may be fired from their jobs or face lawsuits. See the following box for common types of HIPAA violations and ways to avoid them.

Common HIPAA Violations and Ways to Avoid Them[10]

1. **Gossiping in the hallways or otherwise talking about**

10. Patterson, A. (2018). *Most common HIPAA violations with examples*. Inspired eLearning. https://inspiredelearning.com/blog/hipaa-violation-examples/

clients where other people can hear you. It is understandable that you will be excited about what is happening when you begin working with clients and your desire to discuss interesting things that occur. As a student, you will be able to discuss client care in a confidential manner behind closed doors with your instructor. However, as a health care professional, do not talk about clients in the hallways, elevator, breakroom, or with others who are not directly involved with that client's care because it is too easy for others to overhear what you are saying.

2. **Mishandling medical records or leaving medical records unsecured.** You can breach HIPAA rules by leaving your computer unlocked for anyone to access or by leaving written client charts in unsecured locations. You should never share your password with anyone else. Make sure that computers are always locked with a password when you step away from them and paper charts are closed and secured in an area where unauthorized people don't have easy access to them. NEVER take records from a facility or include a client's name on paperwork that leaves the facility.
3. **Illegally or unauthorized accessing of client files.** If someone you know, like a neighbor, coworker, or family member is admitted to the unit you are working on, do not access their medical record unless you are directly caring for them. Facilities have the capability of tracing everything you access within the electronic medical record and holding you accountable. This rule holds true for employees who previously cared for a client as a student; once your shift is over as a student, you should no longer access that client's medical records.

4. **Sharing information with unauthorized people.** Anytime you share medical information with anyone but the client themselves, you must have written permission to do so. For instance, if a husband comes to you and wants to know his spouse's lab results, you must have permission from his spouse before you can share that information with him. Just confirming or denying that a client has been admitted to a unit or agency can be considered a breach of confidentiality. Furthermore, voicemails should not be left regarding protected client information.
5. **Information can generally be shared with the parents of children until they turn 18, although there are exceptions to this rule if the minor child seeks birth control, an abortion, or becomes pregnant.** After a child turns 18, information can no longer be shared with the parent unless written permission is provided, even if the minor is living at home and/or the parents are paying for their insurance or health care. As a general rule, any time you are asked for client information, check first to see if the client has granted permission.
6. **Texting or e-mailing regarding client information on an unencrypted device.** Only use properly encrypted devices that have been approved by your health care facility for e-mailing or faxing protected client information. Also, ensure that the information is being sent to the correct person, address, or phone number.
7. **Sharing information on social media.** Never post anything on social media that has anything to do with your clients, the facility where you are working or have clinical, or even how your day went at the agency. Nurses and other professionals have been fired for violating HIPAA rules on

social media.[11,12,13]

Social Media Guidelines

Nursing students, nurses, and other health care team members must use extreme caution when posting to Facebook, Instagram, Twitter, Snapchat, and other social media sites. Information related to clients, client care, and/or health care agencies should never be posted on social media; health care team members who violate this guideline can lose their jobs and may face legal action and students can be disciplined or expelled from their nursing program. Be aware that even if you think you are posting in a private group, the information can become public.

The American Nurses Association (ANA) has established the following principles for nurses using social media:[14]

- Nurses must not transmit or place online individually identifiable client

11. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557413/

12. American Nurses Association. (n.d.). *About ANA*. https://www.nursingworld.org/ana/about-ana/

13. American Nurses Association. (n.d.). *Scope of practice*. https://www.nursingworld.org/practice-policy/scope-of-practice/

14. American Nurses Association. (n.d.). *Social media*. https://www.nursingworld.org/social/

information.

- Nurses must observe ethically prescribed professional client-nurse boundaries.
- Nurses should understand that clients, colleagues, organizations, and employers may view postings.
- Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
- Nurses should bring content that could harm a client's privacy, rights, or welfare to the attention of appropriate authorities.
- Nurses should participate in developing organizational policies governing online conduct.

In addition to these principles, the ANA has also provided these tips for nurses and nursing students using social media:[15]

- Remember that standards of professionalism are the same online as in any other circumstance.
- Do not share or post information or photos gained through the nurse-client relationship.
- Maintain professional boundaries in the use of electronic media. Online contact with clients blurs this boundary.
- Do not make disparaging remarks about clients, employers, or coworkers, even if they are not identified.
- Do not take photos or videos of clients on personal devices, including cell phones.
- Promptly report a breach of confidentiality or privacy.

15. American Nurses Association. (n.d.). *Social media*. https://www.nursingworld.org/social/

Read more about the ANA's Social Media Principles.

View the *Social Media Guidelines for Nurses* video from the National Council of State Boards of Nursing (NCSBN) on using social media responsibly.

Code of Ethics

In addition to legal considerations, there are also several ethical guidelines for nursing care.

There is a difference between morality, ethical principles, and a **code of ethics**. **Morality** refers to "personal values, character, or conduct of individuals within communities and societies."[16] An **ethical principle** is a general guide, basic truth, or assumption that can be used with clinical judgment to determine a course of action. Four common ethical principles are beneficence (do good), nonmaleficence (do no harm), autonomy (control by the individual), and justice (fairness). A code of ethics is set for a profession and makes their primary obligations, values, and ideals explicit.

The American Nursing Association (ANA) guides nursing practice with the *Code of Ethics for Nurses*.[17] This code provides a framework for ethical nursing

16. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

17. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

care and a guide for decision-making. *The Code of Ethics for Nurses* serves the following purposes:

- It is a succinct statement of the ethical values, obligations, duties, and professional ideals of nurses individually and collectively.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.[18]

The ANA Code of Ethics contains nine provisions. See a brief description of each provision in the following box.

Provisions of the ANA Code of Ethics[19]

The nine provisions of the ANA Code of Ethics are briefly described below. The full code is available to read for free at Nursingworld.org.

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

18. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

19. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

The ANA Center for Ethics and Human Rights

In addition to publishing the Code of Ethics, the ANA Center for Ethics and Human Rights was established to help nurses navigate ethical and value conflicts and life-and-death decisions, many of which are common to everyday practice.

- Read more information about the ANA Center for Ethics and Human Rights.

Check your knowledge with the following questions:

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=709#h5p-57

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=709#h5p-58

1.7 Professional Organizations

OPEN RESOURCES FOR NURSING (OPEN RN)

In addition to the ANA's *Nursing: Scope and Standards of Practice* and *Code of Ethics for Nurses*, there are several professional nursing organizations that provide specialized standards for nursing care and promote continuous quality improvement. The following box contains examples of many organizations that significantly guide the overall nursing profession.

Examples of Professional Nursing Organizations

American Nursing Association: The American Nurses Association (ANA) guides professional nursing practice with publications, in addition to establishing the ANA Scope and Standards of Practice and ANA Code of Ethics. The ANA also publishes a monthly journal on nursing topics for its members called *The American Nurse*.

- Read more information about the ANA.

American Nurses Credentialing Center: The American Nurses Credentialing Center (ANCC) credentials both organizations and individuals. ANCC certification provides individual nurses certification in specialized nursing knowledge.

The ANCC accreditation program recognizes the importance of high-quality continuing nursing education, interprofessional continuing education, transition to practice programs, and skills-

based competency programs. Around the world, ANCC-accredited organizations provide nurses with the knowledge and skills to help improve care and client outcomes.

- Read more about the American Nurses Credentialing Center

National League for Nursing: The focus of the National League for Nursing (NLN) is to promote excellence in nursing education. The NLN establishes standards and evaluates nursing education programs, promotes faculty development, funds nursing education research, and publishes the research journal *Nursing Education Perspectives*.[1]

- Read more about the National League for Nursing.

Accreditation Commission for Education in Nursing: The Accreditation Commission for Education in Nursing (ACEN) is one of the organizations that provide accreditation for nursing education to recognize educational institutions or programs that have been found to meet or exceed standards and criteria for educational quality. ACEN provides accreditation for each of the 16 technical colleges in the Wisconsin Technical College System. As a nursing student, you may be asked to provide vital feedback to ACEN site visitors on your nursing program.

- Read more about ACEN accreditation.

1. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

Commission on Collegiate Nursing Education: The Commission on Collegiate Nursing Education (CCNE) ensures the quality and integrity of baccalaureate, graduate, and residency programs in nursing.

- Read more about CCNE accreditation.

National Student Nurses' Association: The mission of the National Student Nurses' Association (NSNA) is to "mentor students preparing for initial licensure as registered nurses, and to convey the standards, ethics, and skills that students will need as responsible and accountable leaders and members of the profession."[2] NSNA holds national conventions and publishes the journal *Imprint*.

- Read more about the National Student Nurses' Association.

Specialty Nursing Organizations: There are many specialty organizations that provide certification, publish scope of practice documents for that specialty, and issue position statements.[3] Read more about various specialty organizations:

- Academy of Medical-Surgical Nurses
- Wound, Ostomy and Continence Nursing

2. National Student Nurses' Association. (n.d.). *About us*. https://www.nsna.org/about-nsna.html

3. American Nurses Association. (n.d.). *Scope of practice*. https://www.nursingworld.org/practice-policy/scope-of-practice/

- Perioperative Nursing
- Association of Women's Health, Obstetric, and Neonatal Nurses

View this supplementary YouTube video[4] from the former president of the Academy of Medical-Surgical Nurses about important nursing issues.

4. AMSN MSNCB. (2020, May 6). *AMSN...The present* [Video]. YouTube. All rights reserved. https://youtu.be/unRSCXdhCgk

1.8 Quality and Evidence-Based Practice

OPEN RESOURCES FOR NURSING (OPEN RN)

The American Nursing Association (ANA), various professional nursing organizations, and federal agencies continually work to improve the quality of client care. Nurses must also be individually dedicated to providing quality client care based on current evidence-based practices.

Quality of Practice

One of the American Nurses Association (ANA) Standards of Professional Practice is "Quality of Practice." This standard emphasizes that "nursing practice is safe, effective, efficient, equitable, timely, and person-centered."[1] **Quality** is defined as, "The degree to which nursing services for healthcare consumers, families, groups, communities, and populations increase the likelihood of desirable outcomes and are consistent with evolving nursing knowledge."[2] Every nurse is responsible for providing quality care to their clients by following the standards set forth by various organizations, as well as personally incorporating evidence-based practice. Quality is everyone's responsibility, and it takes the entire health care team to ensure that quality care is provided to each and every client. For example, turning an immobile client every two hours to prevent pressure injuries requires the dedication of many staff members throughout the day and night. Quality actions can also

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

be formalized on a specific unit, such as the review of data related to client falls with specific unit-based interventions formally put into place. This commitment to quality practice requires lifelong learning after nurses have completed their formal nursing education to remain current with new evidence-based practices.

Learning how to provide safe, quality nursing practice begins in nursing school. The Quality and Safety Education for Nurses (QSEN) project encourages future nurses to continuously improve the quality and safety of the health care systems in which they work. The vision of the QSEN project is to "inspire health care professionals to put quality and safety as core values to guide their work."[3] Nurses and nursing students are expected to participate in quality improvement (QI) initiatives by identifying gaps where change is needed and implementing initiatives to resolve these gaps. **Quality improvement** is defined as the combined and unceasing efforts of everyone – health care professionals, clients and their families, researchers, payers, planners, and educators – to make the changes that will lead to optimal client outcomes (health), improved system performance (care), and enhanced professional development (learning).[4] Nursing students can immediately begin to contribute to improving the quality of nursing practice by participating in quality improvement initiatives.

Read more about the QSEN project.

3. QSEN Institute. (n.d.). *Project overview*. http://qsen.org/about-qsen/project-overview/

4. Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *BMJ Quality & Safety, 16*(1), 2–3. https://doi.org/10.1136/qshc.2006.022046

Evidence-Based Practice in Nursing

Evidence-based practice is a component of the ANA's "Scholarly Inquiry" Standard of Professional Practice. Evidence-based practice is defined as, "A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the healthcare consumer's history and condition, as well as health care resources; and client, family, group, community, and population preferences and values."[5]

Utilizing evidence-based practice means that nurses and nursing students provide client care based on research studies and clinical expertise and do not just do something "because that's the way it has always been done." A simple example of nurses promoting evidence-based practice to help clients is using peppermint to relieve nausea. Throughout history, peppermint was used for an upset stomach and to relieve the feeling of nausea. This idea was frequently rejected in the medical field because there was no scientific evidence to support it. However, in 2016, Lynn Bayne and Helen Hawrylack, two nurse researchers, developed a peppermint inhaler for clients to use when they were feeling nauseated and found it was 93% effective in relieving nausea.[6]

Nursing students should implement evidence-based practice as they begin their nursing career by ensuring the resources they use to prepare for client care are valid and credible. For this reason, information to credible and reliable sources is provided throughout this textbook.

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

6. ChristianaCare News. (2016). *Nurse researchers develop peppermint inhaler to relieve post-op nausea.* https://news.christianacare.org/2016/05/nurse-researchers-develop-peppermint-inhaler-to-relieve-post-op-nausea/

1.9 Learning Activities

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

Apply what you have learned from this chapter by completing the following learning activities:

1. You are a nursing student observing care in the Critical Care Unit (CCU) as part of your clinical course. You have been assisting a critical care nurse with the care of a client who has been experiencing significantly low blood pressures throughout the day. The nurse has to step away from the bedside to take a phone call and instructs you to increase the intravenous (IV) medication if the client's systolic blood pressure drops below 90 mmHg. What is the appropriate response to this instruction?

2. You are completing a clinical rotation on a medical-surgical unit and are invited to join a few staff nurses in the breakroom for a lunch break. While you are in the breakroom, you notice one of the staff nurses complaining loudly about a client and discussing sensitive client care information. What is an appropriate response to this situation?

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An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=102#h5p-2

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=102#h5p-3

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=102#h5p-56

Test your knowledge using this NCLEX Next Generation-style question. You may reset and resubmit your answers to this question an unlimited number of times.[1]

Test your knowledge using this NCLEX Next Generation-style question. You may reset and resubmit your answers to this question an unlimited number of times.[2]

1. "Chapter 1, Assignment 1" by Tami Davis for OpenRN is licensed under CC BY-NC 4.0

2. "Chapter 1, Assignment 2" by Rebecca Wicks for OpenRN is licensed under CC BY-NC 4.0

I. Glossary

OPEN RESOURCES FOR NURSING (OPEN RN)

Advanced Practice Registered Nurse (APRN): An RN who has a graduate degree and advanced knowledge. There are four categories of APRNs: certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), or certified registered nurse anesthetist (CRNA). These nurses can diagnose illnesses and prescribe treatments and medications.[1] (Chapter 1.4)

ANA Standards of Professional Nursing Practice: Authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently. The Standards of Professional Nursing Practice describe a competent level of nursing practice as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation.[2] (Chapter 1.3)

ANA Standards of Professional Performance: Standards that describe a competent level of behavior in the professional role of the nurse, including activities related to ethics, advocacy, respectful and equitable practice, communication, collaboration, leadership, education, scholarly inquiry, quality of practice, professional practice evaluation, resource stewardship, and environmental health.[3] (Chapter 1.3)

1. NCSBN. https://www.ncsbn.org/index.htm
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Basic nursing care: Care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable.[4] (Chapter 1.4)

Board of Nursing: The state-specific licensing and regulatory body that sets the standards for safe nursing care, decides the scope of practice for nurses within its jurisdiction, and issues licenses to qualified candidates. (Chapter 1.3)

Certification: The formal recognition of specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty. (Chapter 1.4)

Chain of command: A hierarchy of reporting relationships in an agency that establishes accountability and lays out lines of authority and decision-making power. (Chapter 1.4)

Code of ethics: A code that applies normative, moral guidance for nurses in terms of what they ought to do, be, and seek. A code of ethics makes the primary obligations, values, and ideals of a profession explicit. (Chapter 1.6)

Dysphagia: Impaired swallowing. (Chapter 1.4)

Ethical principle: An ethical principle is a general guide, basic truth, or assumption that can be used with clinical judgment to determine a course of action. Four common ethical principles are beneficence (do good), nonmaleficence (do no harm), autonomy (control by the individual), and justice (fairness). (Chapter 1.6)

Evidence-based practice: A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health consumer's history and condition, as well as health care resources;

4. Wisconsin Administrative Code. (2018). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses.* https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

and client, family, group, community, and population preferences and values.[5] (Chapter 1.8)

Expressive aphasia: The impaired ability to form words and speak. (Chapter 1.4)

Licensed Practical Nurse/Vocational Nurse (LPN/LVN): An individual who has completed a state-approved practical or vocational nursing program, passed the NCLEX-PN examination, and is licensed by their state Board of Nursing to provide client care.[6] (Chapter 1.4, Chapter 1.5)

Malpractice: A specific term that looks at a standard of care, as well as the professional status of the caregiver.[7] (Chapter 1.6)

Morality: Personal values, character, or conduct of individuals within communities and societies.[8] (Chapter 1.6)

Negligence: A "general term that denotes conduct lacking in due care, carelessness, and a deviation from the standard of care that a reasonable person would use in a particular set of circumstances."[9] (Chapter 1.6)

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

6. NCSBN. https://www.ncsbn.org/index.htm

7. Missouri Department of Health & Senior Services. (n.d.). *Negligence and malpractice*. https://health.mo.gov/living/lpha/phnursing/negligence.php#:~:text=Negligence%20is%3A,a%20particular%20set%20of%20circumstances

8. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

9. Missouri Department of Health & Senior Services. (n.d.). *Negligence and malpractice*. https://health.mo.gov/living/lpha/phnursing/

Nurse Licensure Compact (NLC): Allows a nurse to have one multistate license with the ability to practice in the home state and other compact states. (Chapter 1.5)

Nursing: Nursing integrates the art and science of caring and focused on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity.[10] (Chapter 1.3)

Nurse Practice Act (NPA): Legislation enacted by each state that establishes regulations for nursing practice within that state by defining the requirements for licensure, as well as the scope of nursing practice. (Chapter 1.3)

Patient confidentiality: Keeping your client's Protected Health Information (PHI) protected and known only by those health care team members directly providing care for the client. (Chapter 1.6)

Primary care: Care that is provided to clients to promote wellness and prevent disease from occurring. This includes health promotion, education, protection (such as immunizations), early disease screening, and environmental considerations. (Chapter 1.4)

Protocol: A precise and detailed written plan for a regimen of therapy.[11] (Chapter 1.3)

negligence.php#:~:text=Negligence%20is%3A,a%20particular%20set%20of%20circumstances

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

11. Wisconsin Administrative Code. (2018). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

Provider: A physician, podiatrist, dentist, optometrist, or advanced practice nurse provider.[12] (Chapter 1.4)

Quality: The degree to which nursing services for health care consumers, families, groups, communities, and populations increase the likelihood of desirable outcomes and are consistent with evolving nursing knowledge."[13] (Chapter 1.8)

Quality improvement: Combined and unceasing efforts of everyone–healthcare professionals, clients and their families, researchers, payers, planners and educators–to make the changes that will lead to better client outcomes (health), better system performance (care) and better professional development (learning). (Chapter 1.8)

Registered Nurse (RN): An individual who has graduated from a state-approved school of nursing, passed the NCLEX-RN examination, and is licensed by a state board of nursing to provide client care.[14] (Chapter 1.4, Chapter 1.5)

Safety culture: A culture established within health care agencies that empowers nurses, nursing students, and other staff members to speak up about risks to clients and to report errors and near misses, all of which drive improvement in client care and reduce the incident of client harm. (Chapter 1.3)

Scope of practice: Services that a qualified health professional is deemed competent to perform and permitted to undertake – in keeping with the terms of their professional license. (Chapter 1.1)

Secondary care: Care that occurs when a person has contracted an illness or injury and is in need of medical care. (Chapter 1.4)

12. Wisconsin Administrative Code. (2018). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

14. NCSBN. https://www.ncsbn.org/index.htm

Tertiary care: A type of care that deals with the long-term effects from chronic illness or condition, with the purpose to restore physical and mental function that may have been lost. The goal is to achieve the highest level of functioning possible with this chronic illness. (Chapter 1.4)

Unlicensed Assistive Personnel (UAP): Any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state tested nursing assistants (STNAs), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs). Certification of UAPs varies between jurisdictions.[15] (Chapter 1.4)

15. NCSBN. https://www.ncsbn.org/index.htm

PART II

COMMUNICATION

2.1 Communication Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Objectives

- Assess one's own communication skills and effectiveness[1]
- Demonstrate cultural humility, professionalism, and respect when communicating[2]
- Use communication styles and methods that demonstrate caring, respect, active listening, authenticity, and trust[3]
- Maintain communication with interprofessional team members and others to facilitate safe transitions and continuity in care delivery[4]

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Confirm the recipient of the communication heard and understands the message[5]
- Use therapeutic communication techniques
- Identify strategies to adapt communication to the client, audience, and situation
- Verify information sources are reliable and current
- Use correct medical terminology and abbreviations
- Describe ways to report client information
- Describe legal and standard documentation guidelines

Strong communication skills are essential to provide safe, quality, client-centered care. Nurses develop therapeutic relationships with clients and family members each day to ensure that health care concerns and needs are addressed. If communication breaks down, information exchange stops and needs go unidentified. Nurses optimize communication channels with clients and families by establishing trust and actively listening to health care concerns. Additionally, the nurse is vital for ensuring that information transfer occurs within the multidisciplinary team. Communication with other health care team members is professional, organized, accurate, complete, and concise. This chapter will review methods for establishing good communication.

Before getting started, view the following video and reflect on the often invisible needs of those around us and the difference we can make by creating caring human connections.

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

View the video: Empathy: The Human Connection to Patient Care.[6]

6. Cleveland Clinic. (2013, February 27). *Empathy: The human connection to patient care* [Video]. YouTube. All rights reserved. https://youtu.be/cDDWvj_q-o8

2.2 Basic Communication Concepts

OPEN RESOURCES FOR NURSING (OPEN RN)

Effective communication is one of the Standards of Professional Performance established by the American Nurses Association. The standard states, "The registered nurse communicates effectively in all areas of practice."[1] There are several concepts related to effective communication such as demonstrating appropriate verbal and nonverbal communication, using assertive communication, being aware of personal space, and overcoming common barriers to effective communication.

Types of Communication

Verbal Communication

Effective communication requires each interaction to include a sender of the message, a clear and concise message, and a receiver who can decode and interpret that message. The receiver also provides a feedback message back to the sender in response to the received message. See Figure 2.1[2] for an image of effective communication between a sender and receiver.

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. "Osgood-Schramm-model-of-communication.jpg" by Jordan Smith at eCampus Ontario is licensed under CC BY 4.0. Access for free at https://ecampusontario.pressbooks.pub/communicationatwork/chapter/1-3-the-communication-process/

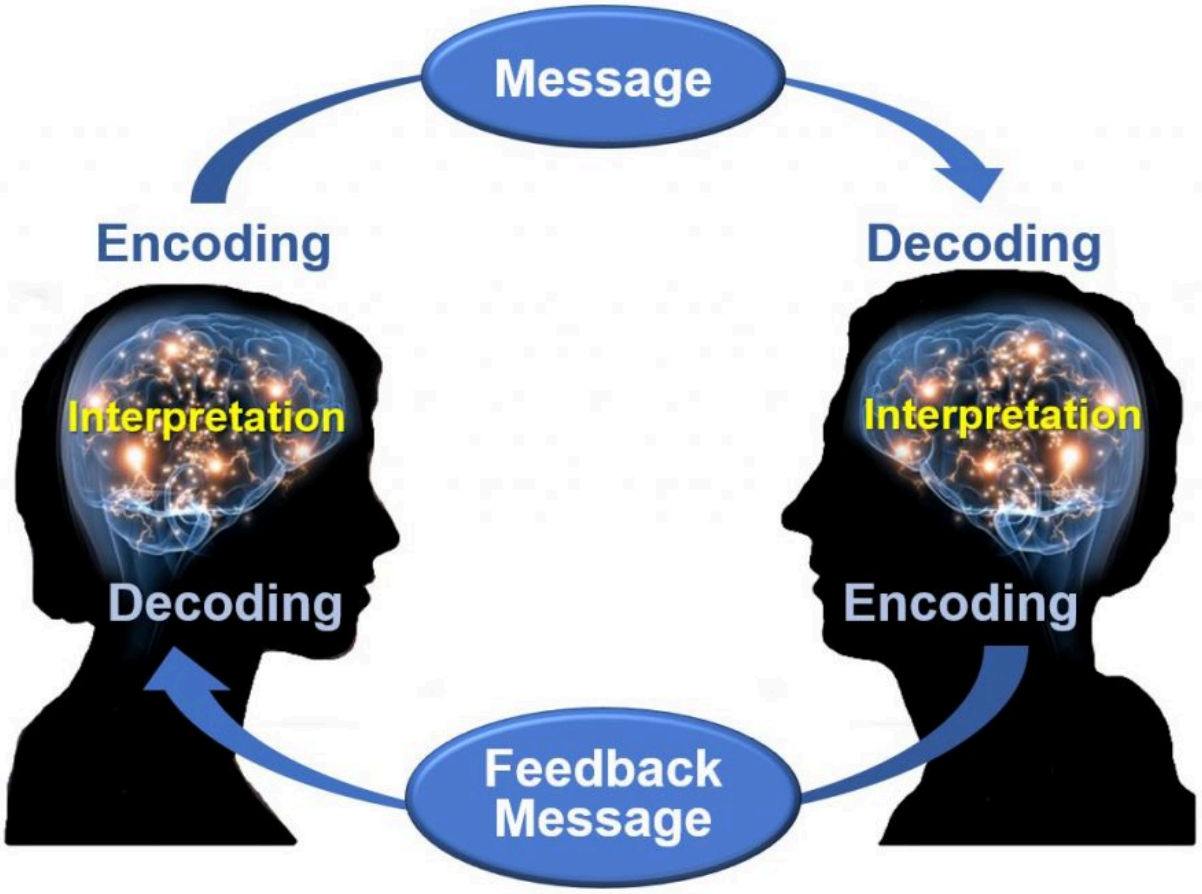

Figure 2.1 Effective Communication

Nurses assist clients and their family members to understand health care needs and treatments by using verbal, nonverbal, and written communication. Verbal communication is more than just talking. Effective **verbal communication** is defined as an exchange of information using words understood by the receiver in a way that conveys professional caring and respect.[3] Nurses who speak using extensive medical jargon or slang may

3. Anonymous. (2024). *Human relations (dias)*. LibreTexts: Social Sciences. https://socialsci.libretexts.org/Bookshelves/Communication/Human_Relations/Human_Relations_(Dias)

create an unintended barrier to their own verbal communication processes. When communicating with others, it is important for the nurse to assess the receiver's preferred method of communication and individual receiver characteristics that might influence communication, and subsequently adapt communication to meet the receiver's needs. For example, the nurse may adapt postsurgical verbal instruction for a pediatric versus an adult client. Although the information requirements regarding signs of infection, pain management, etc., might be similar, the way in which information is provided may be quite different based on developmental level. Regardless of the individual adaptations that are made, the nurse must be sure to always verify client understanding.

Nonverbal Communication

In addition to communicating verbally, the nurse must also be aware of messages sent by **nonverbal communication**. Nonverbal communication includes facial expressions, tone of voice, pace of the conversation, and body language. Nonverbal communication is more powerful than the verbal message and can have a tremendous impact on the communication experience, with up to 80% of communication being nonverbal communication (see Figure 2.2[4]). The importance of nonverbal communication during communication has also been described in percentages of 55, 38, and 7, meaning 55% of communication is body language, 38% is tone of voice, and 7% is the actual words spoken.[5]

4. "Constituents of Communication.png" by jb11ko, lb13an, ad14xz, jb12xu is licensed under CC BY-SA 4.0

5. Thompson, J. (2011). Is nonverbal communication a numbers game? *Psychology Today.* https://www.psychologytoday.com/us/blog/beyond-words/201109/is-nonverbal-communication-numbers-game

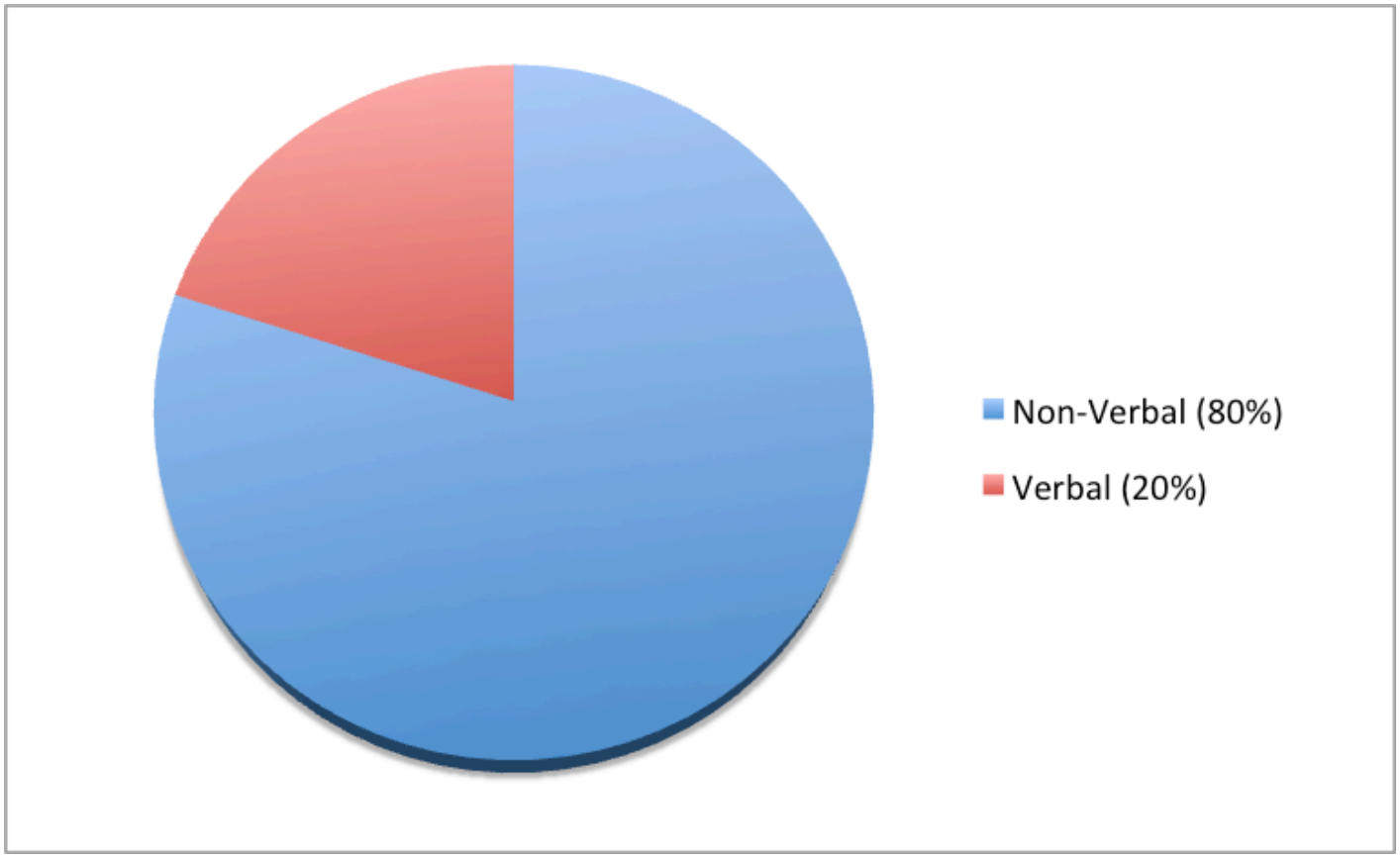

Figure 2.2 Nonverbal Communication

Nonverbal communication includes body language and facial expressions, tone of voice, and pace of the conversation. For example, compare the nonverbal communication messages in Figures 2.3[6] and 2.4.[7] What nonverbal cues do you notice about both toddlers?

6. "I'm angry" by WiLPrZ is licensed under CC BY-NC-ND 2.0

7. "Happy Toddler" by Chris Bloom is licensed under CC BY-SA 2.0

Figure 2.3 Toddler's Nonverbal Communication

Figure 2.4 Toddler's Nonverbal Communication

Nurses should be attentive to their nonverbal communication cues and the messages they provide to clients and their families. Nurses should be purposeful in their use of nonverbal communication that conveys a feeling of

caring.[8] What nonverbal cues do you notice about the nurse in Figure 2.5[9] that provide a perception of professional caring?

Figure 2.5 Nurse's Nonverbal Communication

Nurses use nonverbal communication such as directly facing clients at eye

8. Anonymous. (2024). *Human relations (dias)*. LibreTexts: Social Sciences. https://socialsci.libretexts.org/Bookshelves/Communication/Human_Relations/Human_Relations_(Dias)

9. "PIXNIO-42752-4542×3003.jpg" by James Gathany, Judy Schmidt, USCDCP is in the Public Domain

level, leaning slightly forward, and making eye contact to communicate they care about what the person is telling them and they have their full attention.[10]

It is common for health care team members in an acute care setting to enter a client's room and begin interacting with a client who is seated or lying in bed. However, it is important to remember that initial or sensitive communication exchanges are best received by the client if the nurse and client are at eye level. Bringing a chair to the client's bedside can help to facilitate engagement in the communication exchange. SOLER is common mnemonic used to facilitate nonverbal communication (**s**it with **o**pen posture and **l**ean in with good **e**ye contact in a **r**elaxed manner).

Communication Styles

In addition to verbal and nonverbal communication, people communicate with others using one of three styles: passive, aggressive, or assertive. A passive communicator puts the rights of others before their own. Passive communicators tend to be apologetic or sound tentative when they speak and often do not speak up if they feel they are being wronged. Aggressive communicators, on the other hand, come across as advocating for their own rights despite possibly violating the rights of others. They tend to

10. Stickley, T. (2011). From SOLER to SURETY for effective non-verbal communication. *Nurse Education in Practice, 11*(6), 395-398. https://doi.org/10.1016/j.nepr.2011.03.021

communicate in a way that tells others their feelings don't matter. Assertive communicators, in contrast, respect the rights of others while also standing up for their own ideas and rights when communicating. An assertive person is direct, but not insulting or offensive.[11] **Assertive communication** refers to a way of conveying information that describes the facts and the sender's feelings without disrespecting the receiver's feelings. Using "I" messages such as, "I feel...," "I understand...," or "Help me to understand..." are strategies for assertive communication. This method of communicating is different from aggressive communication that uses "you" messages and can feel as if the sender is verbally attacking the receiver rather than dealing with the issue at hand. For example, instead of saying to a coworker, "Why is it always so messy in your clients' rooms? I dread following you on the next shift!," an assertive communicator would use "I" messages to say, "I feel frustrated spending the first part of my shift decluttering our clients' rooms. Help me understand why it is a challenge to keep things organized during your shift?"

Using assertive communication is an effective way to solve problems with clients, coworkers, and health care team members.

View this supplementary YouTube video[12] on How to Communicate Assertively.

11. Anonymous. (2024). *Human relations (dias)*. LibreTexts: Social Sciences. https://socialsci.libretexts.org/Bookshelves/Communication/Human_Relations/Human_Relations_(Dias)

12. Communication Coach Alexander Lyon. (2022, March 21). *How to Communicate Assertively 4 Tips.* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=hAxCpAnV3-E

Personal Space

While being aware of verbal and nonverbal messages and communicating assertively, it is also important to be aware of others' personal space. Proxemics is the study of personal space and provides guidelines for professional communication. The public zone is over 10 feet of distance between people and generally avoids physical contact. The social zone is four to 10 feet of distance between people. It is used during social interactions and business settings. The personal zone is 18 inches to four feet of space and is generally reserved for friends and family. Less than 18 inches is reserved for close relationships but may be invaded when in crowds or playing sports.[13] Nurses usually communicate within the social zone to maintain professional boundaries. However, when assessing clients and performing procedures, nurses often move into a client's personal zone. Nurses must be aware of clients' feelings of psychological discomfort that can occur when invading this zone. Additionally, cultural considerations may impact the appropriateness of personal space when providing client care. See Figure 2.6 for example of personal space zones.[14]

13. Psychology Today. (n.d.). *Proxemics*. https://www.psychologytoday.com/us/basics/proxemics

14. "Personal Space.svg" by WebHamster is licensed under CC BY-SA 3.0

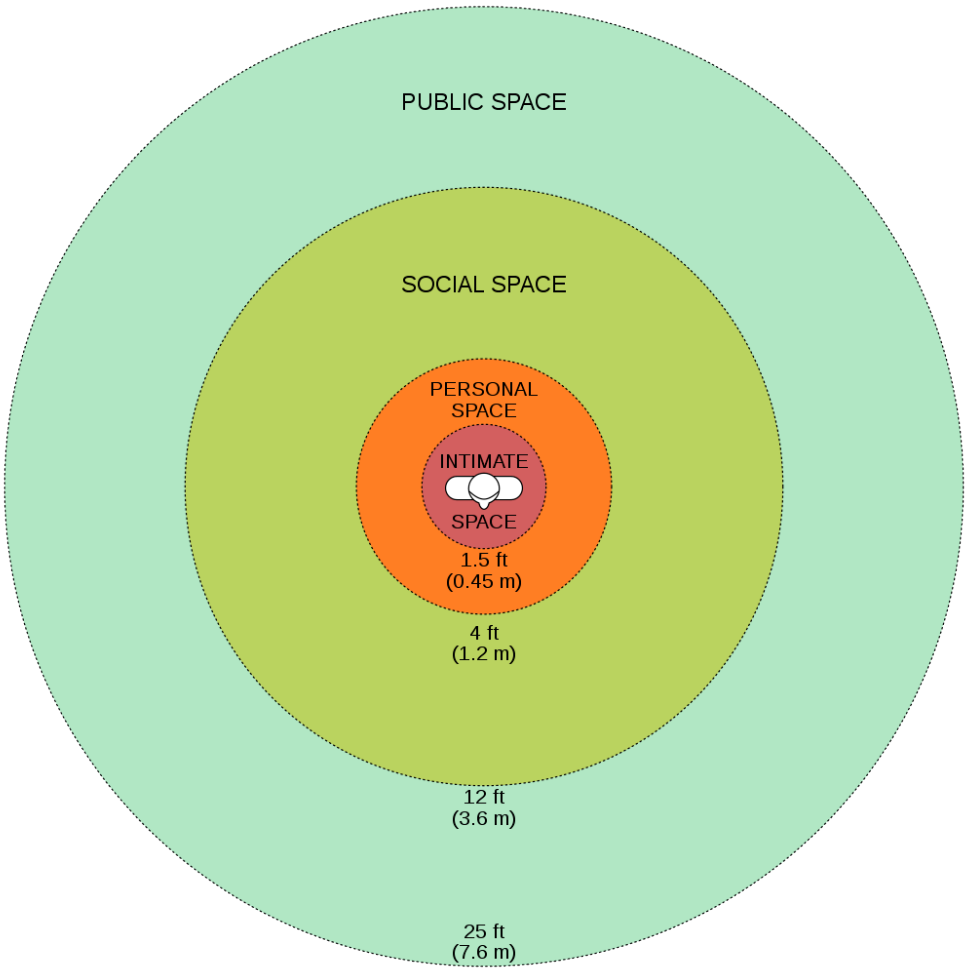

Figure 2.6 Personal Space Zones

Overcoming Common Barriers to Communication

Nurses must reflect on personal factors that influence their ability to communicate effectively. There are many factors that can cause the message you are trying to communicate to become distorted and not perceived by the receiver in the way you intended. For this reason, is important to seek feedback that your message is clearly understood. Nurses must be aware of

these potential barriers and try to reduce their impact by continually seeking feedback and checking understanding.[15]

Common barriers to communication in health care and strategies to overcome them are described in the following box.[16]

Common Barriers to Communication in Health Care

- **Jargon:** Avoid using medical terminology, complicated, or unfamiliar words. When communicating with clients, explain information in plain language that is easy to understand by those without a medical or nursing background.
- **Lack of attention:** Nurses are typically very busy with several tasks to complete for multiple clients. It is easy to become focused on the tasks instead of the client. When entering a client's room, it is helpful to pause, take a deep breath, and mindfully focus on the client in front of you to give them your full attention. Clients should feel as if they are the center of your attention when you are with them, no matter how many other things you have going on.
- **Noise and other distractions:** Health care environments can be very noisy with people talking in the room or hallway, the TV playing, alarms beeping, and pages occurring overhead. Create a calm, quiet environment when communicating with clients by closing doors to the

15. SkillsYouNeed. (n.d.). *Barriers to effective communication*. https://www.skillsyouneed.com/ips/barriers-communication.html

16. SkillsYouNeed. (n.d.). *Barriers to effective communication*. https://www.skillsyouneed.com/ips/barriers-communication.html

hallway, reducing the volume of the TV, or moving to a quieter area, if possible.

- **Light:** A room that is too dark or too light can create communication barriers. Ensure the lighting is appropriate according to the client's preference.
- **Hearing and speech problems:** If your client has hearing or speech problems, implement strategies to enhance communication. See the "Adapting Your Communication" subsection below for strategies to address hearing and speech problems.
- **Language differences:** If English is not your client's primary language, it is important to seek a medical interpreter and to also provide written handouts in the client's preferred language when possible. Most agencies have access to an interpreter service available by phone if they are not available on-site.
- **Differences in cultural beliefs:** The norms of social interaction vary greatly in different cultures, as well as the ways that emotions are expressed. For example, the concept of personal space varies among cultures, and some clients are stoic about pain whereas others are more verbally expressive. Read more about caring for diverse clients in the "Diverse Patients" chapter.
- **Psychological barriers:** Psychological states of the sender and the receiver affect how the message is sent, received, and perceived. For example, if nurses are feeling stressed and overwhelmed with required tasks, the nonverbal communication associated with their messages such as lack of eye contact, a hurried pace, or a short tone can affect how the client perceives the message. If a client is feeling stressed, they may not be able to "hear" the

message or they may perceive it differently than it was intended. It is important to be aware of signs of the stress response in ourselves and our clients and implement appropriate strategies to manage the stress response. See the box below for more information about strategies to manage the stress response.

- **Physiological barriers:** It is important to be aware of clients' potential physiological barriers when communicating. For example, if a client is in pain, they are less likely to hear and remember what was said, so pain relief should be provided as needed before providing client education. However, it is also important to remember that sedatives and certain types of pain medications often impair the client's ability to receive and perceive messages so health care documents cannot be signed by a client after receiving these types of medications.
- **Physical barriers for nonverbal communication:** Providing information via e-mail or text is often less effective than face-to-face communication. The inability to view the nonverbal communication associated with a message such as tone of voice, facial expressions, and general body language often causes misinterpretation of the message by the receiver. When possible, it is best to deliver important information to others using face-to-face communication so that nonverbal communication is included with the message.
- **Differences in perception and viewpoints:** Everyone has their own beliefs and perspectives and wants to feel "heard." When clients feel their beliefs or perspectives are not valued, they often become disengaged from the conversation or the plan of care. Nurses should provide

health care information in a nonjudgmental manner, even if the client's perspectives, viewpoints, and beliefs are different from their own.

Read more about Barriers to Effective Communication.

Managing the Stress Response[17]

The stress response is a common psychological barrier to effective communication. It can affect the message sent by the sender or how it is received by the receiver. The stress response is a common reaction to life events, such as a nurse feeling stressed by being overwhelmed with tasks to complete for multiple clients, or a client feeling stressed when admitted to a hospital or receiving a new diagnosis. Symptoms of the stress response include irritability, sweaty palms, a racing heart, difficulty concentrating, and impaired sleep. It is important to recognize symptoms of the stress response in ourselves and our clients and use strategies to manage the stress response when communicating. Strategies to manage the stress response include the following:

17. American Psychological Association. (2019). *Healthy ways to handle life's stressors.* https://www.apa.org/topics/stress/tips

1. Use **relaxation breathing**. Become aware of your breathing. Take a deep breath in your nose and blow it out through your mouth. Repeat this process at least three times in succession and then as often as needed throughout the day.
2. Make healthy diet choices. Avoid caffeine, nicotine, and junk food because these items can increase feelings of anxiety or being on edge.
3. Make time for exercise. Exercise stimulates the release of natural endorphins that reduce the body's stress response and also helps to improve sleep.
4. Get enough sleep. Set aside at least 30 minutes before going to bed to wind down from the busyness of the day. Avoid using electronic devices like cell phones before bedtime because the backlight can negatively impact sleep.
5. Use **progressive relaxation**. There are several types of relaxation techniques that focus on reducing muscle tension and using mental imagery to induce calmness. Progressive relaxation generally includes the following steps:

    - Start by lying down somewhere comfortable and firm, such as a rug or mat on the floor. Get yourself comfortable.
    - Relax and try to let your mind go blank. Breathe slowly, deeply, and comfortably, while gradually and consciously relaxing all your muscles, one by one.
    - Work around the body one main muscle area at a time, breathing deeply, calmly, and evenly.

For each muscle group, clench the muscles tightly and hold for a few seconds, and then relax them completely. Repeat the process, noticing how it feels. Do this for each of your feet, calves, thighs, buttocks, stomach, arms, hands, shoulders, and face.

2.3 Communicating With Patients

OPEN RESOURCES FOR NURSING (OPEN RN)

THE NURSE-CLIENT RELATIONSHIP

The nurse-client relationship, also called a helping relationship, is crucial for holistic, compassionate nursing care. During a nurse-client relationship, the nurse builds rapport and establishes trust with the purpose of actively engaging the client in discussions about their feelings, emotions, care process, and decision-making. Establishing rapport with clients is of the utmost importance because it facilitates an open and honest dialogue between the client and the nurse. It facilitates therapeutic communication and engages the client in decision-making regarding their plan of care. The nurse-client relationship is a professional relationship in which the nurse practices the "art of nursing," an abstract connection between the client's needs, expressed behaviors, and the nurse's perceptions and exploration of these concepts.[1]

Phases of the Nurse-Client Relationship

The nurse-client relationship evolves through several phases. A well-known nurse theorist named Hildegard Peplau described these three phases as the

1. Ernstmeyer, K., & Christman, E. (2022). *Nursing: Mental health and community concepts*. Open RN. https://wtcs.pressbooks.pub/nursingmhcc/

orientation phase, working phase, and termination phase. Some sources include an additional phase called the pre-interaction phase[2,3]:

- **Preinteraction Phase:** The nurse reviews the medical record or other data in preparation for the orientation phase. The preinteraction phase can also be helpful in identifying preconceived notions about a client situation, acknowledging these feelings, and making a conscious effort to avoid biases.
- **Orientation Phase:** The orientation phase is a brief encounter where the nurse addresses the client by name and then introduces themself to the client, including their name and role. This introduction should include an estimated time frame for the conversation or encounter, and an explanation of what will occur. The nurse should begin to establish trust and rapport by ensuring privacy. This is especially important if sensitive topics will be discussed. While obtaining information about the client, it is important to realize the client is a unique individual with distinct needs, priorities, values and belief systems, and should be treated as such. While the nurse may not agree with the client's values and belief systems, the nurse must respect them. Failure to establish rapport and trust during the orientation phase will block communication and make it difficult for the nurse to fully engage in therapeutic communication with the client.
- **Working Phase:** After the orientation phase is complete, the working phase begins. The majority of a nurse's time is spent in the working phase with a client. Communication during the working phase should be client-focused and based on what is important to the client. Communication generally focuses on their reason for seeking medical care, but deeper

2. Ernstmeyer, K., & Christman, E. (2022). *Nursing: Mental health and community concepts*. Open RN. https://wtcs.pressbooks.pub/nursingmhcc/

3. O'Brien, P. (n.d.). *The nurse client relationship and therapeutic communication*. https://samples.jbpub.com/9781449651749/46080_ch03_obrien.pdf

concerns are discussed and explored as they come up. During the working phase, the nurse engages in therapeutic communication by recognizing cues, such as body language or statements about emotions, and then encourages further discussion about the client's feelings about a particular subject. The conversation should be focused on the client's feelings and thought processes, not the nurse's feelings and thoughts. If rapport and trust were successfully developed during the orientation phase, the client is more likely engage in therapeutic communication with the nurse, who is perceived as an educator and counselor, in addition to a health care professional. The nurse uses therapeutic communication techniques to help the client gain an awareness of their deeper feelings, existing coping mechanisms, and overall goals for care. The nurse should remain nonjudgmental while providing feedback and reflection regarding what the client is saying, both verbally and nonverbally. Therapeutic communication techniques, as well as common communication blocks, are discussed later in this chapter.

- **Termination Phase:** The termination phase is the last phase of the nurse-client relationship and occurs at the end of a communication session. Termination generally occurs when the goals of the therapeutic communication session have been met. Ideally, the nurse should inform the client that termination is approaching rather than abruptly ending the interaction. Abruptly ending the conversation can lead to negative feelings about the interaction and can be perceived as uncaring by the client. The nurse should review the goals of the interaction, achievements made during the interaction, and other sources of support available to the client. Termination should be a concrete occurrence and as such, the nurse should avoid using terms such as, "I'll see you later" or "Keep in touch," because these terms insinuate that termination is temporary.

THERAPEUTIC COMMUNICATION

Therapeutic communication is a type of professional communication used

by nurses with clients. It is defined as, "The purposeful, interpersonal information-transmitting process through words and behaviors based on both parties' knowledge, attitudes, and skills, which leads to client understanding and participation."[4] Therapeutic communication techniques used by nurses have roots going back to Florence Nightingale, who insisted on the importance of building trusting relationships with clients and believed in the therapeutic healing that resulted from nurses' presence with clients.[5] Since then, several professional nursing associations have highlighted therapeutic communication as one of the most vital elements in nursing.

Read an example of a nursing student effectively using therapeutic communication with clients in the following box.

An Example of Nursing Student Using Therapeutic Communication

4. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968

5. Karimi, H., & Masoudi Alavi, N. (2015). Florence Nightingale: The mother of nursing. *Nursing and Midwifery Studies, 4*(2), e29475. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4557413/.

Ms. Z. is a nursing student who enjoys interacting with clients. When she goes to clients' rooms, she greets them and introduces herself and her role in a calm tone. She kindly asks clients about their problems and notices their reactions. She does her best to encourage problem-solving and answer questions. Clients perceive that she wants to help them. She treats clients professionally by respecting boundaries and listening to them in a nonjudgmental manner. She addresses communication barriers and respects clients' cultural beliefs. She notices clients' health literacy and ensures they understand her messages and client education. As a result, clients trust her and

feel as if she cares about them, so they feel comfortable sharing their health care needs with her.[6,7]

Active Listening and Attending Behaviors

Listening is obviously an important part of communication. There are three main types of listening: competitive, passive, and active. Competitive listening happens when we are focused on sharing our own point of view instead of listening to someone else. Passive listening occurs when we are not interested in listening to the other person and we assume we understand what the person is communicating correctly without verifying. During **active listening**, we are communicating verbally and nonverbally that we are interested in what the other person is saying while also actively verifying our understanding with the speaker. For example, an active listening technique is to restate what the person said and then verify our understanding is correct. This feedback process is the main difference between passive listening and active listening.[8]

6. Abdolrahimi, M., Ghiyasvandian, S., Zakerimoghadam, M., & Ebadi, A. (2017). Therapeutic communication in nursing students: A Walker & Avant concept analysis. *Electronic Physician, 9*(8), 4968–4977. https://doi.org/10.19082/4968

7. "beautiful african nurse taking care of senior patient in wheelchair" by agilemktg1 is in the Public Domain

8. Anonymous. (2024). *Human relations (dias)*. LibreTexts: Social Sciences. https://socialsci.libretexts.org/Bookshelves/Communication/Human_Relations/Human_Relations_(Dias)

Touch

Therapeutic use of touch is a powerful way to professionally communicate caring and empathy if done respectfully while being aware of the client's cultural beliefs. Nurses commonly use professional touch when assessing, expressing concern, or comforting clients. For example, simply holding a client's hand during a painful procedure can be very effective in providing comfort. However, nurses must be aware that therapeutic touch may not be appropriate in all situations. It is essential to respect personal boundaries and avoid touch if the client is not receptive. For example, cultural beliefs may view touch by a member of the opposite sex as inappropriate, or the client may have previously experienced trauma that causes touch to be uncomfortable or trigger negative emotions. See Figure 2.7[9] for an image of a nurse using touch as a therapeutic technique when caring for a client.

9. "Flickr – Official U.S. Navy Imagery – A nurse examines a newborn baby..jpg" by MC2 John O'Neill Herrera/U.S. Navy is in the Public Domain

Figure 2.7 Using Touch as Therapeutic Communication

Therapeutic Techniques

Therapeutic communication techniques are specific methods used to provide clients with support and information while focusing on their concerns. These techniques encourage clients to explore their feelings, solve problems, and use coping responses for medical conditions and life events. Nurses assist clients to set goals and select strategies for their plan of care based on their needs, values, skills, and abilities. They recognize the autonomy of the clients to make their own decisions, maintain a nonjudgmental attitude, and avoid interrupting while communicating therapeutically. Depending on the developmental stage and educational needs of the client, appropriate terminology should be used to promote understanding and

rapport. When using therapeutic communication, nurses often ask open-ended statements and questions, repeat information, or use silence to prompt clients to work through problems on their own.[10] Table 2.3a describes a variety of therapeutic communication techniques.[11,12]

Table 2.3a Therapeutic Communication Techniques

10. American Nurse. (n.d.). *Therapeutic communication techniques*. https://www.myamericannurse.com/therapeutic-communication-techniques/

11. American Nurse. (n.d.). *Therapeutic communication techniques*. https://www.myamericannurse.com/therapeutic-communication-techniques/

12. Ernstmeyer, K., & Christman, E. (2022). *Nursing: Mental health and community concepts*. Open RN. https://wtcs.pressbooks.pub/nursingmhcc/

Therapeutic Technique	Description
Active Listening	By using nonverbal and verbal cues such as nodding and saying, "I see," nurses can encourage clients to continue talking. Active listening involves showing interest in what clients have to say, acknowledging that you're listening and understanding, and engaging with them throughout the conversation. Nurses can offer general leads such as "What happened next?" to guide the conversation or propel it forward.
Providing Silence	At times, it's useful to not speak at all. Deliberate silence can give both nurses and clients an opportunity to think through and process what comes next in the conversation. It may give clients the time and space they need to broach a new topic and allows quiet time for self-reflection. When providing silence, the nurse does not verbally respond after a client makes a statement, although they may nod or use other nonverbal communication to demonstrate active listening and validation of the client's message.
Acceptance	Sometimes it is important to acknowledge a client's message and affirm that they've been heard. Acceptance isn't necessarily the same thing as agreement; it can be enough to simply make eye contact and say, "Yes, I hear what you are saying." Clients who feel their nurses are listening to them and taking them seriously are more likely to be receptive to care.
Giving Recognition	Recognition acknowledges a client's behavior and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially concerning routine tasks. An example of a nurse giving recognition would be saying something such as, "I noticed you took all of your medications today." This statement draws attention to the positive action and encourages it.
Offering Self	Hospital stays can be lonely and stressful at times. When nurses are present with their clients, it shows clients they value them and are willing to give them time and attention. Offering to simply sit with clients for a few minutes is a powerful way to create a caring connection.
Giving Broad Openings/ Open-Ended Questions	Therapeutic communication is often most effective when clients direct the flow of conversation and decide what to talk about. To that end, giving clients a broad opening statements such as "Tell me about your concerns," can be a good way to allow clients an opportunity to discuss what's on their mind.
Seeking Clarification	Similar to active listening, asking clients for clarification when they say something confusing or ambiguous is important. Saying something such as "I'm not sure I understand. Can you explain it to me?" helps nurses ensure they understand what's actually being said and can help clients process their ideas more thoroughly.

Placing the Event in Time or Sequence	Asking questions about when certain events occurred in relation to other events can help clients (and nurses) get a clearer sense of the whole picture. It forces clients to think about the sequence of events and may prompt them to remember something they otherwise wouldn't.
Making/ Sharing Observations	Observations about the appearance, demeanor, or behavior of clients can help draw attention to areas that may indicate a problem. For example, stating an observation that a client looks tired may prompt them to explain why they haven't been getting much sleep lately, or making an observation they haven't been eating much may lead to the discovery of a new symptom.
Encouraging Descriptions of Perception	For clients experiencing sensory issues or hallucinations, it can be helpful to ask about these perceptions in an encouraging, nonjudgmental way. If the client looks distracted or frightened as if they see or hear something, it is helpful for the nurse to use phrases such as "It looks like you may be hearing something. What do you hear now?" or "It looks as though you may be seeing something. What does it look like to you?" These phrases give clients a prompt to explain what they're perceiving without casting their perceptions in a negative light. Nurses also establish safety by asking the client if the hallucinations are encouraging the client to harm themselves or others.
Encouraging Comparisons	Clients often draw upon previous experiences to deal with current problems. By encouraging them to make comparisons to situations they have coped with before, nurses can help clients discover solutions to their problems. For example, the following exchange demonstrates encouraging comparisons. Nurse: "It must have been difficult when you went through a divorce. How did you cope with that?" Client: "I walked my dog outside a lot." Nurse: "It sounds like walking your dog outside helps you cope with stress and feel better?"
Summarizing	It is often useful to summarize what clients have said. This demonstrates to clients that the nurse was listening and allows the nurse to verify information. Ending a summary with a phrase such as "Does that sound correct?" gives clients explicit permission to make corrections if they're necessary. For example, the following exchange demonstrates summarizing. Client: "I don't like to take my medications because they make me feel tired and I gain a lot of weight." Nurse: "You haven't been taking your medications this month because of the side effects of fatigue and weight gain. Is that correct?"
Reflecting	Clients often ask nurses for advice about what they should do about particular problems. Nurses can ask clients what they think they should do, which encourages them to be accountable for their own actions and helps them come up with solutions themselves. For example, the following exchange demonstrates reflecting. Client: "Do you think I should do this new treatment or not?" Nurse: "What do you think are the pros and cons for the new treatment plan?

Focusing	Sometimes during a conversation, clients mention something particularly important. When this happens, nurses can focus on their statement, prompting clients to discuss it further. Clients don't always have an objective perspective on what is relevant to their case, but as impartial observers, nurses can more easily pick out the topics on which to focus. For example, the following exchange demonstrates focusing. Client: "I am nervous about going home." Nurse: "You're feeling anxious about going home, tell me more about that."
Confronting	Confronting presents reality, challenges a client's assumptions, or points out inconsistencies with behaviors, feelings, or thoughts. Nurses should only apply this technique during the working phase after they have established trust. Confrontation, when used correctly, can help clients break destructive routines or understand the state of their current situation. For example, the following exchange demonstrates therapeutic confrontation with a client who has been admitted for alcohol withdrawal. Client: "I haven't drunk much alcohol this year." Nurse: "Yesterday you told me that every weekend you go out and drink so much that you don't know where you are when you wake up."
Voicing Doubt	Voicing doubt can be a gentler way to call attention to incorrect or delusional ideas and perceptions of clients. By expressing doubt, nurses can force clients to examine their assumptions.
Offering Hope	Because hospitals can be stressful places for clients, sharing hope that they can persevere through their current situation can help promote coping. However, nurses must avoid giving false reassurance. For example, telling a client who was recently diagnosed with a serious medical condition, "You'll be fine," is false reassurance and not therapeutic. On the other hand, stating, "I remember you shared with me how well you have coped with difficult situations in the past," is an appropriate therapeutic use of offering hope.
Using Humor	Lightening the mood with humor can help nurses establish rapport and promote positive state of mind. However, the client should not be given the impression that their situation is not serious or that the nurse is minimizing their feelings or concerns. Humor must be tailored to the client's sense of humor or clients may take offense.
Offering Empathy	Empathy is the ability to recognize, understand, and share feelings with another person. Empathy involves showing understanding or another's situation or perspective and enables helping behaviors.[13]
Paraphrasing	Paraphrasing rephrases the client's words and key ideas to clarify their message and encourage additional communication. For example, if a client states, "I've been way too busy today," the nurse can therapeutically respond by stating, "Participating in physical and occupational therapy today has kept you busy."

Presenting Reality	Presenting reality restructures the client's distorted thoughts with valid information. For example, if a client who is hallucinating states, "I can't go into that room, there are spiders on the walls," the nurse can therapeutically respond, "I see no evidence of spiders on the walls."
Restating	Restating uses different word choices for the same content stated by the client to encourage elaboration. For example, if a client states, "The nurses hate me here," the nurse can respond therapeutically, "You feel as though the nurses dislike you?"

Communicating honestly, genuinely, and authentically is powerful. It opens the door to creating true connections with others. Communicating with empathy has also been described as providing "unconditional positive regard." Research has demonstrated that when health care teams communicate with empathy, there is improved client healing, reduced symptoms of depression, and decreased medical errors.[14]

NONTHERAPEUTIC RESPONSES

Nurses and nursing students must be aware of potential barriers to communication. In addition to considering common communication barriers discussed in the previous section, there are several **nontherapeutic responses** or communication blocks/barriers to avoid. These responses often

13. Sussex Publishers. (2025). *Empathy*. Psychology Today. https://www.psychologytoday.com/us/basics/empathy

14. Morrison, E. (2019). *Empathetic communication in Healthcare*. https://www.cibhs.org/sites/main/files/file-attachments/empathic_communication_in_healthcare_workbook.pdf?1594162691

block the client's communication of their feelings or ideas. See Table 2.3b for a description of nontherapeutic responses.[15,16]

Table 2.3b Nontherapeutic Responses

15. Burke, A. (2021). *Therapeutic communication: NCLEX-RN*. https://www.registerednursing.org/nclex/therapeutic-communication/

16. Ernstmeyer, K., & Christman, E. (2022). *Nursing: Mental health and community concepts*. Open RN. https://wtcs.pressbooks.pub/nursingmhcc/

Nontherapeutic Response	Description
Asking Personal Questions	Asking personal questions that are not relevant to the situation is not professional or appropriate. Don't ask questions just to satisfy your curiosity. For example, asking, "Why have you and Mary never married?" is not appropriate. A more therapeutic question would be, "How would you describe your relationship with Mary?"
Giving Personal Opinions	Giving personal opinions takes away the decision-making from the client. Effective problem-solving must be accomplished by the client and not the nurse. For example, stating, "If I were you, I'd put your father in a nursing home" is not therapeutic. Instead, it is more therapeutic to say, "Let's talk about what options are available to your father."
Changing the Subject	Changing the subject when someone is trying to communicate with you demonstrates lack of empathy and blocks further communication. It implies you don't care about what they are sharing. For example, stating, "Let's not talk about your insurance problems; it's time for your walk now" is not therapeutic. A more therapeutic response would be, "After your walk, let's talk some more about what's going on with your insurance company."
Stating Generalizations and Stereotypes	Generalizations and stereotypes can threaten nurse-client relationships due to preconceived assumptions about clients that may or may not be true. For example, it is not therapeutic to state the stereotype, "Older adults are always confused." A more therapeutic response is to focus on the client's concern and ask, "Tell me more about your concerns about your father's confusion."
Providing False Reassurances	When a clientis seriously ill or distressed, the nurse may be tempted to offer hope with statements such as "You'll be fine," or "Don't worry; everything will be alright." These comments tend to discourage further expressions of feelings by the client. Additionally, these comments may not present reality. If a client is terminally ill, telling them, "You'll be fine in no time" is not realistic and provides false reassurance. The client may perceive these statements as a minimization of their situation and associated feelings. A more therapeutic response would be, "It must be difficult not to know what the surgeon will find. What can I do to help?"
Showing Sympathy	Sympathy focuses on the nurse's feelings rather than the client. Saying "I'm so sorry about your amputation; I can't imagine losing a leg." This statement shows pity rather than trying to help the client cope with the situation. A more therapeutic response would be, "The loss of your leg is a major change; how do you think this will affect your life?"

Asking "What" or "Why" Questions	A nurse may be tempted to ask the client to explain "why" they believe, feel, or act in a certain way. However, clients and family members may interpret "what" or "why" questions as accusations and become defensive. It is best to phrase a question by avoiding the words "what" or "why." For example, instead of asking, "Why are you so upset?" it is more therapeutic to rephrase the statement as, "You seem upset. Tell me more about how you are feeling."
Showing Approval or Disapproval	Nurses should not impose their own attitudes, values, beliefs, and moral standards on others while in the professional nursing role. Judgmental messages contain terms such as "should," "shouldn't," "ought to," "good," "bad," "right," or "wrong." Agreeing or disagreeing sends the subtle message that nurses have the right to make value judgments about the client's decisions. Approving implies that the behavior being praised is the only acceptable one, and disapproving implies that the client must meet the nurse's expectations or standards. Instead, the nurse should help the client explore their own values, beliefs, goals, and decisions. For example, it is nontherapeutic to state, "You shouldn't consider elective surgery; there are too many risks involved." A more therapeutic response would be, "So you are considering elective surgery. Tell me more about the pros and cons of surgery." This gives the client a chance to express their ideas or feelings without fear of being judged.
Giving Defensive Responses	When clients or family members express criticism, nurses should listen to what they are saying. Listening does not imply agreement. To discover reasons for the client's anger or dissatisfaction, the nurse should listen without criticism, avoid being defensive or accusatory, and attempt to defuse anger. For example, if the client states, "Everyone here is lying to me," it is not therapeutic to state, "No one here would intentionally lie to you." Instead, a more therapeutic response would be, "You believe people have been dishonest with you. Tell me more about what happened." (After obtaining additional information, the nurse may elect to follow the chain of command at the agency and report the client's concerns for follow-up.)
Providing Passive or Aggressive Responses	Passive responses serve to avoid conflict or sidestep issues, whereas aggressive responses provoke confrontation. Passive responses serve to avoid conflict or sidestep issues, whereas aggressive communication provokes confrontation. Nurses should use assertive communication. For example, it is not therapeutic to state, "It's your fault you are feeling ill because you don't take your medication." A therapeutic response would be, "Taking your prescribed medications every day can prevent symptoms from returning." Nurses should use assertive communication as described in the "Basic Communication Concepts" section.

Arguing	Challenging or arguing against client perceptions denies that they are real and valid to the other person. They imply that the other person is lying, misinformed, or uneducated. The skillful nurse can provide information or present reality in a way that avoids argument. For example, it is not therapeutic to state, "How can you say you didn't sleep a wink when I heard you snoring all night long!" A more therapeutic response would be, "You don't feel rested this morning? Let's talk about ways to improve your rest."

Process Recordings

Process recordings are reflective learning activities with an objective to improve a student's therapeutic communication skills. They include a transcript of the verbal and nonverbal responses between a student and a client during a therapeutic communication session. After the session, the transcript is analyzed by the student to identify therapeutic techniques, communication barriers or blocks, and the phases of the nurse-client relationship. The student evaluates the interaction to determine if the overall client-centered goal was met or not met, what went well during the conversation, and what they could improve in their therapeutic communication. As a result of the analysis, the student gains self-awareness regarding the effectiveness of their communication and sets goals for self-improvement in future therapeutic communication sessions.

STRATEGIES FOR EFFECTIVE COMMUNICATION

In addition to using therapeutic communication techniques and avoiding nontherapeutic responses, there are additional strategies for promoting

effective communication when providing client-centered care. Specific questions to ask clients are as follows:

- What concerns do you have about your plan of care?
- What questions do you have about your medications?
- Did I answer your question(s) clearly or is there additional information you would like?[17]

Listen closely for feedback from clients. Feedback provides an opportunity to improve client understanding, improve the client-care experience, and provide high-quality care. Other suggestions for effective communication with hospitalized clients include the following:

- Round with the providers and read progress notes from other health care team members to ensure you have the most up-to-date information about the client's treatment plan and progress. This information helps you to provide safe client care as changes occur and also to accurately answer the client's questions.
- Review information periodically with the client to improve understanding.
- Use client communication boards in their room to set goals and communicate important reminders with the client, family members, and other health care team members. This strategy can reduce call light usage for questions related to diet and activity orders and also gives clients and families the feeling that they always know the current plan of care. However, keep client confidentiality in mind regarding information to publicly share on the board because the board can be seen by anyone entering the room.
- Provide printed information on medical procedures, conditions, and medications. It helps clients and family members to provide information

17. Smith, L. L. (2018, June 12). Strategies for effective patient communication. *American Nurse*. https://www.myamericannurse.com/strategies-for-effective-patient-communication/

in multiple ways.[18]

Adapting Your Communication

When communicating with clients and family members, take note of your audience and adapt your message based on their characteristics such as age, developmental level, cognitive abilities, communication disorders, and language differences.

Adapting communication according to the client's age, developmental level, and language differences includes the following strategies:

- When communicating with children, speak calmly and gently. It is often helpful to demonstrate what will be done during a procedure on a doll or stuffed animal. To establish trust, try using play or drawing pictures.
- When communicating with adolescents, give freedom to make choices within established limits.
- When communicating with older adults, be aware of potential vision and hearing impairments that commonly occur and address these barriers accordingly. For example, if a client has glasses and/or hearing aids, be sure these devices are in place before communicating. See the following box for evidence-based strategies for communication with clients who have impaired hearing and vision.
- For clients with language differences, it is vital to provide trained medical interpreters when important information is communicated. Family members should not be used as translators because medical terms may not translate directly in the native language and there is no way to determine if the information is being translated accurately. It is also possible that certain information is withheld from the client in the event the family does not want to burden them with upsetting information.

18. Smith, L. L. (2018, June 12). Strategies for effective patient communication. *American Nurse*. https://www.myamericannurse.com/strategies-for-effective-patient-communication/

Strategies for Communicating With Clients With Impaired Hearing and Vision[19]

Impaired Hearing

- Gain the client's attention before speaking (e.g., through touch)
- Minimize background noise
- Position yourself 2-3 feet away from the client
- Facilitate lip-reading by facing the client directly in a well-lit environment
- Use gestures, when necessary
- Listen attentively, allowing the client adequate time to process communication and respond
- Refrain from shouting at the client
- Ask the client to suggest strategies for improved communication (e.g., speaking toward better ear and moving to well-lit area)
- Face the client directly, establish eye contact, and avoid turning away mid-sentence
- Simplify language (i.e., do not use slang but do use short, simple sentences), as appropriate
- Note and document the client's preferred method of communication (e.g., verbal, written, lip-reading, or American Sign Language) in plan of care
- Assist the client in acquiring a hearing aid or assistive listening device

19. Wagner, C. M., Butcher, H. K., & Clarke, M. F. (2024). *Nursing interventions classification (NIC)* (8th ed.). Elsevier.

- Refer to the primary care provider or specialist for evaluation, treatment, and hearing rehabilitation

Impaired Vision

- Identify yourself when entering the client's space
- Ensure the client's eyeglasses or contact lenses have current prescription, are cleaned, and stored properly when not in use
- Provide adequate room lighting
- Minimize glare (i.e., offer sunglasses or draw window covering)
- Provide educational materials in large print
- Apply labels to frequently used items (i.e., mark medication bottles using high-contrasting colors)
- Read pertinent information to the client
- Provide magnifying devices
- Provide referral for supportive services (e.g., social, occupational, and psychological)
- Identify item locations on a meal tray using the clock method. For example, the nurse states, "Your milk is at 2:00, the potatoes are at 3:00, and the meat is at 9:00. on your plate."

Clients with communication disorders require additional strategies to ensure effective communication. For example, aphasia is a communication disorder that results from damage to portions of the brain that are responsible for language. **Aphasia** usually occurs suddenly, often following a stroke or head injury, and impairs the client's expression and understanding of language. **Expressive aphasia** refers to difficulty putting thoughts into words. The client may cognitively know what they want to say but are unable to express their thoughts. **Receptive aphasia** refers to difficulty in understanding what is

being communicated to them. The client may be able to verbalize their thoughts and feelings but do not understand what is spoken to them. **Global aphasia** is caused by injuries to multiple language-processing areas of the brain, including those known as Wernicke's and Broca's areas. These brain areas are particularly important for understanding spoken language, accessing vocabulary, using grammar, and producing words and sentences. Individuals with global aphasia may be unable to say even a few words or may repeat the same words or phrases over and over again. They may have trouble understanding even simple words and sentences.[20]

The most common type of aphasia is **Broca's aphasia**. People with Broca's aphasia often understand speech and know what they want to say, but frequently speak in short phrases that are produced with great effort. For example, they may intend to say, "I would like to go to the bathroom," but instead the words, "Bathroom, Go," are expressed. They are often aware of their difficulties and can become easily frustrated. See the box below for evidence-based strategies to enhance communication with a person with impaired speech.

▸ Read more about aphasia.

Strategies to Improve Communication With Clients With Impaired Speech[21]

20. National Institute on Deafness and Other Communication Disorders (NIDCD). (2017). *Aphasia*. https://www.nidcd.nih.gov/health/aphasia

21. Wagner, C. M., Butcher, H. K., & Clarke, M. F. (2024). *Nursing interventions classification (NIC)* (8th ed.). Elsevier.

- Modify the environment to minimize excess noise and decrease emotional distress
- Phrase questions so the client can answer using a simple "Yes" or "No," being aware that clients with expressive aphasia may provide automatic responses that are incorrect
- Monitor the client for frustration, anger, depression, or other responses to impaired speech capabilities
- Provide alternative methods of speech communication (e.g., writing tablet, flash cards, eye blinking, communication board with pictures and letters, hand signals or gestures, and computer)
- Adjust your communication style to meet the needs of the client (e.g., stand in front of the client while speaking, listen attentively, present one idea or thought at a time, speak slowly but avoid shouting, use written communication, or solicit family's assistance in understanding the client's speech)
- Ensure the call light is within reach and central call light system is marked to indicate the client has difficulty with speech
- Repeat what the client said to ensure accuracy
- Instruct the client to speak slowly
- Collaborate with the family and a speech therapist to develop a plan for effective communication

Maintaining Confidentiality

When communicating with clients, their friends, their family members, and other members of the health care team, it is vital for the nurse to maintain client confidentiality. The **Health Insurance Portability and Accountability**

Act (HIPAA) provides standards for ensuring privacy of client information that are enforceable by law. Nurses must always be aware of where and with whom they share client information. For example, information related to client care should not be discussed in public areas, paper charts must be kept in secure areas, computers must be logged off when walked away from, and client information should only be shared with those directly involved in client care. For more information about client confidentiality, see the "Legal and Ethical Considerations" section in the "Scope of Practice" chapter.

- Read more information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2.4 Communicating With Health Care Team Members

OPEN RESOURCES FOR NURSING (OPEN RN)

Professional communication with other members of the health care team is an important component of every nurse's job. See Figure 2.8[1] for an image illustrating communication between health care team members. Common types of professional interactions include reports to health care team members, handoff reports, and transfer reports. Reports may be verbal (e.g., reports given in person, by telephone, or recorded) or written (e.g., reports provided electronically or by fax).

1. "1322557028-huge.jpg" by LightField Studios is used under license from Shutterstock.com

Figure 2.8 Interprofessional Communication

Reports to Health Care Team Members

Nurses routinely report information to other nurses and health care team members, as well as urgently contact health care providers to report changes in client status.

Standardized methods of communication have been developed to allow information to be exchanged between health care team members in a structured, concise, and accurate manner to ensure safe client care. One common format used by health care team members to exchange client information is **ISBARR**, a mnemonic for the components of **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**equest/Recommendations, and **R**epeat back or a simpler version called **SBAR**:

- **Introduction:** Introduce your name, role, and the agency from which you are calling.
- **Situation:** Provide the client's name and location, why you are calling, recent vital signs, and the status of the client.
- **Background:** Provide pertinent background information about the client such as admitting medical diagnoses, code status, recent relevant lab or diagnostic results, and allergies.
- **Assessment:** Share abnormal assessment findings and your evaluation of the current client situation.
- **Request/Recommendations:** State what you would like the provider to do, such as reassess the client, order a lab/diagnostic test, prescribe/change medication, etc.
- **Repeat back:** If you are receiving new orders from a provider, repeat them to confirm accuracy. Be sure to document communication with the provider in the client's chart.

Read an example of an ISBARR report in the following box. Information is provided to a printable ISBARR reference card.

Sample ISBARR Report From a Nurse to a Health Care Provider

I: "Hello Dr. Smith, this is Jane White, RN from the Med Surg unit."

S: "I am calling to tell you about Ms. White in Room 210, who is experiencing an increase in pain, as well as redness at her incision site. The client has no known allergies and is a full code. Her recent vital signs were BP 160/95, heart rate 90, respiratory rate 22, O2 sat 96%, and temperature 38 degrees Celsius. She is stable but her pain is worsening."

B: "Ms. White is a 65-year-old female, admitted yesterday post hip surgical replacement. She has been rating her pain at 3 or 4

out of 10 since surgery with her scheduled medication, but now she is rating the pain as a 7, with no relief from her scheduled medication of Vicodin 5/325 mg administered an hour ago. She is scheduled for physical therapy later this morning and is stating she won't be able to participate because of the pain this morning."

A: "I just assessed the surgical site, and her dressing was clean, dry, and intact, but there is 4 cm redness surrounding the incision, and it is warm and tender to the touch. There is moderate serosanguinous drainage. Otherwise, her lungs are clear, and her heart rate is regular. I am concerned her incision site may be becoming infected and that she will have difficulty with therapy if her pain remains uncontrolled."

R: "I am calling to request an order for a CBC and increased dose of pain medication."

R: "I am repeating back the order to confirm that you are ordering a STAT CBC and an increase of her Vicodin to 10/325 mg."

- View or print an ISBARR reference card

Handoff Reports

Handoff reports are defined by The Joint Commission as "a transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the client's care."[2] In 2017,

2. The Joint Commission. (n.d.). *Sentinel event alert 58: Inadequate hand-off reports*. https://www.jointcommission.org/resources/patient-safety-topics/

The Joint Commission issued a critical alert about inadequate handoff communication that has resulted in client harm such as wrong-site surgeries, delays in treatment, falls, and medication errors. Strategies for improving handoff communication have been implemented at agencies across the country.

Although many types of nursing shift-to-shift handoff reports have been used over the years, evidence strongly supports that **bedside handoff reports** increase client safety, as well as client and nurse satisfaction, by effectively communicating current, accurate client information in real time.[3] See Figure 2.9[4] for an image illustrating two nurses participating in a handoff report. Bedside reports typically occur in hospitals and include the client, along with the off-going and the oncoming nurses in a face-to-face handoff report conducted at the client's bedside. HIPAA rules must be kept in mind if visitors are present, or the room is not a private room. Family members may be included with the client's permission. See a sample checklist for a bedside handoff report from the Agency for Healthcare Research and Quality in Figure 2.10.[5] Although a bedside handoff report is similar to an ISBARR report, it contains additional information to ensure continuity of care across nursing shifts. For example, the "assessment" portion of the bedside handoff report includes detailed pertinent data the oncoming nurse needs to know, such as current head-to-toe assessment findings to establish a baseline; information about equipment such as IVs, catheters, and drainage tubes; and recent changes in medications, lab results, diagnostic tests, and treatments.

sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/

3. Dorvil, B. (2018). The secrets to successful nurse bedside shift report implementation and sustainability. *Nursing Management, 49*(6), 20-25. https://doi.org/10.1097/01.NUMA.0000533770.12758.44

4. "618721604-huge" by Rido is used under license from Shutterstock.com.

5. "Strat3_Tool_2_Nurse_Chklst_508.pdf" by AHRQ is licensed under CC0

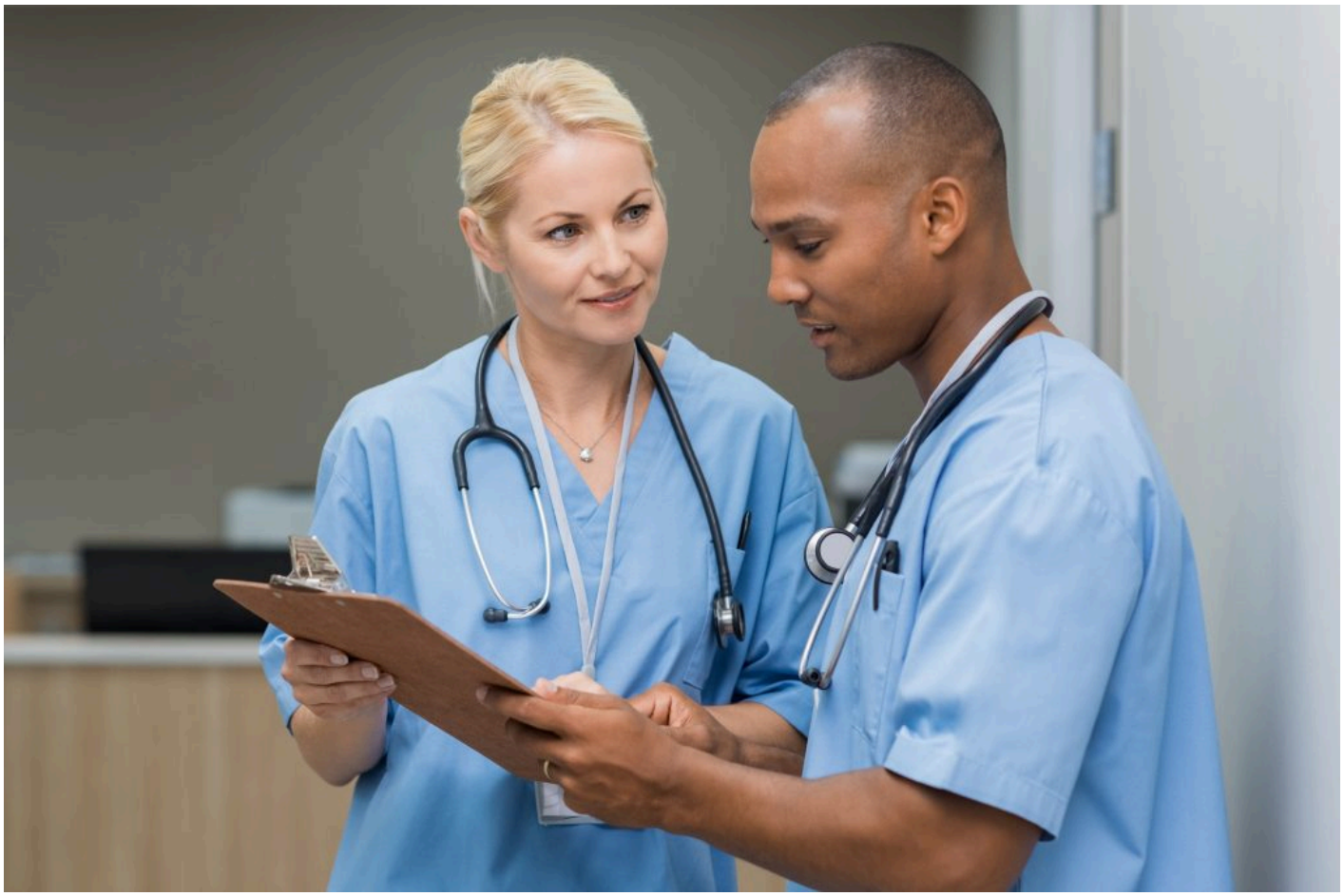

Figure 2.9 Bedside Handoff Report

Bedside Shift Report Checklist

- ☐ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ☐ Open the medical record or access the electronic work station in the patient's room.
- ☐ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

  S = **Situation**. What is going on with the patient? What are the current vital signs?

  B = **Background**. What is the pertinent patient history?

  A = **Assessment**. What is the patient's problem now?

  R = **Recommendation**. What does the patient need?

- ☐ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ☐ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ☐ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?'*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do you want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Figure 2.10 Bedside Handoff Report Checklist

- Print a copy of the AHRQ Bedside Shift Report Checklist.
- View Sample Information to Include in a Shift Report.

View a video on creating shift reports.[6]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=313#oembed-1

Transfer Reports

Transfer reports are provided by nurses when transferring a client to another unit or to another agency. Transfer reports contain similar information as bedside handoff reports but are even more detailed when the client is being transferred to another agency. Checklists are often provided by agencies to ensure accurate, complete information is shared.

6. RegisteredNurseRN. (2015, May 23). *Nursing shift report sheet templates | How to give a nursing shift report* [Video]. YouTube. All rights reserved. Video used with permission. https://youtu.be/X76iKFQhPNw

Conflict in the Workplace

Nurses encounter conflict in their daily work environment, such as misunderstandings or disagreements among staff, clients, providers, family members, or other individuals. Nurses must learn communication methods that lessen conflict and enhance interactions that lead to a better work environment.

- Read additional information about "Conflict Resolution" in Open RN *Nursing Health Alterations*.

2.5 Documentation

OPEN RESOURCES FOR NURSING (OPEN RN)

Using Technology to Access Information

Most client information in acute care, long-term care, and other clinical settings is now electronic and uses intranet technology for secure access by providers, nurses, and other health care team members to maintain client confidentiality. Intranet refers to a private computer network within an institution. An **electronic health record (EHR)** is a real-time, client-centered record that makes information available instantly and securely to authorized users.[1] Computers used to access an EHR can be found in client rooms, on wheeled carts, in workstations, or even on handheld devices. See Figure 2.11[2] for an image of a nurse documenting in an EHR.

1. HealthIT.gov. (2019). *What is an electronic health record (EHR)?* https://www.healthit.gov/faq/what-electronic-health-record-ehr

2. "Winn_Army_Community_Hospital_Pharmacy_Stays_Online_During_Power_Outage.jpg" by Flickr user MC4 Army is licensed under CC BY 2.0

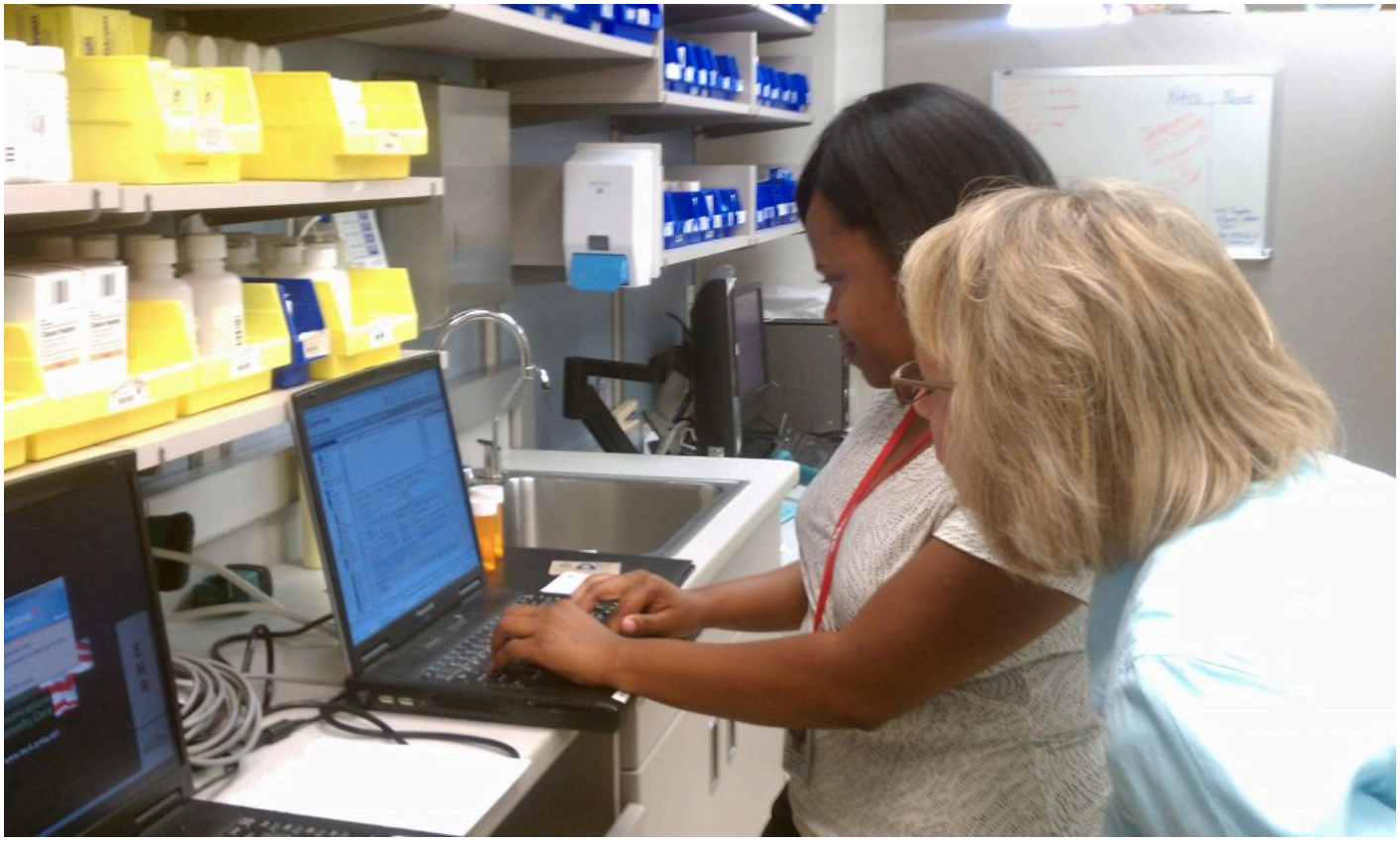

Figure 2.11 Nurse Documenting in EHR

The EHR for each client contains a great deal of information. The most frequent pieces of information that nurses access include the following:

- **History and Physical (H&P):** A history and physical (H&P) is a specific type of documentation created by the health care provider when the client is admitted to the facility. An H&P includes important information about the client's current status, medical history, and the treatment plan in a concise format that is helpful for the nurse to review. Information typically includes the reason for admission, health history, surgical history, allergies, current medications, physical examination findings, medical diagnoses, and the treatment plan.
- **Provider orders:** This section includes the prescriptions, or medical orders, that the nurse must legally implement or appropriately communicate according to agency policy if not implemented.

- **Medication Administration Records (MARs):** Medications are charted through electronic medication administration records (MARs). These records interface the medication orders from providers with pharmacists and are also the location where nurses document medications administered.
- **Treatment Administration Records (TARs):** In many facilities, treatments such as wound care are documented on a treatment administration record.
- **Laboratory results:** This section includes results from blood work and other tests performed in the lab.
- **Diagnostic test results:** This section includes results from diagnostic tests ordered by the provider such as X-rays, ultrasounds, etc.
- **Progress notes:** This section contains notes created by nurses and other health care providers regarding clientcare. It is helpful for the nurse to review daily progress notes by all team members to ensure continuity of care.

View a video of how to read a client's chart.[3]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=318#oembed-1

3. RegisteredNurseRN. (2015, October 16). *Charting for nurses | How to understand a patient's chart as a nursing student or new nurse* [Video]. YouTube. All rights reserved. Video used with permission. https://youtu.be/lNwRvKaNsGc

Legal Documentation

Nurses and health care team members are legally required to document care provided to clients. Any type of documentation in the EHR is considered a legal document. In a court of law, it is generally viewed that, "If it wasn't documented, it wasn't done." Other documentation guidelines include the following:

- Documentation should be objective, factual, and professional. Only document what you personally assessed, observed, or performed.
- Proper medical terminology, grammar, and spelling should be used.
- All types of documentation must include the date, time, and signature of the person documenting.
- Abbreviations should be avoided in legal documentation.
- Documentation must be completed in an accurate and timely manner after the task is performed. Do not document in advance of completing a task.
- Assessments, interventions, medications, or treatments that were not completed should never be charted as completed. This is considered falsification and can present serious legal ramifications for the nurse and the health care facility.
- When using paper documentation, avoid leaving blank lines to prevent others from adding to your documentation. In the event of a charting error, draw a single line through the error and write, "mistaken entry" above the line with your initials. Errors should never be erased, scribbled out, or covered with white-out.
- If electronic documentation is charted in error, it should be corrected with the details of the error and the correction noted in the background should the need arise to review the documentation.

Documentation is used for many purposes. It is used to ensure continuity of care across health care team members and across shifts; monitor standards of care for quality assurance activities; and provide information for reimbursement purposes by insurance companies, Medicare, and Medicaid.

Documentation may also be used for research purposes or, in some instances, for legal concerns in a court of law.

Documentation by nurses includes recording client assessments, writing progress notes, and creating or addressing information included in nursing care plans. Nursing care plans are further discussed in the "Planning" section of the "Nursing Process" chapter.

Common Types of Documentation

Common formats used to document client care include charting by exception, focused DAR notes, narrative notes, SOAPIE progress notes, client discharge summaries, and Minimum Data Set (MDS) charting.

Charting by Exception

Charting by exception (CBE) documentation was designed to decrease the amount of time required to document care. CBE contains a list of normal findings. After performing an assessment, nurses confirm normal findings on the list found on assessment and write only brief progress notes for abnormal findings or to document communication with other team members.

Focused DAR Notes

Focused DAR notes are a type of progress note that are commonly used in combination with charting by exception documentation. **DAR** stands for **D**ata, **A**ction, and **R**esponse. Focused DAR notes are brief. Each note is focused on one client problem for efficiency in documenting and reading.

- **Data:** This section contains information collected during the client assessment, including vital signs and physical examination findings found during the "Assessment" phase of the nursing process. The Assessment phase is further discussed in the "Nursing Process" chapter. Think of the "Data" section as describing the main problem.
- **Action:** This section contains the nursing actions that are planned and implemented for the client's focused problem. This section correlates to

the “Planning” and “Implementation” phases of the nursing process and are further discussed in the “Nursing Process” chapter. Think of the “Action” section as describing what was done about the problem.

- **Response:** This section contains information about the client’s response to the nursing actions and evaluates if the planned care was effective. This section correlates to the “Evaluation” phase of the nursing process that is further discussed in the “Nursing Process” chapter. Think of the “Response” section as describing the result of what happened after performing the actions.

Sample DAR Note

Refer back to the “ISBARR” example provided in a box in Chapter 2.4. The nurse would document the associated provider notification in the EHR using a DAR note:

D: *Client reports increasing pain at the incisional site, rated as 7/10, increased from 4/10 despite receiving oral Vicodin 5/325 at 1030. Vital Signs: BP 160/95, HR 90, RR 22, O2 sat 96%, and temperature 38 degrees C. There is 4 cm of redness surrounding the incision that is warm and tender to touch with moderate serosanguinous drainage. Lung sounds are clear, and HR is regular.*

A: *Dr. Smith was notified at 1210 and orders received for CBC STAT and increased Vicodin dose to 10/325 mg.*

R: *Lab results pending. Additional Vicodin administered per order at 1215. At 1315, client reported decreased pain level of 3/10. Will notify provider of results when they become available. -J. White, RN*

View sample charting by exception paper documentation with associated DAR notes for abnormal findings.

For more information about writing DAR notes, visit What is F-DAR Charting?

View a video explaining F-DAR charting.[4]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=318#oembed-2

Narrative Notes

Narrative notes, also called summary notes, are a type of progress note that chronicles assessment findings and nursing activities for the client that occurred throughout the entire shift or visit. View sample narrative note documentation for body system assessments in the Open RN *Nursing Skills, 2e* textbook.

4. RegisteredNurseRN. (2015, October 27). *FDAR for nurses | How to chart in F-DAR format with examples* [Video]. YouTube. All rights reserved. Video used with permission. https://youtu.be/BXf7wj9Wmfc

Sample Cardiac Narrative Note

Client denies chest pain or shortness of breath. Vital signs are within normal limits. Point of maximum impulse palpable at the fifth intercostal space of the midclavicular line. No lifts, heaves, or thrills identified on inspection or palpation. JVD absent. S1 and S2 heart sounds in regular rhythm with no murmurs or extra sounds. Skin is warm, pink, and dry. Capillary refill is less than two seconds. Color, movement, and sensation are intact in upper and lower extremities. Peripheral pulses are present (+2) and equal bilaterally. No peripheral edema is noted. Hair is distributed evenly on lower extremities.

SOAPIE Notes

SOAPIE is a mnemonic for a type of progress note that is organized by six categories: **S**ubjective, **O**bjective, **A**ssessment, **P**lan, **I**nterventions, and **E**valuation. SOAPIE progress notes are written by nurses, as well as other members of the health care team.

- **Subjective:** This section includes what the client said, such as, "I have a headache." It can also contain information related to pertinent medical history and why the client is in need of care.
- **Objective:** This section contains the observable and measurable data collected during a client assessment, such as the vital signs, physical examination findings, and lab/diagnostic test results.
- **Assessment:** This section contains the interpretation of what was noted in the Subjective and Objective sections, such as a nursing diagnosis in a nursing progress note or the medical diagnosis in a progress note written by a health care provider.
- **Plan:** This section outlines the plan of care based on the Assessment section, including goals and planned interventions.

- **Interventions:** This section describes the actions implemented.
- **Evaluation:** This section describes the client response to interventions and if the planned outcomes were met.

Sample SOAPIE Note

Here is an example of SOAPIE note with the same information previously discussed in the box describing a sample DAR note.

S: *Client reports having incisional pain of 6/10, increased from 4/10 despite receiving oral Vicodin 5/325 at 1030.*

O: *Vital Signs: BP 160/95, HR 90, RR 22, O2 sat 96%, and temperature 38 degrees C. There is 4 cm of redness surrounding the incision that is warm and tender to touch with moderate serosanguinous drainage. Lung sounds are clear, and HR is regular.*

A: *Dr. Smith was notified at 1210.*

P: *New orders received for CBC STAT to check for infection and increased Vicodin dose to 10/325 mg for pain management.*

I: *Additional Vicodin administered per order at 1215.*

E: *At 1315, client reported decreased pain level of 3/10. Will notify provider of results when they become available. -J. White, RN*

Discharge Summary

When a client is discharged from an agency, a discharge summary is documented in the client record, along with clear verbal and written client education and instructions provided to the client. Discharge summary information is frequently provided in a checklist format to ensure accuracy and includes the following:

- Time of departure and method of transportation out of the hospital (e.g., wheelchair)
- Name and relationship of person accompanying the client at discharge
- Condition of the client at discharge
- Client education completed and associated educational materials or other information provided to the client
- Discharge instructions on medications, treatments, diet, and activity
- Follow-up appointments or referrals given

See Figure 2.12[5] for an image of a nurse providing discharge instructions to a client. Discharge teaching typically starts at admission and continues throughout the client's stay because this allows for reinforcement of teaching topics.

Figure 2.12 Discharge Teaching

5. "1934626790-huge.jpg" by TommyStockProject is used under license from Shutterstock.com

Sample Discharge Summary Note

Client discharged home at 1645 with Sarah Jones, his wife, in a wheelchair to their car. Client was in stable condition with the following vital signs: BP 124/76, HR 76, RR 16, O2 sat 98%. Dressing over surgical incision site was dry and intact. Client education was provided on wound care at home and the "Caring for Your Incision" handout was provided. The Discharge Instructions sheet was reviewed with orders for a regular diet and no heavy lifting until follow-up appointment with Dr. Singer on 8/26/2024. Referral completed with ACME Home Health for wound care with the initial home visit scheduled for tomorrow.

Minimum Data Set (MDS) Charting

In long-term care settings, additional documentation is used to provide information for reimbursement by private insurance, Medicare, and Medicaid. The Resident Assessment Instrument **Minimum Data Set (MDS)** is a federally mandated assessment tool created by registered nurses in skilled nursing facilities to track a client's goal achievement, as well as to coordinate the efforts of the health care team to optimize the resident's quality of care and quality of life.[6] This tool also guides nursing care plan development.

View a sample Minimum Data Set (MDS) Form from the CMS.

6. Centers for Medicare & Medicaid Services. (2019). *Long-term care facility resident assessment instrument 3.0 user's manual*. https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf

Incident Reports

Incident reports, also called variance reports, are a specific type of documentation that is completed when there is an unexpected occurrence, such as a medication error, client injury, client fall, or a near miss, where an error did not actually occur, but was prevented from occurring. Refer to agency policies for specific events requiring incident reports.

Incident reports are completed by the staff member involved in the occurrence. Documentation includes the date and time of the event, client involved (if applicable), what occurred, what was done in response to the event, what else was happening at the time the incident occurred, as well as other facility specific required data. Abbreviations, assumptions, or interpretations should be avoided.

Incident reports are intended to be used as a safety tool to identify system issues and process problems that could benefit from quality and safety improvements. Incident reports should be used as a component of a safety culture, not punitively. If used punitively, staff become reluctant to report errors or suggest process improvements for fear of "getting in trouble."

Incident reports are not a part of the medical record and should not be mentioned in the medical record. However, the specific event should be documented in the medical record, along with health care provider notification and interventions provided.[7]

> Read additional information about Incident Reports on the NSO website.

7. Nurses Service Organization. (n.d.). *Incident reports: A safety tool*. https://www.nso.com/Learning/Artifacts/Articles/Incident-reports-A-safety-tool

2.6 Putting It All Together

Client Scenario

Mr. Hernandez is a 47-year-old client admitted to the neurological trauma floor as the result of a motor vehicle accident two days ago. The client sustained significant facial trauma in the accident and his jaw is wired shut. His left eye is currently swollen, and he has significant bruising to the left side of his face. The nurse completes a visual assessment and notes that the client has normal extraocular movement, peripheral vision, and pupillary constriction bilaterally. Additional assessment reveals that Mr. Hernandez also sustained a fracture of the left arm and wrist during the accident. His left arm is currently in a cast and sling. He has normal movement and sensation with his right hand. Mrs. Hernandez is present at the client's bedside and has provided additional information about the client. She reports that Mr. Hernandez's primary language is Spanish but that he understands English well. He has a bachelor's degree in accounting and owns his own accounting firm. He has a history of elevated blood pressure but is otherwise healthy.

The nurse notes that the client's jaw is wired, and he is unable to offer a verbal response. He does understand English well, has appropriate visual acuity, and is able to move his right hand and arm.

Based on the assessment information that has been gathered, the nurse plans several actions to enhance communication. Adaptive communication devices such as communication boards, symbol cards, or electronic messaging systems will be provided. The nurse will eliminate distractions such as television and hallway noise to decrease sources of additional stimuli in the communication experience.

Sample Documentation Using a Summary Note:

6/01/2024, 1615: Mr. Hernandez has impaired verbal communication due to facial fracture and inability to enunciate words around his wired jaw. He understands both verbal and written communication. Mr. Hernandez has left sided facial swelling, but no visual impairment. He has a left arm fracture but is able to move and write with his right hand. The client is supplied with

communication cards and marker board. He responds appropriately with written communication and is able to signal his needs. – J. Smith, RN

2.7 Learning Activities

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

Practice what you have learned in this chapter by completing these learning activities. When accessing the online activities that contain videos, it is best to use Google Chrome or Firefox browsers.

1. To test your understanding of therapeutic and nontherapeutic terms, complete this online quiz: Therapeutic Communication Techniques vs. Non-therapeutic Communication Techniques Quizlet
2. Consider the following scenario and describe actions that you might take to facilitate the communication experience.

You are caring for Mr. Curtis, an 87-year-old client newly admitted to the medical surgical floor with a hip fracture. You are preparing to complete his admission history and need to collect relevant health information and complete a physical exam. You approach the room, knock at the door, complete hand hygiene, and enter. Upon entry, you see Mr. Curtis is in bed surrounded by multiple family members. The television is on in the background, and you also note the sound of meal trays being delivered in the hallway.

Based on the described scenario, what actions might be implemented to aid in your communication with Mr. Curtis?

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=342#h5p-61

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=342#h5p-84

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=342#h5p-85

NEXT GEN RN

Test your knowledge using this NCLEX Next Generation-style

question. You may reset and resubmit your answers to this question an unlimited number of times.[1]

Test your knowledge using this NCLEX Next Generation-style question. You may reset and resubmit your answers to this question an unlimited number of times.[2]

1. "Chapter 2 Assignment 1" by Tami Davis for OpenRN is licensed under CC BY-NC 4.0

2. "Chapter 2, Assignment 2" by Rebecca Wicks for OpenRN is licensed under CC BY-NC 4.0

II Glossary

OPEN RESOURCES FOR NURSING (OPEN RN)

Active listening: Process by which we are communicating verbally and nonverbally that we are interested in what the other person is saying while also actively verifying our understanding with the speaker. (Chapter 2.3)

Aphasia: A communication disorder that results from damage to portions of the brain that are responsible for language. (Chapter 2.3)

Assertive communication: A way to convey information that describes the facts, the sender's feelings, and explanations without disrespecting the receiver's feelings. This communication is often described as using "I" messages: "I feel...," "I understand...," or "Help me to understand..." (Chapter 2.2)

Bedside handoff report: A handoff report in hospitals that involves clients, their family members, and both the off-going and the incoming nurses. The report is performed face to face and conducted at the client's bedside. (Chapter 2.4)

Broca's aphasia: A type of aphasia where clients understand speech and know what they want to say, but frequently speak in short phrases that are produced with great effort. People with Broca's aphasia typically understand the speech of others fairly well. Because of this, they are often aware of their difficulties and can become easily frustrated. (Chapter 2.3)

Charting by exception (CBE): A type of documentation where a list of "normal findings" is provided and nurses document assessment findings by confirming normal findings and writing brief documentation notes for any abnormal findings. (Chapter 2.5)

DAR: A type of documentation often used in combination with charting by exception. DAR stands for Data, Action, and Response. Focused DAR notes are brief, and each note is focused on one client problem for efficiency in documenting, as well as for reading. (Chapter 2.5)

Electronic Health Record (EHR): A digital version of a client's paper chart. EHRs are real-time, client-centered records that make information available instantly and securely to authorized users. (Chapter 2.5)

Expressive aphasia: A type of aphasia where the client has difficulty putting thoughts into words. The client may cognitively know what they want to say but are unable to express their thoughts. (Chapter 1.4, Chapter 2.3)

Global aphasia: A type of aphasia that results from damage to extensive portions of the language areas of the brain. Individuals with global aphasia have severe communication difficulties and may be extremely limited in their ability to speak or comprehend language. They may be unable to say even a few words or may repeat the same words or phrases over and over again. They may have trouble understanding even simple words and sentences. (Chapter 2.3)

Handoff report: A process of exchanging vital client information, responsibility, and accountability between the off-going and incoming nurses in an effort to ensure safe continuity of care and the delivery of best clinical practices. (Chapter 2.4)

Health Insurance Portability and Accountability Act (HIPAA): Standards for ensuring privacy of client information that are enforceable by law. (Chapter 2.3)

Incident reports: Also called variance reports, incident reports are a specific type of documentation that is completed when there is an unexpected occurrence, such as a medication error, client injury, or client fall, or a near miss, where an error did not actually occur, but was prevented from occurring. (Chapter 2.5)

ISBARR: A mnemonic for the format of professional communication among health care team members that includes Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back. (Chapter 2.4)

Minimum Data Set (MDS): A federally mandated assessment tool used in skilled nursing facilities to track a client's goal achievement, as well as to coordinate the efforts of the health care team to optimize the resident's quality of care and quality of life. (Chapter 2.5)

Narrative note: A type of documentation that chronicles all of the client's assessment findings and nursing activities that occurred throughout the shift. (Chapter 2.5)

Nontherapeutic responses: Responses to clients that block communication, expression of emotion, or problem-solving. (Chapter 2.3)

Nonverbal communication: Facial expressions, tone of voice, pace of the conversation, and body language. (Chapter 2.2)

Progressive relaxation: Types of relaxation techniques that focus on reducing muscle tension and using mental imagery to induce calmness. (Chapter 2.2)

Receptive aphasia: A type of aphasia where the client has difficulty in understanding what is being communicated to them. The client may be able to verbalize their thoughts and feelings but does not understand what is spoken to them. (Chapter 2.3)

Relaxation breathing: A breathing technique used to reduce anxiety and control the stress response. (Chapter 2.2)

SOAPIE: A mnemonic for a type of documentation that is organized by six categories: Subjective, Objective, Assessment, Plan, Interventions, and Evaluation. (Chapter 2.5)

Therapeutic communication: The purposeful, interpersonal information transmitting process through words and behaviors based on both parties' knowledge, attitudes, and skills, which leads to client understanding and participation. (Chapter 2.3)

Therapeutic communication techniques: Techniques that encourage clients to explore feelings, problem solve, and cope with responses to medical conditions and life events. (Chapter 2.3)

Verbal communication: Exchange of information using words understood by the receiver. (Chapter 2.2)

PART III

DIVERSE PATIENTS

3.1 Diverse Patients Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Objectives

- Reflect upon personal and cultural values, beliefs, biases, and heritage[1]
- Embrace diversity, equity, inclusivity, health promotion, and health care for individuals of diverse geographic, cultural, ethnic, racial, gender, and spiritual backgrounds across the life span[2]
- Demonstrate respect, equity, and empathy in actions and interactions with all health care consumers[3]

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

- Participate in life-long learning to understand cultural preferences, worldviews, choices, and decision-making processes of diverse clients[4]
- Adapt care considering all aspects of diversity
- Identify principles of protecting client dignity
- Identify principles of holistic, client-centered care
- Identify strategies to advocate for clients
- Identify principles of religion and spirituality

No matter who we are or where we come from, every person was raised with cultural values and beliefs. The impact of culture on a person's health is profound because it affects many health beliefs, such as perceived causes of illness, ways to prevent illness, and acceptance of medical treatments. **Culturally responsive care** integrates these cultural beliefs into an individual's health care. Culturally responsive care is intentional and promotes trust and rapport with clients. At its heart, culturally responsive care is client-centered care. The American Nurses Association (ANA) states, "The art of nursing is demonstrated by unconditionally accepting the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care."[5]

Nurses provide holistic care when incorporating their clients' physical, mental, spiritual, cultural, and social needs into their health care (referred to as **holism**). As a nursing student, you are undertaking a journey of developing cultural competency with an attitude of cultural humility as you learn how to provide holistic care to your clients. **Cultural competence** is a lifelong process

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

of applying evidence-based nursing in agreement with the cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes.[6,7,8]

Cultural humility is defined by the American Nurses Association as, "A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot know everything about other cultures, and approach learning about other cultures as a life-long goal and process."[9] Nurses improve the quality of health care by understanding, respecting, and incorporating their clients' cultural values, beliefs, and preferences, which can ultimately help reduce health disparities.[10]

This chapter will introduce concepts related to adapting nursing care that considers all aspects of diversity.

6. Centers for Disease Control and Prevention. (2024). *Cultural competence in health and human services*. https://npin.cdc.gov/pages/cultural-competence

7. Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18,* 174. https://doi.org/10.1186/s12939-019-1082-3

8. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

9. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

10. U.S. Department of Health and Human Services. (n.d.). *Cultural and linguistically appropriate services (CLAS) in maternal health care*. https://wicworks.fns.usda.gov/resources/culturally-and-linguistically-appropriate-services-maternal-health-care

3.2 Diverse Patients Basic Concepts

OPEN RESOURCES FOR NURSING (OPEN RN)

Let's begin the journey of developing cultural competency by exploring basic concepts related to culture.

Culture and Subculture

Culture is a set of beliefs, attitudes, and practices shared by a group of people or community that is accepted, followed, and passed down to other members of the group. The word "culture" may at times be interchanged with terms such as ethnicity, nationality, or race. See Figure 3.1[1] for an illustration depicting culture by various nationalities. Cultural beliefs and practices bind group or community members together and help form a cohesive identity.[2,3] Culture has an enduring influence on a person's view of the world, expressed through language and communication patterns, family connections and

1. "Cultural diversity large.jpg" by მარიამ იაკობაძე is licensed under CC BY-SA 4.0

2. Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*, 174. https://doi.org/10.1186/s12939-019-1082-3

3. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

kinship, religion, cuisine, dress, and other customs and rituals.[4] Culture is not static but is dynamic and ever-changing; it changes as members come into contact with beliefs from other cultures. For example, sushi is a traditional Asian dish that has become popular in America in recent years.

Figure 3.1 Cultures

Nurses and other health care team members are impacted by their own personal cultural beliefs. For example, a commonly held belief in American health care is the importance of timeliness; medications are administered at specifically scheduled times, and appearing for appointments on time is considered crucial.

Most cultural beliefs are a combination of beliefs, values, and habits that have been passed down through family members and authority figures. The first step in developing cultural competence is to become aware of your own cultural beliefs, attitudes, and practices.

Nurses should also be aware of subcultures. A **subculture** is a smaller group

4. Campinha-Bacote, J. (2011). Coming to know cultural competence: An evolutionary process. *International Journal for Human Caring, 15*(3), 42-48.

of people within a culture, often based on a person's occupation, hobbies, interests, or place of origin. People belonging to a subculture may identify with some, but not all, aspects of their larger "parent" culture. Members of the subculture share beliefs and commonalities that set them apart and do not always conform with those of the larger culture. See Table 3.2a for examples of subcultures.

Table 3.2a Examples of Subcultures

Age/Generation	Baby Boomers, Millennials, Gen Z
Occupation	Truck Driver, Computer Scientist, Nurse
Hobbies/Interests	Birdwatchers, Gamers, Foodies, Skateboarders
Religion	Hinduism, Baptist, Islam
Gender	Male, Female, Nonbinary, Two-Spirit
Geography	Rural, Urban, Southern, Midwestern

Culture is much more than a person's nationality or ethnicity. Culture can be expressed in a multitude of ways, including the following:

- Language(s) spoken
- Religion and spiritual beliefs
- Gender identity
- Socioeconomic status
- Age
- Sexual orientation
- Geography
- Educational background
- Life experiences
- Living situation
- Employment status
- Immigration status
- Ability/Disability

People typically belong to more than one culture simultaneously. These

cultures overlap, intersect, and are woven together to create a person's cultural identity. In other words, the many ways in which a person expresses their cultural identity are not separated, but are closely intertwined, referred to as **intersectionality**.

Assimilation

Assimilation is the process of adopting or conforming to the practices, habits, and norms of a cultural group. As a result, the person gradually takes on a new cultural identity and may lose their original identity in the process.[5] An example of assimilation is a newly graduated nurse, who after several months of orientation on the hospital unit, offers assistance to a colleague who is busy. The new nurse has developed self-confidence in the role and has developed an understanding that helping others is a norm for the nurses on that unit.

Assimilation is not always voluntary, however, and may become a source of distress. There are historic examples of involuntary assimilation in many countries. For example, in the past, authorities in the United States and Canadian governments required indigenous children to attend boarding schools, separated them from their families, and punished them for speaking their native language.[6,7]

5. Cole, N. L. (2018). *How different cultural groups become more alike: Definition, overview and theories of assimilation*. ThoughtCo. https://www.thoughtco.com/assimilation-definition-4149483

6. The Truth and Reconciliation Commission of Canada.(2015). *Honoring the truth, reconciling for the future: A summary of the final report of the truth and reconciliation commission of Canada*. http://www.trc.ca/assets/pdf/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf

7. Smith, A. (2007). Soul wound: The legacy of Native American schools. *Amnesty International Magazine*. https://web.archive.org/web/20121206131053/http://www.amnestyusa.org/node/87342

Cultural Values and Beliefs

Culture provides an important source of values and comfort for clients, families, and communities. Think of culture as a thread that is woven through a person's world and impacts one's choices, perspectives, and way of life. It plays a role in all of a person's life events and threads its way through the development of one's self-concept, sexuality, and spirituality. It affects lifelong nutritional habits, as well as coping strategies with death and dying.

Culture influences how a client interprets "good" health, as well as their perspectives on illness and the causes of illness. The manner in which pain is expressed is also shaped by a person's culture. See Table 3.2b for additional examples of how a person's culture impacts common values and beliefs regarding family patterns, communication patterns, space orientation, time orientation, and nutritional patterns. As you read Table 3.2b, take a moment to reflect on your own cultural background and your personally held beliefs for each of these concepts.

Table 3.2b Cultural Concepts

Cultural Concepts	Examples of Culturally Influenced Values and Be
Family Patterns	Family size Views on contraception Roles of family members Naming customs Value placed on elders and children Discipline/upbringing of children Rites of passage End-of-life care
Communication Patterns	Eye contact Touch Use of silence or humor Intonation, vocabulary, grammatical structure Topics considered personal (i.e., difficult to discus Greeting customs (handshakes, hugs)
Space Orientation	Personal distance and intimate space
Time Orientation	Focus on the past, present, or future Importance of following a routine or schedule Arrival on time for appointments
Nutritional Patterns	Common meal choices Foods to avoid Foods to heal or treat disease Religious practices (e.g., fasting, dietary restrictio Foods to celebrate life events and holidays

A person's culture can also affect encounters with health care providers in other ways, such as the following:

- Level of family involvement in care
- Timing for seeking care
- Acceptance of treatment (as preventative measure or for an actual health problem)
- The accepted decision-maker (i.e., the client or other family members)

- Use of home or folk remedies
- Seeking advice or treatment from nontraditional providers
- Acceptance of a caregiver of the opposite gender

Cultural Diversity and Cultural Humility

Cultural diversity is a term used to describe cultural differences among people. See Figure 3.2[8] for artwork depicting diversity. While it is useful to be aware of specific traits of a culture or subculture, it is just as important to understand that each individual is unique and there are always variations in beliefs among individuals within a culture. Nurses should, therefore, refrain from making assumptions about the values and beliefs of members of specific cultural groups.[9] Instead, a better approach is recognizing that culture is not a static, uniform characteristic but instead realizing there is diversity within every culture and in every person. The American Nurses Association (ANA) defines **cultural humility** as, "A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process."[10]

Current demographics in the United States reveal that the population is predominantly white. People who were born in another country, but now live in the United States, comprise approximately 14% of the nation's total population. However, these demographics are rapidly changing. The United

8. "Pure_Diversity,_Mirta_Toledo_1993.jpg" by Mirta Toledo is licensed under CC BY-SA 4.0

9. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

States Census Bureau projects that more than 50 percent of Americans will belong to a minority group by 2060. With an increasingly diverse population to care for, it is imperative for nurses to integrate culturally responsive care into their nursing practice.[11,12] Creating a culturally responsive environment is discussed in a later subsection of this chapter.

Figure 3.2 Diversity

11. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

12. Kaihlanen, A. M., Hietapakka, L., & Heponiemi, T. (2019). Increasing cultural awareness: Qualitative study of nurses' perceptions about cultural competence training. *BMC Nursing, 18*(1), 1–9. https://doi.org/10.1186/s12912-019-0363-x

Concepts Related to Culture

There are additional concepts related to culture that can impact a nurse's ability to provide culturally responsive care, including stereotyping, ethnocentrism, discrimination, prejudice, and bias. See Table 3.2c for definitions and examples of these concepts.

Table 3.2c Concepts Related to Culture

Concepts	Definitions	Examples
Stereotyping	The assumption that a person has the attributes, traits, beliefs, and values of a cultural group because they are a member of that group.	The nurse teaches the daughter of an older client how to make online doctor appointments, assuming that the older client does not understand how to use a computer.
Ethnocentrism	The belief that one's culture (or race, ethnicity, or country) is better and preferable than another's.	The nurse disparages the client's use of nontraditional medicine and tells the client that traditional treatments are superior.
Discrimination	The unfair and different treatment of another person or group, denying them opportunities and rights to participate fully in society.	A nurse manager refuses to hire a candidate for a nursing position because she is pregnant.
Prejudice	A prejudgment or preconceived idea, often unfavorable, about a person or group of people.	The nurse withholds pain medication from a client with a history of opioid addiction, assuming they are engaging in drug-seeking behavior rather than requesting relief from actual pain.
Bias	An attitude, opinion, or inclination (positive or negative) towards a group or members of a group. Bias can be a conscious attitude (explicit) or an unconscious attitude where the person is not aware of their bias (implicit).	A client does not want the nurse to care for them because the nurse has a tattoo.

Race is a socially constructed idea because there are no true genetically or biologically distinct races. Humans are not biologically different from each

other. **Racism** presumes that races are distinct from one another and views expression of one's cultural beliefs as a heritable trait. It also denotes a hierarchy to race, implying that races are unequal. Ernest Grant, president of the American Nurses Association (ANA), recently declared that nurses are obligated "to speak up against racism, discrimination, and injustice. This is non-negotiable."[13] As frontline health care providers, nurses have an obligation to recognize the impact of racism on their clients and the communities they serve.[14]

Sexual Orientation and Gender Identity

Culture can exert a powerful influence on a person's sexual orientation and gender expression. **Sexual orientation** refers to a person's physical and emotional interest or desire for others. Sexual orientation is on a continuum and is manifested in one's self-identity and behaviors.[15] The acronym **LGBTQAI+** stands for Lesbian, Gay, Bisexual, Transgender, Queer, Asexual, and Intersex. The "+" stands for other identities not encompassed in this short acronym that is often used to refer to the community as a whole. See Figure

13. American Nurses Association. (2020). *ANA president condemns racism, brutality and senseless violence against black communities*. https://www.nursingworld.org/news/news-releases/2020/ana-president-condemns-racism-brutality-and-senseless-violence-against-black-communities/

14. Fulbright-Sumpter, D. (2020). "But I'm not racist …" The nurse's role in dismantling institutionalized racism. *Texas Nursing, 94*(3), 14–17. https://issuu.com/texasnurses/docs/tn-issue3-2020-digital

15. Brydum, S. (2015). The true meaning of the word cisgender. *The Advocate*. https://www.advocate.com/transgender/2015/07/31/true-meaning-word-cisgender

3.3[16] for an image of participants in a rally supporting LGBT rights. Historically, individuals within the LGBTQAI+ community have experienced discrimination and prejudice from health care providers and avoided or delayed health care due to these negative experiences. Despite increased recognition of this community in recent years, members of the LGBTQAI+ community continue to experience significant health disparities. Persistent cultural bias and stigmatization of LGBTQAI+ people have been shown to contribute to higher rates of substance abuse and suicide rates in this population.[17,18,19]

16. "Dublin_LGBTQ_Pride_Festival_2013_-_LGBT_Rights_Matter_(9183564890).jpg" by infomatique is licensed under CC BY-SA 2.0

17. Cole, N. L. (2018). *How different cultural groups become more alike: Definition, overview and theories of assimilation*. ThoughtCo. https://www.thoughtco.com/assimilation-definition-4149483

18. U.S. Department of Health and Human Services. Healthy People 2020. *Lesbian, gay, bisexual, and transgender health*. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

19. Chance, T. F. (2013). Going to pieces over LGBT health disparities: How an amended affordable care act could cure the discrimination that ails the LGBT community. *Journal of Health Care Law and Policy, 16*(2), 375–402. https://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1309&context=jhclp

Figure 3.3 LGBTQ Rally

Gender identity refers to a person's inner sensibility that they are a man, a woman, or perhaps neither. To the extent that a person's gender identity does not conform with the sex assigned to them at birth, they may identify as transgender or as nonbinary. Nonbinary means they don't fall simply into one of two categories, male or female. Transgender and nonbinary people may be sexually oriented toward men, women, both sexes, or neither sex.[20] **Gender**

20. Meerwijk, E. L., & Sevelius, J. M. (2017). Transgender population size in the United States: A meta-regression of population-based probability samples. *American Journal of Public Health, 107*(2), e1–e8. https://doi.org/10.2105/AJPH.2016.303578

expression refers to a person's outward demonstration of gender in relation to societal norms, such as in style of dress, hairstyle, or other mannerisms.[21]

Related Ethical Considerations

Justice, a principle and moral obligation to act on the basis of equality and equity, is a standard linked to fairness for all in society.[22] The ANA states this obligation guarantees not only basic rights (respect, human dignity, autonomy, security, and safety) but also fairness in all operations of societal structures. This includes care being delivered with fairness, rightness, correctness, unbiasedness, and inclusiveness while being based on well-founded reason and evidence.[23]

Social justice is related to respect, equity, and inclusion. The ANA defines **social justice** as equal rights, equal treatment, and equitable opportunities for all.[24] The ANA further states, "Nurses need to model the profession's commitment to social justice and health through actions and advocacy to

21. Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming health care environments. *Sexual Health, 14(*1), 119–122. https://doi.org/10.1071/SH16145

22. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

23. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

24. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

address the social determinants of health and promote well-being in all settings within society."[25]

Social determinants of health are nonmedical factors that influence health outcomes, including conditions in which people are born, grow, work, live, and age, and the wider sets of forces and systems shaping the conditions of daily life.[26] Health outcomes impacted by social determinants of health are referred to as health disparities. Health disparities are further discussed in the "Health Disparities" section later in this chapter.

25. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

26. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

3.3 Patient's Bill of Rights

OPEN RESOURCES FOR NURSING (OPEN RN)

The Patient's Bill of Rights is an evolving document related to providing culturally competent care. In 1973 the American Hospital Association (AHA) adopted the Patient's Bill of Rights.[1] See the following box to review the original Patient's Bill of Rights. The bill has since been updated, revised, and adapted for use throughout the world in all health care settings. There are different versions of the bill, but, in general, it safeguards a client's right to accurate and complete information, fair treatment, and self-determination when making health care decisions. Clients should expect to be treated with sensitivity and dignity and with respect for their cultural values. While the Patient's Bill of Rights extends beyond the scope of cultural considerations, its basic principles underscore the importance of cultural competency when caring for people.

Patient's Bill of Rights[2]

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant,

1. American Hospital Association. (2003). *The patient care partnership*. https://www.aha.org/other-resources/patient-care-partnership

2. American Hospital Association. (2003). *The patient care partnership*. https://www.aha.org/other-resources/patient-care-partnership

current, and understandable information concerning diagnosis, treatment, and prognosis.

3. Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.
4. Patients have the right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, residents, or other trainees.
5. The patient has the right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.
6. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the hospital provides or transfer to another hospital. The hospital should notify patients of any policy that might affect patient choice within the institution.
7. The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by law and hospital policy.

Health care institutions must advise patients of their rights under state law and hospital policy to make informed medical choices, ask if the patient has an advance directive, and include that information in patient records. The patient has the right to timely information about hospital policy that may limit its ability to implement fully a legally valid advance directive.

8. The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.
9. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.
10. The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.
11. The patient has the right to expect that, within its capacity and policies, a hospital will make a reasonable response to the request of a patient for appropriate and medically indicated care and services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The

institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.

12. The patient has the right to ask and be informed of the existence of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.
13. The patient has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.
14. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.
15. The patient has the right to be informed of hospital policies and practices that relate to patient care, treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospital's charges for services and available payment methods.

- Read a current version of the "Patient Care Partnership" brochure from the American Hospital Association that has replaced the Patient's Bill of Rights.

Review information about the right to self-determination and informed consent in the *Legal & Ethical Considerations* section of the "Scope of Practice" chapter.

3.4 Cultural Competence

OPEN RESOURCES FOR NURSING (OPEN RN)

The freedom to express one's cultural beliefs is a fundamental right of all people. Nurses realize that people speak, behave, and act in many different ways due to the influential role that culture plays in their lives and their view of the world. **Cultural competence** is a lifelong process of applying evidence-based nursing in agreement with the cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes.[1,2,3]

Culturally competent care requires nurses to combine their knowledge and skills with awareness, curiosity, and sensitivity about their clients' cultural beliefs. It takes motivation, time, and practice to develop cultural competence, and it will evolve throughout your nursing career. Culturally competent nurses have the power to improve the quality of care leading to better health outcomes for culturally diverse clients. Nurses who accept and uphold the cultural values and beliefs of their clients are more likely to develop supportive and trusting relationships with their clients. In turn, this

1. Centers for Disease Control and Prevention. (2024). *Cultural competence in health and human services*. https://npin.cdc.gov/pages/cultural-competence

2. Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18,* 174. https://doi.org/10.1186/s12939-019-1082-3

3. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

opens the way for optimal disease and injury prevention and leads towards positive health outcomes for all clients.

The roots of providing culturally competent care are based on the original transcultural nursing theory developed by Dr. Madeleine Leininger. **Transcultural nursing** incorporates cultural beliefs and practices of individuals to help them maintain and regain health or to face death in a meaningful way.[4] See Figure 3.4[5] for an image of Dr. Madeleine Leininger. Read more about transcultural nursing theory in the following box.

Figure 3.4 Dr. Madeleine Leininger

4. Murphy, S. C. (2006). Mapping the literature of transcultural nursing. *Journal of the Medical Library Association: JMLA,* 94(2 Suppl), e143–e151. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463039/

5. "Leininger.jpg" by Juda712 is licensed under CC BY-SA 3.0

Madeleine Leininger and the Transcultural Nursing Theory[6]

Dr. Madeleine Leininger (1925-2012) founded the transcultural nursing theory. She was the first professional nurse to obtain a PhD in anthropology. She combined the "culture" concept from anthropology with the "care" concept from nursing and reformulated these concepts into "culture care."

In the mid-1950s, no cultural knowledge base existed to guide nursing decisions or understand cultural behaviors as a way of providing therapeutic care. Leininger wrote the first books in the field and coined the term "culturally congruent practice." **Culturally congruent practice** describes nursing care that is in agreement with the preferred values, beliefs, worldview, and practices of the health care consumer.[7] She developed and taught the first transcultural nursing course in 1966, and master's and doctoral programs in transcultural nursing were launched shortly after. Dr. Leininger was honored as a Living Legend of the American Academy of Nursing in 1998.

6. Murphy, S. C. (2006). Mapping the literature of transcultural nursing. *Journal of the Medical Library Association: JMLA*, 94(2 Suppl), e143–e151. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1463039/

7. Marion, L., Douglas, M., Lavin, M., Barr, N., Gazaway, S., Thomas, L., & Bickford, C. (2016). Implementing the new ANA Standard 8: Culturally congruent practice. *OJIN: The Online Journal of Issues in Nursing, 22*(1). https://ojin.nursingworld.org/table-of-contents/volume-22-2017/number-1-january-2017/articles-on-previously-published-topics/implementing-the-new-ana-standard-8-culturally-congruent-practice/

Nurses have an ethical and moral obligation to provide culturally competent care to the clients they serve.[8] The "Respectful and Equitable Practice" Standard of Professional Performance set by the American Nurses Association (ANA) states that nurses must practice with cultural humility and inclusiveness. The ANA Code of Ethics also states that the nurse should collaborate with other health professionals, as well as the public, to protect human rights, fight discriminatory practices, and reduce disparities.[9] Additionally, the ANA Code of Ethics also states that nurses "are expected to be aware of their own cultural identifications in order to control their personal biases that may interfere with the therapeutic relationship. Self-awareness involves not only examining one's culture but also examining perceptions and assumptions about the client's culture…nurses should possess knowledge and understanding how oppression, racism, discrimination, and stereotyping affect them personally and in their work."[10]

Developing cultural competence begins in nursing school.[11,12] Culture is an

8. Young, S., & Guo, K. (2016). Cultural diversity training: The necessity for cultural competence for healthcare providers and in nursing practice. *The Health Care Manager, 35*(2), 94-102. https://doi.org/10.1097/hcm.0000000000000100

9. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

10. American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/coe-view-only/

11. Gillson, S., & Cherian, N. (2019). The importance of teaching cultural diversity in baccalaureate nursing education. *Journal of Cultural Diversity, 26*(3), 85–88.

12. Knecht, J., Fontana, J. S., Fischer, B., Spitz, K. R., & Tetreault, J. N. (2018). An

integral part of life, but its impact is often implicit. It is easy to assume that others share the same cultural values that you do, but each individual has their own beliefs, values, and preferences. Begin the examination of your own cultural beliefs and feelings by answering the questions below.[13]

Reflect on the following questions carefully and contemplate your responses as you begin your journey of providing culturally responsive care as a nurse. (Questions are adapted from the Anti-Defamation League's "Imagine a World Without Hate" Personal Self-Assessment Anti-Bias Behavior).[14]

- Who are you? With what cultural group or subgroups do you identify?
- When you meet someone from another culture/country/place, do you try to learn more about them?
- Do you notice instances of bias, prejudice, discrimination, and stereotyping against people of other groups or cultures

investigation of the development of cultural competence in baccalaureate nursing students: A mixed methods study. *Journal of Community Medical Health. 2*(3). https://www.gavinpublishers.com/article/view/an-investigation-of-the-development-of-cultural-competence-in-undergraduate-nursing-students-a-mixed-methods-study

13. Zeran, V. (2016). Cultural competency and safety in nursing education: A case study. *Northern Review, 43*, 105–115. https://thenorthernreview.ca/index.php/nr/article/view/591

14. Anti-Defamation League. (2021). *Personal self-assessment of anti-bias behavior worksheet*. *https://www.adl.org/sites/default/files/personal-self-assessment-of-anti-bias-behavior-online-version_0.pdf*

in your environment (home, school, work, TV programs or movies, restaurants, places where you shop)?

- Have you reflected on your own upbringing and childhood to better understand your own implicit biases and the ways you have internalized messages you received?
- Do you ever consider your use of language to avoid terms or phrases that may be degrading or hurtful to other groups?
- When other people use biased language and behavior, do you feel comfortable speaking up and asking them to refrain?
- How ready are you to give equal attention, care, and support to people regardless of their culture, socioeconomic class, religion, gender expression, sexual orientation, or other "difference"?

The Process of Developing Cultural Competence

Dr. Josephine Campinha-Bacote is an influential nursing theorist and researcher who developed a model of cultural competence. The model asserts there are specific characteristics that a nurse becoming culturally competent possesses, including cultural awareness, cultural knowledge, cultural skill, and cultural encounters.[15]

Cultural awareness is a deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, attitudes,

15. Transcultural C.A.R.E. Associates. (2020). *The process of cultural competemility.* http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/

practices, and problem-solving strategies of a client's culture. To become culturally aware, the nurse must undergo reflective exploration of personal cultural values while also becoming conscious of the cultural practices of others. In addition to reflecting on one's own cultural values, the culturally competent nurse seeks to reverse harmful prejudices, ethnocentric views, and attitudes they have. Cultural awareness goes beyond a simple awareness of the existence of other cultures and involves an interest, curiosity, and appreciation of other cultures. Although cultural diversity training is typically a requirement for health care professionals, **cultural desire** refers to the intrinsic motivation and commitment on the part of a nurse to develop cultural awareness and cultural competency.

Acquiring cultural knowledge is another important step towards becoming a culturally competent nurse. **Cultural knowledge** refers to seeking information about cultural health beliefs and values to understand clients' world views. To acquire cultural knowledge, the nurse actively seeks information about other cultures, including common practices, beliefs, values, and customs, particularly for those cultures that are prevalent within the communities they serve.[16] Cultural knowledge also includes understanding the historical backgrounds of culturally diverse groups in society, as well as physiological variations and the incidence of certain health conditions in culturally diverse groups. Cultural knowledge is best obtained through cultural encounters with clients from diverse backgrounds to learn about individual variations that occur within cultural groups and to prevent stereotyping.

While obtaining cultural knowledge, it is important to demonstrate cultural sensitivity. **Cultural sensitivity** means being tolerant and accepting of cultural practices and beliefs of people. Cultural sensitivity is demonstrated when the nurse conveys nonjudgmental interest and respect through words and action and an understanding that some health care treatments may conflict with a

16. Gillson, S., & Cherian, N. (2019). The importance of teaching cultural diversity in baccalaureate nursing education. *Journal of Cultural Diversity, 26*(3), 85–88.

person's cultural beliefs.[17] Cultural sensitivity also implies a consciousness of the damaging effects of stereotyping, prejudice, or biases on clients and their well-being. Nurses who fail to act with cultural sensitivity may be viewed as uncaring or inconsiderate, causing a breakdown in trust for the client and their family members. When a client experiences nursing care that contradicts with their cultural beliefs, they may experience moral or ethical conflict, nonadherence, or emotional distress.

Cultural desire, awareness, sensitivity, and knowledge are the building blocks for developing cultural skill. **Cultural skill** is reflected by the nurse's ability to gather and synthesize relevant cultural information about their clients while planning care and using culturally sensitive communication skills. Nurses with cultural skill provide care consistent with their clients' cultural needs and deliberately take steps to secure a safe health care environment that is free of discrimination or intolerance. For example, a culturally skilled nurse will make space and seating available within a client's hospital room for accompanying family members when this support is valued by the client.[18]

A **cultural encounter** is a process where the nurse directly engages in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

By developing the characteristics of cultural awareness, cultural knowledge, cultural skill, and cultural encounters, a nurse develops cultural competence.

17. Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*, 174. https://doi.org/10.1186/s12939-019-1082-3

18. Brooks, L., Manias, E., & Bloomer, M. (2019). Culturally sensitive communication in healthcare: A concept analysis. *Collegian, 26*(3), 383-391. https://doi.org/10.1016/j.colegn.2018.09.007

3.5 Health Disparities

OPEN RESOURCES FOR NURSING (OPEN RN)

Despite decades of promoting culturally competent care and the Patient's Bill of Rights, disparities in health care continue. Vulnerable populations continue to experience increased prevalence and burden of diseases, as well as problems accessing quality health care. In 2003 the Institute of Medicine (IOM) published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* sharing evidence that "bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care."[1] The health care system in the United States was shaped by the values and beliefs of mainstream white culture and originally designed to primarily serve English-speaking clients with financial resources.[2] In addition, most health care professionals in the United States are members of

1. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley, B. D., Stith, A. Y., Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. National Academies Press. https://doi.org/10.17226/12875

2. Meedzan, N. (2015). Cultural immersion experiences in nursing education. In S. Breakey, I. Corless, N. Meedzan, & P. Nicholas (Eds.) *Global nursing in the 21st century*. Springer. pp. 441-452.

the white culture and medical treatments tend to arise from that perspective.[3,4]

The term **health disparities** describes the differences in health outcomes resulting from entrenched economic, sociopolitical, or environmental factors, referred to as social determinants of health. Social determinants of health are conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.[5]

Vulnerable populations experience increased prevalence and burden of diseases, as well as problems accessing quality health care because of social determinants of health. Health disparities negatively impact groups of people based on their ethnicity, gender, age, mental health, disability, sexual orientation, gender identity, socioeconomic status, geographic location, or other characteristics historically linked to discrimination or exclusion.[6] A

3. Hart, P. L., & Mareno, N. (2016). Nurses' perceptions of their cultural competence in caring for diverse patient populations. *Online Journal of Cultural Competence in Nursing & Healthcare, 6*(1), 121–137. https://doi.org/10.9730/ojccnh.org/v6n1a10

4. Ong-Flaherty, C. (2015). Critical cultural awareness and diversity in nursing: A minority perspective. *Nurse Leader, 13(*5), 58-62. http://dx.doi.org/10.1016/j.mnl.2015.03.012

5. Healthy People 2030. (n.d.). *Social determinants of health*. https://health.gov/healthypeople/priority-areas/social-determinants-health

6. U.S. Department of Health and Human Services. *Healthy people 2030*. Health Equity. https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

related term is **health care disparity** that refers to differences in access to health care and insurance coverage. Health disparities and health care disparities can lead to decreased quality of life, increased personal costs, and lower life expectancy. More broadly, these disparities also translate to greater societal costs, such as the financial burden of uncontrolled chronic illnesses.

The Agency for Healthcare Research and Quality (AHRQ) releases an annual *National Healthcare Quality and Disparities Report* that provides a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups. Quality is described in terms of client safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Although access to health care and quality have improved since 2000 in the wake of the Affordable Care Act (ACA), the 2022 report shows continued disparities, especially for poor and uninsured populations[7]:

- There was a decline in overall health expectancy in 2022 due to COVID, with a greater decline for Hispanic and non-Hispanic Black group compared to non-Hispanic White groups.
- The percentage of people with health insurance coverage has increased greatly in the past decade. However, those gains vary by race and ethnicity, with Hispanic groups and Non-Hispanic American Indian or Alaska Native groups being significantly less likely to be insured.
- Disproportionately more rural counties than metropolitan counties are designated as primary care shortage areas.
- The United States has worse maternal health and health care than other industrialized nations with suboptimal maternal health outcomes for multiple measures, as well as considerable racial disparities for those measures.

7. Agency for Healthcare Research and Quality. (2022). *2022 National healthcare quality and disparities report*. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html

There are several initiatives and agencies designed to combat the problem of health disparities in the United States. See Table 3.5 for a list of available resources to combat health disparities.

Table 3.5 Resources to Combat Health Disparities

Agency for Healthcare Research and Quality (AHRQ)	AHRQ publishes the *National Healthcare Quality and Disparities Report*, a report on measures related to access to care, affordable care, care coordination, effective treatment, healthy living, client safety, and person-centered care.
Healthy People 2030	A new Healthy People initiative is launched every ten years. The initiative guides national health promotion and disease prevention efforts to improve the health of the nation.
Office of Minority Health (OMH)	The Office of Minority Health works to improve the health of minority populations and to act as a resource for health care providers. The Office of Minority Health provides resources on Cultural and Linguistic Competency, including national standards for Culturally and Linguistically Appropriate Services (CLAS).
Racial and Ethnic Approaches to Community Health Across the United States (REACH-US)	This initiative, overseen by the Centers for Disease Control (CDC), seeks to remove barriers to health linked to race or ethnicity, education, income, location, or other social factors.
National Partnership for Action to End Health Disparities (NPA) Toolkit for Community Action	The mission of the NPA is to raise awareness and increase the effectiveness of programs targeting health disparities.
Robert Wood Johnson Foundation **(RWJF)**	RWJF is a philanthropic organization with the goal of identifying the root causes of health disparities and removing barriers to improve health outcomes.

The Sullivan Alliance	The nonprofit Sullivan Alliance was formed to strengthen the capacity and quality of the nation's health workforce by increasing the number of historically marginalized people in every area of health care and across all aspects of academic health centers.
Transcultural Nursing Society – Many Cultures One World **(TCNS)**	The mission of TCNS is to improve the quality of culturally congruent and equitable care for people worldwide by promoting cultural competence in nursing practice, scholarship, education, research, and administration.

Nurses are involved in advocating for community health and reducing health disparities. See the following box for an example of nurses addressing a community health care disparity during the water crisis in Flint, Michigan.

Nurses Addressing the Flint Michigan Water Crisis[8]

In 2014 the water system in Flint, Michigan, was discovered to be contaminated with lead. The city's children were found to have perilously elevated lead levels. Children from poor households were most affected by the crisis. Lead is a dangerous neurotoxin. Elevated lead levels are linked to slowed physical development; low IQ; problems with cognition, attention, and memory; and learning disabilities.

In Flint approximately 150 local nurses and nursing students answered the call, organizing and arranging educational seminars, as well as setting up lead testing clinics to determine

8. Householder, M. (2016). *Health workers get lead-test help from Flint student nurses*. Associated Press. https://detroit.cbslocal.com/2016/04/12/health-workers-get-lead-test-help-from-flint-student-nurses/

who had been affected by the water contamination. A nursing student involved in the effort told CBS Detroit that this situation has illustrated that "the need for health care, the need for nursing, goes way outside the hospital walls." See Figure 3.5[9] for an image of the water crisis in Flint, Michigan.

9. "Flint_Water_Crisis.jpg" by Shannon Nobles is licensed under CC BY-SA 4.0

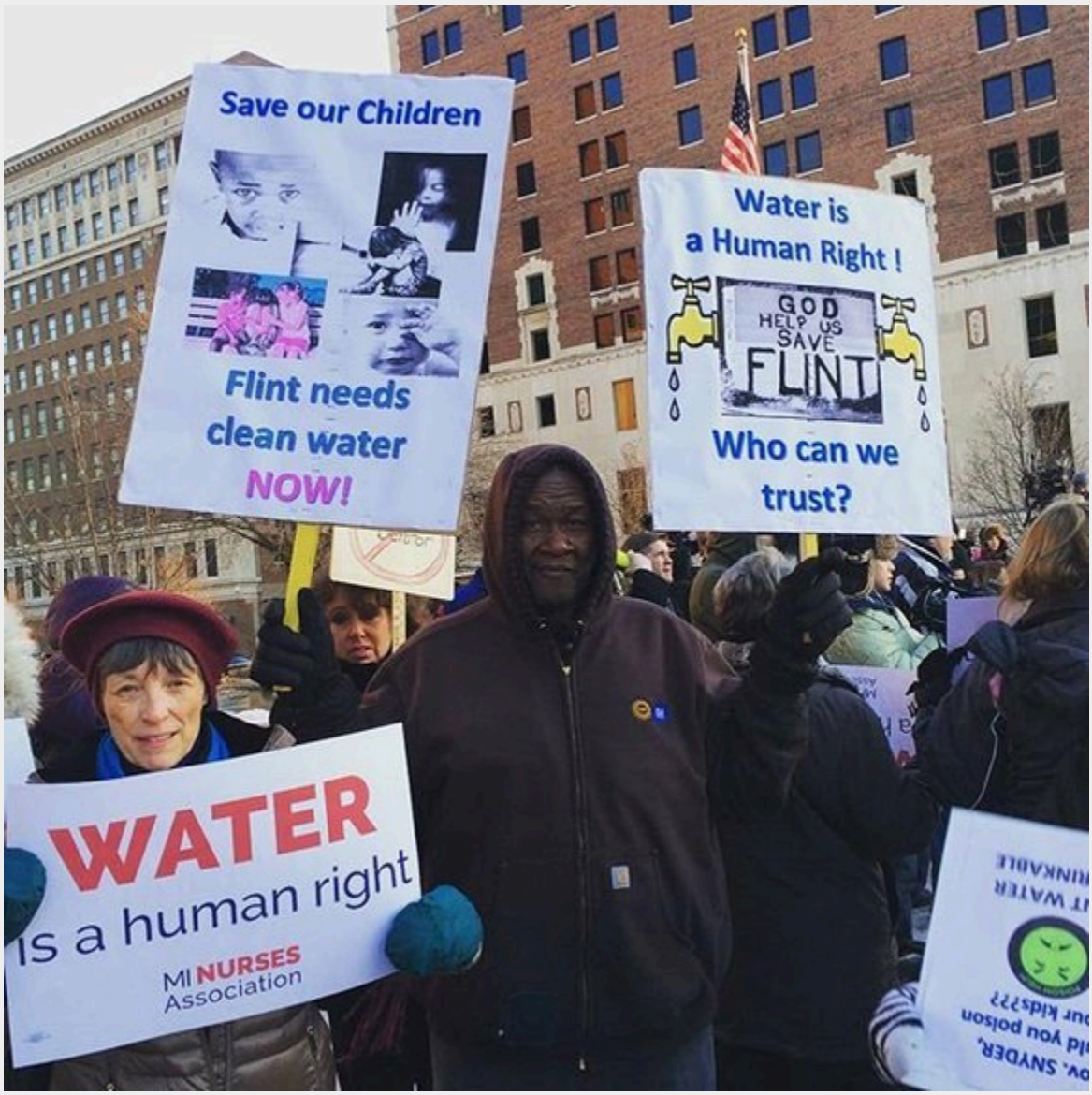

Figure 3.5 Flint Michigan Water Crisis

Reflective Questions

1. What factors led to the children from poor households being so disproportionately harmed by this crisis?
2. What are ways that you as a nursing student and future nurse can make a difference for vulnerable or marginalized people?

Providing culturally responsive care is a key strategy for reducing health disparities.[10] While there are multiple determinants contributing to a person's health, nurses play an important role in reducing health disparities by providing a culturally sensitive environment, performing a cultural assessment, and providing culturally responsive care. These interventions will be further discussed in the following sections. On the other hand, a lack of culturally responsive care potentially contributes to miscommunication between the client and the nurse. The client may experience distress or loss of trust in the nurse or the health care system as a whole and may not adhere to prescribed treatments. Nurses are uniquely positioned to directly impact client outcomes as we work together to overcome health disparities.

10. Zeran, V. (2016). Cultural competency and safety in nursing education: A case study. *Northern Review, 43*, 105–115. https://thenorthernreview.ca/index.php/nr/article/view/591

3.6 Culturally Sensitive Care

OPEN RESOURCES FOR NURSING (OPEN RN)

Providing culturally responsive care integrates an individual's cultural beliefs into their health care. Begin by conveying cultural sensitivity to clients and their family members with these suggestions[1]:

- Set the stage by introducing yourself by name and role when meeting the client and their family for the first time. Until you know differently, address the client formally by using their title and last name. Ask the client how they wish to be addressed and record this in the client's chart. Respectfully acknowledge any family members and visitors at the client's bedside.
- Begin by standing or sitting at least arm's length from the client.
- Observe the client and family members in regards to eye contact, space orientation, touch, and other nonverbal communication behaviors and follow their lead.
- Make note of the language the client prefers to use and record this in the client's chart. If English is not the client's primary language, determine if a medical interpreter is required before proceeding with interview questions. See the box below for guidelines in using a medical interpreter.
- Use inclusive language that is culturally sensitive and appropriate. For example, do not refer to someone as "wheelchair bound"; instead say "a person who uses a wheelchair."[2]

1. Brooks, L., Manias, E., & Bloomer, M. (2019). Culturally sensitive communication in healthcare: A concept analysis. *Collegian, 26*(3), 383-391. https://doi.org/10.1016/j.colegn.2018.09.007

2. UK Office for Disability Issues. (2018, December 13). *Inclusive language: Words to use and avoid when writing about disability.* https://www.gov.uk/

- Be open and honest about the extent of your knowledge of their culture. It is acceptable to politely ask questions about their beliefs and seek clarification to avoid misunderstandings.
- Adopt a nonjudgmental approach and show respect for the client's cultural beliefs, values, and practices. It is possible that you may not agree with a client's cultural expressions, but it is imperative that the client's rights are upheld. As long as the expressions are not unsafe for the client or others, the nurse should attempt to integrate them into their care.
- Assure the client that cultural considerations are a priority in their care.

Using Medical Interpreters

When caring for clients whose primary language is not English and they have a limited ability to speak, read, write, or understand the English language, seek the services of a trained medical interpreter. Health care facilities are mandated by The Joint Commission to provide qualified medical interpreters. Use of a trained medical interpreter is linked to fewer communication errors, shorter hospital stays, reduced 30-day readmission rates, and improved client satisfaction.

Refrain from asking a family member to act as an interpreter. The client may withhold sensitive information from them, or family members may possibly edit or change the information provided. Unfamiliarity with medical terminology can also cause misunderstanding and errors.

Medical interpreters may be on-site or available by videoconferencing or telephone. The nurse should also consider coordinating client and family member conversations with other health care team members to streamline communication, while being aware of cultural implications such as who can discuss what health care topics and who makes the decisions. When possible, obtain a medical interpreter of the same gender as the client to prevent potential embarrassment if a sensitive matter is being discussed.

government/publications/inclusive-communication/inclusive-language-words-to-use-and-avoid-when-writing-about-disability

Guidelines for Using a Medical Interpreter[3]

- Allow extra time for the interview or conversation with the client.
- Whenever possible, meet with the interpreter beforehand to provide background.
- Document the name of the medical interpreter in the progress note.
- Always face and address the client directly, using a normal tone of voice. Do not direct questions or conversation to the interpreter.
- Speak in the first person (using "I").
- Avoid using idioms, such as, "Are you feeling under the weather today?" Avoid abbreviations, slang, jokes, and jargon.
- Speak in short paragraphs or sentences. Ask only one question at a time. Allow sufficient time for the interpreter to finish interpreting before beginning another statement or topic.
- Ask the client to repeat any instructions and explanations given to verify that they understood.

Discussing Sexuality

It is common for nurses to encounter clients who wish to have discussions pertaining to their sexuality. **Sexuality** encompasses sex, sexual orientation,

3. Juckett, G., & Unger, K. (2014). Appropriate use of medical interpreters. *American Family Physician, 90*(7), 476-80. https://pubmed.ncbi.nlm.nih.gov/25369625/

gender identity, gender roles, among other topics. The need for sexuality discussions may be a result of medication sexual side effects, disease processes that may affect a person's sexuality, surgical procedures affecting sexuality, sexually transmitted infections, sexual trauma, or other health needs of LGBTQAI+ and straight clients. Sexual topics can be uncomfortable for both the nurse and the client The client may feel embarrassed or as if they cannot initiate the conversation due to social stigmas about certain topics. For this reason, nurses should let clients know they can talk about sexual concerns in a non-judgmental environment by using the following guidelines.[4]

Guidelines for Discussing Sexuality in a Sensitive Manner[5]

- Provide a private area free of interruptions for use during the conversation
- Do not appear hurried and give the client your undivided attention. Clients may be reluctant to open up if they feel the nurse is too busy to engage with them.
- Provide a sense of normalcy with what the client may be feeling without minimizing their concerns and ask permission before further discussing sexuality. For example, if a male client is taking medications with the sexual side effect of erectile dysfunction, the nurse could state, "Some clients taking this medication experience erectile

4. Southard, N.Z., Keller, J. (2009). The importance of assessing sexuality: A patient perspective. *Clinical Journal of Oncology Nursing, 13*(2), 213-7. https://doi.org/10.1188/09.CJON.213-217

5. Southard, N. Z., & Keller, J. (2009). The importance of assessing sexuality: A patient perspective. *Clinical Journal of Oncology Nursing, 13*(2), 213-7. https://doi.org/10.1188/09.CJON.213-217

dysfunction. Is this something that you would like to talk about?

- Be aware of certain situations that may warrant using additional resources such as other staff nurses. For example, if a female has experienced sexual trauma by a male perpetrator, she likely will not be comfortable with a male RN performing her assessment. It may be necessary to confer with the charge RN to change client assignments to allow this client to be cared for by female staff.
- Remain nonjudgmental and respectful in your interaction even if you may not agree with your client's sexuality.
- It's ok not to have all the answers for your client. It is acceptable and advised to recognize your limitations as a nurse and seek additional referrals and information as necessary.

3.7 Cultural Assessment

OPEN RESOURCES FOR NURSING (OPEN RN)

After establishing a culturally sensitive environment, nurses should incorporate a cultural assessment when caring for all clients. There are many assessment guides used for client interviews that are adaptable to a variety of health care settings and are designed to facilitate understanding and communication. The Four Cs of Culture model[1] is an example of a quick cultural assessment tool that asks questions about what the client **C**onsiders to be a problem, the **C**ause of the problem, how they are **C**oping with the problem, and how **C**oncerned they are about the problem. See the following box for examples of sample answers to the four Cs assessment.

Four Cs of Culture[2]

- What does the client **Consider** to be the problem and what they **Call** it. (In other words, "What do you think is wrong? What is worrying you?")
    - For example, a client diagnosed with pneumonia believes his body is "unbalanced."
- What does the client think **Caused** this problem?

1. Galanti, G. A. (2014). *Caring for patients from different cultures* (5th ed.). University of Pennsylvania Press.
2. Galanti, G. A. (2014). *Caring for patients from different cultures* (5th ed.). University of Pennsylvania Press.

- For example, the client believes this illness is a punishment for a misdeed. The client avoids eating certain foods to treat the illness while also using home remedies such as herbal tea.

- How **Concerned** is the client about this problem. (In other words, how serious is this problem?)
    - For example, a client views the illness as being "God's will" and states, "It's in God's hands."

A more comprehensive cultural assessment tool, inspired by R. E. Spector's Heritage Assessment interview,[3] is described in the following box.

Sample Cultural Assessment Interview (Adapted from Spector's Heritage Assessment Tool)[4]

- Where were you born? Where were your parents born?
- What pronoun do you use (he, she, they)?
- In what language are you most comfortable speaking and reading?
- Did you grow up in a city or a town or a rural setting?

3. Spector, R. E. (2017). *Cultural diversity in health and illness* (9th ed.). Pearson Education.

4. Spector, R. E. (2017). *Cultural diversity in health and illness* (9th ed.). Pearson Education.

- When you were growing up, who lived with you and your family?
- Are your friends from the same cultural background as you?
- What is your religious preference?
- Do you have any dietary preferences related to your religious or cultural beliefs?
- In your culture, how do you celebrate the birth of a baby? A wedding?
- When a woman is pregnant, are there any special customs she needs to follow? Any special foods?
- When someone in your family is ill, who cares for them? What foods are prepared? Is there anything the ill person should avoid or refrain from doing?
- What home remedies might be used if someone is ill?
- As a family member is approaching death, what actions do you find comforting?
- After a loved one dies, what rituals are performed?
- What do you think a nurse should know about your culture if a family member is hospitalized?
- Who makes the decisions in your family?
- How are elders viewed in your culture?
- Are there any special beliefs regarding organ donation or blood transfusions that are held in your culture?
- Is your culture known for any special customs (e.g., rites of passage, foods, holidays, etc.)?

3.8 Culturally Responsive Care

OPEN RESOURCES FOR NURSING (OPEN RN)

After establishing a culturally sensitive environment and performing a cultural assessment, nurses and nursing students can continue to promote culturally responsive care. Culturally responsive care includes creating a culturally safe environment, using cultural negotiation, and considering the impact of culture on clients' time orientation, space orientation, eye contact, and food choices.

Culturally Safe Environment

A primary responsibility of the nurse is to ensure the environment is culturally safe for the client. A **culturally safe environment** is a safe space for clients to interact with the nurse, without judgment or discrimination, where the client is free to express their cultural beliefs, values, and identity. This responsibility belongs to both the individual nurse and also to the larger health care organization.

Cultural Negotiation

Many aspects of nursing care are influenced by the client's cultural beliefs, as well as the beliefs of the health care culture. For example, the health care culture in the United States places great importance on punctuality for medical appointments, yet a client may belong to a culture that views "being on time" as relative. In some cultures, time is determined simply by whether it is day or night or time to wake up, eat, or sleep. Making allowances or accommodations for these aspects of a client's culture is instrumental in fostering the nurse-client relationship. This accommodation is referred to as

cultural negotiation. See Figure 3.6[1] for an image illustrating cultural negotiation. During cultural negotiation, both the client and nurse seek a mutually acceptable way to deal with competing interests of nursing care, prescribed medical care, and the client's cultural needs. **Cultural negotiation** is reciprocal and collaborative. When a client's cultural needs do not significantly or adversely affect their treatment plan, their cultural needs should be accommodated when feasible.

As an example, think about the client previously discussed for whom a fixed schedule is at odds with their cultural views. Instead of teaching the client to take a daily medication at a scheduled time, the nurse could explain that the client should take the medication every day when he awakens rather than every morning at 0800. Another example of cultural negotiation is illustrated by a scenario in which the nurse is preparing a client for a surgical procedure. As the nurse goes over the preoperative checklist, the nurse asks the client to remove her head covering (hijab). The nurse is aware that personal items should be removed before surgery; however, the client wishes to keep on the hijab. As an act of cultural negotiation and respect for the client's cultural beliefs, the nurse makes arrangements with the surgical team to keep the client's hijab in place for the surgical procedure and covering the client's hijab with a surgical cap.

1. "handshake-3378251_1920.jpg" by geralt is licensed under CC0

Figure 3.6 Cultural Negotiation

Decision-Making

Health care culture in the United States mirrors cultural norms of the country, with an emphasis on individuality, personal freedom, and self-determination. **Self-determination** refers to a person's right to determine what will be done with and to their own body. This perspective may conflict with a client whose cultural background values group decision-making and decisions made to benefit the group, not necessarily the individual. As an example, in the 2019 film *The Farewell*, a Chinese-American family decides to not tell the family matriarch she is dying of cancer and only has a few months left to live. The family keeps this secret from the woman in the belief that the family should bear the emotional burden of this knowledge, which is a collectivistic viewpoint in contrast to American individualistic viewpoint.

Space Orientation

The amount of space that a person surrounds themselves with to feel

comfortable is influenced by culture. See Figure 3.7[2] for an image illustrating space orientation. For example, for some people, it would feel awkward to stand four inches away from another person while holding a social conversation, but for others a small personal space is expected when conversing with another.[3] There are times when a nurse must enter a client's intimate or personal space, which can cause emotional distress for some clients. The nurse should always ask for permission before entering a client's personal space and explain why close contact is necessary and what is about to happen.

Clients may also be concerned about their modesty or being exposed. A client may deal with the violation of their space by removing themselves from the situation, pulling away, or closing their eyes. The nurse should recognize these cues for what they are, an expression of cultural preference, and allow the client to assume a position or distance that is comfortable for them.

Similar to cultural influences on personal space, touch is also culturally determined. This has implications for nurses because depending on the culture, it may be inappropriate for a male nurse to provide care for a female client and vice versa. In some cultures, it is also considered rude to touch a person's head without permission.

2. "Proxemics.png" by Natbrock Alicia Tom is licensed under CC BY-SA 3.0

3. Kreuz, R., & Roberts, R. (2019). Proxemics 101: Understanding personal space across cultures. *The MITPress Reader.* https://thereader.mitpress.mit.edu/understanding-personal-space-proxemics/

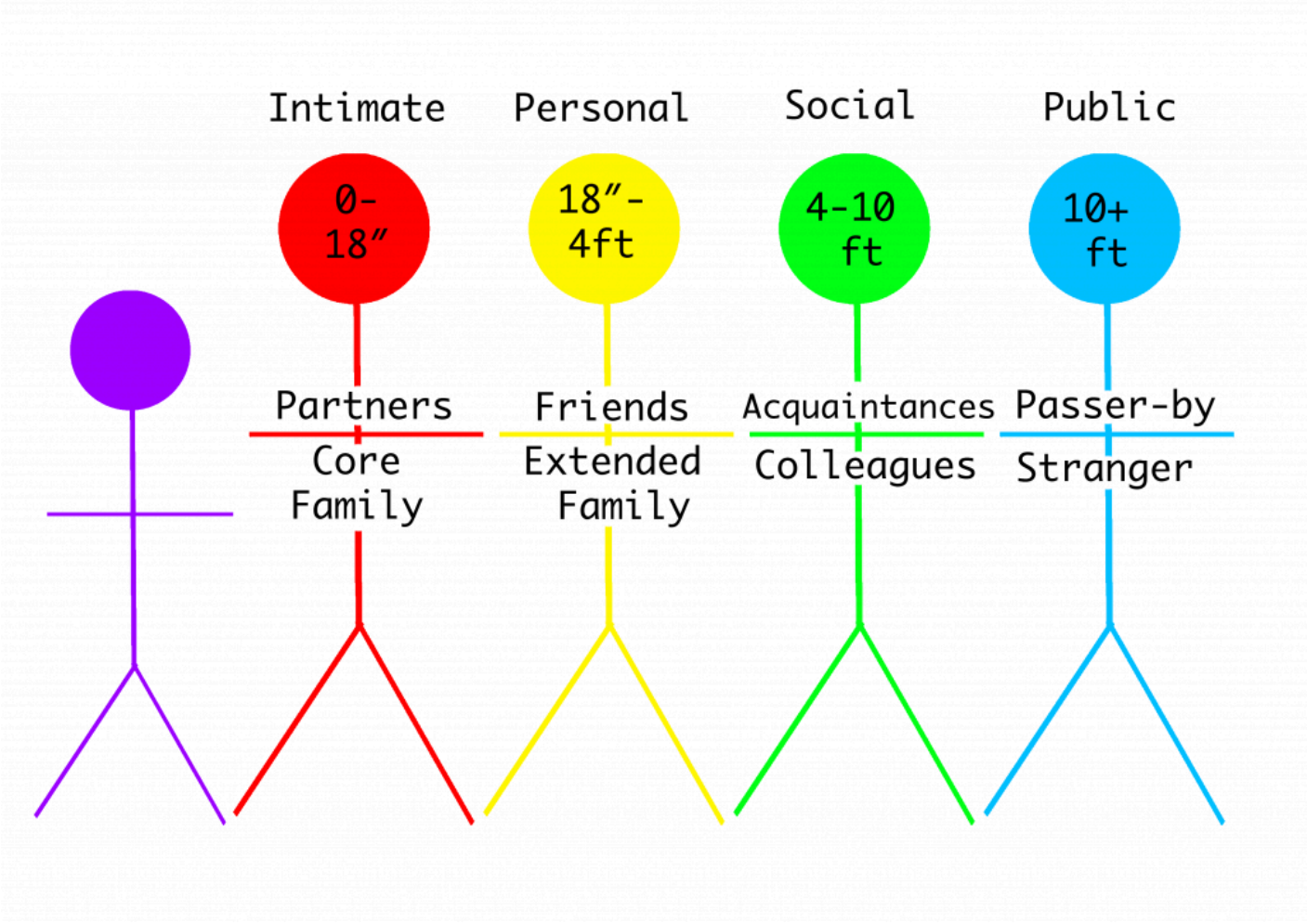

Figure 3.7 Space Orientation

Review more information about space orientation in the "Communication" chapter.

Eye Contact

Eye contact is also a culturally mediated behavior. See Figure 3.8[4] for an image of eye contact. In the United States, direct eye contact is valued when communicating with others, but in some cultures, direct eye contact is interpreted as being rude or bold. Rather than making direct eye contact, a client may avert their eyes or look down at the floor to show deference and respect to the person who is speaking. The nurse should notice these cultural cues from the client and mirror the client's behaviors when possible.

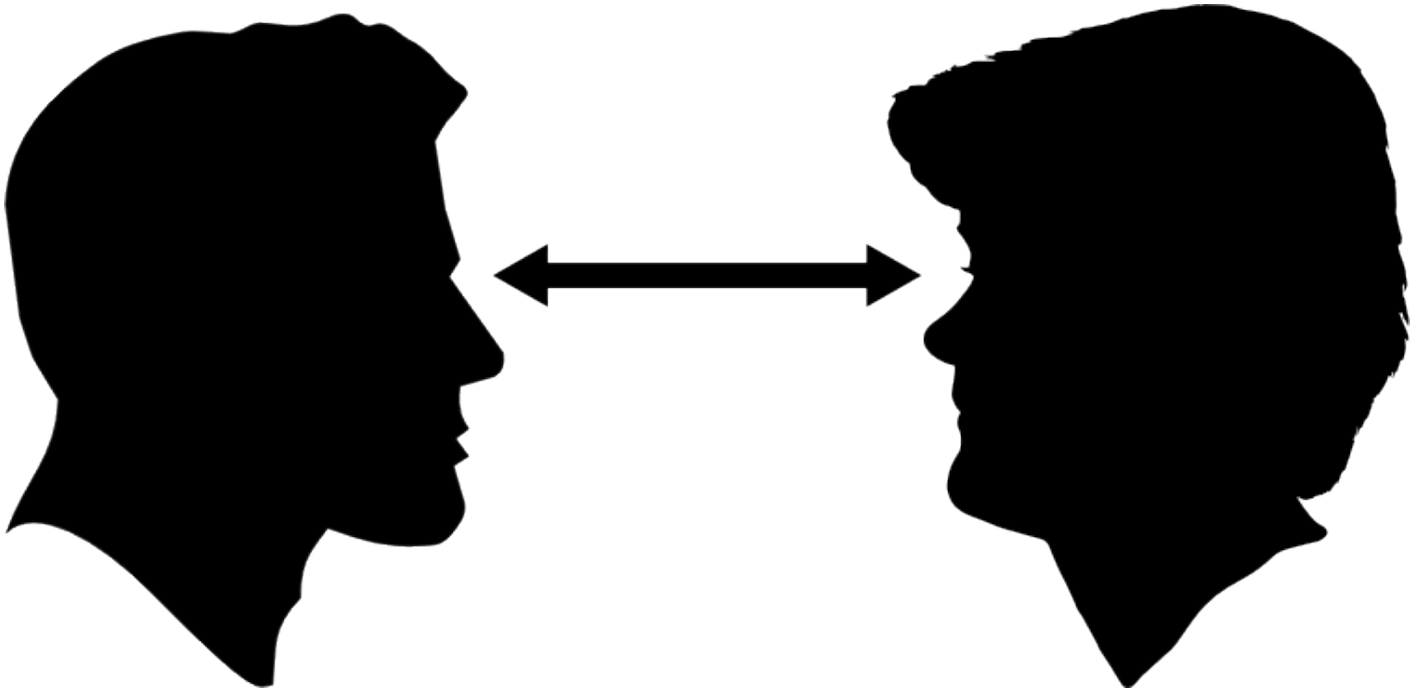

Figure 3.8 Eye Contact

Food Choices

Culture plays a meaningful role in the dietary practices and food choices of many people. Food is used to celebrate life events and holidays. Most cultures have staple foods, such as bread, pasta, or rice and particular ways of

4. "271509.png" by amcolley is in the Public Domain

preparing foods. See Figure 3.9[5] for an image of various food choices. Special foods are prepared to heal and to cure or to demonstrate kinship, caring, and love. For example, in the United States, chicken noodle soup is often prepared and provided to family members who are ill. In certain Asian cultures, individuals prefer "heating" or "cooling" foods depending on the illness, with the belief that each specific food will help bring balance back to their system.[6] Additionally, certain foods and beverages (such as meat and alcohol) are forbidden in some cultures. Nurses should accommodate or negotiate dietary requests of their clients, knowing that food holds such an important meaning to many people. See a summary of common food choices across cultures and religions in Table 3.8.

Figure 3.9 Food Choices

5. "wanna-cuppa-singapore-cafe-food-bistro-trees-dishes-craft-beer-ale-breakfast-lunch-dinner-dark-1920×1080.jpg" by Jennette Kwok is licensed under CC BY-NC-SA 4.0

6. College of Naturopathy Medicine. (n.d.). *The energy of foods in Chinese medicine*. https://www.naturopathy-uk.com/news/news-cnm-blog/blog/2020/07/16/the-energy-of-foods-in-chinese-medicine/

Table 3.8 Common Food Choices and Other Considerations Across Cultures and Religions[7, 8]

	Buddhist & Hindu	Christian	Hispanic	Hmong	Jewish	M
Common dietary choices	Lentils, tofu, vegetables, spices, and rice.	Varies across denominations. Some choose to eat fish on Friday rather than meat.	Rice, beans, pork, beef, chicken, goat, eggs, corn, avocado, and tropical fruits	Pho, laab, spring rolls, khao niew (sticky rice), rice, pork, chicken, beef, fish, tofu, leafy greens, tropical fruits	Kosher diet includes preparation of meat and dairy, kosher-certified foods	H p p a p h n
Other	Clients may practice vegetarianism and mindful eating practices.	During Lent, clients may fast or avoid certain foods.	Diet is often a blend of tradition and modern cuisine that dates back to the first agricultural communities, such as the Mayans & Aztec Empire.	During the postpartum period, clients may choose boiled chicken, rice, & warm/hot water for 30 days.	During Yom Kippur, clients may fast for 24 hours.	D P c n f t

Read more information about cultural dietary preferences

7. A to Z World Food. (n.d.). *Food Culture: National Cuisine*. https://www.atozworldfood.com/australia/culture/national-cuisine.html

8. Yang, P. (n.d.). *Hmong Postpartum Diet*. https://hmongtimes.com/hmong-postpartum-diet/3030/

- and restrictions in the "Common Religions and Spiritual Practices" section of the "Spirituality" chapter.

Summary

In summary, there are several steps in the journey of becoming a culturally competent nurse with cultural humility who provides culturally responsive care to clients. As you continue in your journey of developing cultural competency, keep the summarized points in the following box in mind.

Summary of Developing Cultural Competency

- Cultural competence is an ongoing process for nurses and takes dedication, time, and practice to develop.
- Pursuing the goal of cultural competence in nursing and other health care disciplines is a key strategy in reducing health care disparities.
- Culturally competent nurses recognize that culture functions as a source of values and comfort for clients, their families, and communities.
- Culturally competent nurses intentionally provide client-centered care with sensitivity and respect for culturally diverse populations.
- Misunderstandings, prejudices, and biases on the part of the health care provider interfere with the client's health outcomes.

- Culturally competent nurses negotiate care with clients so the care is congruent with their cultural beliefs and values.
- Nurses should examine their own biases, ethnocentric views, and prejudices so as not to interfere with the client's care.
- Nurses who respect and understand the cultural values and beliefs of their clients are more likely to develop positive, trusting relationships with their clients.

3.9 Putting It All Together

Client Scenario

Mrs. Rosas is a 76-year-old client admitted to the cardiology floor with an exacerbation of heart failure. The client's primary language is Spanish, and she has a limited understanding of English. The client's daughter is present in the room and reports that the client has been experiencing increased swelling in her ankles and increased shortness of breath over the last three weeks. During the admission assessment the nurse attempts to collect additional information related to current symptoms, diet, and history. The client nods in response to questions and converses quietly in Spanish with her daughter. The nurse notes that the client does not respond to questions appropriately and is unable to converse in English. She defers to her daughter to provide interpretation of questions and relay information.

Based on the assessment information that has been gathered, the nurse plans the following care for Mrs. Rosas:

- The nurse will obtain interpreter services in order to facilitate client communication. In-person interpreter or language line telephone services will be utilized to ensure that the client receives information about her care.
- The nurse will eliminate distractions such as the television, hallway noise, etc., to decrease sources of additional stimuli in the communication experience.
- The nurse will communicate directly with the client, utilizing appropriate eye contact, and nonverbal cues to enhance the communication experience.

As a result of these interventions by the nurse to promote culturally sensitive care, Mrs. Rosas engages with staff through the use of interpreter services and actively participates in her own care.

3.10 Learning Activities

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Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

1. Test yourself for implicit bias at the Learning for Justice website.
2. Consider the following scenario.

You are completing the admission assessment for Mr. Xiong, a 64-year-old client admitted to the medical-surgical floor with acute kidney injury. Mr. Xiong speaks Hmong and some English. What actions should be undertaken to ensure that you are providing culturally responsive care to Mr. Xiong?

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=433#h5p-89

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=433#h5p-83

Test your knowledge using this NCLEX Next Generation-style question. You may reset and resubmit your answers to this question an unlimited number of times.[1]

1. "Chapter 3 Assignment 1" by Rebecca Wicks for OpenRN is licensed under CC BY-NC 4.0

3.11 Supplementary Videos

OPEN RESOURCES FOR NURSING (OPEN RN)

View these supplementary videos regarding cultural diversity and cultural competence:

- Haley Yeates | It's Past Time to Appreciate Cultural Diversity[1]
- Becoming a Culturally Competent Nurse[2]

1. TED Institute. (2018, February 15). *It's (past) time to appreciate cultural diversity | Hayley Yeates | TED Institute* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=C2fyHNMOvjg

2. Johnson & Johnson Nursing. (2018, December 3). *Becoming a culturally competent nurse* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=r62Zp99U67Y&feature=emb_title

III Glossary

OPEN RESOURCES FOR NURSING (OPEN RN)

Assimilation: The process of adopting or conforming to the practices, habits, and norms of a cultural group. As a result, the person gradually takes on a new cultural identity and may lose their original identity in the process. (Chapter 3.2)

Bias: To carry an attitude, opinion, or inclination (positive or negative) towards a group or members of a group. Bias can be a conscious attitude (explicit), or a person may not be aware of their bias (implicit). (Chapter 3.2)

Cultural awareness: A deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem-solving strategies of a client's culture. Cultural awareness goes beyond a simple awareness of the existence of other cultures and involves an interest, curiosity, and appreciation of other cultures. (Chapter 3.4)

Cultural competence: The process of applying evidence-based nursing in agreement with the preferred cultural values, beliefs, worldview, and practices of clients to produce improved client outcomes. (Chapter 3.1, Chapter 3.4)

Cultural congruent practice: Nursing care that is in agreement with the preferred values, beliefs, worldview, and practices of the health care consumer.[1] (Chapter 3.4)

Cultural desire: Refers to the intrinsic motivation and commitment on the

1. Marion, L., Douglas, M., Lavin, M., Barr, N., Gazaway, S., Thomas, L., & Bickford, C. (2016). Implementing the new ANA Standard 8: Culturally congruent practice. *OJIN: The Online Journal of Issues in Nursing, 22*(1). https://ojin.nursingworld.org/table-of-contents/volume-22-2017/number-1-january-2017/articles-on-previously-published-topics/implementing-the-new-ana-standard-8-culturally-congruent-practice/

part of a nurse to develop cultural awareness and cultural competency. (Chapter 3.4)

Cultural diversity: Cultural differences in people. (Chapter 3.2)

Cultural encounters: A process where the nurse directly engages in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping. (Chapter 3.4)

Cultural humility: A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot know everything about other cultures, and approach learning about other cultures as a lifelong goal and process.[2] (Chapter 3.1, Chapter 3.2)

Cultural knowledge: Seeking information about cultural health beliefs and values to understand clients' world views. (Chapter 3.4)

Cultural negotiation: A process where the client and nurse seek a mutually acceptable way to deal with competing interests of nursing care, prescribed medical care, and the client's cultural needs. Cultural negotiation is reciprocal and collaborative. When the client's cultural needs do not significantly or adversely affect their treatment plan, the cultural needs can be accommodated. (Chapter 3.8)

Cultural sensitivity: Being tolerant and accepting of cultural practices and beliefs of people. (Chapter 3.4)

Culturally responsive care: Nursing actions that integrate a person's cultural beliefs into their care. (Chapter 3.1)

Culturally safe environment: A safe space for clients to interact with health professionals, without judgment or discrimination, where the client is free to express their cultural beliefs, values, and identity. (Chapter 3.8)

Cultural skill: The ability to gather and synthesize relevant cultural information about their clients while planning care and using culturally sensitive communication skills while doing so. (Chapter 3.4)

Culture: A set of beliefs, attitudes, and practices shared by a group of

2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

people or community that is accepted, followed, and passed down to other members of the group. (Chapter 3.2)

Discrimination: Unfair and different treatment of another person or group, denying them opportunities and rights to participate fully in society. (Chapter 3.2)

Ethnocentrism: The belief that one's culture (or race, ethnicity, or country) is better and preferable than another's. (Chapter 3.2)

Gender expression: A person's outward demonstration of gender in relation to societal norms, such as in style of dress, hairstyle, or other mannerisms. (Chapter 3.2)

Gender identity: A person's inner sensibility that they are a man, a woman, or perhaps neither. (Chapter 3.2)

Health disparities: Differences in health outcomes resulting from entrenched economic, sociopolitical, or environmental disadvantages. Health disparities negatively impact groups of people based on their ethnicity, gender, age, mental health, disability, sexual orientation or gender identity, socioeconomic status, geographic location, or other characteristics historically linked to discrimination or exclusion. (Chapter 3.5)

Health care disparities: Differences in access to health care and insurance coverage. (Chapter 3.5)

Holism: Treatment of the whole person, including physical, mental, spiritual, and social needs. (Chapter 3.1)

Intersectionality: The many ways in which a person expresses their cultural identity are not separated but are closely intertwined. (Chapter 3.2)

Justice: A principle and moral obligation to act on the basis of equality and equity; a standard linked to fairness for all in society.[3] (Chapter 3.2)

LGBTQAI+: Lesbian, gay, bisexual, transgender, queer, or questioning in reference to sexual orientation. (Chapter 3.2)

Prejudice: To "prejudge"; a preconceived idea, often unfavorable, about a person or group of people. (Chapter 3.2)

3. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Race: A socially constructed idea; there are no truly genetically or biologically distinct races. Humans are biologically similar to each other, not different. (Chapter 3.2)

Racism: The presumption that races are distinct from one another and there is a hierarchy to race, implying that races are unequal. In racism, expression of one's cultural beliefs is viewed as a heritable trait. (Chapter 3.2)

Self-determination: Refers to a person's right to determine what will be done with and to their own body. (Chapter 3.8)

Sexuality: Encompasses sex, sexual orientation, gender identity, gender roles, among other topics. (Chapter 3.6)

Sexual orientation: A person's physical and emotional interest or desire for others. Sexual orientation is on a continuum and is manifested in one's self-identity and behaviors. (Chapter 3.2)

Social determinants of health: Nonmedical factors that influence health outcomes, including conditions in which people are born, grow, work, live, and age, and the wider sets of forces and systems shaping the conditions of daily life.[4] (Chapter 3.2)

Social justice: Equal rights, equal treatment, and equitable opportunities for all.[5] (Chapter 3.2)

Stereotyping: Assuming that a person has the attributes, traits, beliefs, and values of a group because they are a member of that group.(Chapter 3.2)

Subculture: A smaller group of people within a larger culture, often based on a person's occupation, hobbies, interests, or place of origin. (Chapter 3.2)

Transcultural nursing: Incorporating cultural beliefs and practices of people to help them maintain and regain health or to face death in a meaningful way. (Chapter 3.4)

4. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

5. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

PART IV

NURSING PROCESS

4.1 Nursing Process Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Objectives

- Use the nursing process to provide client care
- Describe components of a client-centered plan of care
- Differentiate priorities of client care
- Describe the roles of the RN, LPN/VN, and UAP in providing client care

Have you ever wondered how a nurse can receive a quick handoff report from another nurse and immediately begin providing care for a client they previously knew nothing about? How do they know what to do? How do they prioritize and make a plan?

Nurses know how to analyze pertinent information and use the nursing process as a critical thinking model to guide client care. The nursing process becomes a road map for the actions and interventions that nurses implement to optimize their clients' well-being and health. This chapter will explain how to use the **nursing process** as standards of professional nursing practice to provide safe, client-centered care.

4.2 Basic Concepts

OPEN RESOURCES FOR NURSING (OPEN RN)

Before learning how to use the nursing process, it is important to understand basic concepts concerning how critical thinking relates to nursing practice. Let's take a deeper look at how nurses think.

Critical Thinking and Clinical Reasoning

Nurses make decisions while providing client care by using critical thinking and clinical reasoning. **Critical thinking** is a broad term used in nursing that includes "reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow."[1] Using critical thinking means that nurses take extra steps to maintain client safety and don't just "follow orders." It also means the accuracy of client information is validated and plans for caring for clients are based on their needs, current clinical practice, and research.

"Critical thinkers" possess certain attitudes that foster rational thinking. These attitudes are as follows:

- **Independence of thought:** Thinking on your own
- **Fair-mindedness:** Treating every viewpoint in an unbiased, unprejudiced way
- **Insight into egocentricity and sociocentricity:** Thinking of the greater good and not just thinking of yourself. Knowing when you are thinking of yourself (egocentricity) and when you are thinking or acting for the

1. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221. doi: 10.1097/01.NEP.0000000000000669. PMID: 32569111. https://pubmed.ncbi.nlm.nih.gov/32569111/

greater good (sociocentricity)

- **Intellectual humility:** Recognizing your intellectual limitations and abilities
- **Nonjudgmental:** Using professional ethical standards and not basing your judgments on your own personal or moral standards
- **Integrity:** Being honest and demonstrating strong moral principles
- **Perseverance:** Persisting in doing something despite it being difficult
- **Confidence:** Believing in yourself to complete a task or activity
- **Interest in exploring thoughts and feelings:** Wanting to explore different ways of knowing
- **Curiosity:** Asking "why" and wanting to know more

Clinical reasoning is defined as, "A complex cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and weigh alternative actions."[2] To make sound judgments about client care, nurses must generate alternatives, weigh them against the evidence, and choose the best course of action. The ability to clinically reason develops over time and is based on knowledge and experience.[3]

Inductive and Deductive Reasoning and Clinical Judgment

Inductive and deductive reasoning are important critical thinking skills. They

2. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221.

3. Powers, L., Pagel, J., & Herron, E. (2020). Nurse preceptors and new graduate success. *American Nurse Journal, 15*(7), 37-39. https://www.myamericannurse.com/nurse-preceptors-and-new-graduate-success/

help the nurse use clinical judgment when implementing the nursing process.

Inductive reasoning involves noticing cues, making generalizations, and creating hypotheses based on specific information or incidents. **Cues** are data that fall outside of expected findings that give the nurse a hint or indication of a client's potential problem or condition. The nurse organizes these cues into patterns and creates a generalization. A **generalization** is a judgment formed from a set of facts, cues, and observations and is similar to gathering pieces of a jigsaw puzzle into patterns until the whole picture becomes more clear. Based on generalizations created from patterns of data, the nurse creates a hypothesis regarding a client problem. A **hypothesis** is a proposed explanation for a situation. It attempts to explain the "why" behind the problem that is occurring. If a "why" is identified, then a solution can begin to be explored.

No one can draw conclusions without first noticing cues. Paying close attention to a client, the environment, and interactions with family members is critical for inductive reasoning. As you work to improve your inductive reasoning, begin by first noticing details about the things around you. A nurse is similar to the detective looking for cues in Figure 4.1.[4] Be mindful of your five primary senses: the things that you hear, feel, smell, taste, and see. Nurses need strong inductive reasoning patterns and be able to take action quickly, especially in emergency situations. They can see how certain objects or events form a pattern (i.e., generalization) that indicates a common problem (i.e., hypothesis).

Example: A nurse assesses a client and finds the surgical incision site is red, warm, and tender to the touch. The nurse recognizes these cues form a pattern of signs of infection and creates a hypothesis that the incision has become infected. The provider is notified of the client's change in condition, and a new prescription is received for an antibiotic. This is an example of the use of inductive reasoning in nursing practice.

4. "The Detective" by paurian is licensed under CC BY 2.0

Figure 4.1 Inductive Reasoning Includes Looking for Cues

Deductive reasoning is another type of critical thinking that is referred to as "top-down thinking." Deductive reasoning relies on using a general standard or rule to create a strategy. Deductive reasoning relies on a general statement or hypothesis – sometimes called a premise or standard – that is held to be true. The premise is used to reach a specific, logical conclusion. Nurses use standards set by their state's Nurse Practice Act, federal regulations, the American Nursing Association, professional organizations, and their employer to make decisions about client care and solve problems.

Example: Based on research findings, hospital leaders determine clients recover more quickly if they receive adequate rest. The hospital creates a policy for quiet zones at night by initiating no overhead paging, promoting low-speaking voices by staff, and reducing lighting in the hallways. (See

Figure 4.2).[5] The nurse further implements this policy by organizing care for clients that promotes periods of uninterrupted rest at night. This is an example of deductive thinking because the intervention is applied to all clients regardless if they have difficulty sleeping or not.

Figure 4.2 Deductive Reasoning Example: Implementing Interventions for a Quiet Zone Policy

5. "In the Quiet Zone..." by C.O.D. Library is licensed under CC BY-NC-SA 2.0

Clinical judgment is the result of critical thinking and clinical reasoning using inductive and deductive reasoning. Clinical judgment is defined by the National Council of State Boards of Nursing (NCSBN) as, "The observed outcome of critical thinking and decision-making. It uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care."[6] The NCSBN administers the national licensure exam (NCLEX) that evaluates the decision-making ability of nursing graduates and sets a minimum standard for safe, competent nursing care by entry-level licensed nurses. The NCLEX uses the NCSBN Clinical Judgment Measurement Model (NCJMM) to measure clinical judgment.

Evidence-based practice (EBP) is defined by the American Nurses Association (ANA) as, "A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer's history and condition, as well as health care resources; and client, family, group, community, and population preferences and values."[7]

Nursing Process

The nursing process is a critical thinking model based on a systematic approach to client-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing client care. The nursing process is based on the Standards of Professional Nursing Practice established by the American Nurses Association (ANA). These standards are authoritative statements of the actions and behaviors that all registered nurses (RNs), regardless of role, population, specialty, and setting,

6. NCSBN. (n.d.). *NCSBN clinical judgment measurement model*. https://www.ncsbn.org/14798.htm

7. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

are expected to perform competently.[8] The mnemonic **ADOPIE** is an easy way to remember the ANA Standards and the nursing process. Each letter refers to the six components of the nursing process: **A**ssessment, **D**iagnosis, **O**utcomes Identification, **P**lanning, **I**mplementation, and **E**valuation.

The nursing process is a continuous, cyclical process that is constantly adapting to the client's current health status. See Figure 4.3a[9] for an illustration of the nursing process.

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

9. "The Nursing Process" by Kim Ernstmeyer at Chippewa Valley Technical College is licensed under CC BY 4.0

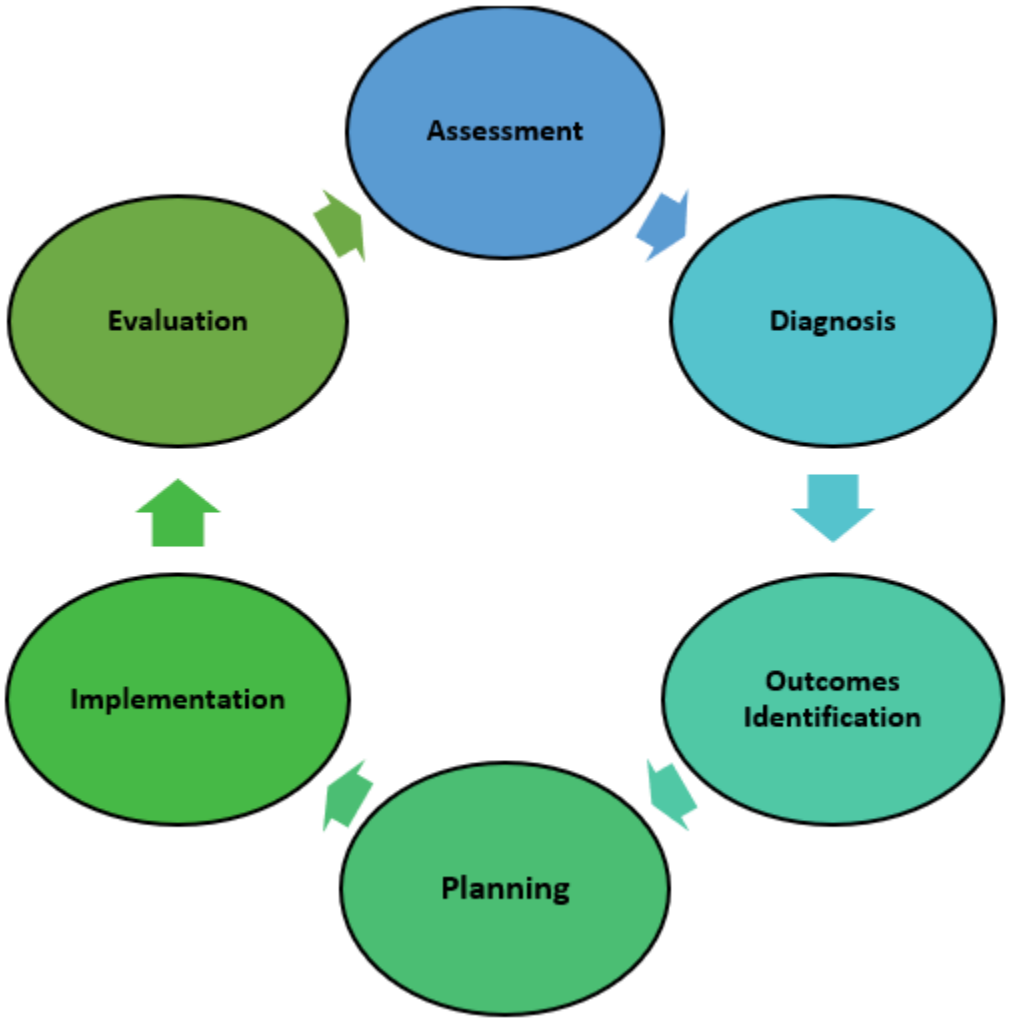


Figure 4.3a The Nursing Process

The ANA's Standards of Professional Nursing Practice associated with each component of the nursing process are described below.

Assessment

The "Assessment" Standard of Practice is defined as, "The registered nurse collects pertinent data and information relative to the health care consumer's

health or the situation."[10] A registered nurse uses a systematic method to collect and analyze client data. Assessment includes physiological data, as well as psychological, sociocultural, spiritual, economic, and lifestyle data. For example, a nurse's assessment of a hospitalized client in pain includes recognizing cues such as the client's response to pain, such as the inability to get out of bed, refusal to eat, withdrawal from family members, or anger directed at hospital staff.[11]

Licensed practical/vocational nurses (LPN/VNs) assist with gathering data according to their state's scope of practice, but do not analyze data because this is outside their scope of practice. The "Assessment" component of the nursing process is further described in the "Assessment" section of this chapter.

Diagnosis

The "Diagnosis" Standard of Practice is defined as, "The registered nurse analyzes the assessment data to determine actual or potential diagnoses, problems, and issues."[12] A nursing diagnosis is the nurse's clinical judgment about the response from the **client** to actual or potential health conditions or needs. Nursing diagnoses are the bases for the nurse's care plan and are different than medical diagnoses.[13]

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
11. American Nurses Association. (n.d.). *The nursing process.* https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/
12. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
13. American Nurses Association. (n.d.). *The nursing process*.

Analyzing assessment data and formulating a nursing diagnosis is outside the scope of practice for LPN/VNs, and as such, they do not assist with this phase of the nursing process. The "Diagnosis" component of the nursing process is further described in the "Diagnosis" section of this chapter.

Outcome Identification

The "Outcome Identification" Standard of Practice is defined as, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation."[14] The nurse sets measurable and achievable short- and long-term goals and specific outcomes in collaboration with the client based on their assessment data and nursing diagnoses.

Outcome identification is outside the scope of practice of LPN/VNs, and as such, they do not assist with this phase of the nursing process. The "Outcome Identification" component of the nursing process is further described in the "Outcome Identification" section of this chapter.

Planning

The "Planning" Standard of Practice is defined as, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes."[15] Assessment data, diagnoses, and goals are used to select evidence-based nursing interventions customized to each client's needs in order to achieve their previously established goals and outcomes. Nursing

https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

14. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

15. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

interventions are planned and documented by RNs in the client's nursing care plan so that nurses, as well as other health professionals, can refer to it for continuity of care.[16]

The "Planning" component of the nursing process is further described in the "Planning" section of this chapter.

Nursing Care Plans

Creating nursing care plans is a part of the "Planning" step of the nursing process. A **nursing care plan** is a type of documentation that demonstrates the individualized planning and delivery of nursing care for each specific client using the nursing process. RNs create nursing care plans so that the care provided to the client across shifts is consistent among health care personnel. Some interventions can be delegated to LPN/VNs or trained Unlicensed Assistive Personnel (UAPs) with RN supervision.

Creating the nursing care plan is outside the scope of practice, and as such, the LPN/VNs do not perform this task, although they may contribute to it. Developing nursing care plans and implementing appropriate delegation are further discussed under the "Planning" and "Implementation of Interventions" sections of this chapter.

Implementation

The "Implementation" Standard of Practice is defined as, "The nurse implements the identified plan."[17] Nursing interventions are implemented or delegated with supervision according to the care plan to assure continuity of

16. American Nurses Association. (n.d.). *The nursing process*. https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

17. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (3rd ed.). American Nurses Association.

care across multiple nurses and health professionals caring for the client. Interventions are documented in the client's electronic medical record as they are completed.[18] LPN/VNs implement interventions contained in the nursing care plan, provided they are within their scope of practice. The LPN/VN is responsible for documenting the interventions they perform in the client's medical record.

The "Implementation" Standard of Professional Practice also includes the subcategories "Coordination of Care" and "Health Teaching and Health Promotion" to promote health and a safe environment.[19]

The "Implementation" component of the nursing process is further described in the "Implementation of Interventions" section of this chapter.

Evaluation

The "Evaluation" Standard of Practice is defined as, "The registered nurse evaluates progress toward attainment of goals and outcomes."[20] During evaluation, nurses reassess the client and compare the findings against established outcomes to determine the effectiveness of the interventions and overall nursing care plan. During this phase, RNs ask, "Were outcomes met? Are any modifications required for the nursing care plan?" Both the client's status and the effectiveness of the nursing care plan are continuously evaluated and modified as needed.[21]

18. American Nurses Association. (n.d.) *The nursing process*. https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

19. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

20. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

21. American Nurses Association. (n.d.). *The nursing process*.

Evaluating and modifying the nursing care plan is outside the scope of practice of LPN/VNs, although they can assist in gathering assessment data to assist the RN in performing this step of the nursing process. The "Evaluation" component of the nursing process is further described in the "Evaluation" section of this chapter.

Benefits of Using the Nursing Process

Using the nursing process has many benefits for nurses, clients, and other members of the health care team. The benefits of using the nursing process include the following:

- Promotes quality client care
- Decreases omissions and duplications
- Provides a guide for all staff involved to provide consistent and responsive care
- Encourages collaborative management of a client's health care problems
- Improves client safety
- Improves client satisfaction
- Identifies a client's goals and strategies to attain them
- Increases the likelihood of achieving positive client outcomes
- Saves time, energy, and frustration by creating a care plan that is accessible to all staff caring for a client

By using these components of the nursing process as a critical thinking model, nurses plan outcomes and interventions that are customized to the client's specific needs, ensure the interventions are evidence-based, and evaluate the effectiveness of interventions in meeting the client's needs.

https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

NCSBN Clinical Judgment Measurement Model

The NCSBN Clinical Judgment Measurement Model (NCJMM) complements the nursing process, but it is a model that assesses an NCLEX candidate's clinical judgment. Terminology used by this model includes recognize cues, analyze cues, prioritize hypotheses, generate solutions, take action, and evaluate outcomes. See Figure 4.3b[22] and Table 4.2 for comparisons of NCJMM terms and the nursing process.[23,24,25]

22. "Nursing Process and NCJMM" by Tami Davis is licensed under CC BY 4.0

23. NCSBN (n.d.) *NCSBN Clinical Judgment Measurement Model*. https://www.ncsbn.org/14798.htm

24. Ignativicius, V., & Silvestri, L. (2022). *Preparing for the Next-Generation NCLEX (NGN): A "how-to" step-by-step faculty resource manual*. Elsevier. https://evolve.elsevier.com/education/wp-content/uploads/sites/2/NGN_FacultyGuide_Final.pdf

25. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

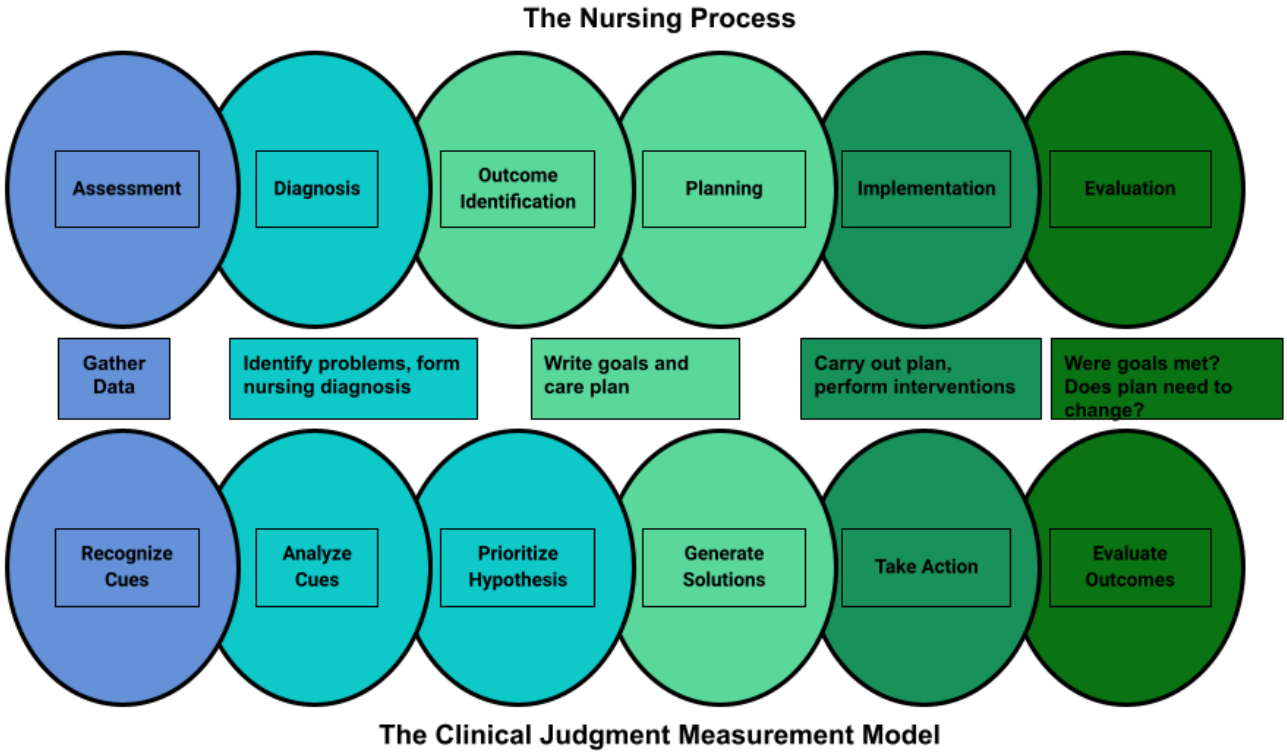


Figure 4.3b Comparison of the Steps of the NCJMM to the Nursing Process

Table 4.2 Comparison of the NCJMM to the Nursing Process

NCSBN Clinical Judgment Skill	Description	Corresponding Step of the Nursing Process
Recognize Cues	*What data is clinically significant?* Determining what client findings are significant, most important, and of immediate concern to the nurse (i.e., identifying "relevant cues").	**Assessment**
Analyze Cues	*What does the data mean?* Analyzing data to determine if it is "expected" or "unexpected" or "normal" or "abnormal" for this client at this time according to their age, development, and clinical status. Making a clinical judgment concerning the client's "human response to health conditions/life processes, or a vulnerability for that response"; also referred to as "forming a hypothesis."	**Diagnosis** (Analysis of Data)
Prioritize Hypotheses	*What hypotheses should receive priority attention?* Ranking client conditions and problems according to urgency, complexity, and time.	**Planning**
Generate Solutions	*What should be done?* Planning individualized interventions that meet the desired outcomes for the client; may include gathering additional assessment data.	**Planning**

Take Action	*What will I do now?* Implementing interventions that are safe and most appropriate for the client's current priority conditions and problems.	**Implementation**
Evaluate Outcomes	*Did the interventions work?* Comparing actual client outcomes with desired client outcomes to determine effectiveness of care and making appropriate revisions to the nursing care plan.	**Evaluation**

Learning activities are incorporated throughout this book to help students practice answering NCLEX Next Generation-style test questions.

Review Scenario A in the following box for an example of a nurse using the nursing process and NCJMM skills while providing client care.

Client Scenario A: Using the Nursing Process[26]

26. "Patient Image in LTC.JPG" by ARISE project is licensed under CC BY 4.0

A nurse is caring for a hospitalized client with a medical diagnosis of heart failure who has a prescription to receive furosemide 80mg IV every morning. The nurse uses critical thinking according to the nursing process and the NCJMM before administering the prescribed medication:

Assessment/Recognize Cues: During the morning assessment, the nurse notes that the client has a blood pressure of 98/60, heart rate of 100, respirations of 18, and a temperature of 98.7F.

Diagnosis/Analyze Cues: The nurse reviews the medical record for the client's vital signs baseline and observes the blood pressure trend is around 110/70 and the heart rate in the 80s.

Planning/Prioritize Hypothesis: The nurse recognizes cues

(assessment data) that form a pattern related to fluid imbalance and hypothesizes that the client may be dehydrated.

Planning/Generate Solutions: The nurse gathers additional information and notes the client's weight has decreased four pounds since yesterday. The nurse talks with the client and validates the hypothesis when the client reports that their mouth feels like cotton, and they feel light-headed. By using critical thinking and clinical judgment, the nurse diagnoses the client with the nursing diagnosis Fluid Volume Deficit and plans interventions for reestablishing fluid balance.

Implementation/Take Action: The nurse withholds the administration of IV furosemide and contacts the health care provider to discuss the client's current fluid status. After contacting the provider, the nurse initiates additional nursing interventions to promote oral intake and closely monitors hydration status.

Evaluation/Evaluate Outcomes: By the end of the shift, the nurse evaluates the client status and determines that fluid balance has been restored.

In Scenario A, the nurse is using clinical judgment and not just "following orders" to administer the Lasix as scheduled. The nurse assesses the client, recognizes and analyzes cues, creates a hypothesis regarding the fluid status, plans and implements nursing interventions, and evaluates outcomes. While performing these steps, the nurse promotes client safety by contacting the provider before administering a medication that could cause harm to the client at this time.

Holistic Nursing Care

Using the nursing process and clinical judgment while implementing evidence-based practices is referred to as the "science of nursing." Before

getting deeper into the science of nursing in the remainder of this chapter, it is important to discuss the "art of nursing" that relies on holistic care provided in a compassionate and caring manner using the nursing process.

The American Nurses Association (ANA) defines **nursing** as, "Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in the recognition of the connection of all humanity."[27]

The ANA further describes nursing as a learned profession built on a core body of knowledge that integrates both the art and science of nursing. The **art of nursing** is defined as, "Unconditionally accepting the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care."[28]

Nurses care for individuals holistically, including their emotional, spiritual, psychosocial, cultural, and physical needs. They consider problems, issues, and needs that the person experiences as a part of a family and a community as they use the nursing process. Review a scenario illustrating holistic nursing care provided to a client and their family in the following box.

Holistic Nursing Care Scenario

A single mother brings her child to the emergency room for

27. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

28. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

ear pain and a fever. The physician diagnoses the child with an ear infection and prescribes an antibiotic. The mother is advised to make a follow-up appointment with their primary provider in two weeks. While providing discharge teaching, the nurse discovers that the family is unable to afford the expensive antibiotic prescribed and cannot find a primary care provider in their community they can reach by a bus route. The nurse asks a social worker to speak with the mother about affordable health insurance options and available providers in her community and follows up with the prescribing physician to obtain a prescription for a less expensive generic antibiotic. In this manner, the nurse provides holistic care and advocates for improved health for the child and their family.

▶ Review how to provide culturally responsive care and reduce health disparities in the "Diverse Patients" chapter.

Caring and the Nursing Process

The American Nurses Association (ANA) states, "The act of caring is foundational to the practice of nursing."[29] Successful use of the nursing process requires the development of a care relationship with the client. A **care relationship** is a mutual relationship that requires the development of trust between both parties. This trust is often referred to as the development of **rapport** and underlies the art of nursing. While establishing a caring relationship, the whole person is assessed, including the individual's beliefs, values, and attitudes, while also acknowledging the vulnerability and dignity

29. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

of the client and family. Assessing and caring for the whole person takes into account the physical, mental, emotional, and spiritual aspects of being a human being.[30] Caring interventions can be demonstrated in simple gestures such as active listening, making eye contact, using therapeutic touch, and providing emotional support while respecting their cultural beliefs associated with caring behaviors.[31] See Figure 4.4[32] for an image of a nurse using touch as a therapeutic communication technique to communicate caring.

> Review more about the caring relationship and how to communicate with clients using therapeutic communication techniques like active listening in the "Communication" chapter.

Dr. Jean Watson is a nurse theorist who has published many works on the art and science of caring in the nursing profession. Her theory of human caring sought to balance the cure orientation of medicine, giving nursing its unique disciplinary, scientific, and professional standing with itself and the public. Dr. Watson's caring philosophy encourages nurses to be authentically present with their clients while creating a healing environment.[33]

30. Walivaara, B., Savenstedt, S., & Axelsson, K. (2013). Caring relationships in home-based nursing care – registered nurses' experiences. *The Open Journal of Nursing, 7*, 89-95. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3722540/pdf/TONURSJ-7-89.pdf

31. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

32. "hospice-1793998_1280.jpg" by truthseeker08 is licensed under CC0

33. Watson Caring Science Institute. (n.d.). Watson Caring Science Institute. *Jean Watson, PHD, RN, AHN-BC, FAAN, (LL-AAN)*. https://www.watsoncaringscience.org/jean-bio/

Read more about Dr. Watson's Caring Science and Human Caring Theory.

Figure 4.4 Touch as a Therapeutic Communication Technique

Now that we have discussed basic concepts related to the nursing process, as well as the science and art of nursing, let's look more deeply at each component of the nursing process in the following sections.

4.3 Assessment

OPEN RESOURCES FOR NURSING (OPEN RN)

Assessment is the first step of the nursing process (and the first *Standard of Practice* by the American Nurses Association). This standard is defined as, "The registered nurse collects pertinent data and information relative to the health care consumer's health or the situation." This includes collecting "pertinent data related to the health and quality of life in a systematic, ongoing manner, with compassion and respect for the wholeness, inherent dignity, worth, and unique attributes of every person, including, but not limited to, demographics, environmental and occupational exposures, social determinants of health, health disparities, physical, functional, psychosocial, emotional, cognitive, spiritual/transpersonal, sexual, sociocultural, age-related, environmental, and lifestyle/economic assessments."[1] See Figure 4.5a[2] for an illustration of how the Assessment phase of the nursing process corresponds to the NCSBN Clinical Judgment Measurement Model (NCJMM).

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. "Assessment in the Nursing Process Compared to the NCJMM" by Tami Davis is licensed under CC BY 4.0

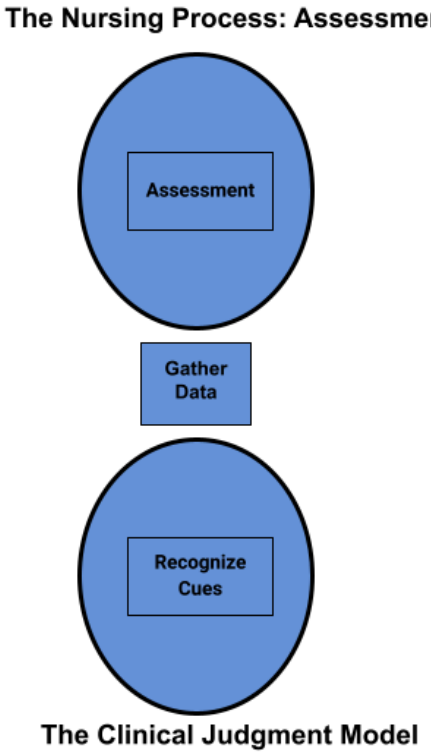


Figure 4.5a Comparison of the Assessment Phase of the Nursing Process to the NCJMM

Nurses assess clients to gather information, then use critical thinking to analyze the data and recognized cues. Data is considered subjective or objective and can be collected from multiple sources.

Subjective Assessment Data

Subjective data is information obtained from the client and/or family members and offers important cues from their perspectives. When documenting subjective data stated by a client, it should be in quotation marks and start with verbiage such as, "*The client reports…*" It is vital for the nurse to establish rapport with a client to obtain accurate, valuable subjective data regarding the mental, emotional, and spiritual aspects of their condition.

There are two types of subjective information, primary and secondary. **Primary data** is information provided directly by the client. Clients are the best source of information about their bodies and feelings, and the nurse who

actively listens to a client will often learn valuable information while also promoting a sense of well-being. Information collected from a family member, chart, or other sources is known as **secondary data**. Family members can provide important information, especially for individuals with memory impairments, infants, children, or when clients are unable to speak for themselves.

See Figure 4.5b[3] for an illustration of a nurse obtaining subjective data and establishing rapport after obtaining permission from the client to sit on the bed.

Example of Subjective Data

An example of how to document subjective data obtained during a client assessment is, *"The client reports, 'My pain is a level 2 on a 1-10 scale.'"*

3. "361341143-huge.jpg" by Monkey Business Images is used under license from Shutterstock.com

Figure 4.5b Obtaining Subjective Data in a Care Relationship

Objective Assessment Data

Objective data is anything that you can observe through your sense of hearing, sight, smell, and touch while assessing the client. Objective data is reproducible, meaning another person can easily obtain the same data. Examples of objective data are vital signs, physical examination findings, and laboratory results. See Figure 4.6[4] for an image of a nurse performing a physical examination.

4. "133946607116O3.jpg" by CDC/Amanda Mills is in the Public Domain

Example of Objective Data

An example of documented objective data obtained during a client assessment is, "*The client's radial pulse is 58 and regular, and their skin feels warm and dry.*"

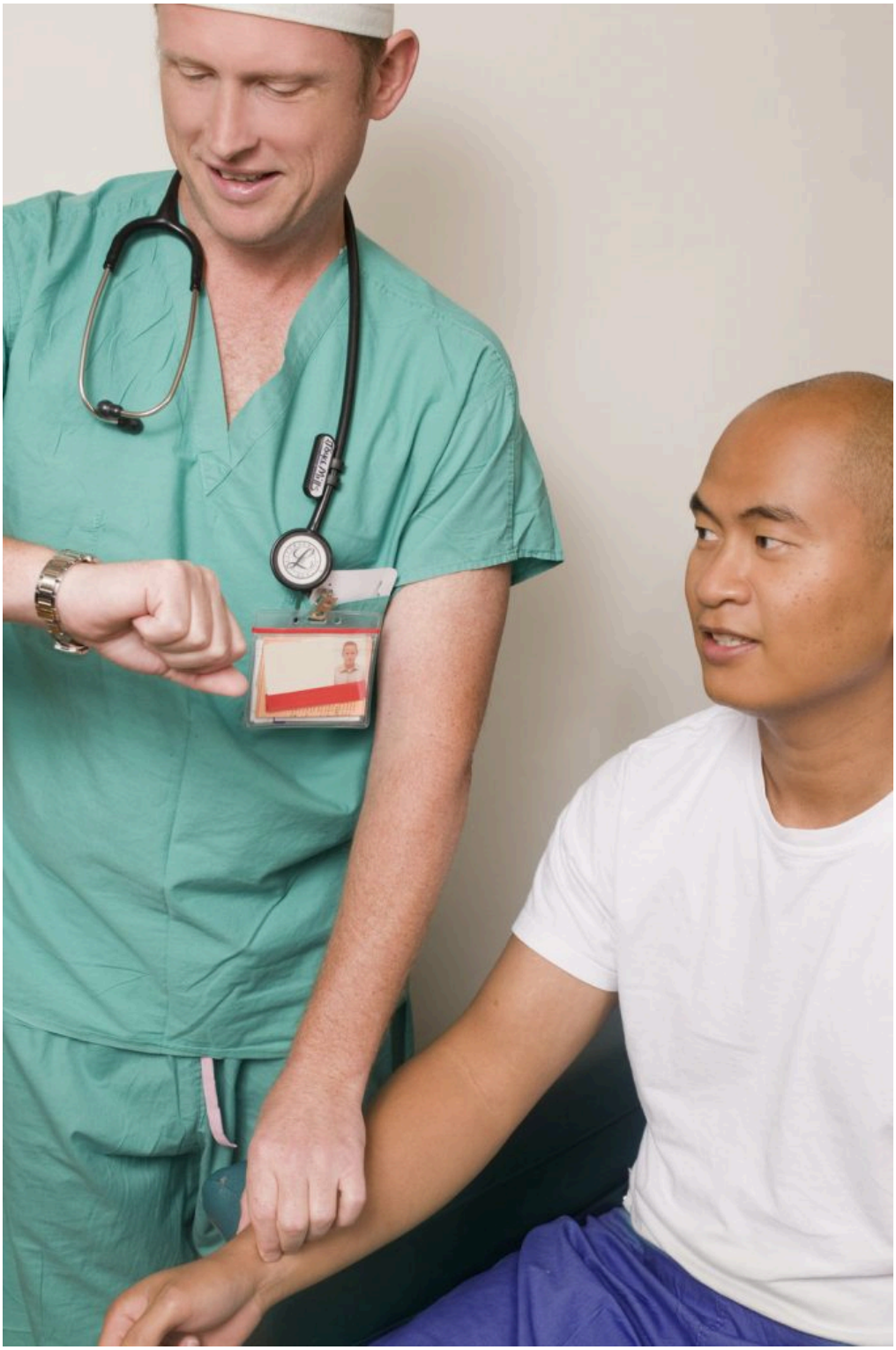


Figure 4.6 Physical Examination

Sources of Assessment Data

There are three sources of assessment data: interview, physical examination, and review of laboratory or diagnostic test results.

Interviewing

Interviewing includes asking the client and their family members questions, listening, and observing verbal and nonverbal communication. Reviewing the chart prior to interviewing the client may eliminate redundancy in the interview process and allows the nurse to hone in on the most significant areas of concern or need for clarification. However, if information in the chart does not make sense or is incomplete, the nurse should use the interview process to verify data with the client.

After performing client identification, the best way to initiate a caring relationship is to introduce yourself to the client and explain your role. Share the purpose of your interview and the approximate time it will take. When beginning an interview, it may be helpful to start with questions related to the client's **medical diagnoses**. Medical diagnoses are diseases, disorders, or injuries diagnosed by a physician or advanced health care provider, such as a nurse practitioner or physician's assistant. Reviewing the medical diagnoses allows the nurse to gather information about how they have affected the client's functioning, relationships, and lifestyle. Listen carefully and ask for clarification when something isn't clear to you. Clients may not volunteer important information because they don't realize it is important for their care. By using critical thinking and active listening, you may discover valuable cues that are important to provide safe, quality nursing care. Sometimes nursing students can feel uncomfortable having difficult conversations or asking personal questions due to generational or other cultural differences. Don't shy away from asking about information that is important to know for safe client care. Most clients will be grateful that you cared enough to ask and listen.

Be alert and attentive to how the client answers questions, as well as when they do not answer a question. Nonverbal communication and body language can be cues to important information that requires further investigation. A keen sense of observation is important. To avoid making

inappropriate **inferences**, the nurse should validate cues for accuracy. For example, a nurse may make an inference that a client appears depressed when the client avoids making eye contact during an interview. However, upon further questioning, the nurse may discover that the client's cultural background believes direct eye contact to be disrespectful and this is why they are avoiding eye contact. To read more information about communicating with clients, review the "Communication" chapter of this book.

Physical Examination

A **physical examination** is a systematic data collection method of the body that uses the techniques of inspection, auscultation, palpation, and percussion. Inspection is the observation of a client's anatomical structures. Auscultation is listening to sounds, such as heart, lung, and bowel sounds, created by organs using a stethoscope. Palpation is the use of touch to evaluate organs for size, location, or tenderness. Percussion is an advanced physical examination technique typically performed by providers where body parts are tapped with fingers to determine their size and if fluid or air are present. Detailed physical examination procedures of various body systems can be found in the Open RN *Nursing Skills, 2e* textbook with a head-to-toe checklist in Appendix C. Physical examination also includes the collection and analysis of vital signs.

Registered nurses (RNs) complete the initial physical examination and analyze the findings as part of the nursing process. Collection of follow-up physical examination data can be delegated to **licensed practical nurses/ licensed vocational nurses (LPNs/LVNs)**, or measurements such as vital signs and weight may be delegated to trained **unlicensed assistive personnel (UAP)** when appropriate to do so. However, the RN remains responsible for supervising these tasks, analyzing the findings, and ensuring they are documented.

A physical examination can be performed as a comprehensive head-to-toe assessment or as a focused assessment related to a particular condition or problem. Assessment data is documented in the client's medical record,

either in their **electronic medical record (EMR)** or their paper chart, depending upon agency policies and procedures.

Reviewing Laboratory and Diagnostic Test Results

Reviewing laboratory and diagnostic test results provides relevant and useful information related to the needs of the client. Understanding how normal and abnormal results affect client care is important when implementing the nursing care plan and administering provider prescriptions. If results cause concern, it is the nurse's responsibility to notify the provider and verify the appropriateness of prescriptions based on the client's current status before implementing them.

Types of Assessments

Several types of nursing assessment are used in clinical practice:

- **Primary Survey:** Used during every client encounter to briefly evaluate level of consciousness, airway, breathing, and circulation and implement emergency care if needed.
- **Admission Assessment:** A comprehensive assessment completed when a client is admitted to a facility that involves assessing a large amount of information using an organized approach.
- **Ongoing Assessment:** In acute care agencies such as hospitals, a head-to-toe assessment is completed and documented at least once every shift. Any changes in client condition are reported to the health care provider.
- **Focused Assessment:** Focused assessments are used to reevaluate the status of a previously diagnosed problem.
- **Time-lapsed Reassessment:** Time-lapsed reassessments are used in long-term care facilities when three or more months have elapsed since the previous assessment to evaluate progress on previously identified outcomes.[5]

Putting It Together

Review Scenario C in the following box to apply concepts of assessment to a client scenario.

Scenario C[6]

5. Gordon, M. (2008). *Assess notes: Nursing assessment and diagnostic reasoning*. F.A. Davis Company.

6. "grandmother-1546855_960_720.jpg" by vendie4u is licensed under CC0

Ms. J. is a 74-year-old woman who is admitted directly to the medical unit after visiting her physician because of shortness of breath, increased swelling in her ankles and calves, and fatigue. Her medical history includes hypertension (30 years), coronary artery disease (18 years), heart failure (2 years), and type 2 diabetes (14 years). She takes 81 mg of aspirin every day, metoprolol 50 mg twice a day, furosemide 40 mg every day, and metformin 2,000 mg every day.

Ms. J.'s vital sign values on admission were as follows:

- Blood Pressure: 162/96 mm Hg
- Heart Rate: 88 beats/min
- Oxygen Saturation: 91% on room air
- Respiratory Rate: 28 breaths/minute
- Temperature: 97.8 degrees F orally

Her weight is up 10 pounds since the last office visit three weeks prior. The client states, "I am so short of breath" and "My ankles are so swollen I have to wear my house slippers." Ms. J. also shares, "I am so tired and weak that I can't get out of the house to shop for groceries," and "Sometimes I'm afraid to get out of bed because I get so dizzy." She confides, "I would like to learn more about my health so I can take better care of myself."

The physical assessment findings of Ms. J. are bilateral basilar crackles in the lungs and bilateral 2+ pitting edema of the ankles and feet. Laboratory results indicate a decreased serum potassium level of 3.4 mEq/L.

As the nurse completes the physical assessment, the client's daughter enters the room. She confides, "We are so worried about mom living at home by herself when she is so tired all the time!"

Critical Thinking Questions

1. Identify relevant subjective data.
2. Identify relevant objective data.
3. Provide an example of secondary data.

Answers are located in the Answer Key at the end of the book.

4.4 Diagnosis

OPEN RESOURCES FOR NURSING (OPEN RN)

Diagnosis is the second step of the nursing process (and the second Standard of Practice by the American Nurses Association). This standard is defined as, "The registered nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues." The RN "prioritizes diagnoses, problems, and issues based on mutually established goals to meet the needs of the health care consumer across the health–illness continuum and the care continuum." Diagnoses, problems, strengths, and issues are documented in a manner that facilitates the development of expected outcomes and a collaborative plan.[1] See Figure 4.7a for an illustration of how the Diagnosis phase of the nursing process corresponds to the NCSBN Clinical Judgment Measurement Model (NCJMM).[2]

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.
2. "Diagnosis in the Nursing Process Compared to the NCJMM" by Tami Davis is licensed under CC BY 4.0

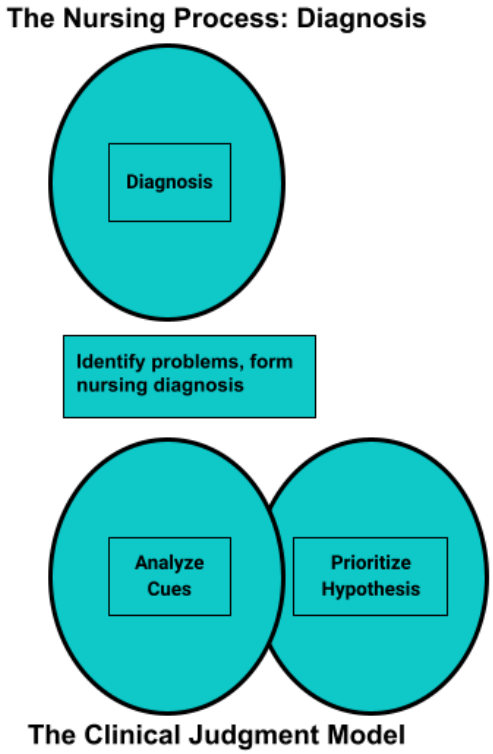


Figure 4.7a Comparison of the Diagnosis Phase of the Nursing Process to the NCJMM

Analyzing Assessment Data

After collection of assessment data, the RN analyzes the data to form generalizations and create and prioritize hypotheses for nursing diagnoses. Steps for analyzing assessment data include performing data analysis, clustering information, identifying hypotheses for potential nursing diagnosis, performing additional in-depth assessment as needed, and establishing nursing diagnosis statements. The nursing diagnoses are then prioritized and the nursing care plan is developed based on them.[3] Analyzing assessment data is completed by an RN and falls outside of the scope of practice of the

3. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

LPN/VN. However, LPN/VNs must understand data analysis so that new, concerning data is promptly reported to the RN for follow-up.

Performing Data Analysis

After nurses collect assessment data from a client, they use their nursing knowledge to analyze that data to determine if it is "expected" or "unexpected" or "normal" or "abnormal" for that client according to their age, development, and baseline status. From there, nurses determine what data is "clinically relevant" as they prioritize their nursing care.[4]

Example of Analyzing Cues

In Scenario C in the "Assessment" section of this chapter, the nurse analyzes the vital signs data and determines the blood pressure, heart rate, and respiratory rate are elevated, and the oxygen saturation is decreased for this client. These findings are considered "relevant cues" because they are abnormal compared to this client's baseline and may indicate a new health problem or complication is occurring.

Clustering Information/Seeing Patterns/Making Hypotheses

After analyzing the data and determining relevant cues, the nurse begins **clustering data** into similar domains or patterns. Evidence-based assessment frameworks, such as Gordon's **Functional Health Patterns**, assist nurses in clustering data based on patterns of human responses. See the box below for

4. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

an outline of Gordon's Functional Health Patterns.[5] Concepts related to many of these patterns will be discussed in chapters later in this book.

Gordon's Functional Health Patterns[6]

Health Perception-Health Management: A client's perception of their health and well-being and how it is managed

Nutritional-Metabolic: Food and fluid consumption relative to metabolic need

Elimination: Excretory function, including bowel, bladder, and skin

Activity-Exercise: Exercise and daily activities

Sleep-Rest: Sleep, rest, and daily activities

Cognitive-Perceptual: Perception and cognition

Self-perception and Self-concept: Self-concept and perception of self-worth, self-competency, body image, and mood state

Role-Relationship: Role engagements and relationships

Sexuality-Reproductive: Reproduction and satisfaction or dissatisfaction with sexuality

Coping-Stress Tolerance: Coping and effectiveness in terms of stress tolerance

5. Gordon, M. (2008). *Assess notes: Nursing assessment and diagnostic reasoning*. F.A. Davis Company.

6. Gordon, M. (2008). *Assess notes: Nursing assessment and diagnostic reasoning*. F.A. Davis Company.

Value-Belief: Values, beliefs (including spiritual beliefs), and goals that guide choices and decisions

Example of Using Gordon's Health Patterns to Cluster Data

Refer to Scenario C in the "Assessment" section of this chapter. The nurse clusters the following relevant cues: elevated blood pressure, elevated respiratory rate, crackles in the lungs, weight gain, worsening edema, shortness of breath, medical history of heart failure, and currently prescribed a diuretic medication into a pattern of fluid balance, which can be classified under Gordon's Nutritional-Metabolic Functional Health Pattern. Based on the related data in this cluster, the nurse makes a hypothesis that the client has excess fluid volume present.

Identifying Nursing Diagnoses

After the nurse has analyzed and clustered the data from the client assessment, the next step is to begin to answer the question, "What are my client's human responses to their health condition(s) (i.e., their nursing diagnoses)?" A **nursing diagnosis** is defined as, "A clinical judgment concerning a human response to health conditions/life processes, or susceptibility to that response, by an individual, caregiver, family, group, or community."[7] Nursing diagnoses are customized to each client and drive the development of the nursing care plan. The nurse should refer to a care

7. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

planning resource and review the definitions and defining characteristics of the hypothesized nursing diagnoses to determine if additional in-depth assessment is needed before selecting the most accurate nursing diagnosis. Formulation of nursing diagnoses is completed by an RN and is outside the scope of practice of LPN/VNs.

Nursing diagnoses are developed by nurses, for use by nurses. For example, NANDA International (NANDA-I) is a global professional nursing organization that develops nursing terminology that names actual or potential human responses to health problems and life processes based on research findings. Currently, there are over 220 NANDA-I nursing diagnoses developed by nurses around the world. This list is continuously updated, with new nursing diagnoses added and old nursing diagnoses retired that no longer have supporting evidence.[8] A list of commonly used NANDA-I diagnoses is listed in Appendix A. For a full list of NANDA-I nursing diagnoses, refer to a current nursing care plan reference.

NANDA-I nursing diagnoses are grouped into 13 domains that assist the nurse in selecting diagnoses based on the patterns of clustered data. These domains are similar to Gordon's Functional Health Patterns and include health promotion, nutrition, elimination and exchange, activity/rest, perception/cognition, self-perception, role relationship, sexuality, coping/stress tolerance, life principles, safety/protection, comfort, and growth/development.

NANDA Diagnoses and the NCLEX

Knowledge regarding specific NANDA-I nursing diagnoses is not assessed on the NCLEX. However, analyzing cues, clustering

8. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

data, forming appropriate hypotheses, and prioritizing hypotheses are components of clinical judgment assessed on the NCLEX and used in nursing practice. Read more about the Next Generation NCLEX in the "Scope of Practice" chapter.

Nursing Diagnoses vs. Medical Diagnoses

You may be asking yourself, "How are nursing diagnoses different from medical diagnoses?" Medical diagnoses focus on diseases or other medical problems that have been identified by the physician, physician's assistant, or advanced nurse practitioner. Nursing diagnoses focus on the *human response* to health conditions and life processes and are made independently by RNs. Clients with the same medical diagnosis will often *respond* differently to that diagnosis and thus have different nursing diagnoses. For example, two clients have the same medical diagnosis of heart failure. However, one client may be interested in learning more information about the condition and the medications used to treat it, whereas another client may be experiencing anxiety when thinking about the effects this medical diagnosis will have on their family. The nurse must consider these different responses when creating the nursing care plan. Nursing diagnoses consider the client's and family's needs, attitudes, strengths, challenges, and resources as a customized nursing care plan is created to provide holistic and individualized care for each client.

Example of a Medical Diagnosis

A medical diagnosis identified for Ms. J. in Scenario C in the "Assessment" section is heart failure. This cannot be used as a nursing diagnosis because it is outside the nurse's scope of practice to make a medical diagnosis, but it is considered as an

"associated condition" when creating hypotheses for nursing diagnoses. Associated conditions are medical diagnoses, injuries, procedures, medical devices, or pharmacological agents that are not independently modifiable by the nurse, but support accuracy in nursing diagnosis. The nursing diagnosis in Scenario C will relate to the client's responses to her medical diagnosis of heart failure, such as "Excess Fluid Volume."

Additional Definitions Used in NANDA-I Nursing Diagnoses

The following definitions are used in association with NANDA-I nursing diagnoses.

Patient

The NANDA-I definition of a "patient" includes the following[9]:

- **Individual:** a single human being distinct from others (i.e., a person).
- **Caregiver:** a family member or helper who regularly looks after a child or a sick, elderly, or disabled person.
- **Family:** two or more people having continuous or sustained relationships, perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood and/or choice.
- **Group:** a number of people with shared characteristics
- **Community:** a group of people living in the same locale under the same governance, such as neighborhoods and cities.

9. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

Age

The age of the person who is the subject of the diagnosis is defined by the following terms[10]:

- **Fetus:** an unborn human more than eight weeks after conception, until birth.
- **Neonate:** a person less than 28 days of age.
- **Infant:** a person greater than 28 days and less than 1 year of age.
- **Child:** a person less than or equal to 19 years of age, unless national law defines a person to be an adult at an earlier age
- **Adolescent:** a person aged 10 to 19 years.
- **Adult:** a person older than 19 years of age unless national law defines a person as being an adult at an earlier age.
- **Older adult:** a person 65-84 years of age.
- **Aged adult:** Person 85 years or older.

Time

The duration of the diagnosis is defined by the following terms[11]:

- **Acute:** lasting less than three months.
- **Chronic:** lasting greater than three months.
- **Intermittent:** stopping or starting again at intervals.
- **Continuous:** uninterrupted, going on without stop.

10. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

11. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

Two terms used to assist in creating nursing diagnosis statements are at-risk populations and associated conditions[12]:

- **At-risk populations**are groups of people who share a sociodemographic characteristics, health/family history, stages of growth/development, exposure to certain events/experiences that cause each member to be susceptible to a particular human response. These characteristics are not modifiable by independent nursing interventions.
- **Associated conditions** are medical diagnoses, diagnostic/surgical procedures, medical/surgical devices, or pharmaceutical preparations. These conditions are not modifiable by independent nursing interventions.

Types of Nursing Diagnoses

There are four types of NANDA-I nursing diagnoses[13]:

- Problem-Focused
- Health Promotion
- Risk
- Syndrome

A **problem-focused nursing diagnosis** is a clinical judgment concerning an

12. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

13. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

undesirable human response to health conditions/life processes that is recognized in an individual, caregiver, family, group, or community.[14]

To make an accurate problem-focused diagnosis, related factors and defining characteristics must be present. **Related factors** (also called etiology) are antecedent factors shown to have a partnered relationship with the human response. These factors must be modifiable by independent nursing interventions, and whenever possible, interventions should be aimed at these etiological factors Problem-focused and syndromes must have related factors; health promotion diagnoses may have related factors if they help clarify the diagnosis.[15]

Defining characteristics are observable cues or inferences that cluster as manifestations of a problem-focused diagnosis, health promotion diagnosis, or syndrome. Defining characteristics refer to things a nurse can see, hear, touch, or smell.[16]

A **health promotion nursing diagnosis** is a clinical judgment concerning motivation and desire to increase well-being and to actualize human health potential that is recognized in an individual, caregiver, family, group, or community. These responses are expressed by the client's readiness to enhance specific health behaviors. In individuals who are unable to express their own readiness to enhance health behaviors, the nurse may determine a condition for health promotion exists and act on the client's behalf. To make a

14. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

15. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

16. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

health promotion nursing diagnosis, defining characteristics must be present.[17]

A **risk nursing diagnosis** is a clinical judgment concerning the susceptibility for developing an undesirable human response to health conditions/life processes that is recognized in an individual, caregiver, family, group, or community. To make a risk nursing diagnosis, risk factors must be present that contribute to increased susceptibility.[18] A risk nursing diagnosis is different from the problem-focused diagnosis in that the problem has not yet actually occurred. However, problem diagnoses should not be automatically viewed as more important than risk diagnoses because sometimes a risk diagnosis can have the highest priority for a client.

A **syndrome nursing diagnosis** is a clinical judgment concerning a specific cluster of nursing diagnoses that occur together and are best addressed together and through similar interventions. To make a syndrome nursing diagnosis, defining characteristics must include two or more nursing diagnosis and related factors.[19]

Establishing Nursing Diagnosis Statements

NANDA-I recommends creating statements for nursing diagnosis that include the *nursing diagnosis* and *related factors* as exhibited by *defining characteristics*. The accuracy of the nursing diagnosis is validated when a

17. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

18. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

19. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

nurse is able to clearly link the defining characteristics, related factors, and/or risk factors found during the client's assessment.[20]

To create a nursing diagnosis statement, the RN analyzes the client's subjective and objective data and clusters the data into patterns. Based on these patterns, the RN generates hypotheses for nursing diagnoses based on how the patterns meet defining characteristics of a nursing diagnosis. Recall that "defining characteristics" are the signs and symptoms related to a nursing diagnosis. Defining characteristics are included in care planning resources for each nursing diagnosis, along with a definition of that diagnosis, so the nurse can select the most accurate diagnosis.

Example

An RN clusters objective and subjective data such as weight, height, and dietary intake as a pattern related to nutritional status and then compares these signs and symptoms to the defining characteristics for the NANDA nursing diagnosis, "Imbalanced Nutrition: Less Than Body Requirement."

When creating a nursing diagnosis statement, the nurse also identifies the cause, or etiology, of the problem for that specific client. Recall that the term "related factors" refers to the underlying causes (etiology) of a client's problem or situation. Related factors should not refer to medical diagnoses, but instead should be causes that the nurse can treat. When possible, the nursing interventions planned for nursing diagnoses should attempt to modify or remove these underlying causes of the nursing diagnosis.

Creating nursing diagnosis statements is also called "using **PES format**."

20. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

The PES mnemonic no longer applies to the current terminology used by NANDA-I, but the components of a nursing diagnosis statement remain the same. A nursing diagnosis statement should contain the problem, related factors, and defining characteristics. These terms fit under the former PES format in this manner:

Problem (P): The **p**roblem (i.e., the nursing diagnosis)

Etiology (E): The related factors (i.e., the **e**tiology/cause) of the nursing diagnosis; phrased as "related to" or "R/T"

Signs and Symptoms (S): The defining characteristics manifested by the client (i.e., the **s**igns and **s**ymptoms/subjective and objective data/clinical cues) that led to the identification of that nursing diagnosis/hypothesis for the client; phrased with "as manifested by" (AMB) or "as evidenced by" (AEB).

Examples of different types of nursing diagnoses are further explained in the following sections.

Problem-Focused Nursing Diagnosis

A problem-focused nursing diagnosis contains all three components of the PES format:

Problem (P): Client problem (nursing diagnosis)

Etiology (E): Related factors causing the nursing diagnosis

Signs and Symptoms (S): Defining characteristics/cues manifested by that client (i.e., the signs and symptoms demonstrating there is a problem)

Example of a Problem-Focused Nursing Diagnosis

Refer to Scenario C of the "Assessment" section of this chapter. The cluster of data for Ms. J. (elevated blood pressure, elevated respiratory rate, crackles in the lungs, weight gain, worsening edema, and shortness of breath) are defining characteristics for the NANDA-I Nursing Diagnosis *Excess Fluid Volume*. The NANDA-I definition of *Excess Fluid Volume* is "surplus retention

of fluid." The related factor (etiology) of the problem is that the client has excessive fluid intake.[21]

The components of a **problem-focused nursing diagnosis** statement for Ms. J. would be:

Problem (P): Excess Fluid Volume

Etiology (E): Related to excessive fluid intake

Signs and Symptoms (S): As manifested by bilateral basilar crackles in the lungs, bilateral 2+ pitting edema of the ankles and feet, increased weight of 1ten pounds, and the client reports, "*My ankles are so swollen*."

A correctly written problem-focused nursing diagnosis statement for Ms. J. would be written as follows:

Excess Fluid Volume related to excessive fluid intake as manifested by bilateral basilar crackles in the lungs, bilateral 2+ pitting edema of the ankles and feet, an increase weight of ten pounds, and the client reports, "My ankles are so swollen."

Health-Promotion Nursing Diagnosis

A health-promotion nursing diagnosis statement contains the problem (P) and the defining characteristics (S). The defining characteristics component of a health-promotion nursing diagnosis statement should begin with the

21. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition.* Thieme Publishers New York.

phrase “expresses desire to enhance,” followed by what the client states in relation to improving their health status:[22]

A health-promotion diagnosis statement consists of the following:

Problem (P): Client problem (nursing diagnosis)

Signs and Symptoms (S): The client’s expressed desire to enhance

Example of a Health-Promotion Nursing Diagnosis

Refer to Scenario C in the “Assessment” section of this chapter. Ms. J. demonstrates a readiness to improve her health status when she told the nurse that she would like to “learn more about my health so I can take better care of myself.” This statement is a defining characteristic of the NANDA-I nursing diagnosis *Readiness for Enhanced Health Self-Management*, which is defined as “a pattern of satisfactory management of symptoms, treatment regimen, physical, psychosocial, and spiritual consequences and lifestyle changes inherent in living with a chronic condition, which can be strengthened.”[23]

The components of a **health-promotion nursing diagnosis** for Ms. J. would be:

Problem (P): Readiness for Enhanced Health Self-Management

22. NANDA International. (n.d.). *Glossary of terms*. https://nanda.org/nanda-i-resources/glossary-of-terms/

23. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

Symptoms (S): Expressed desire to "learn more about my treatment regimen so I can take better care of myself."

A correctly written health-promotion nursing diagnosis statement for Ms. J. would be written as follows:

Enhanced Readiness for Health Promotion as manifested by expressed desire to "learn more about my treatment regimen so I can take better care of myself."

Risk Nursing Diagnosis

A risk nursing diagnosis should be supported by evidence of the client's risk factors for developing that problem. For example, the phrase "as evidenced by" is used to refer to the risk factors for developing that diagnosis.[24]

A risk diagnosis consists of the following:

Problem (P): Client problem (nursing diagnosis)

As Evidenced By: Risk factors for developing the problem

Example of a Risk Nursing Diagnosis

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J. has an increased risk of falling due to weakness and fear of falling that she is experiencing. The NANDA-I definition of *Risk for Adult Falls* is "an adult susceptible to experiencing an event

24. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

resulting in coming to rest inadvertently on the ground, floor, or other level, which may compromise health."[25]

The components of a **risk nursing diagnosis** statement for Ms. J. would be:

Problem (P): Risk for Adult Falls

As Evidenced By: Decreased lower extremity strength and fear of falling

A correctly written risk nursing diagnosis statement for Ms. J. would be written as follows:

Risk for Adult Falls as evidenced by decreased lower extremity strength and fear of falling.

Syndrome Nursing Diagnosis

A syndrome nursing diagnosis statement is a cluster of nursing diagnoses that occur together and are best addressed together and through similar interventions. To create a syndrome diagnosis, two or more nursing diagnoses must be used as defining characteristics (S) that create a syndrome. Related factors may be used if they add clarity to the definition but are not required.[26]

A syndrome statement consists of these items:

Problem (P): The syndrome

25. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

26. NANDA International. (n.d.). *Glossary of terms*. https://nanda.org/nanda-i-resources/glossary-of-terms/

Signs and Symptoms (S): The defining characteristics are two or more similar nursing diagnoses

Example of a Syndrome Nursing Diagnosis

Refer to Scenario C in the "Assessment" section of this chapter. Clustering the data for Ms. J. identifies several similar NANDA-I nursing diagnoses of *Decreased Activity Tolerance* and *Social Isolation nursing diagnoses* that can be categorized under a syndrome diagnosis called *Frail Elderly Syndrome*. This syndrome is defined as a "dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domains of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability."[27]

Example

The components of a **syndrome nursing diagnosis** for Ms. J. would be:

Problem (P): Risk for Frail Elderly Syndrome

Signs and Symptoms (S): The nursing diagnoses of *Activity Intolerance* and *Social Isolation*

Additional related factor: Fear of falling

A correctly written syndrome diagnosis statement for Ms. J. would be written as follows:

27. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition.* Thieme Publishers New York.

Risk for Frail Elderly Syndrome related to activity intolerance, social isolation, and fear of falling

See Table 4.4a for a summary of the types of nursing diagnoses.

Table 4.4a. Types of Nursing Diagnoses

Diagnosis	What Is It?	Example of Nursing Diagnosis Statement
Problem-Focused (Actual)	Problem is present at the time of assessment	(PES) Fluid Volume Excess R/T excessive fluid intake AEB bilateral basilar crackles in the lungs, bilateral 2+ pitting edema in the ankles and feet, an increased weight of 10 pounds over 1 week, and the client reports, "My ankles feel swollen."
Health-Promotion	A motivation/desire to increase well-being or a client's strength	Enhanced Readiness for Health Promotion AEB expressed desire to "learn more about health so I can take better care of myself."
Risk	Problem is likely to develop	Risk for Falls AEB dizziness and decreased lower extremity strength
Syndrome	Cluster of nursing diagnoses that occur together and are best addressed together	Risk for Frail Elderly Syndrome R/T activity intolerance, social isolation, and fear of falling

It can feel overwhelming for nursing students to determine which nursing diagnoses to use for their clients due to the complexity of nursing diagnoses. Rest assured, use of nursing diagnoses becomes easier with practice and exposure to client care plans. Refer to trustworthy sources, such as a nursing diagnosis handbook or reputable care-planning resources to become aware of current NANDA-I nursing diagnoses.

Nursing diagnoses can be viewed to establish familiarity with them on the Nanda Diagnoses website, but be aware this is not an official NANDA nursing diagnosis site. Evidence-based care planning resources should be used when planning client care.

Prioritization

After identifying nursing diagnoses, the next step is prioritizing diagnoses and actions according to the specific needs of the client. Nurses prioritize their actions while providing client care multiple times every day. **Prioritization** is the skillful process of deciding which actions to complete first for client safety and optimal client outcomes. Through prioritization, the most significant nursing problems, as well as the most important interventions in the nursing care plan, are identified.

Client care situations fall somewhere between routine care and a medical crisis. It is essential that life-threatening concerns and crises are identified immediately and addressed quickly. Depending on the severity of a problem, the steps of the nursing process may be performed in a matter of seconds for

life-threatening concerns, such as respiratory arrest or cardiac arrest. Critical situations can occur at any time when providing nursing care for clients, and the steps of the nursing process must be performed rapidly. Nursing students must have a full understanding of how to correctly analyze cues, cluster data, form appropriate hypotheses, and prioritize hypotheses to take appropriate action using clinical judgment. Nurses recognize cues signaling a change in client condition, apply evidence-based practices in a crisis, and communicate effectively with interprofessional team members.

There are several concepts used to prioritize, including Maslow's Hierarchy of Needs, the "ABCs" (Airway, Breathing and Circulation), and acute, uncompensated conditions. See the infographic in Figure 4.7b[28] on *The How To of Prioritization*.

28. "The How To of Prioritization" by Valerie Palarski for Chippewa Valley Technical College is licensed under CC BY 4.0

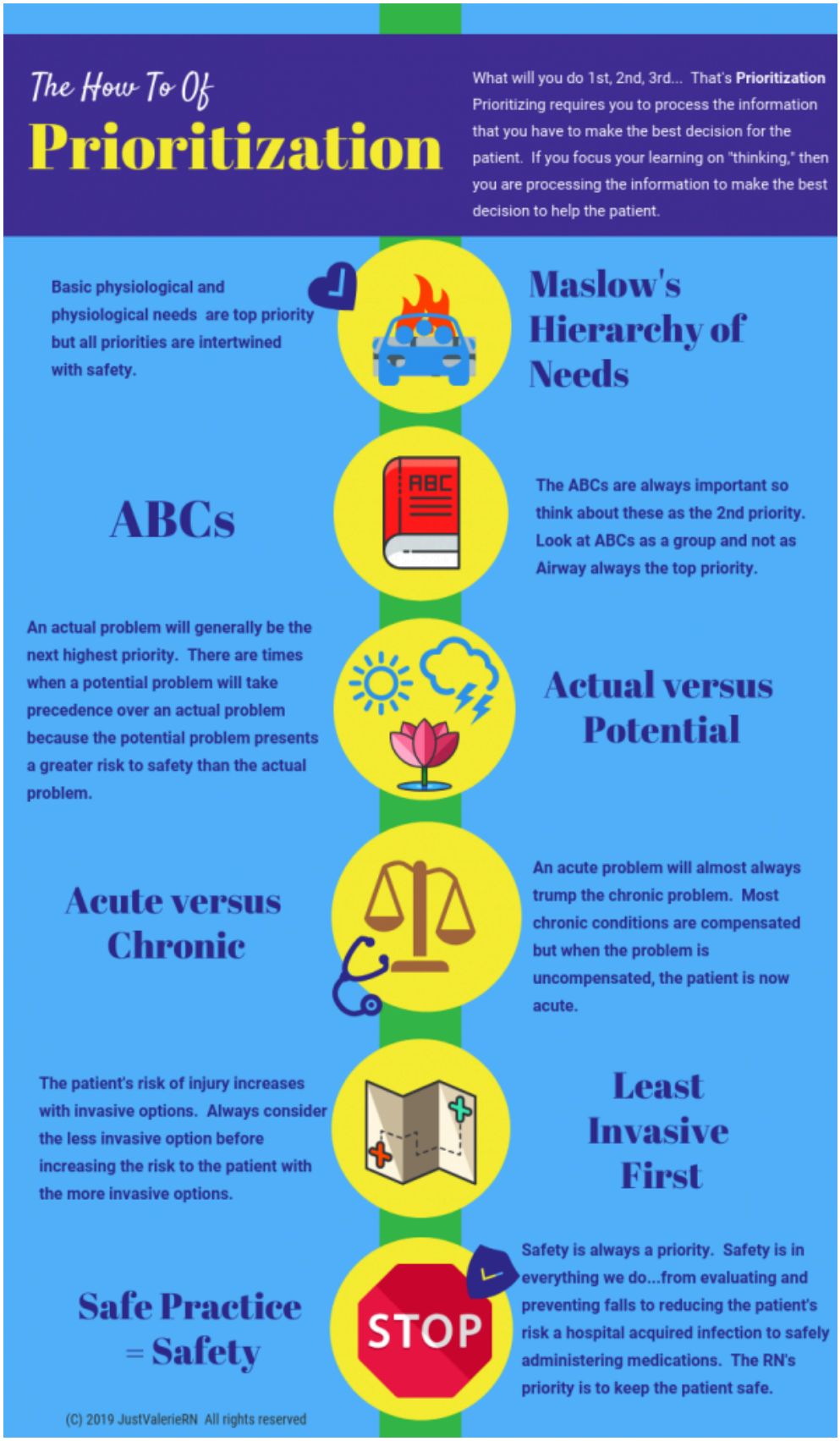


Figure 4.7b The How To of Prioritization

Maslow's Hierarchy of Needs is used to categorize the most urgent client needs. The bottom levels of the pyramid represent the top priority needs of physiological needs intertwined with safety. See Figure 4.8[29] for an image of Maslow's Hierarchy of Needs. You may be asking yourself, "What about the ABCs – isn't airway the most important?" The answer to that question is "it depends on the situation and the associated safety considerations." Consider this scenario – you are driving home after a lovely picnic in the country and come across a fiery car crash. As you approach the car, you see that the passenger is not breathing. Using Maslow's Hierarchy of Needs to prioritize your actions, you remove the passenger from the car first due to safety even though he is not breathing. After ensuring safety and calling for help, you follow the steps to perform cardiopulmonary resuscitation (CPR) to establish circulation, airway, and breathing until help arrives.

29. "Maslow's hierarchy of needs.svg" by J. Finkelstein is licensed under CC BY-SA 3.0

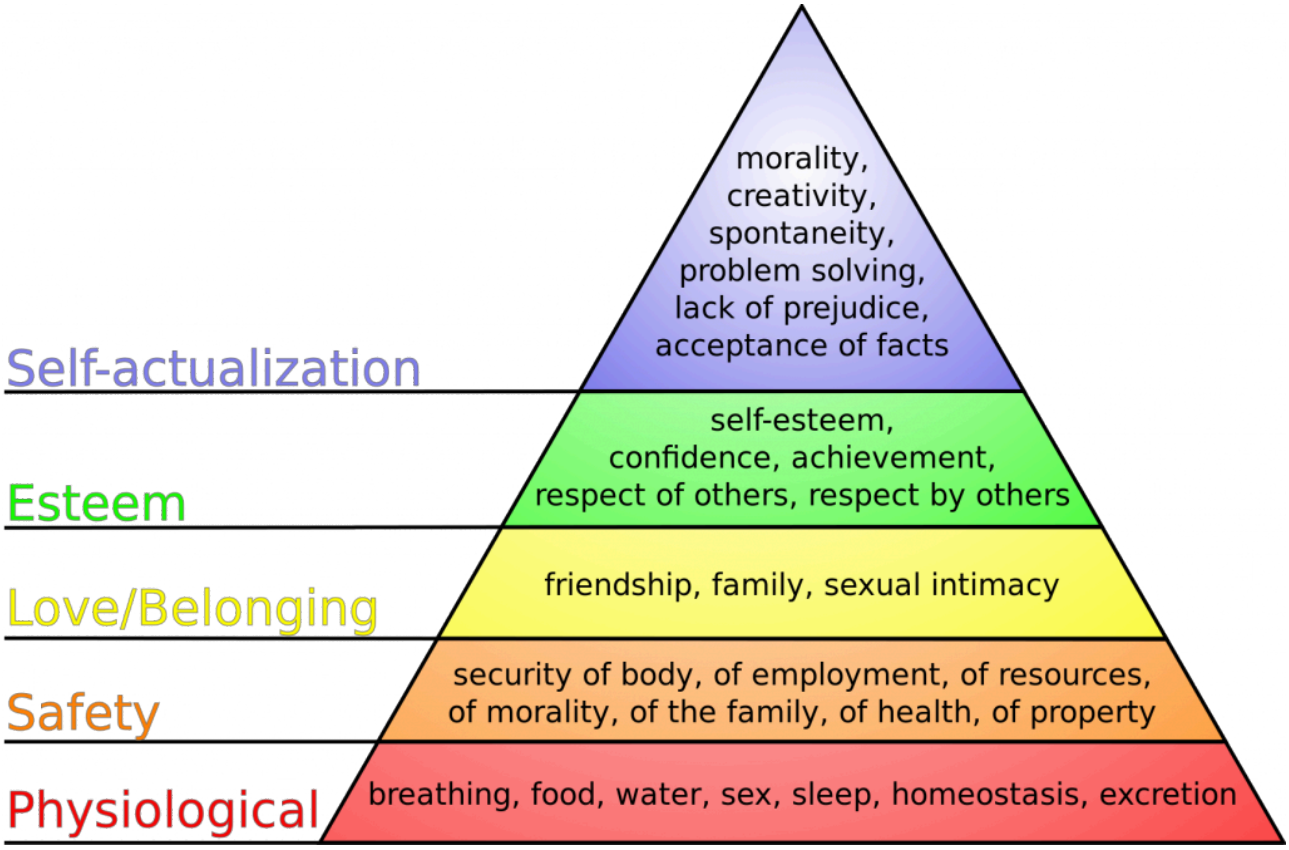


Figure 4.8 Maslow's Hierarchy of Needs

In addition to using Maslow's Hierarchy of Needs and the ABCs of airway, breathing, and circulation, the nurse also considers if the client's condition is an acute or chronic problem. Acute, uncompensated conditions require priority interventions over chronic conditions. Additionally, actual problems generally receive priority over potential problems, but risk problems sometimes receive priority depending on the client vulnerability and risk factors.

Example of Prioritization

Refer to Scenario C in the "Assessment" section of this chapter. Four types of nursing diagnoses were identified for Ms. J.: *Excess*

Fluid Volume, Enhanced Readiness for Health Promotion, Risk for Falls, and *Risk for Frail Elderly Syndrome*. The top priority diagnosis is *Excess Fluid Volume* because this condition affects the physiological needs of breathing, homeostasis, and excretion. However, the *Risk for Falls* diagnosis comes in a close second because of safety implications and potential injury that could occur if the client fell.

4.5 Outcome Identification

OPEN RESOURCES FOR NURSING (OPEN RN)

Outcome Identification is the third step of the nursing process (and the third Standard of Practice by the American Nurses Association). This standard is defined as, "The registered nurse identifies expected outcomes for a plan individualized to the health care consumer or the situation." The RN collaborates with the health care consumer, interprofessional team, and others to identify expected outcomes integrating the health care consumer's culture, values, and ethical considerations. Expected outcomes are documented as measurable goals with a time frame for attainment.[1] Outcome identification is performed by RNs and is outside the scope of practice for LPN/VNs, but LPN/VNs must be aware of expected outcomes for clients in their nursing care plan.

An **outcome** is a measurable behavior demonstrated response to nursing interventions.[2] Outcomes should be identified before nursing interventions are planned. After nursing interventions are implemented, the nurse will evaluate if the outcomes were met in the time frame indicated for that client.

Outcome identification includes setting short- and long-term goals and then creating specific expected outcome statements for each nursing diagnosis. See Figure 4.9a[3] for an illustration of how the Outcome

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

3. "Outcome Identification in the Nursing Process Compared to the NCJMM" by Tami Davis is licensed by CC BY 4.0

Identification phase of the nursing process correlates to the NCSBN Clinical Judgment Model.

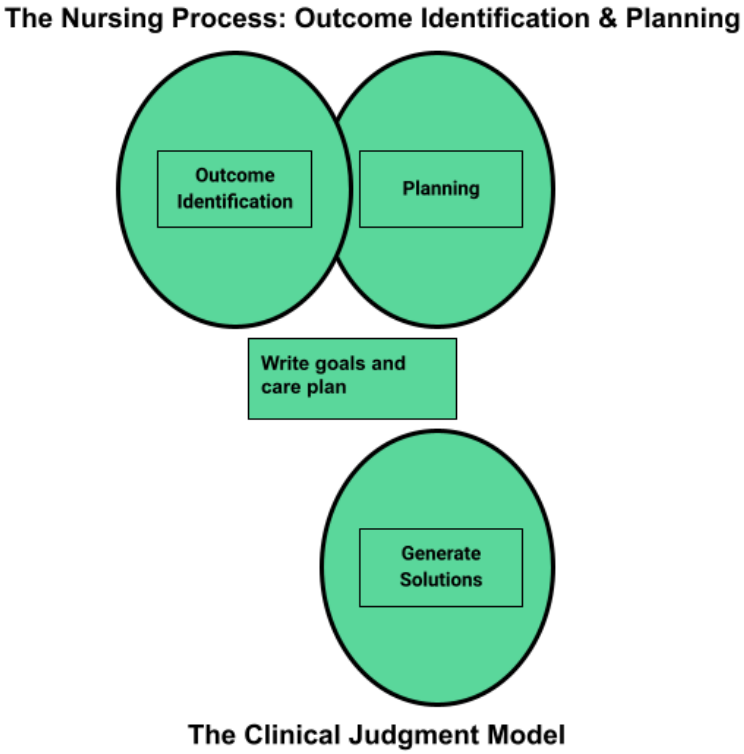


Figure 4.9a Comparison of Outcome Identification to the NCJMM

Short-Term and Long-Term Goals

Nursing care should always be individualized and client centered. No two people are the same, and neither should nursing care plans be the same for two people. Goals and outcomes should be tailored specifically to each client's needs, values, and cultural beliefs. Clients and family members should be included in the goal-setting process when feasible. Involving clients and family members promotes awareness of identified needs, ensures realistic goals, and motivates their participation in the treatment plan to achieve the mutually agreed upon goals and live life to the fullest with their current condition.

The nursing care plan is a road map used to guide client care so that all health care providers are moving toward the same client goals. **Goals** are broad statements of purpose that describe the overall aim of care. Goals can

be short- or long-term. The time frame for short- and long-term goals is dependent on the setting in which the care is provided. For example, in a critical care area, a short-term goal might be set to be achieved within an 8-hour nursing shift, and a long-term goal might be in 24 hours. In contrast, in an outpatient setting, a short-term goal might be set to be achieved within one month and a long-term goal might be within six months.

A nursing goal is the overall direction in which the client must progress to improve the problem/nursing diagnosis and is often the opposite of the problem.

Example of a Broad Goal

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J. had a priority nursing diagnosis of Excess *Fluid Volume*. A broad goal would be, "*Ms. J. will achieve a state of fluid balance.*"

Expected Outcomes

Goals are broad, general statements, but outcomes are specific and measurable. **Expected outcomes** are statements of measurable action for the client within a specific time frame that are responsive to nursing interventions. Nurses may create expected outcomes independently or refer to classification systems for assistance.

Client-Centered

Outcome statements are always client-centered. They should be developed in collaboration with the client and individualized to meet a client's unique needs, values, and cultural beliefs. They should start with the phrase "The client will..." Outcome statements should be directed at resolving the defining characteristics the client is exhibiting for the nursing diagnosis. Additionally, the outcome must be something the client would like to achieve.

Outcome statements should contain five components easily remembered using the "SMART" mnemonic:[4]

- **S**pecific
- **M**easurable
- **A**ttainable/Action oriented
- **R**elevant/Realistic
- **T**imeframe

See Figure 4.9b[5] for an image of the SMART components of outcome statements. Each of these components is further described in the following subsections.

Figure 4.9b SMART Components of Outcome Statements

4. Campbell, J. (2020). *SMART criteria*. Salem Press Encyclopedia.

5. "SMART-goals.png" by Dungdm93 is licensed under CC BY-SA 4.0

Specific

Outcome statements should state precisely what is to be accomplished. See examples of a not specific and a specific outcome in the following box.

Example

- **Not specific outcome:** "*The client will increase the amount of exercise.*"
- **Revised as a specific outcome:** "*The client will participate in a bicycling exercise session daily for 30 minutes.*"

Additionally, only one action should be included in each expected outcome. See examples in the following box.

Example

- ***More than one action:*** *"The client will walk 50 feet three times a day with standby assistance of one and will shower in the morning until discharge"* is actually two goals written as one. The outcome of ambulation should be separate from showering for precise evaluation. For instance, the client could shower but not ambulate, which would make this outcome statement very difficult to effectively evaluate.
- **Revised to create two outcome statements so each can be measured:** *The client will walk 50 feet three times a day with standby assistance of one until discharge. The client will shower every morning until discharge.*

Measurable

Measurable outcomes have numeric parameters or other concrete methods of judging whether the outcome was met. It is important to use objective data to measure outcomes. If terms like “acceptable” or “normal” are used in an outcome statement, it is difficult to determine whether the outcome is attained. Refer to Figure 4.10[6] for examples of verbs that are measurable and not measurable in outcome statements.

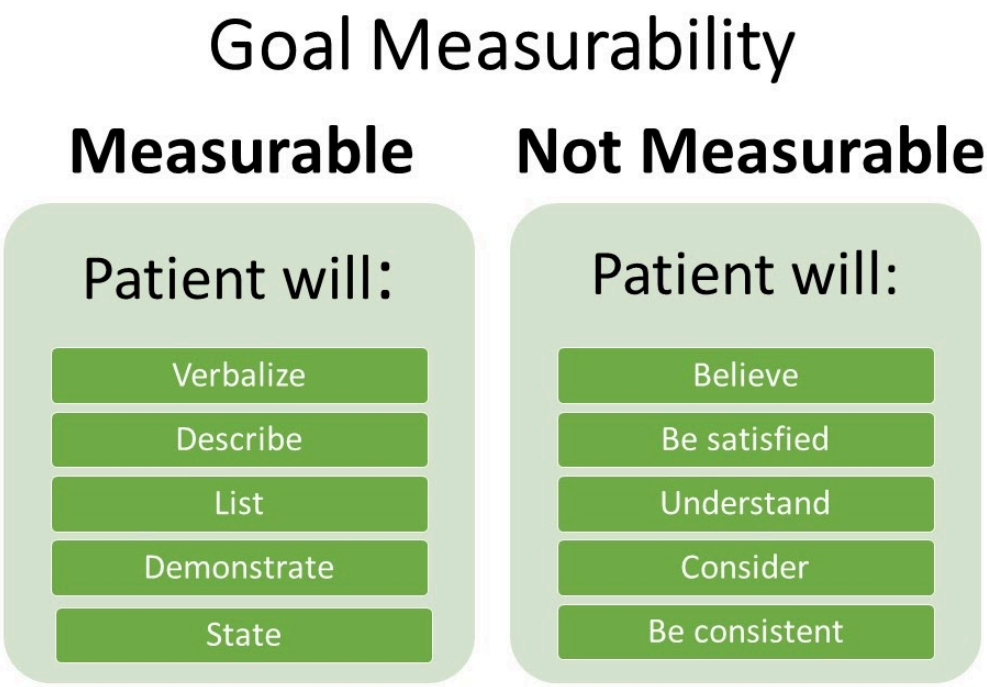


Figure 4.10 Measurable Outcomes

Examples of a non-measurable outcome revised to a measurable outcome is described in the following box.

6. “Measurable Outcomes” by Valerie Palarski for Chippewa Valley Technical College is licensed under CC BY 4.0

Example

- **Not measurable outcome:** "*The client will drink adequate fluid amounts every shift.*"
- **Revised into a measurable outcome:** "*The client will drink 24 ounces of fluids during every day shift (0600-1400).*"

Action-Oriented and Attainable

Outcome statements should be written so that there is a clear action to be taken by the client or significant others. This means that the outcome statement should include a verb. Refer to Figure 4.11[7] for examples of action verbs.

7. "Action Verbs" by Valerie Palarski for Chippewa Valley Technical College is licensed under CC BY 4.0

Figure 4.11 Action Verbs

An example of a non-action-oriented outcome revised to an action-oriented outcome is provided in the following box.

Example

- **Not action-oriented outcome:** "*The client will get increased physical activity.*"
- **Revised into an action-oriented outcome:** "*The client will list three types of aerobic activity that he would enjoy completing every week.*"

Realistic and Relevant

Realistic outcomes consider the client's physical and mental condition; their cultural and spiritual values, beliefs, and preferences; and their socioeconomic status in terms of their ability to attain these outcomes. Consideration should be also given to disease processes and the effects of conditions such as pain and decreased mobility on the client's ability to reach expected outcomes. Other barriers to outcome attainment may be related to health literacy or lack of available resources. Outcomes should always be reevaluated and revised for attainability as needed. If an outcome is not attained, it is commonly because the original time frame was too ambitious, or the outcome was not realistic for the client.

See an example of how to revise an outcome that is not realistic into a realistic outcome in the following box.

Example

- **Not realistic outcome:** *"The client will jog one mile every day when starting the exercise program."*
- **Revised into a realistic outcome:** *"The client will walk ½ mile three times a week for two weeks."*

Time Limited

Outcome statements should include a time frame for evaluation. The time frame depends on the intervention and the client's current condition. Some outcomes may need to be evaluated every shift, whereas other outcomes may be evaluated daily, weekly, or monthly. During the evaluation phase of the nursing process, the outcomes will be assessed according to the time frame specified for evaluation. If it has not been met, the nursing care plan should be revised.

See an example an outcome that is not time limited revised into a time limited outcome in the following box.

Example

- **Not time limited:** "*The client will stop smoking cigarettes.*"
- **Time limited:** "*The client will complete the smoking cessation plan by December 12, 2025.*"

Putting It Together

An example of a SMART outcome for Scenario C is provided in the following box.

Example of a SMART Expected Outcome

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J.'s priority nursing diagnosis statement was *Excess Fluid Volume related to excess fluid intake as manifested by bilateral basilar crackles in the lungs, bilateral 2+ pitting edema of the ankles and feet, an increase weight of ten pounds, and the client reports, "My ankles are so swollen."*

The broad goal was, "*Ms. J. will achieve a state of fluid balance.*"

An example of a SMART expected outcome to achieve this broad goal is, "*The client will have clear bilateral lung sounds within the next 24 hours.*"

4.6 Planning

OPEN RESOURCES FOR NURSING (OPEN RN)

Planning is the fourth step of the nursing process (and the fourth Standard of Practice by the American Nurses Association). This standard is defined as, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes." The RN develops an individualized, holistic, evidence-based plan in partnership with the health care consumer, family, significant others, and interprofessional team. Elements of the plan are prioritized for client safety and optimal client outcomes. The plan is modified according to the ongoing assessment of the health care consumer's response and other indicators. The plan is documented using standardized language or terminology.[1]

After expected outcomes are identified, the nurse begins planning nursing interventions to implement. **Nursing interventions** are evidence-based actions that the nurse performs to achieve client outcomes. Just as a provider makes medical diagnoses and writes prescriptions to improve the client's medical condition, a nurse formulates nursing diagnoses and plans nursing interventions to resolve client problems. Nursing interventions should focus on eliminating or reducing the related factors (etiology) of the nursing diagnoses when possible.[2] Nursing interventions, goals, and expected outcomes are written in the nursing care plan for continuity of care across shifts, nurses, and health professionals. Planning is outside the scope of practice for LPN/VNs, although they may assist in performing planned

1. American Nurses Association. (2021). *Nursing*: *Scope and standards of practice* (4th ed.). American Nurses Association.

2. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

interventions during the Implementation phase according to their scope of practice. Refer to Figure 4.9a in the "Outcome Identification" section for a illustration of how the Planning phase of the nursing process correlates to NCSBN's Clinical Judgment Measurement Model.

Planning Nursing Interventions

You might be asking yourself, "How do I know what evidence-based nursing interventions to include in the nursing care plan?" There are several sources that nurses and nursing students can use to select nursing interventions. Many agencies have care planning tools and references included in the electronic health record that are easily documented in the client chart. Nurses can also refer to other care planning books or sources such as the Nursing Interventions Classification (NIC) system. Based on research and input from the nursing profession, NIC categorizes and describes nursing interventions that are regularly evaluated and updated. Interventions included in NIC are considered evidence-based nursing practices. The RN is responsible for using clinical judgment to make decisions about which interventions are best suited to meet an individualized client's needs.[3]

Direct and Indirect Care

Nursing interventions are considered direct care or indirect care. **Direct care** refers to interventions that are carried out by having personal contact with clients. Examples of direct care interventions are wound care, repositioning, and ambulation. **Indirect care** interventions are performed when the nurse provides assistance in a setting other than with the client. Examples of indirect care interventions are attending care conferences, documenting, and communicating about client care with other providers.

3. Wagner, C. M., Butcher, H. K., & Clarke, M. F. (2024). *Nursing interventions classification (NIC)* (8th ed.). Elsevier.

Classification of Nursing Interventions

There are three types of nursing interventions: independent, dependent, and collaborative. (See Figure 4.12[4] for an image of a nurse collaborating with the health care team when planning interventions.)

Figure 4.12 Collaborative Nursing Interventions

Independent Nursing Interventions

Any intervention that the nurse can independently provide without obtaining a prescription or consulting another member of the health care team is

4. "400845937-huge.jpg" by Flamingo Images is used under license from Shutterstock.com

considered an **independent nursing intervention**. An example of an independent nursing intervention is when the nurse monitors the client's 24-hour intake/output record for trends because of a risk for imbalanced fluid volume. Another example of independent nursing interventions is the therapeutic communication that a nurse uses to assist clients to cope with a new medical diagnosis.

Example of an Independent Nursing Intervention

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J. was diagnosed with *Excess Fluid Volume*. An example of an evidence-based independent nursing intervention is, "*The nurse will reposition the client with dependent edema frequently, as appropriate.*"[5] The nurse would individualize this evidence-based intervention to the client and include agency policy by stating, "*The nurse will reposition the client every two hours.*"

Dependent Nursing Interventions

Dependent nursing interventions require a prescription or order before they can be performed. **Prescriptions** are interventions specifically related to medication as directed by an authorized primary health care provider. An **order** is an intervention, remedy, or treatment as directed by an authorized primary health care provider.[6] A **primary health care provider** is a member of the health care team (usually a physician, advanced practice nurse, or physician's assistant) who is licensed and authorized to formulate

5. Wagner, C. M., Butcher, H. K., & Clarke, M. F. (2024). Nursing interventions classification (NIC) (8th ed.). Elsevier.

6. NCSBN. (2024). *Test plans*. https://www.nclex.com/test-plans.page

prescriptions on behalf of the client. For example, administering medication is a dependent nursing intervention. The nurse incorporates dependent interventions into the client's overall care plan by associating each intervention with the appropriate nursing diagnosis.

Example of a Dependent Nursing Intervention

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J. was diagnosed with *Excess Fluid Volume*. An example of a dependent nursing intervention is, *"The nurse will administer scheduled diuretics as prescribed."*

Collaborative Nursing Interventions

Collaborative nursing interventions are actions that the nurse carries out in collaboration with other health team members, such as physicians, social workers, respiratory therapists, physical therapists, and occupational therapists. These actions are developed in consultation with other health care professionals and incorporate their professional viewpoint.[7]

Example of a Collaborative Nursing Intervention

Refer to Scenario C in the "Assessment" section of this chapter. Ms. J. was diagnosed with *Excess Fluid Volume*. An example of a

7. Vera, M. (2020). *Nursing care plan (NCP): Ultimate guide and database.* https://nurseslabs.com/nursing-care-plans/#:~:text=Collaborative%20interventions%20are%20actions%20that,to%20gain%20their%20professional%20viewpoint

collaborative nursing intervention is the nurse consulting with a respiratory therapist when the client has deteriorating oxygen saturation levels. The respiratory therapist plans oxygen therapy and obtains a prescription from the provider. The nurse would document "*The nurse will manage oxygen therapy in collaboration with the respiratory therapist*" in the care plan.

Individualization of Interventions

It is vital for the planned interventions to be individualized to the client to be successful. For example, adding prune juice to the breakfast meal of a client with constipation will only work if the client likes to drink the prune juice. If the client does not like prune juice, then this intervention should not be included in the care plan. Collaboration with the client, family members, significant others, and the interprofessional team is essential for selecting effective interventions. There is not a set number of interventions required to be included in a nursing care plan, but instead, the number of quality individualized interventions is based on what is required to meet the specific, identified outcomes established for that client.

Creating Nursing Care Plans

Nursing care plans are created by registered nurses (RNs). Documentation of individualized nursing care plans are legally required in long-term care facilities by the Centers for Medicare and Medicaid Services (CMS) and in hospitals by The Joint Commission. CMS guidelines state, "Residents and their representative(s) must be afforded the opportunity to participate in their care planning process and to be included in decisions and changes in care, treatment, and/or interventions. This applies both to initial decisions about care and treatment, as well as the refusal of care or treatment. Facility staff must support and encourage participation in the care planning process. This

may include ensuring that residents, families, or representatives understand the comprehensive care planning process, holding care planning meetings at the time of day when a resident is functioning at their best and client representatives can be present, providing sufficient notice in advance of the meeting, scheduling these meetings to accommodate a resident's representative (such as conducting the meeting in-person, via a conference call, or video conferencing), and planning enough time for information exchange and decision-making. A resident has the right to select or refuse specific treatment options before the care plan is instituted."[8] The Joint Commission conceptualizes the care planning process as the structuring framework for coordinating communication that will result in safe and effective care.[9]

Many facilities have established standardized nursing care plans with lists of possible interventions that can be customized for each specific client. Other facilities require the nurse to develop each care plan independently. Whatever the format, nursing care plans should be individualized to meet the specific and unique needs of each client. See Figure 4.13[10] for an image of a standardized care plan.

8. Centers for Medicare and Medicaid Services. (2017). *State operations manual: Appendix PP – Guidance to surveyors for long term care facilities*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

9. The Joint Commission (n.d.). *Standards and guides pertinent to nursing practice*. https://www.jointcommission.org/resources/for-nurses/nursing-resources/

10. "Figure 3-3. An example of a nursing care plan in an Australian residential aged care home..png" by NurseRecord is licensed under CC BY-SA 4.0

Nursing Care Plan

CLIENT ID:
NAME:
D.O.B.:
DOCTOR:
PERSION:

LIFESTYLE SUPPORT NEEDS	*GOAL OF CARE*	*CARE OR INTERVENTION REQUIRED* *Tick and/or Highlight Appropriate Response*
Links to Assessments: *Eating & Assessment (11-09a)* *Nutrition Assessments for Residents at Risk (11-41)* Dietician Assessment Speech Therapist Assessment	**RESIDENTS NUTRITION &HYDRATION IS MAINTAINED AT OPTIMUM LEVEL**	**Preferences** Size of meals: ☐ small ☐ medium ☐ large Likes:..... Dislikes:..... Preferred drinks: Tea ☐ Coffee ☐ Milk ☐ Other ☐ **Preferred eating arrangements** ☐ Breakfast in dining room/sitting room/own room ☐ Lunch in dining room/sitting room/own room ☐ Evening meal in dining room/sitting room/own room **Diet** ☐ Normal ☐ Modified ☐ Specify..... ☐ Supplements: Type: ..... Amount: .....Frequency..... **Dysphagia management** Difficulty with chewing ☐Yes ☐No Difficulty with swallowing ☐Yes ☐No Thickened fluids ☐ full thick ☐ 1/2 thick ☐ 1/4 thick **Enteral feeding** PEG feeds (type): ..... If PEG, ☐ Bolus ☐ Continuous **Assistance required:** ☐ Cut up food ☐ Butter bread & apply spreads ☐ Leave glass of fluid within reach (type): ..... ☐ Place utensils in residents hand ☐ Special utensils required ☐ Refill fluids at each attention ☐ Guide food into residents mouth ☐ Encourage finger food ☐ Place food into residents mouth ☐ Supervise eating/drinking ☐ Entire meal ☐ Part of meal ☐ Encourage to remain at table ☐ Weigh-frequency ☐ Other .....
Name		***Designation***
Signature		***Date***
Notes		

Figure 4.13 Standardized Care Plan

Nursing care plans created in nursing school can also be in various formats such as concept maps or tables. Some are fun and creative, while others are more formal. Appendix B contains a template that can be used for creating nursing care plans.

4.7 Implementation of Interventions

OPEN RESOURCES FOR NURSING (OPEN RN)

Implementation is the fifth step of the nursing process (and the fifth Standard of Practice by the American Nurses Association). This standard is defined as, "The registered nurse implements the identified plan." The RN may delegate planned interventions after considering the circumstance, person, task, communication, supervision, and evaluation, as well as the state Nurse Practice Act, federal regulation, and agency policy.[1]

Implementation of interventions requires the RN to use critical thinking and clinical judgment. After the initial plan of care is developed, continual reassessment of the client is necessary to detect any changes in the client's condition requiring modification of the plan. The need for continual client reassessment underscores the dynamic nature of the nursing process and is crucial to providing safe care.

During the implementation phase of the nursing process, the nurse prioritizes planned interventions, assesses client safety while implementing interventions, delegates interventions as appropriate, and documents interventions performed. LPN/VNs have an active role in the Implementation phase, provided the interventions falls within the LPN/VN scope of practice. See Figure 4.14[2] for an illustration of how the Implementation phase of the

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. "Implementation Phase of the Nursing Process Compared to the NCSBN Clinical Judgment Model" by Tami Davis is licensed by CC BY 4.0.

nursing process correlates to NCSBN's Clinical Judgment Measurement Model.

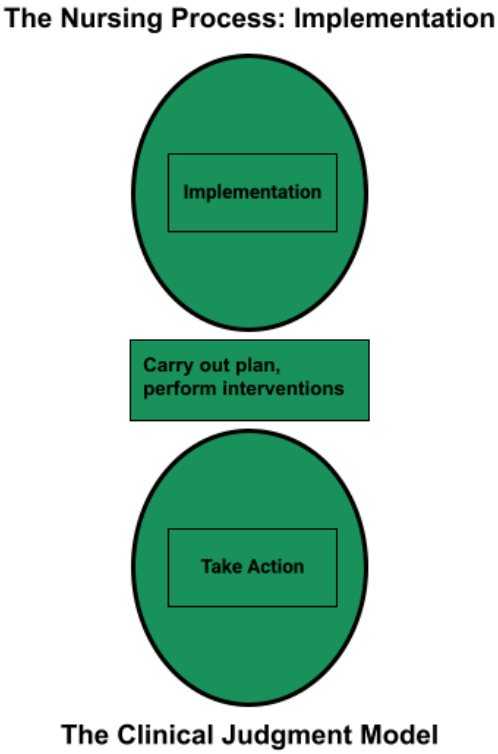


Figure 4.14 Implementation Phase of the Nursing Process Compared to the NCSBN Clinical Judgment Measurement Model

Prioritizing Implementation of Interventions

Prioritizing implementation of interventions follows a similar method as to prioritizing nursing diagnoses. Maslow's Hierarchy of Needs and the ABCs of airway, breathing, and circulation are used to establish top priority interventions. When possible, least invasive actions are usually preferred due to the risk of injury from invasive options. Read more about methods for prioritization under the "Diagnosis" section of this chapter.

The potential impact on future events, especially if a task is not completed at a certain time, is also included when prioritizing nursing interventions. For example, if a client is scheduled to undergo a surgical procedure later in the day, the nurse prioritizes initiating a NPO (nothing by mouth) prescription prior to completing pre-op client education about the procedure. The

rationale for this decision is that if the client eats food or drinks water, the surgery time will be delayed. Knowing and understanding the client's purpose for care, current situation, and expected outcomes are necessary to accurately prioritize interventions.

Client Safety

It is essential to consider client safety when implementing interventions. At times, clients may experience a change in condition that makes a planned nursing intervention or provider prescription no longer safe to implement. For example, an established nursing care plan for a client states, *"The nurse will ambulate the client 100 feet three times daily."* However, during assessment this morning, the client reports feeling dizzy today, and their blood pressure is 90/60. Using critical thinking and clinical judgment, the nurse decides to not implement the planned intervention of ambulating the client. This decision and supporting assessment findings should be documented in the client's chart and also communicated during the shift handoff report, along with appropriate notification of the provider of the client's change in condition.

Implementing interventions goes far beyond implementing provider prescriptions and completing tasks identified on the nursing care plan and must focus on client safety. As frontline providers, nurses are in the position to stop errors before they reach the client.

In 2000 the Institute of Medicine (IOM) issued the historic, groundbreaking report titled *To Err Is Human: Building a Safer Health System*. The report stated that as many as 98,000 people die in U.S. hospitals each year as a result of preventable medical errors. *To Err Is Human* broke the silence that previously surrounded the consequences of medical errors and set a national agenda for reducing medical errors and improving client safety through the design of a safer health system.[3] In 2007 the IOM published a follow-up report

3. Institute of Medicine (US) Committee on Quality of Health Care in America, Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human: Building a safer health system*. National Academies Press. https://pubmed.ncbi.nlm.nih.gov/25077248/

titled *Preventing Medication Errors* and reported that more than 1.5 million Americans are injured every year in American hospitals, and the average hospitalized client experiences at least one medication error each day. This report emphasized actions that health care systems could take to improve medication safety.[4]

> Read additional information about specific actions that nurses can take to prevent medication errors; go to the "Preventing Medication Errors" section of the "Legal/Ethical" chapter of the Open RN *Nursing Pharmacology, 2e* textbook.

The Quality and Safety Education for Nurses (QSEN) project began in 2005 to assist in preparing future nurses to continuously improve the quality and safety of the health care systems in which they work. The vision of the QSEN project is to "inspire health care professionals to put quality and safety as core values to guide their work."[5] Nurses and nursing students are expected to participate in quality improvement (QI) initiatives by identifying gaps where change is needed and assisting in implementing initiatives to resolve these gaps. **Quality improvement** is defined as, "The combined and unceasing efforts of everyone – health care professionals, clients and their families, researchers, payers, planners and educators – to make the changes that will lead to better client outcomes (health), better system performance (care), and better professional development (learning)."[6]

4. Institute of Medicine. (2007). *Preventing medication errors*. National Academies Press. https://doi.org/10.17226/11623.

5. QSEN Institute. (n.d.). *Project overview: The evolution of the quality and safety education for nurses (QSEN) initiative*. http://qsen.org/about-qsen/project-overview/

6. Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare?. *BMJ Quality & Safety, 16*(1), 2–3. https://doi.org/10.1136/qshc.2006.022046

Delegation of Interventions

While implementing interventions, RNs may elect to delegate nursing tasks. **Delegation** is defined by the American Nurses Association as, "The assignment of the performance of activities or tasks related to client care to unlicensed assistive personnel or licensed practical nurses (LPNs) while retaining accountability for the outcome."[7] RNs are accountable for determining the appropriateness of the delegated task according to the condition of the client and the circumstance; the communication provided to an appropriately trained LPN or UAP; the level of supervision provided; and the evaluation and documentation of the task completed. The RN must also be aware of the state Nurse Practice Act, federal regulations, and agency policy before delegating. The RN cannot delegate responsibilities requiring clinical judgment.[8] See the following box for information regarding legal requirements associated with delegation according to the Nurse Practice Act.

Delegation According to the Wisconsin Nurse Practice Act[9]

"During the supervision and direction of delegated acts a Registered Nurse shall do all of the following:

7. American Nurses Association. (2013). *ANA's principles for delegation by registered nurses to unlicensed assistive personnel (UAP)*. American Nurses Association. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principlesofdelegation.pdf

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

9. Wisconsin Administrative Code. (2024). *Chapter N 6 standards of practice for registered nurses and licensed practical nurses*. https://docs.legis.wisconsin.gov/code/admin_code/n/6.pdf

(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.

(b) Provide direction and assistance to those supervised.

(c) Observe and monitor the activities of those supervised.

(d) Evaluate the effectiveness of acts performed under supervision.

The standard of practice for Licensed Practical Nurses in Wisconsin states, "In the performance of acts in basic patient situations, the LPN shall, under the general supervision of an RN or the direction of a provider:

(a) Accept only patient care assignments which the LPN is competent to perform.

(b) Provide basic nursing care. Basic nursing care is defined as care that can be performed following a defined nursing procedure with minimal modification in which the responses of the patient to the nursing care are predictable.

(c) Record nursing care given and report to the appropriate person changes in the condition of a patient.

(d) Consult with a provider in cases where an LPN knows or should know a delegated act may harm a patient.

(e) Perform the following other acts when applicable:

1. Assist with the collection of data.
2. Assist with the development and revision of a nursing care plan.
3. Reinforce the teaching provided by an RN provider and provide basic health care instruction.
4. Participate with other health team members in meeting basic patient needs."

- Read additional details about the scope of practice of registered nurses (RNs) and licensed practical nurses (LPNs) in Wisconsin's Nurse Practice Act in Chapter N 6 Standards of Practice.
- Read more about the American Nurses Association's Principles for Delegation.

Table 4.7 outlines general guidelines for delegating nursing tasks in the state of Wisconsin according to the role of the health care team member.

Table 4.7 General Guidelines for Delegating Nursing Tasks

	RN	LPN	CNA
Assessment	Complete client assessment	Assist with the collection of data for stable clients	Collect measurements such as weight, input/output, and vital signs in stable clients
Diagnosis	Analyze assessment data and create nursing diagnoses	Not applicable	Not applicable
Outcome Identification	Identify SMART client outcomes	Not applicable	Not applicable
Planning	Plan nursing interventions	Assist with the development of a nursing care plan	Not applicable
Implementation of Interventions	Implement independent, dependent, and collaborative nursing interventions; delegate interventions as appropriate, with supervision; document interventions performed	Participate with other health team members in meeting basic client needs and document interventions provided Reinforce the teaching provided by an RN provider and provide basic health care instruction	Implement and document delegated interventions associated with basic nursing care such as providing assistance in ambulating or tasks within their scope of practice
Evaluation	Evaluate the attainment of outcomes and revise the nursing care plan as needed	Contribute data regarding the achievement of client outcomes; assist in the revision of a nursing care plan	Not applicable

Documentation of Interventions

As interventions are performed, they must be documented in the client's record in a timely manner. As previously discussed in the "Ethical and Legal Issues" subsection of the "Basic Concepts" section, lack of documentation is

considered a failure to communicate and a basis for legal action. A basic rule of thumb is if an intervention is not documented, it is considered not done in a court of law. It is also important to document administration of medication and other interventions in a timely manner to prevent errors that can occur due to delayed documentation time.

Coordination of Care and Health Teaching/Health Promotion

ANA's Standard of Professional Practice for Implementation also includes the standards *5A Coordination of Care* and *5B Health Teaching and Health Promotion*.[10] **Coordination of Care** includes competencies such as organizing the components of the plan, engaging the client in self-care to achieve goals, and advocating for the delivery of dignified and holistic care by the interprofessional team. **Health Teaching and Health Promotion** is defined as, "Employing strategies to teach and promote health and wellness."[11] Client education is an important component of nursing care and should be included during every client encounter. For example, client education may include teaching about side effects while administering medications or teaching clients how to self-manage their conditions at home.

Putting It Together

See an example of implementation in the following box.

10. American Nurses Association. (2021). *Nursing: Scope and standards of practice (*4th ed.). American Nurses Association.

11. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Example of Implementation

Refer to Scenario C in the "Assessment" section of this chapter. The nurse implemented the nursing care plan documented in Appendix C. Interventions related to breathing were prioritized. Administration of the diuretic medication was completed first, and lung sounds were monitored frequently for the remainder of the shift. Weighing the client before breakfast was delegated to the CNA. The client was educated about her medications and methods to use to reduce peripheral edema at home. All interventions were documented in the electronic medical record (EMR).

4.8 Evaluation

OPEN RESOURCES FOR NURSING (OPEN RN)

Evaluation is the sixth step of the nursing process (and the sixth Standard of Practice by the American Nurses Association). This standard is defined as, "The registered nurse evaluates progress toward attainment of goals and outcomes."[1] Both the client status and the effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.[2]

Evaluation focuses on the effectiveness of the nursing interventions by reviewing the expected outcomes to determine if they were met by the time frames indicated. During the evaluation phase, nurses use critical thinking to analyze reassessment data and determine if a client's expected outcomes have been met, partially met, or not met by the time frames established. If outcomes are not met or only partially met by the time frame indicated, the care plan should be revised. Reassessment should occur every time the nurse interacts with a client, discusses the care plan with others on the interprofessional team, or reviews updated laboratory or diagnostic test results. Nursing care plans should be updated as higher priority goals emerge. The results of the evaluation must be documented in the client's medical record. Evaluation is outside the scope of practice for LPN/VNs, but they may assist in collecting reassessment data for the RN to evaluate.

Ideally, when the planned interventions are implemented, the client will respond positively, and the expected outcomes are achieved. However, when interventions do not assist in progressing the client toward the expected

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

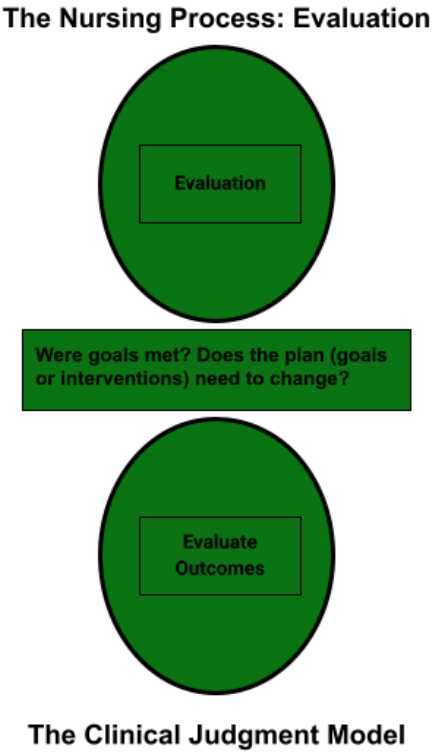
2. American Nurses Association. (n.d.) *The nursing process*. https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/the-nursing-process/

outcomes, the nursing care plan must be revised to more effectively address the needs of the client These questions can be used as a guide when revising the nursing care plan:

- Did anything unanticipated occur?
- Has the client's condition changed?
- Were the expected outcomes and their time frames realistic?
- Are the nursing diagnoses accurate for this client at this time?
- Are the planned interventions appropriately focused on supporting outcome attainment?
- What barriers were experienced as interventions were implemented?
- Does ongoing assessment data indicate the need to revise diagnoses, outcome criteria, planned interventions, or implementation strategies?
- Are different interventions required?

See Figure 4.15[3] for a comparison of the Evaluation phase of the nursing process to the NCSBN Clinical Judgment Model.

3. "Evaluation Phase of the Nursing Process Compared to the NCSBN Clinical Judgment Model" by Tami Davis is licensed by CC BY 4.0.



4.15 Comparison of the Evaluation Phase of the Nursing Process to the NCSBN Clinical Judgment Model

Putting It Together

See an example of the Evaluation phase in the following box.

Example of Evaluation

Refer to Scenario C in the "Assessment" section of this chapter and Appendix C. The nurse evaluates the client's progress toward achieving the expected outcomes.

For the nursing diagnosis *Excess Fluid Volume*, the nurse evaluated four expected outcomes to determine if they were met during the time frames indicated:

1. *The client will report decreased dyspnea within the next 8 hours*.
2. *The client will have clear lung sounds within the next 24 hours*.
3. *The client will have decreased edema within the next 24 hours*.
4. *The client's weight will return to baseline by discharge*.

Evaluation of the client condition on Day 1 included the following data: "*The client reported decreased shortness of breath, and there were no longer crackles in the lower bases of the lungs. Weight decreased by 1 kg, but 2+ edema continued in ankles and calves*." Based on this data, the nurse evaluated the expected outcomes as "*Partially Met*" and revised the care plan with two new interventions:

1. *Request prescription for TED hose from provider*.
2. *Elevate client's legs when sitting in chair*.

For the second nursing diagnosis, *Risk for Falls*, the nurse evaluated the outcome criteria as "*Met*" based on the evaluation, "*The client verbalizes understanding and is appropriately calling for assistance when getting out of bed. No falls have occurred*."

The nurse will continue to reassess the client's progress according to the care plan during hospitalization and make revisions to the care plan as needed. Evaluation of the care plan is documented in the client's medical record.

4.9 Summary of the Nursing Process

OPEN RESOURCES FOR NURSING (OPEN RN)

You have now learned how to perform each step of the nursing process according to the ANA Standards of Professional Nursing Practice. Critical thinking, clinical reasoning, and clinical judgment are used when assessing the client, creating a nursing care plan, and implementing interventions. Frequent reassessment, with revisions to the care plan as needed, is important to help the client achieve expected outcomes. Throughout the entire nursing process, the client always remains the cornerstone of nursing care. Providing individualized, client-centered care and evaluating whether that care has been successful in achieving client outcomes are essential for providing safe, professional nursing practice.

Video Review of Creating a Sample Care Plan[1]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=123#oembed-1

1. RegisteredNurseRN. (2015, June11). *Nursing care plan* tutorial | *How to complete a care plan in nursing school* [Video]. YouTube. All rights reserved. Video used with permission. https//youtu.be/07Z4ywfmLg8

4.10 Learning Activities

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

Instructions: Apply what you've learned in this chapter by creating a nursing care plan using the following scenario. Use the template in Appendix B as a guide.

The client, Mark S., is a 57-year-old male who was admitted to the hospital with "severe" abdominal pain that was unable to be managed in the Emergency Department. The physician has informed Mark that he will need to undergo some diagnostic tests. The tests are scheduled for the morning.

After receiving the news about his condition and the need for diagnostic tests, Mark begins to pace the floor. He continues to pace constantly. He keeps asking the nurse the same question ("How long will the tests take?") about his tests over and over again. The client also remarked, "I'm so uptight I will never be able to sleep tonight." The nurse observes that the client avoids eye contact during their interactions and that he continually fidgets with the call light. His eyes keep darting around the room. He appears tense and has a strained expression on his face. He states,

"My mouth is so dry." The nurse observes his vital signs to be: T 98, P 104, R 30, BP 180/96. The nurse notes that his skin feels sweaty (diaphoretic) and cool to the touch.

Critical Thinking Activity:

1. Group (cluster) the cues (subjective and objective data).
2. Create a problem-focused nursing diagnosis (hypothesis).
3. Develop a broad goal and then identify an expected outcome in "SMART" format.
4. Outline three interventions for the nursing diagnosis to meet the goal and their rationale. Cite an evidence-based source for the interventions and rationale
5. Imagine that you implemented the interventions that you identified. Evaluate the degree to which the expected outcome was achieved: Met – Partially Met – Not Met.

View a sample nursing care plan created for this scenario using the template in Appendix B

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=125#h5p-60

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=125#h5p-11

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=125#h5p-12

Test your knowledge using this NCLEX Next Generation-style question. You may reset and resubmit your answers to this question an unlimited number of times.[1]

1. "Chapter 4 Assignment 1" by Rebecca Wicks for OpenRN is licensed under CC BY-NC 4.0

IV Glossary

OPEN RESOURCES FOR NURSING (OPEN RN)

ADOPIE: An easy way to remember the ANA Standards and the nursing process. Each letter refers to the six components of the nursing process: Assessment, Diagnosis, Outcomes Identification, Planning, Implementation, and Evaluation. (Chapter 4.2)

Art of nursing: Unconditional acceptance of the humanity of others, respecting their need for dignity and worth, while providing compassionate, comforting care.[1] (Chapter 4.2)

At-risk populations: Groups of people who share a sociodemographic characteristics, health/family history, stages of growth/development, exposure to certain events/experiences that cause each member to be susceptible to a particular human response. These characteristics are not modifiable by independent nursing interventions.[2](Chapter 4.4)

Associated conditions: Medical diagnoses, diagnostic/surgical procedures, medical/surgical devices, or pharmaceutical preparations that are not modifiable by independent nursing interventions.[3] (Chapter 4.4)

Care relationship: A relationship described as one in which the whole

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

2. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

3. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

person is assessed while balancing the vulnerability and dignity of the client and family.[4] (Chapter 4.2)

Client: Individual, family, or group, which includes significant others and populations.[5] (Chapter 4.2)

Clinical judgment: The observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and access presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care.[6] (Chapter 4.2)

Clinical reasoning: A complex cognitive process that uses formal and informal thinking strategies to gather and analyze client information, evaluate the significance of this information, and weigh alternative actions.[7] (Chapter 4.2)

Clustering data: Grouping data into similar domains or patterns. (Chapter 4.4)

Collaborative nursing interventions: Nursing interventions that require cooperation among health care professionals and unlicensed assistive personnel (UAP). (Chapter 4.6)

4. Walivaara, B., Savenstedt, S., & Axelsson, K. (2013). Caring relationships in home-based nursing care – registered nurses' experiences. *The Open Journal of Nursing, 7,* 89-95. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3722540/pdf/TONURSJ-7-89.pdf

5. NCSBN. (2024). *Test plans*. https://www.nclex.com/test-plans.page

6. NCSBN. (n.d.). *NCSBN clinical judgment model*. https://www.ncsbn.org/14798.htm

7. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221. doi: 10.1097/01.NEP.0000000000000669. PMID: 32569111. https://pubmed.ncbi.nlm.nih.gov/32569111/

Coordination of care: While implementing interventions during the nursing process, includes competencies such as organizing the components of the plan with input from the health care consumer, engaging the client in self-care to achieve goals, and advocating for the delivery of dignified and person-centered care by the interprofessional team.[8] (Chapter 4.7)

Critical thinking: Reasoning about clinical issues such as teamwork, collaboration, and streamlining workflow.[9] (Chapter 4.2)

Cues: Subjective or objective data that gives the nurse a hint or indication of a potential problem, process, or disorder. (Chapter 4.2)

Deductive reasoning: "Top-down thinking" or moving from the general to the specific. Deductive reasoning relies on a general statement or hypothesis—sometimes called a premise or standard—that is held to be true. The premise is used to reach a specific, logical conclusion. (Chapter 4.2)

Defining characteristics: Observable cues/inferences that cluster as manifestations of a problem-focused, health-promotion diagnosis, or syndrome. This does not only imply those things that the nurse can see, but also things that are seen, heard (e.g., the client/family tells us), touched, or smelled.[10] (Chapter 4.4)

Delegation: The assignment of the performance of activities or tasks

8. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (3rd ed.). American Nurses Association.

9. Klenke-Borgmann, L., Cantrell, M. A., & Mariani, B. (2020). Nurse educator's guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives, 41*(4), 215-221. doi: 10.1097/01.NEP.0000000000000669. PMID: 32569111. https://pubmed.ncbi.nlm.nih.gov/32569111/

10. NANDA International. (n.d.). *Glossary of terms*. https://nanda.org/nanda-i-resources/glossary-of-terms/

related to client care to unlicensed assistive personnel while retaining accountability for the outcome.[11] (Chapter 4.7)

Dependent nursing interventions: Interventions that require a prescription from a physician, advanced practice nurse, or physician's assistant. (Chapter 4.6)

Direct care: Interventions that are carried out by having personal contact with a client. (Chapter 4.6)

Electronic Medical Record (EMR): An electronic version of the client's medical record. (Chapter 4.3)

Evidence-Based Practice (EBP): A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer's history and condition, as well as health care resources; and client, family, group, community, and population preferences and values.[12] (Chapter 4.2)

Expected outcomes: Statements of measurable action for the client within a specific time frame and in response to nursing interventions. "SMART" outcome statements are specific, measurable, action-oriented, realistic, and include a time frame. (Chapter 4.5)

Functional Health Patterns: An evidence-based assessment framework for identifying client problems and risks during the assessment phase of the nursing process. (Chapter 4.4)

Generalization: A judgment formed from a set of facts, cues, and observations. (Chapter 4.2)

11. American Nurses Association. (2013). *ANA's principles for delegation by registered nurses to unlicensed assistive personnel (UAP)*. American Nurses Association. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principlesofdelegation.pdf

12. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Goals: Broad statements of purpose that describe the aim of nursing care. (Chapter 4.5)

Health promotion-wellness nursing diagnosis: A clinical judgment concerning motivation and desire to increase well-being and to actualize human health potential. (Chapter 4.4)

Health teaching and health promotion: Employing strategies to teach and promote health and wellness.[13] (Chapter 4.7)

Hypothesis: A proposed explanation for a situation. It attempts to explain the "why" behind the problem that is occurring. (Chapter 4.2)

Independent nursing interventions: Any intervention that the nurse can provide without obtaining a prescription or consulting anyone else. (Chapter 4.6)

Indirect care: Interventions performed by the nurse in a setting other than directly with the client. An example of indirect care is creating a nursing care plan. (Chapter 4.6)

Inductive reasoning: A type of reasoning that involves forming generalizations based on specific incidents. (Chapter 4.2)

Inference: Interpretations or conclusions based on cues, personal experiences, preferences, or generalizations. (Chapter 4.3)

Licensed Practical Nurses or Licensed Vocational Nurses (LPNs/LVNs): Nurses who have had specific training and passed a licensing exam. The training is generally less than that of a Registered Nurse. The scope of practice of an LPN/LVN is determined by the facility and the state's Nurse Practice Act. (Chapter 4.3)

Maslow's Hierarchy of Needs: A theory used to prioritize the most urgent client needs to address first. The bottom levels of the pyramid represent the most important physiological needs intertwined with safety. (Chapter 4.4)

Medical diagnosis: A disease or illness diagnosed by a physician or advanced health care provider such as a nurse practitioner or physician's

13. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

assistant. Medical diagnoses are a result of clustering signs and symptoms to determine what is medically affecting an individual. (Chapter 4.3)

Nursing: Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in the recognition of the connection of all humanity.[14] (Chapter 4.2)

Nursing care plan: Specific documentation of the planning and delivery of nursing care that is required by The Joint Commission. (Chapter 4.2)

Nursing diagnosis: A clinical judgment concerning a human response to health conditions/life processes, or susceptibility to that response, by an individual, caregiver, family, group, or community. (Chapter 4.4)

Nursing interventions: Evidence-based actions that the nurse performs to achieve client outcomes. (Chapter 4.6)

Nursing process: A systematic approach to client-centered care with steps including assessment, diagnosis, outcome identification, planning, implementation, and evaluation; otherwise known by the mnemonic "ADOPIE." (Chapter 4.1)

Objective data: Data that the nurse can see, touch, smell, or hear or is reproducible such as vital signs. Laboratory and diagnostic results are also considered objective data. (Chapter 4.3)

Order: An intervention, remedy or treatment as directed by an authorized primary health care provider.[15] (Chapter 4.6)

Outcome: A measurable behavior demonstrated by the client's response to nursing interventions.[16] (Chapter 4.5)

14. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

15. NCSBN. (2024). T*est Plans*. https://www.nclex.com/test-plans.page

16. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses:*

PES format: The format of a nursing diagnosis statement that includes:

- Problem (P) – statement of the client problem (i.e., the nursing diagnosis)
- Etiology (E) – related factors (etiology) contributing to the cause of the nursing diagnosis
- Signs and Symptoms (S) – defining characteristics manifested by the client of that nursing diagnosis (Chapter 4.4)

Physical examination: A systematic data collection method of the body that uses the techniques of inspection, auscultation, palpation, and percussion. (Chapter 4.3)

Prescription: Intervention as it relates to medication specifically as directed by an authorized primary health care provider.[17] (Chapter 4.6)

Primary data: Information collected from the client. (Chapter 4.3)

Primary health care provider: Member of the health care team (usually a medical physician, nurse practitioner, etc.) licensed and authorized to formulate prescriptions on behalf of the client.[18] (Chapter 4.6)

Prioritization: The skillful process of deciding which actions to complete first for client safety and optimal client outcomes. (Chapter 4.4)

Problem-focused nursing diagnosis: A clinical judgment concerning an undesirable human response to health condition/life processes that exist in an individual, family, group, or community. (Chapter 4.4)

Quality improvement: The "combined and unceasing efforts of everyone — health care professionals, clients and their families, researchers, payers, planners, and educators — to make the changes that will lead to better client

Definitions and classification 2021-2023, Twelfth Edition. Thieme Publishers New York.

17. NCSBN. (2024). *Test plans*. https://www.nclex.com/test-plans.page

18. NCSBN. (2024). *Test plans*. https://www.nclex.com/test-plans.page

outcomes (health), better system performance (care), and better professional development (learning)."[19] (Chapter 4.7)

Rapport: Developing a relationship of mutual trust and understanding. (Chapter 4.2)

Registered Nurse (RN): A nurse who has had a designated amount of education and training in nursing and is licensed by a state Board of Nursing. (Chapter 4.3)

Related factors: The underlying cause (etiology) of a nursing diagnosis. (Chapter 4.4)

Risk nursing diagnosis: A clinical judgment concerning the vulnerability of an individual, family, group, or community for developing an undesirable human response to health conditions/life processes. (Chapter 4.4)

Secondary data: Information collected from sources other than the client. (Chapter 4.3)

Subjective data: Data that the client or family reports or data that the nurse makes as an inference, conclusion, or assumption, such as *"The client appears anxious."* (Chapter 4.3)

Syndrome nursing diagnosis: A clinical judgment concerning a specific cluster of nursing diagnoses that occur together and are best addressed together and through similar interventions. (Chapter 4.4)

Unlicensed Assistive Personnel (UAP): Any unlicensed personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated.[20] (Chapter 4.3)

19. Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *BMJ Quality & Safety, 16*(1), 2–3. https://doi.org/10.1136/qshc.2006.022046

20. NCSBN. (2024). *Test plans*. https://www.nclex.com/test-plans.page

PART V

SAFETY

5.1 Safety Introduction

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Objectives

- Identify safety considerations for adults of all ages
- Indicate correct identification of client prior to performing any client care measures
- Describe industry standards and regulations regarding microbiological, physical, and environmental safety
- Differentiate safety considerations among diverse clients
- Apply decision-making related to measures to minimize use of restraints

A national focus on reducing medical errors has been in place since 1999 when the Institute of Medicine (IOM) released a report titled *To Err is Human: Building a Safer Health System*. This historic report broke the silence surrounding health care errors and encouraged safety to be built into the processes of providing client care. It was soon followed by the establishment of several safety initiatives by The Joint Commission, including the release of annual National Patient Safety Goals. Additionally, the Quality and Safety Education for Nurses (QSEN) Institute was developed to promote emphasis on high-quality, safe client care in nursing. This chapter will discuss several safety initiatives that promote a safe health care environment.

5.2 Basic Safety Concepts

OPEN RESOURCES FOR NURSING (OPEN RN)

Safety: A Basic Need

Safety is a basic foundational human need and always receives priority in client care. Nurses typically use Maslow's Hierarchy of Needs to prioritize urgent client needs, with the bottom two rows of the pyramid receiving top priority. See Figure 5.1[1] for an image of Maslow's Hierarchy of Needs. Safety is intertwined with basic physiological needs.

Consider the following scenario: You are driving back from a relaxing weekend at the lake and come upon a fiery car crash. You run over to the car to help anyone inside. When you get to the scene, you notice that the lone person in the car is not breathing. Your first priority is not to initiate rescue breathing inside the burning car, but to move the person to a safe place where you can safely provide CPR.

1. "Maslow's hierarchy of needs.svg" by J. Finkelstein is licensed under CC BY-SA 3.0

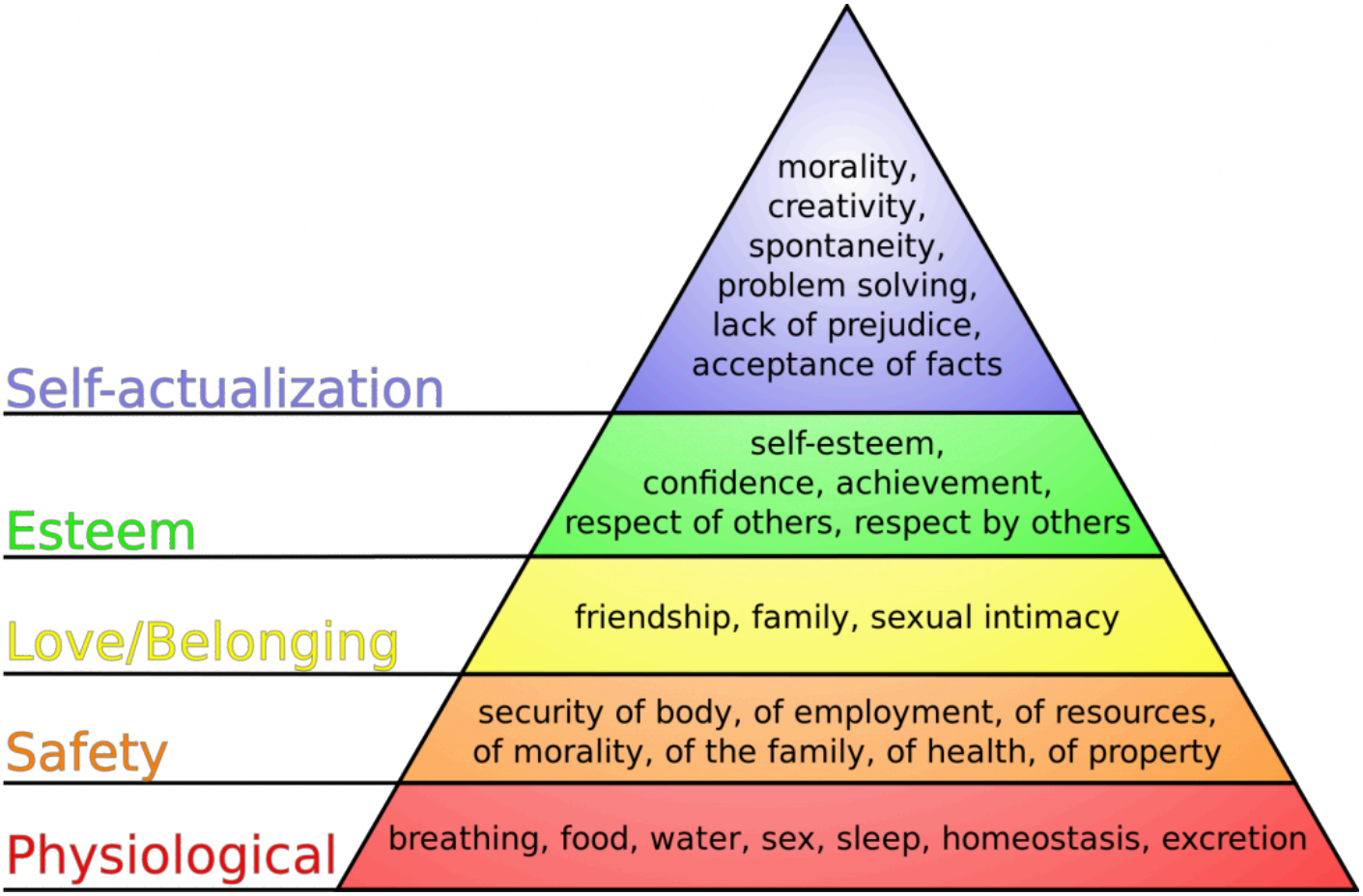


Figure 5.1 Maslow's Hierarchy of Needs

In nursing, the concept of client safety is central to everything we do in all health care settings. As a nurse, you play a critical role in promoting client safety while providing care. You also teach clients and their caregivers how to prevent injuries and remain safe in their homes and in the community. Safe client care also includes measures to keep you safe in the health care environment; if you become ill or injured, you will not be able to effectively care for others.

Safe client care is a commitment to providing the best possible care to every client and their caregivers in every moment of every day. Clients come to health care facilities expecting to be kept safe while they are treated for illnesses and injuries. Unfortunately, you may have heard stories about situations when that did not happen. Medical errors can be devastating to

clients and their families. Consider the true story in the following box that illustrates factors affecting client safety.

The Josie King Story

In 2001, 18-month-old Josie King died as a result of medical errors in a well-known hospital from a hospital-acquired infection and an incorrectly administered pain medication. How did this preventable death happen? Watch this video of her mother, Sorrel King, telling Josie's story and explaining how Josie's death spurred her work on improving client safety in hospitals everywhere.[2]

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://wtcs.pressbooks.pub/nursingfundamentals/?p=939#oembed-1

Reflective Questions:

1. What factors contributed to Josie's death?
2. How could these factors be resolved?

Read more about the Josie King Foundation.

Never Events

The event described in the Josie King story is considered a "never event." **Never events** are adverse events that are clearly identifiable, measurable, serious (resulting in death or significant disability), and preventable. In 2007

2. Healthcare.gov. (2011, May 25). *Introducing the partnerships for patients with Sorrel King* [Video]. YouTube. https://youtu.be/ak_5X66V5Ms

the Centers for Medicare and Medicaid Services (CMS) discontinued payment for costs associated with never events, and this policy has been adopted by most private insurance companies. Never events are publicly reported, with the goal of increasing accountability by health care agencies and improving the quality of client care. The current list of never events includes seven categories of events:

- Surgical or procedural event, such as surgery performed on the wrong body part
- Product or device, such as injury or death from a contaminated drug or device
- Client protection, such as client suicide in a health care setting
- Care management, such as death or injury from a medication error
- Environmental, such as death or injury as the result of using restraints
- Radiologic, such as a metallic object in an MRI area
- Criminal, such as death or injury of a client or staff member resulting from physical assault on the grounds of a health care setting

Sentinel Events

Sentinel events are very similar to never events although they may not be entirely preventable. They are defined by The Joint Commission as an "A client safety event that reaches a client and results in death, permanent harm, or severe temporary harm requiring interventions to sustain life." Such events are called "sentinel" because they signal the need for immediate investigation and response. Each accredited organization is strongly encouraged, but not required, to report sentinel events to The Joint Commission.[3] It is helpful to facilities to self-report sentinel events so that other facilities can learn from these events and future sentinel events can be prevented through knowledge sharing and risk reduction. Investigations into sentinel events are typically achieved through a process called root cause analysis.

3. The Joint Commission. (2024). *Sentinel event*. https://www.jointcommission.org/resources/sentinel-event/

Root cause analysis is a structured method used to analyze serious adverse events to identify underlying problems that increase the likelihood of errors, while avoiding the trap of focusing on mistakes by individuals. A multidisciplinary team analyzes the sequence of events leading up to the error with the goal of identifying how and why the event occurred. The ultimate goal of root cause analysis is to prevent future harm by eliminating hidden problems within a health care system that contribute to adverse events. For example, when a medication error occurs, a root cause analysis goes beyond focusing on the mistake by the nurse and looks at other system factors that contributed to the error, such as similar-looking drug labels, placement of similar-looking medications next to each other in a medication dispensing machine, or vague instructions in a provider order.

Root cause analysis uses human factors science as part of the investigation. **Human factors** focus on the interrelationships among humans, the tools and equipment they use in the workplace, and the environment in which they work. Safety in health care is ultimately dependent on humans – the doctors, nurses, and health care professionals – providing the care.

Near Misses

In addition to investigating sentinel events and never events, agencies use root cause analysis to investigate near misses. **Near misses** are defined by the World Health Organization (WHO) as, "An error that has the potential to cause an adverse event (client harm) but fails to do so because of chance or because it is intercepted." Errors and near misses are rarely the result of poor motivation or incompetence of the health care professional but are often caused by key contributing factors such as poor communication, less-than-optimal teamwork, memory overload, reliance on memory for complex procedures, and lack of standardization of policies and procedures. In an effort to prevent near misses, medical errors, sentinel events, and never events, several safety strategies have been developed and implemented in health care organizations across the country. These strategies will be discussed throughout the remainder of the chapter.

Incident Reports and Client Safety

Recall from the previous discussion in Chapter 2.5 that an incident report is a specific type of documentation performed when there is an error, near miss, or other unexpected occurrence that occurs during client care. Incident reports are used to identify process problems or other areas that could benefit from safety and quality improvement and are not included in the client's medical record. They are a component of an agency's culture of safety and are used during investigations like root cause analysis to help improve the safety and quality of client care.

5.3 Safety Strategies

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Safety strategies have been developed based on research to reduce the likelihood of errors and to create safe standards of care. Examples of safety initiatives include strategies to prevent medication errors, standardized checklists, and structured team communication tools.

Medication Errors

Several initiatives have been developed nationally to prevent medication errors, such as the establishment of a "Do Not Use List of Abbreviations," a "List of Error-Prone Abbreviations," "Frequently Confused Medication List," "High-Alert Medications List," and the "Do Not Crush List." Additionally, it is considered a standard of care for nurses to perform three checks of the rights of medication administration whenever administering medication. View more information about these safety initiatives to prevent medication errors in the box below. Specific strategies to prevent medication errors are discussed in the "Preventing Medication Errors" of the "Legal/Ethical" chapter of the Open RN *Nursing Pharmacology, 2e* textbook. The rights of medication administration are discussed in the "Basic Concepts of Administering Medications" section of the "Administration of Enteral Medications" chapter of the Open RN *Nursing Skills, 2e* textbook.

Read more about safety initiatives implemented to prevent medication errors:

- ISMP List of Error-Prone Abbreviations
- ISMP List of Confused Drug Names

- ISMP List of High-Alert Medications

Checklists

Performance of complex medical procedures is often based on memory, even though humans are prone to short-term memory loss, especially when we are multitasking or under stress. The point-of-care checklist is an example of a client care safety initiative that reduces this reliance on fallible memory. For example, a surgical checklist developed by the World Health Organization (WHO) has been adopted by most surgical providers around the world as a standard of care. It has significantly decreased injuries and deaths caused by surgeries by focusing on teamwork and communication. The Association of PeriOperative Registered Nurses (AORN) combined recommendations from The Joint Commission and the WHO to create a specific surgical checklist for nurses. See Figure 5.2[1] for an image of the WHO surgical checklist.

1. "9789241598590_eng_Checklist.pdf" by WHO is in the Public Domain

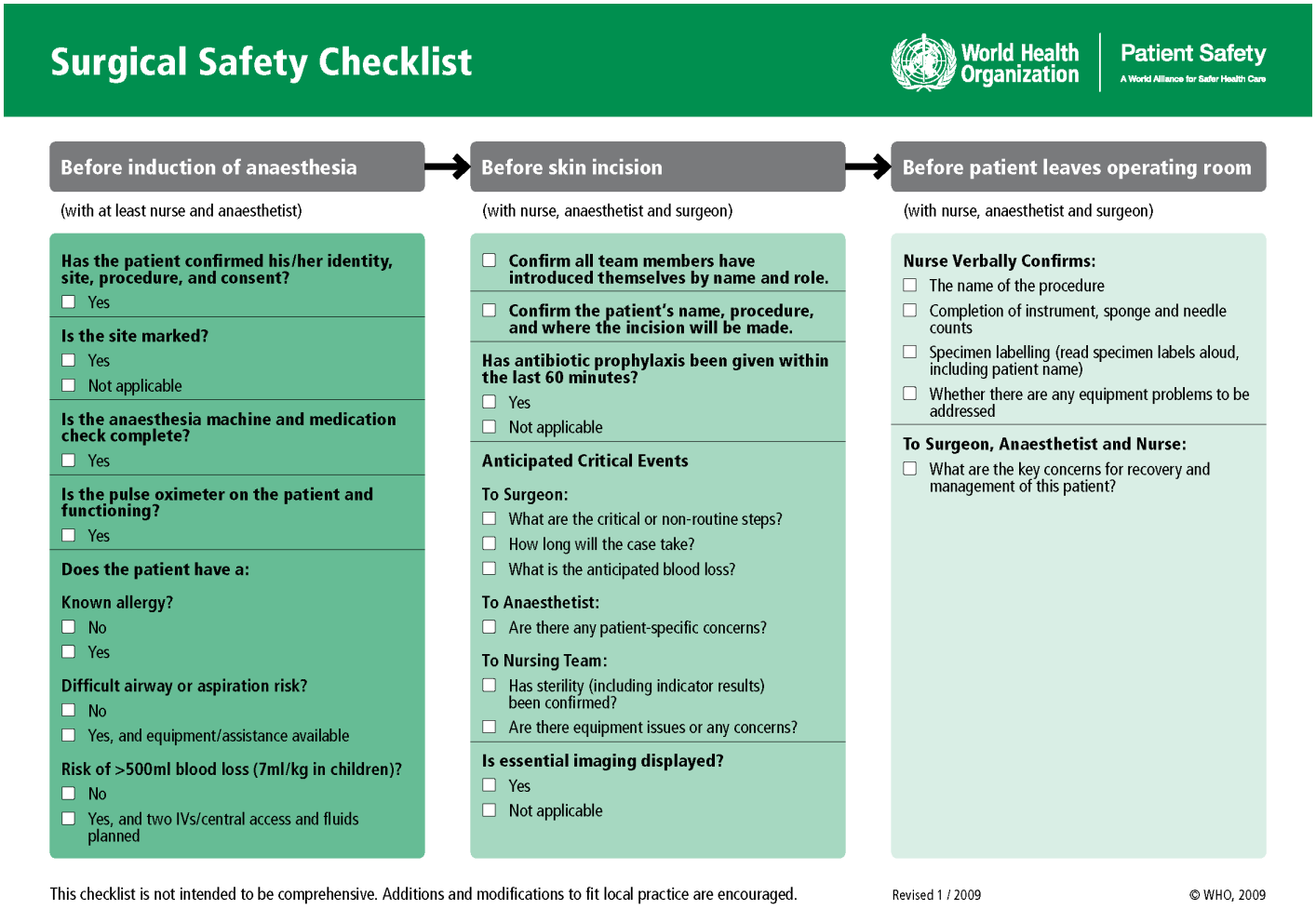


Figure 5.2 Surgical Checklist

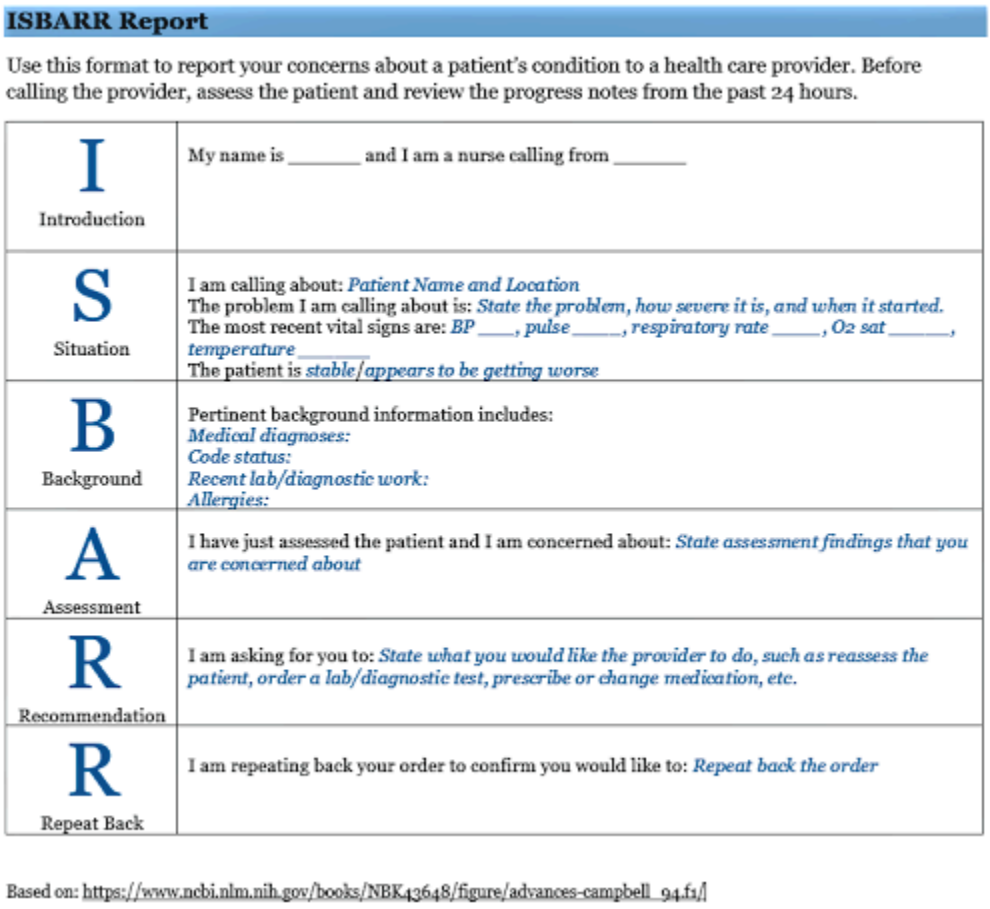
View an example of a Preop Checklist in the "Preoperative Care" section of the "Perioperative" chapter of Open RN *Nursing Health Alterations.*

Team Communication

Nurses routinely communicate with multidisciplinary health care team members and contact health care providers to report changes in client status.

Serious client harm can occur when client information is absent, incomplete, erroneous, or delayed during team communication. Standardized methods of communication are used to ensure that accurate information is exchanged among team members in a structured and concise manner, such as ISBARR reports and handoff reports.

ISBARR is a mnemonic for the components of Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back. See Figure 5.3[2] for an image of an ISBARR reference card.



ISBARR Report

Use this format to report your concerns about a patient's condition to a health care provider. Before calling the provider, assess the patient and review the progress notes from the past 24 hours.

I Introduction	My name is _____ and I am a nurse calling from _____
S Situation	I am calling about: *Patient Name and Location* The problem I am calling about is: *State the problem, how severe it is, and when it started.* The most recent vital signs are: *BP ____, pulse _____, respiratory rate _____, O2 sat _____, temperature _____* The patient is *stable/appears to be getting worse*
B Background	Pertinent background information includes: *Medical diagnoses:* *Code status:* *Recent lab/diagnostic work:* *Allergies:*
A Assessment	I have just assessed the patient and I am concerned about: *State assessment findings that you are concerned about*
R Recommendation	I am asking for you to: *State what you would like the provider to do, such as reassess the patient, order a lab/diagnostic test, prescribe or change medication, etc.*
R Repeat Back	I am repeating back your order to confirm you would like to: *Repeat back the order*

Based on: https://www.ncbi.nlm.nih.gov/books/NBK43648/figure/advances-campbell_94.f1/

Figure 5.3 ISBARR Reference Card

2. "ISBARR Reference Card" by Kim Ernstmeyer at Chippewa Valley Technical College is licensed under CC BY 4.0

Handoff reports are a specific type of team communication as client care is transferred. Handoff reports are defined by The Joint Commission as, "A transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the client's care."[3]

> Review information about ISBARR and handoff reports in *Communicating with Health Care Team Members* section of the "Communications" chapter.

3. The Joint Commission. (2017). *Sentinel Event Alert: Inadequate Handoff Communication*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pd

5.4 Culture of Safety

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In addition to implementing safety strategies to improve safe client care, leaders of a health care agency must also establish a culture of safety. A **culture of safety** reflects the behaviors, beliefs, and values within and across all levels of an organization as they relate to safety and clinical excellence, with a focus on people. In 2021 The Joint Commission released a sentinel event regarding the essential role of leadership in establishing a culture of safety. According to The Joint Commission, leadership has an obligation to be accountable for protecting the safety of all health care consumers, including clients, employees, and visitors. Without adequate leadership and an effective culture of safety, there is higher risk for adverse events. Inadequate leadership can contribute to adverse effects in a variety of ways, including, but not limited to, the following[1]:

- Insufficient support of client safety event reporting
- Lack of feedback or response to staff and others who report safety vulnerabilities
- Allowing intimidation of staff who report events
- Refusing to consistently prioritize and implement safety recommendations
- Not addressing staff burnout

1. The Joint Commission. (2021). *The essential role of leadership in developing a safety culture*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf

Three components of a culture of safety are the following[2]:

- **Just Culture:** People are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors.
- **Reporting Culture:** People report errors and near-misses.
- **Learning Culture:** The willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated.

The American Nurses Association further describes a culture of safety as one that includes openness and mutual respect when discussing safety concerns and solutions without shifting to individual blame, a learning environment with transparency and accountability, and reliable teams. In contrast, complexity, lack of clear measures, hierarchical authority, the "blame game," and lack of leadership are examples of barriers that do not promote a culture of safety. If staff fear reprisal for mistakes and errors, they will be less likely to report errors, processes will not be improved, and client safety will continue to be impaired. See the following box for an example of safety themes established during a health care institution's implementation of a culture of safety.

Safety Themes in a Culture of Safety[3]

2. The Joint Commission. (2021). *The essential role of leadership in developing a safety culture*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf

3. Institute of Medicine (US) Committee on the Work Environment for

Kaiser Permanente implemented a culture of safety in 2001 that focused on instituting the following six strategic themes:

- **Safe culture:** Creating and maintaining a strong safety culture, with client safety and error reduction embraced as shared organizational values.
- **Safe care:** Ensuring that the actual and potential hazards associated with high-risk procedures, processes, and client care populations are identified, assessed, and managed in a way that demonstrates continuous improvement and ultimately ensures that clients are free from accidental injury or illness.
- **Safe staff:** Ensuring that staff possess the knowledge and competence to perform required duties safely and contribute to improving system safety performance.
- **Safe support systems:** Identifying, implementing, and maintaining support systems—including knowledge-sharing networks and systems for responsible reporting—that provide the right information to the right people at the right time.
- **Safe place:** Designing, constructing, operating, and maintaining the environment of health care to enhance its efficiency and effectiveness.
- **Safe clients:** Engaging clients and their families in reducing medical errors, improving overall system safety

Nurses and Patient Safety. (2004). Creating and sustaining a culture of safety. In *Keeping patients safe: Transforming the work environment of nurses*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK216181

performance, and maintaining trust and respect.

A strong safety culture encourages all members of the health care team to identify and reduce risks to client safety by reporting errors and near misses so that root cause analysis can be performed and identified risks are removed from the system. However, in a poorly defined and implemented culture of safety, staff often conceal errors due to fear or shame. Nurses have been traditionally trained to believe that clinical perfection is attainable, and that "good" nurses do not make errors. Errors are perceived as being caused by carelessness, inattention, indifference, or uninformed decisions. Although expecting high standards of performance is appropriate and desirable, it can become counterproductive if it creates an expectation of perfection that impacts the reporting of errors and near misses. If employees feel shame when they make an error, they may feel pressure to hide or cover up errors. Evidence indicates that approximately three of every four errors are detected by those committing them, as opposed to being detected by an environmental cue or another person. Therefore, employees need to be able to trust that they can fully report errors without fear of being wrongfully blamed. This provides the agency with the opportunity to learn how to further improve processes and prevent future errors from occurring. For many organizations, the largest barrier in establishing a culture of safety is the establishment of trust. A model called "Just Culture" has successfully been implemented in many agencies to decrease the "blame game," promote trust, and improve the reporting of errors.

Just Culture

The American Nurses Association (ANA) officially endorses the Just Culture model. In 2019 the ANA published a position statement on Just Culture, stating, "Traditionally, healthcare's culture has held individuals accountable for all errors or mishaps that befall clients under their care. By contrast, a Just Culture recognizes that individual practitioners should not be held

accountable for system failings over which they have no control. A Just Culture also recognizes many individual or 'active' errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts 'no blame' as its governing principle, a Just Culture does not tolerate conscious disregard of clear risks to clients or gross misconduct (e.g., falsifying a record or performing professional duties while intoxicated)."

The Just Culture model categorizes human behavior into three causes of errors. Consequences of errors are based on whether the error is a simple human error or caused by at-risk or reckless behavior.

- **Simple human error:** A simple human error occurs when an individual inadvertently does something other than what should have been done. Most medical errors are the result of human error due to poor processes, programs, education, environmental issues, or situations. These errors are managed by correcting the cause, looking at the process, and fixing the deviation. For example, a nurse appropriately checks the rights of medication administration three times, but due to the similar appearance and names of two different medications stored next to each other in the medication dispensing system, administers the incorrect medication to a client. In this example, a root cause analysis reveals a system issue that must be modified to prevent future errors (e.g., change the labelling and storage of look alike-sound alike medication).
- **At-risk behavior:** An error due to at-risk behavior occurs when a behavioral choice is made that increases risk where the risk is not recognized or is mistakenly believed to be justified. For example, a nurse scans a client's medication with a barcode scanner prior to administration, but an error message appears on the scanner. The nurse mistakenly interprets the error to be a technology problem and proceeds to administer the medication instead of stopping the process and further investigating the error message, resulting in the wrong dosage of a medication being administered to the client. In this case, ignoring the error message on the scanner can be considered "at-risk behavior" because the behavioral choice was considered justified by the nurse at

the time.

- **Reckless behavior:** Reckless behavior is an error that occurs when an action is taken with conscious disregard for a substantial and unjustifiable risk.[4] For example, a nurse arrives at work intoxicated and administers the wrong medication to the wrong client. This error is considered due to reckless behavior because the decision to arrive intoxicated was made with conscious disregard for substantial risk.

These examples show three different causes of medication errors that would result in different consequences to the employee based on the Just Culture model. Under the Just Culture model, after root cause analysis is completed, system-wide changes are made to decrease factors that contributed to the error. Managers appropriately hold individuals accountable for errors if they were due to simple human error, at-risk behavior, or reckless behaviors.

If an individual commits a simple human error, managers console the individual and consider changes in training, procedures, and processes. In the "simple human error" above, system-wide changes would be made to change the label and location of the medication to prevent future errors from occurring with the same medication.

Individuals committing at-risk behavior are held accountable for their behavioral choice and often require coaching with incentives for less risky behaviors and situational awareness. In the "at-risk behavior" example above where the nurse ignored an error message on the barcode scanner, mandatory training on using a barcode scanner and responding to errors would be implemented, and the manager would track the employee's correct usage of the barcode scanner for several months following training.

If an individual demonstrates reckless behavior, remedial action and/or

4. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

punitive action is taken.[5] In the "reckless behavior" example above, the manager would report the nurse's behavior to the state's Board of Nursing with mandatory substance abuse counseling to maintain their nursing license. Employment may be terminated with consideration of patterns of behavior.

A Just Culture in which employees aren't afraid to report errors is a highly successful way to enhance client safety, increase staff and client satisfaction, and improve outcomes. Success is achieved through good communication, effective management of resources, and an openness to changing processes to ensure the safety of clients and employees. The infographic in Figure 5.4[6] illustrates the components of a culture of safety and Just Culture.

5. American Nursing Association. (2010). *Position statement: Just culture*. https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf

6. "Just Culture Infographic.png" by Valeria Palarski 2020. Used with permission.

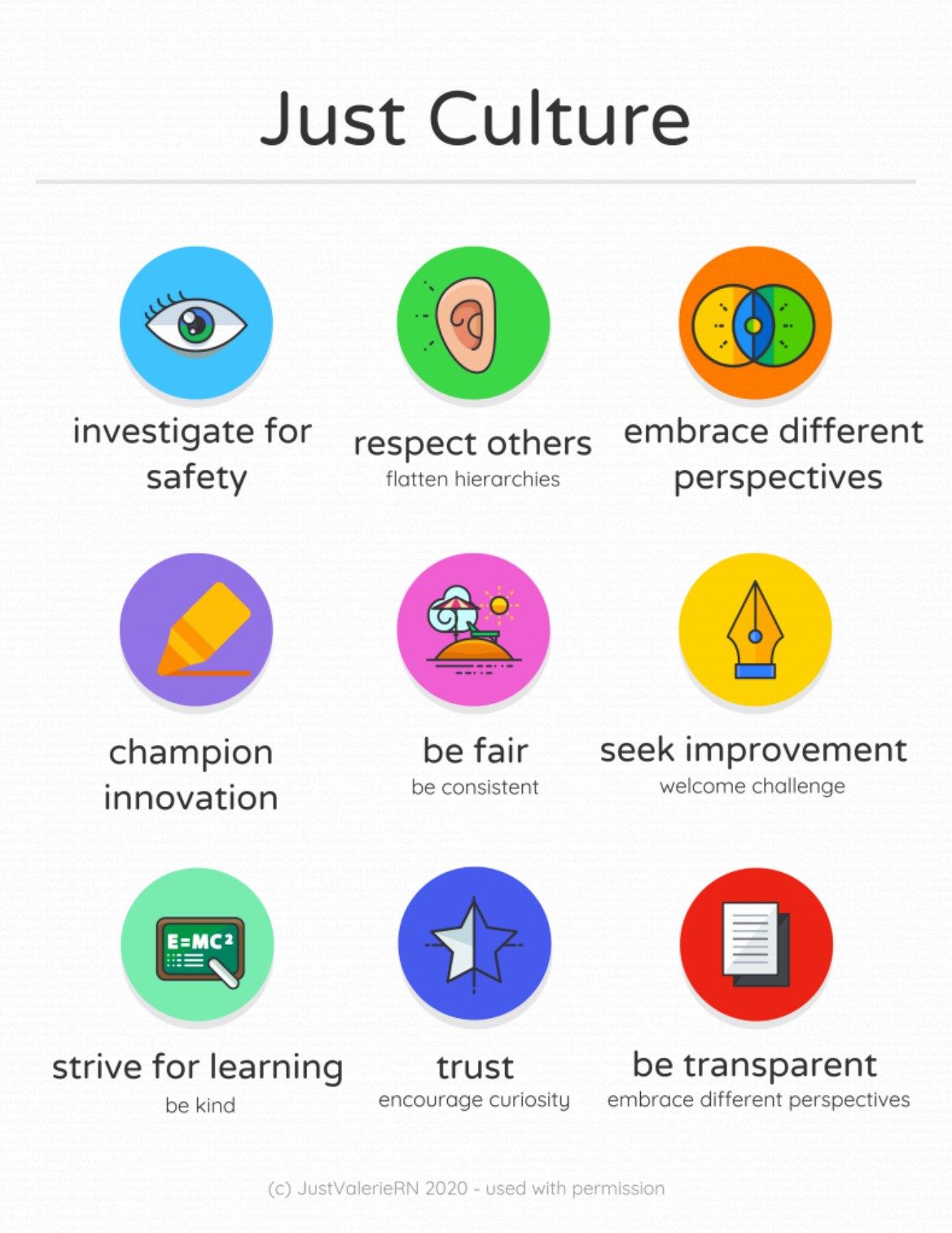

Figure 5.4 Just Culture. Used with permission.

The principles of culture of safety, including Just Culture, Reporting Culture, and Learning Culture are also being adopted in nursing education. It's

understood that mistakes are part of learning and that a shared accountability model promotes individual- and system-level learning for improved client safety. Under a shared accountability model, students are responsible for the following[7]:

- Being fully prepared for clinical experiences, including laboratory and simulation assignments
- Being rested and mentally ready for a challenging learning environment
- Accepting accountability for their part in contributing to a safe learning environment
- Behaving professionally
- Reporting their own errors and near mistakes
- Keeping up-to-date with current evidence-based practice
- Adhering to ethical and legal standards

Students know they will be held accountable for their actions, but will not be blamed for system faults that lie beyond their control. They can trust that a fair process will be used to determine what went wrong if a client care error or near miss occurs. Student errors and near misses are addressed based on an investigation determining if it was simple human error, an at-risk behavior, or reckless behavior. For example, a simple human error by a student can be addressed with coaching and additional learning opportunities to remedy the knowledge deficit. However, if a student acts with recklessness (for example, repeatedly arrives to clinical unprepared despite previous faculty feedback or falsely documents an assessment or procedure), they are appropriately and fairly disciplined, which may include dismissal from the program.[8]

7. Barnsteiner, J., & Disch, J. (2017). Creating a fair and just culture in schools of nursing. *American Journal of Nursing, 117*(11), 42-48. https;//doi.org/10.1097/01.NAJ.0000526747.84173.97.

8. Barnsteiner, J., & Disch, J. (2017). Creating a fair and just culture in schools of nursing. *American Journal of Nursing, 117*(11), 42-48. https://doi.org/ 10.1097/01.NAJ.0000526747.84173.97.

5.5 National Patient Safety Goals

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Every year, national safety goals are published by The Joint Commission to improve clientsafety. **National Patient Safety Goals** are goals and recommendations tailored to seven different types of health care agencies based on client safety data from experts and stakeholders. The seven health care areas include ambulatory health care settings, behavioral health care settings, critical access hospitals, home care, hospital settings, laboratories, nursing care centers, and office-based surgery settings. These goals are updated annually based on safety data and include evidence-based interventions. It is important for nurses and nursing students to be aware of the current National Patient Safety Goals for the settings in which they provide client care and use the associated recommendations.

The National Patient Safety Goals for nursing care settings (otherwise known as long-term care centers) are described in Table 5.5. (Note that the term “bedsore” is used in the last goal. This is a historic term for the current term “pressure injuries.”)

Table 5.5 National Patient Safety Goals for Nursing Care Centers[1]

1. The Joint Commission. (n.d.). *National patient safety goals*. https://www.jointcommission.org/standards/national-patient-safety-goals/

Goal	Recommendations and Rationale
Identify residents correctly	Use at least two ways to identify clients. For example, use the client's or resident's name and date of birth. This is done to make sure that each client gets the correct medication and treatment.
Use medicines safely	Take extra care with clients who take medications to thin their blood. Record and pass along correct information about a client's medications. Find out what medications the client is taking. Compare those medications to new medications prescribed for the client. Give the client written information about the medications they need to take. Tell the client it is important to bring their up-to-date list of medications every time they visit a doctor.
Prevent infection	Use the hand hygiene guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.
Prevent residents from falling	Find out which clients are most likely to fall. For example, is the client taking any medications that might make them weak, dizzy, or sleepy? Implement fall precautions for these clients.
Prevent bed sores	Find out which clients are most likely to have bed sores (i.e., pressure injuries). Take action to prevent pressure injuries in these clients at risk. Per agency protocol, frequently assess clients for pressure injuries.

- Read more about National Patient Safety Goals established by The Joint Commission.
- Read more details about how to identify clients correctly, administer medications safely, and prevent infection by visiting the following sections in Open RN Nursing Skills, 2e:
  - Initiating Patient Interaction
  - Aseptic Technique Basic Concepts
  - Basic Concepts of Administering Medications

Read more about “Pressure Injuries” (the current term used for “bed sores”) in the “Integumentary” chapter.

5.6 Preventing Falls

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"Prevent residents from falling" is one of the National Patient Safety Goals for nursing care centers. Client falls, whether in the nursing care center, home, or hospital, are very common and can cause serious injury and death. Older adults have the highest risk of falling. Each year, 3 million older people are treated in emergency departments for fall injuries, and over 800,000 clients a year are hospitalized because of a head injury or hip fracture resulting from a fall. Many older adults who fall, even if they're not injured, become afraid of falling. This fear may cause them to limit their everyday activities. However, when a person is less active, they become weaker, which further increases their chances of falling.[1]

Many conditions contribute to client falls, including the following:[2]

- Lower body weakness
- Vitamin D deficiency
- Difficulties with walking and balance
- Medications, such as tranquilizers, sedatives, antihypertensives, or antidepressants
- Vision problems
- Foot pain or poor footwear
- Environmental hazards, such as throw rugs or clutter that can cause tripping

1. Centers for Disease Control and Prevention. (2024). *Older adult fall prevention*. https://www.cdc.gov/falls/index.html
2. Centers for Disease Control and Prevention. (2024). *Older adult fall prevention*. https://www.cdc.gov/falls/index.html

Most falls are caused by a combination of risk factors. The more risk factors a person has, the greater their chances of falling. Many risk factors can be changed or modified to help prevent falls.

The Centers for Disease Control has developed a program called "STEADI – Stopping Elderly Accidents, Deaths & Injuries" to help reduce the risk of older adults from falling at home. Three screening questions to determine risk for falls are as follows:

- Do you feel unsteady when standing or walking?
- Do you have worries about falling?
- Have you fallen in the past year? If yes, how many times? Were you injured?

If the individual answers "Yes" to any of these questions, further assessment of risk factors is performed.[3]

> Read more about the CDC's STEADI initiative at STEADI – Stopping Elderly Accidents, Deaths & Injuries.
> Read more information about preventing falls in older adults at CDC's Older Adult Fall Prevention.

Fall Assessment Tools

By virtue of being ill, all hospitalized clients are at risk for falls, but some clients are at higher risk than others. Assessment is an ongoing process with the goal of identifying a client's specific risk factors and implementing interventions in their care plan to decrease their risk of falling. Commonly used fall assessment tools used to identify clients at high risk for falls are the Morse Fall Scale, the Hendrich II Fall Risk Model, and the Hester Davis Scale for fall risk assessment. Read more about these fall risk assessment tools

3. Centers for Disease Control and Prevention. (2024). STEADI – Older adult fall prevention. https://www.cdc.gov/steadi/index.html

using the hyperlinks provided below. Key risk factors for falls in hospitalized clients are as follows:[4]

- **History of falls:** All clients with a recent history of falls, such as a fall in the past three months, should be considered at higher risk for future falls.
- **Mobility problems and use of assistive devices:** Clients who have problems with their gait or require an assistive device (such as a cane or a walker) for mobility are more likely to fall.
- **Medications:** Clients taking several prescription medications or those taking medications that could cause sedation, confusion, impaired balance, or orthostatic blood pressure changes are at higher risk for falls.
- **Mental status:** Clients with delirium, dementia, or psychosis may be agitated and confused, putting them at risk for falls.
- **Continence:** Clients who have urinary frequency or who have frequent toileting needs are at higher fall risk.
- **Equipment:** Clients who are tethered to equipment such as an IV pole or a Foley catheter are at higher risk of tripping.
- **Impaired vision:** Clients with impaired vision or those who require glasses but who are not wearing them are at a higher fall risk because of their decreased recognition of an environmental hazard.
- **Orthostatic hypotension:** Clients whose blood pressure drops upon standing often experience light-headedness or dizziness that can cause falls.

View these common fall risk assessment tools:

4. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

- Morse Fall Scale[5]
- Hendrich II Fall Risk Model[6]
- Hester Davis Fall Prevention Program

Interventions to Prevent Falls

Universal fall precautions are established for all clients to reduce their risk for falling. In addition to universal fall precautions, a care plan is created based on the client's fall risk assessment findings to address their specific risks and needs.

Universal Fall Precautions

Falls are the most commonly reported client safety incidents in the acute care setting. Hospitals pose an inherent fall risk due to the unfamiliarity of the environment and various hazards in the hospital room that pose a risk. During inpatient care, nurses assess their clients' risk for falling during every shift and implement interventions to reduce the risk of falling. Universal fall precautions have been developed that apply to all clients all the time. Universal fall precautions are called "universal" because they apply to all

5. Agency for Healthcare Research and Quality. (2023). *Preventing falls in hospitals: Tool 3H: Morse Fall Scale for identifying fall risk factors*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/morse-fall-scale.html

6. The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers School of Nursing. (n.d.). *Assessment tools for best practices of care for older adults*. https://hign.org/consultgeri-resources/try-this-series

clients, regardless of fall risk, and revolve around keeping the client's environment safe and comfortable.[7]

Universal fall precautions include the following[8]:

- Familiarize the client with the environment.
- Have the client demonstrate call light use.
- Maintain the call light within reach. See Figure 5.5[9] for an image of a call light.
- Keep the client's personal possessions within safe reach.
- Have sturdy handrails in client bathrooms, rooms, and hallways.
- Place the hospital bed in the low position when a client is resting. Raise the bed to a comfortable height when the client is transferring out of bed.
- Keep the hospital bed brakes locked.
- Keep wheelchair wheels in a "locked" position when stationary.
- Keep non-slip, comfortable, and well-fitting footwear on the client.
- Use night lights or supplemental lighting.
- Keep floor surfaces clean and dry. Clean up all spills promptly.
- Keep client care areas uncluttered.
- Follow safe client handling practices.

7. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

8. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

9. "Hill-Rom_hospital_bed_TV_remote_control.JPG" by BrokenSphere is licensed under CC BY-SA 3.0.

Figure 5.5 Call Light

Interventions Based on Risk Factors

Fall prevention care planning is a process where the client's risk assessment information is translated into an action plan to specifically address the identified client needs, in addition to universal fall precautions. There are many interventions available to prevent falls and fall-related injuries based on the client's specific risk factors. See Table 5.6a for interventions categorized by risk factor.

Table 5.6a Interventions Based on Fall Risk Factors[10]

10. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

Risk Factor	Interventions
Altered Mental Status	Clients with new altered mental status should be assessed for delirium and treated by a trained nurse or physician. See a tool for assessing delirium below. For cognitively impaired clients who are agitated or trying to wander, more intense supervision (e.g., sitter or checks every 15 minutes) may be needed. Some hospitals implement designated safety zones that include low beds, mats for each side of the bed, nightlight, gait belt, and a "STOP" sign to remind clients not to get up. Clients with altered mental status should also have their medications reviewed, as medications can both contribute to agitation as well as help calm patients whose agitation is a threat to themselves or others or is interfering with the delivery of necessary care.
Impaired Gait or Mobility	Clients with impaired gait or mobility will need assistance with mobility during their hospital stay. All clients should have any needed assistive devices, such as canes or walkers, in good repair at the bedside and within safe reach. If clients bring their assistive devices from home, staff should make sure these devices are safe for use in the hospital environment. Even with assistive devices, clients often need staff assistance when transferring out of bed or walking. Use a gait belt when assisting clients to transfer or ambulate per agency policy.
Frequent Toileting Needs	Clients with frequent toileting needs should be taken to the toilet on a regular basis via a scheduled rounding protocol. Read more about scheduled rounding in the following subsection.
Visual Impairment	Clients with visual impairment should have clean corrective lenses easily within reach and applied when walking.
High-Risk Medications (medications that could cause sedation, confusion, impaired balance, orthostatic blood pressure changes, or cause frequent urination)	Clients on high-risk medications should have their medications reviewed by a pharmacist with fall risk in mind and recommendations made to the prescribing provider for discontinuation, substitution, or dose adjustment when possible. If a pharmacist is not immediately available, the prescribing provider should carry out a medication review. See Table 5.6b for a tool to review medications that may increase fall risk. Clients taking medications that can cause orthostatic hypotension should have their orthostatic blood pressure routinely monitored. The client and their caregivers should be educated about fall risk and steps to prevent falls when the client is taking these medications.
Frequent Falls	Clients with a history of frequent falls should have their risk for injury assessed, including checking for a history of osteoporosis and use of aspirin and anticoagulants.

Scheduled Hourly Rounding

Scheduled hourly rounds are scheduled hourly visits to each client's room to integrate fall prevention activities with client care. Scheduled hourly rounds have been found to greatly decrease the incidence of falls because the client's needs are proactively met, reducing the motivation for the client to get out of bed unassisted. See the box below for a list of activities to complete during hourly rounds. These activities can be completed by unlicensed assistive personnel, nurses, or nurse managers.[11]

Hourly Rounding Protocol[12]

- Assess client pain levels using a pain-assessment scale. (If staff other than a nurse is doing the rounding and the client is in pain, contact the nurse immediately so the client does not have to use the call light for pain medication.)
- Put pain medication that is ordered "as needed" on an RN's task list and offer the dose when it is due.
- Offer toileting assistance.
- Ensure the client is using correct footwear (e.g., specific shoes/slippers, no-skid socks).
- Check that the bed is in the locked position.
- Place the hospital bed in a low position when the client is

11. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

12. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

resting; ask if the client needs to be repositioned and is comfortable.

- Make sure the call light/call bell button is within the client's reach and the client can demonstrate accurate use.
- Put the telephone within the client's reach.
- Put the TV remote control and bed light switch within the client's reach.
- Put the bedside table next to the bed or across the bed.
- Put the tissue box and water within the client's reach.
- Put the garbage can next to the bed.
- Prior to leaving the room, ask, "Is there anything I can do for you before I leave?"
- Tell the client that a member of the nursing staff (use names on whiteboard) will be back in the room in an hour to round again.

Medications Causing Elevated Risk for Falls

Evaluate medication-related fall risk for clients on admission and at regular intervals thereafter. Add up the point value (risk level) in Table 5.6b for every medication the client is taking. If the client is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a client at risk, a pharmacist should review the client's list of medications and determine if medications may be tapered, discontinued, or changed to a safer alternative.[13]

13. Agency for Healthcare Research and Quality. (2024). *Preventing falls in*

Table 5.6b Medications Causing High Risk for Falls[14]

Point Value (Risk Level)	Medication Class	Fall Risks
3 (High)	Analgesics, antipsychotics, anticonvulsants, and benzodiazepines	Sedation, dizziness, postural disturbances, altered gait and balance, and impaired cognition
2 (Medium)	Antihypertensives, cardiac drugs, antiarrhythmics, and antidepressants	Induced orthostasis, impaired cerebral perfusion, and poor health status
1 (Low)	Diuretics	Increased ambulation and induced orthostasis
Score ≥ 6		Elevated risk for falls; ask pharmacist or prescribing provider to evaluate medications for possible modification to reduce risk

▸ View tools used to assess delirium and confusion in the Delirium Evaluation Bundle shared by the Agency for Healthcare Research and Quality.

hospitals. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

14. Agency for Healthcare Research and Quality. (2024). *Preventing falls in hospitals*. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/index.html

5.7 Restraints

OPEN RESOURCES FOR NURSING (OPEN RN)

Definition of Restraints

Restraints are devices used in health care settings to prevent clients from causing harm to themselves or others when alternative interventions are not effective. A restraint is a device, method, or process that is used for the specific purpose of restricting a client's freedom of movement without the permission of the person. See Figure 5.6[1] for an image of a simulated client with restraints applied.

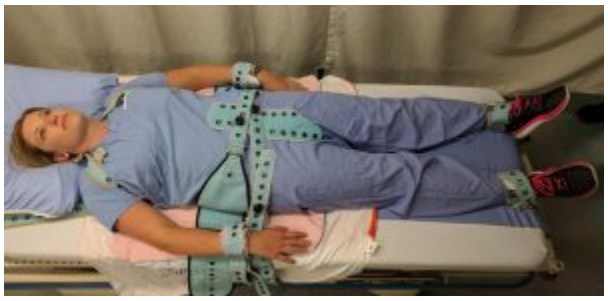

Figure 5.6 Restraints Used in a Psychiatric Setting

Restraints include mechanical devices such as a tie wrist device, chemical restraints, or seclusion. The Joint Commission defines **chemical restraint** as a drug used to manage a client's behavior, restrict the client's freedom of movement, or impair the client's ability to appropriately interact with their surroundings that is not standard treatment or dosage for the client's condition. It is important to note that the definition states the medication "is

1. "PinelRestraint.jpg" by James Heilman, MD is licensed under CC BY-SA 4.0

not standard treatment or dosage for the client's condition."[2] **Seclusion** is defined as the confinement of a client in a locked room from which they cannot exit on their own. It is generally used as a method of discipline for behavior that can cause harm to themselves or others, or as a method of decreasing environmental stimulation. Seclusion limits freedom of movement because, although the client is not mechanically restrained, they cannot leave the area.

Although restraints are used with the intention to keep a client safe, they impact a client's psychological safety and dignity and can cause additional safety issues and death. A restrained person has a natural tendency to struggle and try to remove the restraint and can fall or become fatally entangled in the restraint. Furthermore, immobility that results from the use of restraints can cause pressure injuries, contractures, and muscle loss. Restraints take a large emotional toll on the client's self-esteem and may cause humiliation, fear, and anger.

Restraint Guidelines

The American Nurses Association (ANA) has established evidence-based guidelines that state a restraint-free environment is the standard of care. The ANA encourages the participation of nurses to reduce client restraints and seclusion in all health care settings. Restraining or secluding clients is viewed as contrary to the goals and ethical traditions of nursing because it violates the fundamental client rights of autonomy and dignity. However, the ANA also recognizes there are times when there is no viable option other than restraints to keep a client safe, such as during an acute psychotic episode when client and staff safety are in jeopardy due to aggression or assault. The ANA also states that restraints may be justified in some clients with severe dementia or delirium when they are at risk for serious injuries such as a hip fracture due to falling.

2. The Joint Commission. (2024). *Joint Commission Online – July 17, 2024*. The Joint Commission. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/joint-commission-online/july-17-2024/

The ANA provides the following guidelines: "When restraint is necessary, documentation should be done by more than one witness. Once restrained, the client should be treated with humane care that preserves human dignity. In those instances where restraint, seclusion, or therapeutic holding is determined to be clinically appropriate and adequately justified, registered nurses who possess the necessary knowledge and skills to effectively manage the situation must be actively involved in the assessment, implementation, and evaluation of the selected emergency measure, adhering to federal regulations and the standards of The Joint Commission (2009) regarding appropriate use of restraints and seclusion."[3] Nursing documentation typically includes information such as client behavior necessitating the restraint, alternatives to restraints that were attempted, the type of restraint used, the time it was applied, the location of the restraint, and client education regarding the restraint.

Medical Restraints

Restraints used to manage nonviolent, non-self-destructive behaviors are referred to as **medical restraints**. Medical restraints may be appropriate to manage behavior such as the client attempting to remove life-sustaining tubes, drains, IV catheters, urinary catheters, or endotracheal tubes. These types of restraints often include hand mitts or soft wrist restraints. Medical restraints may also be used for clients attempting to get out of bed and as such are a high risk for falls. These types of restraints include siderails, vest restraints, and roll belts. Each facility is required to have a policy in place for the use of medical restraints. Policies typically include requirements for documentation of the reason for the restraint, alternative measures tried, type of restraint applied, behavioral criteria for removal of restraint, range of

3. American Nurses Association. (2012). *Position statement: Reduction of patient restraint and seclusion in health care settings*. https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/reduction-of-patient-restraint-and-seclusion-in-health-care-settings/

motion and cares while in restraints, and the date and time the restraint is applied or removed. A medical restraint requires a registered nurse to apply or supervise application of the restraint, a new order every 24 hours, and may never be issued as an as needed order. If the primary care provider did not order the restraint, they should be notified as soon as possible. Medical restraints are more commonly encountered in the general hospital setting rather than behavioral restraints.[4,5]

Behavioral Restraints

Restraints used to manage violent, self-destructive behaviors are referred to as **behavioral restraints**. Behavioral restraints are used when clients exhibit behaviors such as hitting or kicking staff or other clients, physically harming themselves or others, or threatening to do so. Behavioral restraints are used in emergency situations where safety concerns need to be immediately addressed to prevent harm.[6]

RNs need special training to apply behavioral restraints, including safe application of the restraint, maintaining personal safety, and techniques to de-escalate the violent or aggressive behavior. Behavioral restraints are typically used in mental health units, emergency departments, or critical care units. Similar to medical restraints, each agency must have a policy in place for the use of behavioral restraints. Health care facilities that accept Medicare

4. Rose, C. (2015). *Choosing the right restraint*. https://www.myamericannurse.com/choosing-restraints/

5. University Hospital. (n.d). *CMS regulations: Restraints and seclusion*. https://uhnj.org/mdstfweb/documents/CMS_Regulations_Restraints_Seclusion.pdf

6. Rose, C. (2015). *Choosing the right restraint*. https://www.myamericannurse.com/choosing-restraints/

and Medicaid reimbursement must also follow federal guidelines for the use of behavioral restraints that include the following:

Guidelines for the use of behavioral restraints include the following:

- When a restraint is the only viable option, it must be discontinued at the earliest possible time.
- Orders for the use of seclusion or restraint can never be written as a standing order or PRN (as needed).
- The treating physician must be consulted as soon as possible if the restraint or seclusion is not ordered by the client's treating physician.
- A physician or licensed independent practitioner must see and evaluate the need for the restraint or seclusion within one hour after the initiation.
- After restraints have been applied, the nurse should follow agency policy for frequent monitoring and regularly changing the client's position to prevent complications. Nurses must also ensure the client's basic needs (i.e., hydration, nutrition, and toileting) are met. Some agencies require a 1:1 client sitter when restraints are applied.[7]
- Each written order for a physical restraint or seclusion is limited to 4 hours for adults, 2 hours for children and adolescents ages 9 to 17, or 1 hour for clients under 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician or licensed independent practitioner (if allowed under state law) must see and assess the client before issuing a new order.[8]

7. Moore, G. P., Moore, M. J., & Imm, D. (2024). *The acutely agitated or violent adult: Overview, assessment, and nonpharmacological management*. UpToDate. https://www.uptodate.com/contents/assessment-and-emergency-management-of-the-acutely-agitated-or-violent-adult?csi=49b96b98-3589-484d-9a71-5c7a88d4fb72&source=contentShare

8. HealthPartners. (n.d.). *Patients' bill of rights (federal)*. https://www.healthpartners.com/care/hospitals/regions/patient-guest-support/federal-rights/

Side Rails and Enclosed Beds

Side rails and enclosed beds may also be considered a restraint, depending on the purpose of the device. Recall the definition of a restraint as "a device, method, or process that is used for the specific purpose of restricting a clients freedom of movement or access to movement without the permission of the person." If the purpose of raising the side rails is to prevent a client from voluntarily getting out of bed or attempting to exit the bed, then use of the side rails would be considered a restraint. On the other hand, if the purpose of raising the side rails is to prevent the client from inadvertently falling out of bed, or to help the client with repositioning, then it is not considered a restraint. If a client does not have the physical capacity to get out of bed, regardless if side rails are raised or not, then the use of side rails is not considered a restraint.[9]

Hand Mitts, Soft Limb Restraints, and Vest Restraints

A hand mitt is a large, soft glove that covers a confused client's hand to prevent them from inadvertently dislodging medical equipment. Hand mitts are considered a restraint by The Joint Commission if used under these circumstances[10]:

- Are pinned or otherwise attached to the bed or bedding
- Are applied so tightly that the client's hands or finger are immobilized
- Are so bulky that the client's ability to use their hands is significantly

9. The Joint Commission. (2020, June 29). *Restraint and seclusion – Enclosure beds, side rails, and mitts*. https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/provision-of-care-treatment-and-services-pc/000001668/

10. The Joint Commission. (2020, June 29). *Restraint and seclusion – Enclosure beds, side rails, and mitts*. https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/provision-of-care-treatment-and-services-pc/000001668/

reduced
- Cannot be easily removed intentionally by the client in the same manner it was applied by staff, considering the client's physical condition and ability to accomplish the objective

Soft limb restraints are a type of medical restraint that is designed to immobilize either one or both arms or legs through application around the wrist(s) or ankle(s). The restraint is made of a soft material designed to minimize the risk of pressure injuries or other injuries. Soft limb restraints are implemented to prevent inadvertent removal of tubes, drains, catheters, or other medical equipment by the client.[11]

Vest restraints are a type of mesh or cloth vest applied over the client's chest and tied to an immovable part of each side of the bed. The purpose of vest restraints is to prevent a client from getting out of bed and injuring themselves. As with any restraint, vest restraints should only be used for impulsive or confused clients when other alternatives are not effective, and not as a means of convenience.[12]

It is important for the nurse to be aware of current best practices and guidelines for restraint use because they are continuously changing. For example, meal trays on chairs were previously used in long-term care facilities to prevent residents from getting out of the chair and falling. However, by the definition of a restraint, this action is now considered a restraint and is no longer used. Instead, several alternative interventions to restraints are now being used.

Alternatives to Restraints

Many alternatives to using restraints in long-term care centers have been

11. Rose, C. (2015). *Choosing the right restraint*. https://www.myamericannurse.com/choosing-restraints/

12. Rose, C. (2015). *Choosing the right restraint*. https://www.myamericannurse.com/choosing-restraints/

developed. Most interventions focus on the individualization of client care and elimination of medications with side effects that cause aggression and the need for restraints. Common interventions used as alternatives to restraints include routine daily schedules, regular feeding times, intentional rounding, frequent toileting, and effective pain management.[13]

Diversionary techniques such as television, music, games, or looking out a window can also be used to help to calm a restless client. Encouraging restless clients to spend time in a supervised area, such as a dining room, lounge, or near the nurses' station, helps to prevent their desire to get up and move around. If these techniques are not successful, bed and chair alarms or the use of a sitter at the bedside are also considered alternatives to restraints.

13. Raveesh, B. N., Gowda, G. S., & Gowda, M. (2019). Alternatives to use of restraint: A path toward humanistic care. *Indian Journal of Psychiatry, 61*(Suppl 4), S693–S697. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482675/

5.8 Safety Considerations Across the Life Span

OPEN RESOURCES FOR NURSING (OPEN RN)

To promote safety for clients of all ages, nurses should be knowledgeable about safety risks according to age and developmental stages because the types and frequencies of accidents vary among age groups. Information from the Centers for Disease Control (CDC) regarding safety tips for each age group is summarized in the following subsections.[1]

Infants and Preschoolers

Motor vehicle accidents, falls, choking, drowning, and accidental poisoning are safety concerns for this age group. Infants and toddlers are curious, but they lack the judgement to recognize the dangers of their actions, so childproofing the home and providing adult supervision are essential for this developmental age group.[2] See Figure 5.7[3] for an image of an infant car seat used to protect infants in the event of a motor vehicle accident. Nurses help educate parents about the proper use, positioning, and installation of car seats.

1. Centers for Disease Control and Prevention. (2024). *Parent information*. https://www.cdc.gov/parents/index.html
2. Centers for Disease Control and Prevention. (2024). *Parent information*. https://www.cdc.gov/parents/index.html
3. "ARISE Newborn in Car Seat 144049.jpg" by ARISE project is licensed under CC BY 4.0

Figure 5.7 Infant Car Seat

School-Aged Children

In children aged 4-11, motor vehicle injuries are a major cause of unintentional injury, along with drowning and poisoning. This age group is more aware of dangers and limitations, but adult supervision is still important. The nurse should educate parents of school-aged children about safety seats, booster seats, or shoulder seat belts while riding in the car.[4]

Bicycle accidents are also a common concern in this age group. Many bike accidents involve the head or face because of the lack of helmet use. Nurses provide health teaching to school-aged children regarding bicycle safety and helmet use. See Figure 5.8[5] for an image of a girl wearing a bike helmet.

4. Centers for Disease Control and Prevention. (2024). *Parent information*. https://www.cdc.gov/parents/index.html

5. "539478754.jpg" by thechatat is used under license from Shutterstock.com

Figure 5.8 Bike Helmet

Because this age group is beginning to enjoy more independence, basic instructions and education on how to recognize and respond to potentially dangerous situations with strangers should also be provided. Parents should also be educated about the AMBER alert system that can be activated if a child is missing and believed to be kidnapped or in danger. This AMBER alert system uses the resources of law enforcement and the media to notify the public about a possible abduction or a missing child in danger.[6]

Nurses must also be aware of signs of maltreatment and child abuse because millions of children are affected each year. Child abuse includes physical, sexual, emotional abuse, and neglect. According to the American Academy of Child and Adolescent Psychiatry (AACAP), after abuse or violence, many children develop mental health problems, including depression and post-traumatic stress disorder. These children may also have serious medical problems, learning problems, and problems getting along with friends and

6. Amber Alert. https://amberalert.ojp.gov/

family members. Every state has laws that require health care professionals to report suspected child abuse no matter what form this abuse takes.[7]

> Read more about trauma and child abuse at the AACAP Trauma and Child Abuse Resource Center.

Adolescents

Motor vehicle accidents are the number one cause of death for adolescents. Teens aged 16-19 are three times more likely to be in a fatal crash than drivers older than age 20. Adolescent males are twice as likely to die in a motor vehicle accident than females of the same age. Texting while driving is a common cause of distracted driving and accidents in adolescents. Because much of an adolescent's time is spent away from the home, it is difficult for parents to control many of the decisions that adolescents make. Nurses educate teenagers to use seat belts, obey speed limits, and never use a cell phone or text while driving.[8] See Figure 5.9[9] for an image reminding teenage drivers to not text and drive.

7. American Academy of Child & Adolescent Psychiatry. (2024). *Trauma and child abuse resource center*. https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Child_Abuse_Resource_Center/Home.aspx
8. Centers for Disease Control and Prevention. (2024). *Parent information*. https://www.cdc.gov/parents/index.html
9. "texting-while-driving/man-texting-while-driving-md.jpg" by unknown at QuoteInspector.com is licensed under CC BY-ND 4.0.

Figure 5.9 No Texting While Driving

Traumatic brain injuries (TBI) may occur in this age group due to participation in sports and recreation-related activities. TBI results from a blow, jolt, or hit to the head that causes a disruption in blood function or flow to the brain. Nurses should always be alert for indications of a concussion when a sports injury has occurred. Signs of a concussion requiring immediate medical attention include the following:

- Headache, vomiting, balance problems, fatigue, or drowsiness
- A dazed and confused appearance or difficulty concentrating or remembering; confusion
- Emotional irritability, nervousness, or a change in personality

The CDC has comprehensive information and education materials for parents, coaches, players, and health care providers as part of their "Heads Up" program.[10]

Substance abuse is another significant concern in the adolescent population and includes substances such as tobacco, alcohol, illicit drugs, prescription medication, over-the-counter medications, and bath salts. The

10. Centers for Disease Control and Prevention. (2024). *Helmet safety*. https://www.cdc.gov/headsup/helmets/index.html

National Institutes of Health provides many resources for educating teens and their parents about substance abuse.[11]

Adults

Intimate partner violence and substance abuse are common safety issues in the adult population.

Intimate Partner Violence

Intimate partner violence (IPV) is widespread in the United States and is the most prevalent adult safety issue. Intimate partner violence includes physical or sexual violence, stalking, and psychological or coercive aggression by current or former intimate partners. Victims can be female or male, and sexual orientation can be heterosexual or LGBTQ+. The nurse is often the initial health care professional in contact with a victim of IPV. Prompt recognition of a potential or actual threat to client and staff safety is crucial. It is often the nurse's assessment that plays an important role in identifying a client experiencing IPV. Compassion and understanding are important to show to this vulnerable population. Effective communication is necessary to help victims come forward and share their experiences of abuse. IPV is a complex issue, and the client may not initially consider leaving the abuser as an option. See Figure 5.10[12] for an image of a sign in a community demonstrating support against domestic violence.

11. National Institute on Drug Abuse. (n.d.). *NIDA for teens*. https://teens.drugabuse.gov/

12. "Domestic_violence_free-zone.jpg" by Ben Pollard is licensed under CC BY-SA 2.0

Figure 5.10 Community Sign Against IPV

See the following tools and resources to share with clients experiencing IPV. For example, the Danger Assessment Tool is a self-administered survey that is free to use and is available in several languages.[13] Nurses can refer clients experiencing IPV to the National Center on Domestic Violence, the Trauma and Mental Health database for resources,[14] and the National Domestic Violence Hotline for free, confidential support.[15] Most importantly, nurses should assist clients experiencing IPV to create a safety plan.

13. Danger Assessment. (n.d.). *View the Instrument*. Danger Assessment: DA Tools. https://www.dangerassessment.org/DATools.aspx

14. National Center on Domestic Violence, Trauma & Mental Health. (n.d.). *National domestic violence organizations*. http://www.nationalcenterdvtraumamh.org/resources/national-domestic-violence-organizations/

15. U.S. Department of Justice. (2024). *National Domestic Violence Hotline*. The Hotline. https://www.thehotline.org/

View the tools and resources available at these hyperlinks to share with individuals experiencing intimate partner violence:

- Danger Assessment Tool
- National Center on Domestic Violence, Trauma & Mental Health
- National Domestic Violence Hotline

Substance Abuse

Substance abuse is defined by the World Health Organization (WHO) as a maladaptive pattern of using alcohol and/or drugs despite it causing persistent social, occupational, psychological, or physical problems that can be physically hazardous. Substance misuse continues to be a safety issue that affects adults across all socioeconomic levels. In 2022, over 108,000 people died in the United States as a result of an opioid overdose.[16] Misuse of prescription pain medication (such as oxycontin and fentanyl) and street drugs like heroin is a national crisis that plagues social and economic welfare. Substance misuse not only affects an individual, but also causes harm to their family members. Early identification of substance use disorders, rehabilitation interventions, and continued support are key for helping the individual, as well as their family members, in the recovery process. See Figure 5.11[17] for an image of a heroin needle found in a community setting.

16. Centers for Disease Control and Prevention. (2024). *Overdose Prevention*. https://www.cdc.gov/overdose-prevention/

17. "Heroin syringe" by Thomas Marthinsen is licensed under CC BY-NC-SA 2.0

Figure 5.11 Substance Abuse in the Community

Older Adults

According to the Centers for Disease Control and Prevention, falls and motor vehicle accidents are leading causes of injury in older adults. However, several other issues pose significant hazards for this population, such as fires, accidental overdosing on medications, elder abuse, and financial exploitation.[18]

In most reported cases of elder abuse, a caregiver or a person in trusted relationship is the perpetrator. For various reasons such as fear and disappointment, most of these cases go unreported. Abuse, including neglect and exploitation, is experienced by about 1 in 10 people aged 60 and older who live at home. From 2002 to 2016, more than 643,000 older adults were treated in the emergency department for nonfatal assaults and over 19,000 homicides occurred.[19] Read an example of an older adult experiencing financial exploitation in the following box.

18. Centers for Disease Control and Prevention (n.d.). *Injury prevention and control*. https://www.cdc.gov/injury/index.html

19. Centers for Disease Control and Prevention (n.d.). *Elder abuse*. https://www.cdc.gov/violenceprevention/elderabuse/

Financial Exploitation of an Older Adult

Consider the story of John, a 92-year-old male who lost his wife over a year ago and has been lonely ever since. He lives alone in a large home in the country. John hired a repairman to fix his roof. The repairman befriended John, bringing him homemade cookies and pies and even running errands for him. The repairman often stayed for coffee, and the two of them spent time talking about fishing and gardening. The repairman convinced John to take out a reverse mortgage to pay for additional improvements on his home. Then, knowing John's bank account numbers and login information, the repairman stole $250,000 that John received for his reverse mortgage.

Most victims of elder abuse are frequently seen in the emergency department several times before they are admitted to the hospital. Nurses must be alert to any indications of elder abuse, such as suspicious injuries or behaviors, and report suspected incidents to local adult protective services agencies. Commons signs of elder abuse or maltreatment include the following[20]:

- Bruises, cuts, burns, or broken bones that are unexplainable or suspiciously explained
- Malnourishment or weight loss
- Poor hygiene, an unkempt appearance, unclean clothing, or dirty, matted hair
- Foul odor from clothing or body
- Anxiety, depression, or confusion
- Unexplained transactions or loss of money
- Withdrawal from family members or friends

▶ Download the Elder Mistreatment Assessment tool from The Hartford Institute for Geriatric Nursing.[21]

20. Nursing Home Abuse Center. (2020). *Signs of elder abuse*. https://www.nursinghomeabusecenter.com/elder-abuse/signs/

View additional resources related to elder abuse in the following box.

Additional resources for older adults suspected as being victims of elder abuse:

- NAPSA Help in Your Area
- Financial Exploitation of Older Adults
- National Clearinghouse on Abuse in Later Life (NCALL)

21. The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers School of Nursing. (n.d.). *Assessment tools for best practices of care for older adults*. https://hign.org/consultgeri-resources/try-this-series

5.9 Environmental Safety

OPEN RESOURCES FOR NURSING (OPEN RN)

In addition to promoting safety for clients and their families, it is important for nurses to be aware of safety risks in the environments and to take measures to protect themselves. Common safety risks to nurses include sharps injuries, exposure to blood-borne pathogens, lifting injuries, and lack of personal protective equipment (PPE).

Workplace Safety

The World Health Organization (WHO) defines a **healthy environment** as a place of physical, mental, and social well-being supporting optimal health and safety. The American Nurses Association (ANA) created the Nurses' Bill of Rights, a document that sets forth seven basic principles concerning expectations for workplace environments. One of the ANA principles states, "Nurses have the right to a work environment that is safe for themselves and their patients."[1] *Environmental Health* is also one of the ANA Standards of Professional Performance. This standard includes "creating a safe and healthy workplace and professional environment."[2]

Preventing Sharps Injuries and Blood-Borne Pathogen Exposure

Exposure to sharps and blood-borne pathogens is a critical safety issue that

1. American Nurses Association. (n.d.). *Healthy work environment*. https://www.nursingworld.org/practice-policy/work-environment/
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

nurses face in the workplace.[3] Blood-borne pathogen exposure can cause life-threatening illnesses such as hepatitis B, hepatitis C, and HIV. Regulations and laws, such as the Blood-borne Pathogen Standard from the Occupational Safety and Health Administration (OSHA) and the Needlestick Safety and Prevention Act of 2002, have been effective in significantly reducing sharps injuries and blood exposures among health care workers. Areas covered by these regulations include sharps disposal practices, evaluation and selection of safety-engineered sharps devices and personal protective equipment (PPE), training, record keeping for needlestick injuries, hepatitis B vaccination, and post exposure follow-up. Medical device manufacturers have also played an important role in reducing sharps injury risks to health care workers by developing innovative safety-engineered technology, such as needleless IV access devices.[4] While substantial progress has been made to reduce injuries, preventable sharps injuries and blood exposures continue to occur in health care settings. According to the Centers for Disease Control and Prevention (CDC), around 385,000 sharps-related injuries occur annually among health care workers in hospitals, but it has been estimated that as many as half of injuries go unreported.[5] See Figure 5.12[6] for an image of a sharps container used to prevent sharps-related injuries.

3. American Nurses Association. (n.d.). *Healthy work environment*. https://www.nursingworld.org/practice-policy/work-environment/

4. American Nurse. (2012). *Moving the sharps safety agenda forward: Consensus statement and call to action*. https://www.myamericannurse.com/moving-the-sharps-safety-agenda-forward-consensus-statement-and-call-to-action/

5. American Nurses Association. (n.d.). *Healthy work environment*. https://www.nursingworld.org/practice-policy/work-environment/

6. "Sharps Container.jpg" by William Rafti of the William Rafti Institute is licensed under CC BY 2.5

Figure 5.12 Sharps Container

> Read more information about evidence-based practices to prevent needlestick injuries in the "Administration of Parental Medications" chapter in Open RN *Nursing Skills, 2e*.

> Read more information from OSHA about "Protecting Yourself When Handling Contaminated Sharps."

If you do experience a sharps injury or are exposed to the blood or other body fluid of a client, follow agency and school policy and immediately follow these steps according to the injury site[7]:

- Wash puncture and small wounds with soap and water for 15 minutes.
- Apply direct pressure to lacerations to control bleeding and seek medical attention.
- Flush mucous membranes with water.
- Report the incident to your instructor or supervisor.
- Seek medical care to determine your risk associated with the exposure.

7. Centers for Disease Control and Prevention. (2019). *Stop sticks campaign*. *https://www.cdc.gov/nora/councils/hcsa/stopsticks/whattodo.html*.

Safe Client Handling

Back injuries and other musculoskeletal disorders can be caused by one bad client lift or from the daily wear and tear of manually lifting clients. At least 56% of nurses have reported pain from musculoskeletal disorders that were exacerbated by requirements of their job. Consequences of these injuries can be devastating to nurses and their careers; musculoskeletal injuries related to client handling are responsible for more lost work time, long-term medical care needs, and permanent disabilities than any other work-related injury. Even using proper body mechanics and the use of gait belts can result in client handling injuries in nurses and health care workers. The ANA has established safe patient handling and mobility initiatives with the goal of complete elimination of manual patient handling.[8] See Figure 5.13[9] for an example of safe client handling equipment.

8. American Nurses Association. (2015). *Safe patient handling & mobility: Understanding the benefits of a comprehensive SPHM program* [Brochure]. https://www.nursingworld.org/~498de8/globalassets/practiceandpolicy/work-environment/health–safety/ana-sphmcover__finalapproved.pdf

9. "User-Integra-lifter1.jpg" by Integracp is licensed under CC BY-SA 3.0

Figure 5.13 Safe Patient Handling Equipment

Read more about Safe Patient Handling and Mobility from the American Nurses Association.

View these videos on safe client handling and mobility from the ANA:

Preventing Nurse Injuries[10]

10. American Nurses Association. (2015, July 7). *Preventing nurse injuries* [Video]. YouTube. All rights reserved. https://youtu.be/qJH-91w5PHA

ANA Presents Safe Patient Handling and Mobility[11]

Personal Protective Equipment

The Occupational Safety and Health Administration (OSHA) requires employers to provide personal protective equipment (PPE) to their workers and ensure its proper use.[12] In health care settings, the use of PPE includes gloves, gowns, goggles, face shields, and N95 respirators according to a client's condition. Health care workers rely on personal protective equipment to protect themselves and their clients from being infected and infecting others. It is vital to follow agency procedures regarding PPE and transmission precautions to avoid exposure to infectious disease. See Figure 5.14[13] for an image of health care team members wearing PPE. Unfortunately, the COVID-19 pandemic created global shortages of PPE, resulting in many nurses and health care workers being exposed to the fatal disease. The ANA continues to advocate for adequate PPE for nurses in their work environments. Review additional information about PPE using the hyperlink below.

11. American Nurses Association. (2016, April 6). *ANA presents safe patient handling and mobility* [Video]. YouTube. All rights reserved. https://youtu.be/Bss2VEvrdcw

12. United States Department of Labor. (n.d.). *Personal protective equipment*. Occupational Safety and Health Administration. https://www.osha.gov/personal-protective-equipment

13. "Healthcare_workers_wearing_PPE_03.jpg" by Javed Anees is licensed under CC0 1.0

Read more about PPE and transmission precautions in the "Aseptic Technique" chapter of Open RN *Nursing Skills, 2e*.

Figure 5.14 Personal Protective Equipment

Fire Safety

Health care workers are required to understand fire safety in terms of what to do in the event of a fire, where fire alarms and fire extinguishers are located and how to access them, and where fire doors and fire exits are located. Fire safety is such a crucial aspect of safe client care that The Joint Commission and Centers for Medicare and Medicaid have mandated that all health care facilities receiving Medicare or Medicaid reimbursement must have a fire response plan, fire safety training for staff members, and functioning fire response equipment, such as fire alarms, fire extinguishers, overhead sprinkler systems, and clearly identified fire exit doors. The Joint Commission requires that facilities routinely conduct fire alarm drills as a means of practicing what to do in the event of a fire. These drills must be audited and documented with areas for improvements noted and addressed.[14]

14. The Joint Commission. (2024). *Fire protection: Clinical impact*.

RACE and PASS

Fire safety revolves around the acronyms RACE and PASS. RACE is an acronym that tells people what to do in the event of a fire. PASS is an acronym that tells people how to use a fire extinguisher correctly. Both acronyms are described below.

RACE stands for **R**escue, **A**ctivate, **C**onfine, and **E**xtinguish[15]:

- **Rescue:** Rescue anyone in immediate danger. This includes removing clients from the immediate vicinity of the fire, as well as yourself. Maintain your safety while rescuing clients so you do not become a fire victim. This becomes especially important to keep in mind if the fire is between you and the client.
- **Activate:** Activate the fire alarm. This allows others to realize there is a fire or potential fire so that safety measures can begin immediately. Sometimes the activate step is also stated as "Alarm."
- **Confine:** Confine the fire by closing doors and windows. This includes closing fire doors to help prevent the fire from breaching one fire zone and encroaching on another.
- **Extinguish or Evacuate:** Extinguish small fires if possible. Again, maintain your safety before trying to extinguish a fire. If the fire cannot be easily extinguished, then evacuate the fire zone or the building if necessary.

PASS stands for **P**ull, **A**im, **S**queeze, and **S**weep[16]:

https://www.jointcommission.org/resources/the-physical-environment/fire-protection/clinical-impact/

15. Whitlock, M., & Boone, W. (2014). Improving fire safety in an ambulatory setting. *Nursing 44*(8), 67. https://doi.org/10.1097/01.NURSE.0000451537.40340.d0

16. Whitlock, M., & Boone, W. (2014). Improving fire safety in an ambulatory

- **Pull:** Pull the pin on the fire extinguisher handle. This action is necessary to allow the handle to be depressed and allow fire extinguisher contents to be released.
- **Aim:** Aim low towards the base of the fire with the fire extinguisher nozzle or hose. It is important to aim the fire extinguisher contents to the base of the fire because this is what will extinguish the fire through smothering. The top part of the fire will not be smothered by the fire extinguisher contents because it is too large and spread out
- **Squeeze:** Squeeze down on the handle of the fire extinguisher to depress it and allow contents to be released from the extinguisher.
- **Sweep:** Sweep the hose or nozzle from side to side as the fire extinguisher contents are being sprayed on the base of the fire. This helps to fully cover the base of the fire in the hope of extinguishing it. Continue sweeping the fire extinguisher nozzle, spraying contents at the base of the fire until the fire is extinguished, or the fire extinguisher is empty. If the fire reignites, begin the steps of RACE and PASS again.

Safety Data Sheets

Safety Data Sheets (SDS), formerly referred to as Material Safety Data Sheets (MSDS), are hazardous communication sheets that let workers know certain information about chemicals they encounter in the workplace. OSHA requires that SDS's are readily available and easily readable for each chemical in the workplace. SDS include the following mandatory information[17]:

- Section 1: Identification of the chemical and recommended uses, along with the contact information of the supplier.
- Section 2: Hazard(s) identification, classification of the chemical, and

setting. *Nursing 44*(8), 67. https://doi.org/10.1097/01.NURSE.0000451537.40340.d0

17. OSHA. (2012). *Hazardous communication standard: Safety data sheets*. https://www.osha.gov/sites/default/files/publications/OSHA3514.pdf

warning information about the hazards present.

- Section 3: Composition and information about ingredients contained in the product, including the chemical name, concentration, and impurities or stabilizing additives that may be present in the product.
- Section 4: First aid measures, including initial care for individuals who have been exposed to the chemical by varying routes.
- Section 5: Firefighting measures, including type of extinguishing equipment required and hazardous combustion products produced if the chemical burns.
- Section 6: Accidental release measures, including and appropriate response to spills or leaks and associated cleanup recommendations.
- Section 7: Handling and storage recommendations for the chemical.
- Section 8: Exposure controls and personal protection required for the chemical.
- Section 9: Physical and chemical properties of the substance.
- Section 10: Stability and reactivity hazards of the chemical.
- Section 11: Toxicological information, including health effects of exposure to the chemical and whether these are immediate, delayed, or chronic effects. Symptoms associated with exposure are also included.

▸ Read more about SDS requirements in this OSHA Brief.

▸ Explore the *Healthy Work Environment* web page by the American Nursing Association (ANA) for additional strategies that promote safe work environments for nurses, including the Nurses' Bill of Rights and ways to put this plan into action.

5.10 Putting It All Together

Client Scenario

Mr. Olson is a 64-year-old client admitted to the medical-surgical floor with a diagnosis of pneumonia. The client has severe macular degeneration and limited visual acuity. He is alert and oriented but notes that he has suffered a "few stumbles" at home over the last few weeks. He ambulates without assistance but relies heavily on tactile cues to help provide guidance.

Applying the Nursing Process

Assessment: The nurse notes that Mr. Olson's macular degeneration and limited visual acuity pose a significant safety risk. He has reported "stumbling" at home and uses tactile cues to establish room boundaries.

Based on the assessment information that has been gathered, the following nursing care plan is created for Mr. Olson.

Nursing Diagnosis: *Risk for Injury AMB altered visual acuity, stumbling at home, and using tactile cues to mobility.*

Overall Goal: *The client will be free from falls.*

SMART Expected Outcome: *Mr. Olson will be free from falls throughout his hospitalization.*

Planning and Implementing Nursing Interventions:

The nurse will provide the client with education regarding the room layout and tactile boundary cues. The nurse will keep the client's room free from clutter and provide appropriate lighting. The nurse will instruct the client to utilize the call light and request assistance when ambulating throughout the room. The nurse will provide the client with nonskid footwear to enhance safety during ambulation.

Sample Documentation:

Mr. Olson is at risk for falls as a result of his decreased visual acuity and hospitalization in an unfamiliar environment. The client has been provided education and safety equipment to decrease his risk of injury. The client has

received education regarding the room layout and has been encouraged to request assistance when ambulating about the room.

Evaluation:

During the client's hospitalization, Mr. Olson utilizes the recommended safety equipment and requests assistance when ambulating and no falls occurred. SMART outcome was "met."

View a sample nursing care plan for this scenario that was created using the template found in Appendix B.

5.11 Learning Activities

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Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

Assessing a client's risk for falls and planning interventions to prevent falls are common safety strategies completed by nurses. This section uses a client scenario to demonstrate how to use the nursing process to assess a client and then create a nursing care plan to prevent falls. Begin by reading the Handoff Report received from the nurse on the previous shift.

Figure 5.15 Simulated Client

Handoff Report

Mr. Moore is a 72-year-old widower recovering in the hospital after sustaining injuries he received from a fall at home. See Figure 5.15 for an image of Mr. Moore.[1] He fractured his right hip and underwent surgical repair two days ago. He is receiving IV fluids and morphine for pain control. He has a history of hypertension and cardiovascular disease. He wears glasses and hearing aids. Per recommendations from the physical therapist, he is able to transfer with one assist with a walker but is weak on his right side. He has an order to ambulate at least 100 feet four times daily with a wheeled walker. He is 6 feet tall and weighs 165 pounds. Prior to the fall, he lived at home alone

1. "old-man-1208210_960_720.jpg" by Free-Photos at Pixabay is licensed under CC0

independently, and he is looking forward to returning home.

Assessment

The nurse collects the following assessment findings:

- Vital Signs: Blood pressure 90/60, heart rate 56, respiratory rate 18, temperature 37 degrees Celsius, pulse oximetry reading 92%, current pain level 0
- Alert and oriented x 3 to person, place, and time
- Lungs clear
- Cardiovascular Assessment: Heart rate is regular, capillary refill less than 3 seconds in fingers and toes, pedal pulses 2+
- Right lower extremity strength is 1+ (weak)
- Ambulates with walker with assistance; gait is unsteady

Critical Thinking Questions

1. Describe the fall risk factors for Mr. Moore.

2. Use the Morse Fall Risk Scale to assess Mr. Moore's risk for falling.

Diagnosis

The NANDA-I nursing diagnosis is established: *Risk for Falls as evidenced by lower extremity weakness and difficulty with gait*.

Outcome Identification

Overall Goal: *Mr. Moore will remain free from falls during his hospitalization stay.*

SMART Expected Outcomes:

- *Mr. Moore will not experience a fall during hospitalization.*
- *Mr. Moore will correctly use his assistive device (walker) every time he ambulates during hospitalization.*

Planning Interventions

The following interventions are planned based on Mr. Moore's fall risk factors.

- Remove clutter from the floor.
- Provide adequate lighting with a night-light at the bedside.
- Use half side rails to prevent falls from the bed.
- Monitor gait, balance, and fatigue with ambulation and encourage resting as needed.
- Place personal items within easy reach of the client at the bedside.
- Provide an elevated toilet seat.
- Encourage the use of prescribed glasses and hearing aids when walking.

- Obtain orthostatic blood pressures daily and notify the provider as indicated.
- Ensure the client wears shoes that fit properly, are fastened securely, and have no-skid soles.
- Suggest home adaptations to improve safety after discharge, such as adjusting the toilet seat height, installing grab bars in the bathroom, and using a rubber mat in the shower.

Critical Thinking Question

3. What additional interventions could be implemented for Mr. Moore to reduce his risk of falls that target his specific risk factors?

Implementation of Interventions

The following day, upon entering the room, you find Mr. Moore has climbed out of bed and is on his way to the bathroom. He states, "I need to go to the bathroom for a bowel movement and didn't have time to ring the call light and wait." You assist him with his walker, but he seems unsteady on his feet as he walks toward the bathroom. You're not sure if he will make it to the toilet without falling. He says, "We need to hurry or I'm not going to make it."

Critical Thinking Question

4. What is the best response?

Evaluation

The nurse evaluates Mr. Moore's progress based on the established expected outcomes:

- *Mr. Moore will not experience a fall during hospitalization: Outcome Met.*
- *Mr. Moore will use his assistive device (walker) correctly during hospitalization: Outcome Partially Met.*

Mr. Moore forgets to call for assistance and uses a walker when he needs to go to the bathroom. A "stop" sign has been placed within client view to remind him to use the call light before getting up. In addition to hourly rounding, toileting will be performed at scheduled intervals every two hours. An icon has been posted on the doorframe to alert staff that the client is at high risk for falls. In addition to the bed being kept low and locked, a mat will be placed next to the bed at night. If Mr. Moore continues to forget to call for assistance, a bed alarm will be placed to alert staff of movement so that quick assistance can be offered.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=955#h5p-62

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=955#h5p-15

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://wtcs.pressbooks.pub/nursingfundamentals/?p=955#h5p-16

V Glossary

OPEN RESOURCES FOR NURSING (OPEN RN)

At-risk behavior: According to the Just Culture model, an error that occurs when a behavioral choice is made that increases risk where risk is not recognized or is mistakenly believed to be justified. (Chapter 5.4)

Behavioral restraints: Restraints used to manage violent, self-destructive behaviors such as hitting or kicking staff or other clients, physically harming themselves or others, or threatening to do so. Behavioral restraints are used in emergency situations where safety concerns need to be immediately addressed to prevent harm. (Chapter 5.7)

Chemical restraint: A drug used to manage a client's behavior, restrict the client's freedom of movement, or impair the client's ability to appropriately interact with their surroundings that is not a standard treatment or dosage for the client's condition. (Chapter 5.7)

Culture of safety: The behaviors, beliefs, and values within and across all levels of an organization as they relate to safety and clinical excellence, with a focus on people. (Chapter 5.4)

Handoff reports: A transfer and acceptance of client care responsibility achieved through effective communication. It is a real-time process of passing client specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the client's care. (Chapter 5.3)

Healthy environment: A place of physical, mental, and social well-being supporting optimal health and safety. (Chapter 5.9)

Human factors: A science that focuses on the interrelationships between humans, the tools and equipment they use in the workplace, and the environment in which they work. (Chapter 5.2)

Intimate Partner Violence (IPV): Physical or sexual violence, stalking, and psychological or coercive aggression by current or former intimate partners. (Chapter 5.8)

ISBARR: A mnemonic for the components of health care team member

communication that stands for Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back. (Chapter 5.3)

Just Culture: A quality of an institutional culture of safety where people are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors. (Chapter 5.4)

Learning Culture: A quality of an institutional culture of safety that demonstrates the willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated. (Chapter 5.4)

Medical restraints: Restraints used to manage nonviolent, non-self-destructive behaviors such as the client attempting to remove life-sustaining tubes, drains, IV catheters, urinary catheters, or endotracheal tubes. (Chapter 5.7)

National Patient Safety Goals: Annual safety goals and recommendations tailored for seven different types of health care agencies based on client safety data from experts and stakeholders. (Chapter 5.5)

Near misses: An error that has the potential to cause an adverse event (client harm) but fails to do so because of chance or because it is intercepted. (Chapter 5.2)

Never events: Adverse events that are clearly identifiable, measurable, serious (resulting in death or significant disability), and preventable. (Chapter 5.2)

PASS: A mnemonic for actions to take when using a fire extinguisher, including Pull, Aim, Squeeze, and Sweep. (Chapter 5.9)

RACE: A mnemonic for actions to immediately take during a fire, standing for Rescue, Activate, Confine, and Extinguish. (Chapter 5.9)

Reckless behavior: According to the Just Culture model, an error that occurs when an action is taken with conscious disregard for a substantial and unjustifiable risk. (Chapter 5.4)

Reporting Culture: A quality of an institutional culture of safety where people report errors and near misses. (Chapter 5.4)

Restraint: A device, method, or process that is used for the specific purpose

of restricting a client's freedom of movement without the permission of the person. (Chapter 5.7)

Root cause analysis: A structured method used to analyze serious adverse events to identify underlying problems that increase the likelihood of errors, while avoiding the trap of focusing on mistakes by individuals. (Chapter 5.2)

Safety Data Sheets (SDS): Safety Data Sheets, formerly referred to as Material Safety Data Sheets (MSDS), are hazardous communication sheets that let workers know certain information about chemicals they encounter in the workplace. OSHA requires that SDS's are readily available and easily readable for each chemical in the workplace. (Chapter 5.9)

Scheduled hourly rounds: Scheduled hourly visits to each client's room to integrate fall prevention activities with the rest of a client's care. (Chapter 5.6)

Seclusion: The confinement of a client in a locked room from which they cannot exit on their own. It is generally used as a method of discipline for behavior that can cause harm to themselves or others, or as a way to decrease environmental stimulation. (Chapter 5.7)

Sentinel event: A client safety event that reaches a client and results in death, permanent harm, or severe temporary harm requiring interventions to sustain life. (Chapter 5.2)

Simple human error: According to the Just Culture model, this is an error that occurs when an individual inadvertently does something other than what should have been done. Most errors are the result of human error due to poor processes, programs, education, environmental issues, or situations. These are managed by correcting the cause, looking at the process, and fixing the deviation. (Chapter 5.4)

Substance abuse: A maladaptive pattern of continued use of alcohol or a drug despite it causing persistent social, occupational, psychological, or physical problems that can be physically hazardous. (Chapter 5.8)

Universal fall precautions: A set of interventions to reduce the risk of falls for all clients and focus on keeping the environment safe and comfortable. (Chapter 5.6)

PART VI

COGNITIVE IMPAIRMENTS

6.1 Cognitive Impairments Introduction

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Learning Objectives

- Identify risk factors for cognitive impairments
- Identify cues related to cognitive impairments across the life span
- Identify evidence-based interventions to support diverse clients (individual, family, or group) with cognitive impairments
- Contribute to a plan of care for clients with cognitive and sensory impairments
- Include adaptations to the environment to maintain safety for the client with impaired cognition
- Incorporate nursing strategies to maximize cognitive functioning
- Outline resources for clients with a cognitive impairment and their family members or caregivers

Cognition is the term used to describe our ability to think. As humans, we are continually receiving input from the world around us and making decisions about how to respond. Some of these decisions are made with awareness, while others are reflexive responses. For example, cognitive development in

infants is based on their experiences with their environment. Cognitive processes continue to develop throughout childhood, adolescence, and adulthood as we learn how to adapt and use knowledge to solve problems and reach desired outcomes.

Many factors can influence an individual's continuously evolving cognitive function from fetal development through adulthood. For example, diseases and health conditions can impair a person's cognitive development and functioning during childhood and beyond. Impaired ability to think and make decisions can be temporarily affected by things such as infection, alcohol, drugs and medications, poor oxygenation, stress, or grief. Sensory deprivation and sensory overload can also affect an individual's ability to process information. (See the "Sensory Impairments" chapter for more information on this topic.)

Nurses monitor for changes in mental status and report them to health care providers to assist in the diagnosis and treatment for underlying causes of impairment. This chapter will review cognitive development, as well as common acute and chronic cognitive impairments in adults.

6.2 Basic Concepts

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Before learning about cognitive impairment, it is important to understand the physiological processes of normal growth and development. **Growth** includes physical changes that occur during the development of an individual beginning at the time of conception. **Development** encompasses these biological changes, as well as social and cognitive changes that occur continuously throughout our lives. Cognition starts at birth and continues throughout the life span. See Figure 6.1[1] for an image of the human life cycle.

Figure 6.1 Human Life Cycle

There are multiple factors that affect human cognitive development. While there are expected milestones along the way, cognitive development encompasses several different skills that develop at different rates. Cognition takes the form of many paths leading to unique developmental ends. Each human has their own individual experience that influences development of intelligence and reasoning as they interact with one another. With these

1. "shutterstock_149010437.jpg" by Robert Adrian Hillman is used under license from Shutterstock.com

unique experiences, everyone has a memory of feelings and events that is exclusive to them.[2]

Developmental Stages

As newborns, we learn behavior and communication to help us to interact with the world around us and to fulfill our needs. For example, crying provides communication to cue parents or caregivers about a newborn's needs. The human brain undergoes tremendous development throughout the first year of life. As infants receive and experience input from the environment, they begin to interact with the individuals around them as they learn and grow.

Erikson's Psychosocial Stages of Development

Erikson's psychosocial development theory emphasizes the social nature of our development rather than its sexual nature. It describes eight sequential stages of individual human development influenced by biological, psychological, and social factors throughout the life span that contribute to an individual's personality. Erikson's stages of development are trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus identity confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair.[3, 4]

2. Vallotton, C. D., & Fischer, K. W. (2008). Cognitive development. *Encyclopedia of infant and early childhood development.* Academic Press. https://doi.org/10.1016/B978-012370877-9.00038-4

3. Orenstein, G. A. (2022). *Erikson's stages of Psychosocial Development*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK556096/

4. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

- **Trust vs. Mistrust:** The first stage that develops is trust (or mistrust) that basic needs, such as nourishment and affection, will be met. Trust is the basis of our development during infancy (birth to 12 months). Infants are dependent upon their caregivers for their needs. Caregivers who are responsive and sensitive to their infant's needs help their baby to develop a sense of trust, and the infant will perceive the world as a safe, predictable place. Unresponsive caregivers who do not meet their baby's needs can engender feelings of anxiety, fear, and mistrust, and the infant will perceive the world as unpredictable.[5]

- **Autonomy vs. Shame:** Toddlers begin to explore their world and learn that they can control their actions and act on the environment to get results. They begin to show clear preferences for certain elements of the environment, such as food, toys, and clothing. A toddler's main task is to resolve the issue of autonomy versus shame and doubt by working to establish independence. For example, we might observe a budding sense of autonomy in a two-year-old child who wishes to choose their own clothes and dress themselves. Although the outfits might not be appropriate for the situation, the input in basic decisions has an effect on the toddler's sense of independence. If denied the opportunity to act on their environment, they may begin to doubt their abilities, which could lead to low self-esteem and feelings of shame.[6]

- **Initiative vs. Guilt:** After children reach the preschool stage (ages 3–6 years), they are capable of initiating activities and asserting control over their world through social interactions and play. By learning to plan and

5. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

6. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

achieve goals while interacting with others, preschool children can master a feeling of initiative and develop self-confidence and a sense of purpose. Those who are unsuccessful at this stage may develop feelings of guilt.[7]

- **Industry vs. Inferiority:** During the elementary school stage (ages 7–11), children begin to compare themselves to their peers to see how they measure up. They either develop a sense of pride and accomplishment in their schoolwork, sports, social activities, and family life, or they may feel inferior and inadequate if they feel they don't measure up to their peers.[8]

- **Identity vs. Identity Confusion:** In adolescence (ages 12–18), children develop a sense of self. Adolescents struggle with questions such as, "Who am I?" and "What do I want to do with my life?" Along the way, adolescents try on many different selves to see which ones fit. Adolescents who are successful at this stage have a strong sense of identity and are able to remain true to their beliefs and values in the face of problems and other people's perspectives. Teens who do not make a conscious search for identity, or those who are pressured to conform to their parents' ideas for the future, may have a weak sense of self and experience role confusion as they are unsure of their identity and confused about the future.[9]

7. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

8. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

9. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

- **Intimacy vs. Isolation:** People in early adulthood (i.e., 20s through early 40s) are ready to share their lives and become intimate with others after they have developed a sense of self. Adults who do not develop a positive self-concept in adolescence may experience feelings of loneliness and emotional isolation.[10]

- **Generativity vs. Stagnation:** When people reach their 40s, they enter a time period known as middle adulthood that extends to the mid-60s. The developmental task of middle adulthood is generativity versus stagnation. Generativity involves finding your life's work and contributing to the development of others through activities such as volunteering, mentoring, and raising children. Adults who do not master this developmental task may experience stagnation with little connection to others and little interest in productivity and self-improvement.[11]

- **Integrity vs. Despair:** The mid-60s to the end of life is a period of development known as late adulthood. People in late adulthood reflect on their lives and feel either a sense of satisfaction or a sense of failure. People who feel proud of their accomplishments feel a sense of integrity and often look back on their lives with few regrets. However, people who are not successful at this stage may feel as if their life has been wasted. They focus on what "would have," "should have," or "could have" been. They face the end of their lives with feelings of bitterness, depression, and despair.[12]

10. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

11. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction – psychology 2E*. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

12. Spielman, R. M., Jenkins, W. J., & Lovett, M. D. (2020). *Ch. 1 introduction –*

Piaget's Theory of Development

Jean Piaget, a well-known cognitive development theorist, noted that children explore the world as they attempt to make sense of their experiences. His theory explains that humans move from one stage to another as they seek cognitive equilibrium and mental balance. There are four stages in Piaget's theory of development that occur in children from all cultures:

- **Sensorimotor:** The first stage is the sensorimotor period. It extends from birth to approximately two years and is a period of rapid cognitive growth. During this period, infants develop an understanding of the world by coordinating sensory experiences (seeing, hearing) with motor actions (reaching, touching). The main development during the sensorimotor stage is the understanding that objects exist, and events occur in the world independently of one's own actions.[13] Infants develop an understanding of what they want and what they must do to have their needs met. They begin to understand language used by those around them to make needs met.
- **Pre-Operational:** Infants progress from the sensorimotor period to a pre-operational period in their toddler years that continues through early school age years. This is the time frame when children learn to think in images and symbols. Play is an important part of cognitive development during this period.
- **Concrete Operations:** Older school age children (age 7 years to 11 years) enter a concrete operations period. They learn to think in terms of processes and can understand that there is more than one perspective when discussing a concept.[14] This stage is considered a major turning

psychology 2E. OpenStax. https://openstax.org/books/psychology-2e/pages/1-introduction

13. McLeod, S. (2020). *Piaget's theory and stages of development*. SimplyPsychology. https://www.simplypsychology.org/piaget.html

point in the child's cognitive development because it marks the beginning of logical or operational thought.
- **Formal Operations:** Adolescents transition to the formal operations stage around age 12 as they become self-conscious and egocentric. As adolescents enter this stage, they gain the ability to think in an abstract manner by manipulating ideas in their head. Moving toward adulthood, this further develops into the ability to critically reason.[15,16]

Cognitive Impairments in Children

Cognitive impairments in children range from mild impairment in these specific operations to profound intellectual impairments leading to minimal independent functioning. **Cognitive impairment** is a term used to describe impairment in mental processes that drive how an individual understands and acts in the world, affecting the acquisition of information and knowledge. The following areas are domains of cognitive functioning:

- Attention
- Decision-making
- General knowledge
- Judgment
- Language
- Memory
- Perception
- Planning

14. Ginsburg, H. P., & Opper, S. (1988). *Piaget's theory of intellectual development* (3rd ed.). Prentice-Hall, Inc.

15. Ginsburg, H. P., & Opper, S. (1988). *Piaget's theory of intellectual development* (3rd ed.). Prentice-Hall, Inc.

16. McLeod, S. (2020). *Piaget's theory and stages of development*. SimplyPsychology. https://www.simplypsychology.org/piaget.html

- Reasoning
- Visuospatial[17]

Intellectual disability (formerly referred to as mental retardation) is a diagnostic term that describes intellectual and adaptive functioning deficits identified during the developmental period. In the United States, the developmental period refers to the span of time prior to the age 18. Children with intellectual disabilities may demonstrate a delay in developmental milestones (e.g., sitting, speaking, walking) or demonstrate mild cognitive impairments that may not be identified until school age. Intellectual disability is typically nonprogressive and lifelong. It is diagnosed by multidisciplinary clinical assessments and standardized testing and is treated with a multidisciplinary treatment plan that maximizes quality of life.[18] See Figure 6.2[19] for an image of an adolescent with an intellectual disability participating in a Special Olympics event.

Figure 6.2 Special Olympics

17. Schofield, D. W. (2018). *Cognitive deficits*. Medscape. https://emedicine.medscape.com/article/917629-overview

18. Schofield, D. W. (2018). *Cognitive deficits*. Medscape. https://emedicine.medscape.com/article/917629-overview

19. "22605761265_9f8e65a7ad_k.jpg" by Special Olympics 2017 is in the Public Domain

Cognitive Impairments in Adults and Older Adults

There are several physical changes that occur in the brain due to aging. The structure of neurons changes, including a decreased number and length of dendrites, loss of dendritic spines, a decrease in the number of axons, an increase in axons with segmental demyelination, and a significant loss of synapses. Loss of synapse is a key marker of aging in the nervous system. These physical changes occur in older adults experiencing cognitive impairments, as well as in those who do not.[20] See Figure 6.3[21] of an older adult experiencing typical physical changes of aging.

Figure 6.3 Older Adult

It is a common myth that all individuals experience cognitive impairments as

20. Murman, D. L. (2015). The impact of age on cognition. *Seminars in Hearing, 36*(3), 111–121. https://doi.org/10.1055/s-0035-1555115

21. "3546874802_8b4cf9c822_o.jpg" by United Nations Photo is licensed under CC BY-NC-ND 2.0

they age. Many people are afraid of growing older because they fear becoming forgetful, confused, and incapable of managing their daily life leading to incorrect perceptions and ageism. Ageism refers to stereotyping older individuals because of their age. Losing language skills, becoming unable to make decisions appropriately, and being disoriented to self or surroundings are not normal aging changes.

Dementia, Delirium, and Depression

If cognitive changes in adults occur, a complete assessment is required to determine the underlying cause of the change and if it is caused by an acute or chronic condition. For example, dementia is a chronic condition that affects cognition whereas depression and delirium can cause acute confusion with a similar clinical appearance to dementia.

Dementia

Dementia is a chronic condition of impaired cognition, caused by brain disease or injury, and marked by personality changes, memory deficits, and impaired reasoning. Dementia can be caused by a group of conditions, such as Alzheimer's disease, vascular dementia, frontal-temporal dementia, and Lewy body disease. Clinical manifestations of dementia include forgetfulness, impaired social skills, and impaired decision-making and thinking abilities that interfere with daily living. Dementia is gradual, progressive, and irreversible.[22] While dementia is not reversible, appropriate assessment and nursing care improve the safety and quality of life for those affected by dementia.

As dementia progresses and cognition continues to deteriorate, nursing care must be individualized to meet the needs of the client and family. Providing client safety and maintaining quality of life while meeting physical

22. Alzheimer's Association. (2025). *Alzheimer's & dementia*. Alzheimer's Association. https://www.alz.org/alzheimers-dementia

and psychosocial needs are important aspects of nursing care. Unsafe behaviors put individuals with dementia at increased risk for injury. These unsafe or inappropriate behaviors often occur due to the client having a need or emotion without the ability to express it, such as pain, hunger, anxiety, or the need to use the bathroom. The client's family/caregivers require education and support to recognize that behaviors are often a symptom of dementia and/or a communication of a need and to help them to best meet the needs of their family member.[23]

Delirium

Delirium is an acute state of cognitive impairment that typically occurs suddenly due to a physiological cause, such as infection, hypoxia, electrolyte imbalances, drug effects, or other acute brain injury. Sensory overload, excess stress, and sleep deprivation can also cause delirium. Hospitalized older adults are at increased risk for developing delirium, especially if they have been previously diagnosed with dementia. One third of clients aged 70 years or older exhibit delirium during their hospitalization. Delirium is the most common surgical complication for older adults, occurring in 15 to 25% of clients after major elective surgery and up to 50% of clients experiencing hip-fracture repair or cardiac surgery.[24]

The symptoms of delirium usually start suddenly, over a few hours or a few days, and they often come and go. Common symptoms include the following:

23. Downing, L. J., Caprio, T. V., & Lyness, J. M. (2013). Geriatric psychiatry review: Differential diagnosis and treatment of the 3 D's – delirium, dementia, and depression. *Current Psychiatry Reports, 15*(6), 365. https://doi.org/10.1007/s11920-013-0365-4

24. Marcantonio, E. R. (2017). Delirium in hospitalized older adults. *The New England Journal of Medicine, 377*(15), 1456–1466. https://doi.org/10.1056/NEJMcp1605501

- Changes in alertness (usually most alert in the morning and decreased at night)
- Changing levels of consciousness
- Confusion
- Disorganized thinking or talking in a way that does not make sense
- Disrupted sleep patterns or sleepiness
- Emotional changes: anger, agitation, depression, irritability, overexcitement
- Hallucinations and delusions
- Incontinence
- Memory problems, especially with short-term memory
- Trouble concentrating[25]

Delirium and dementia have similar symptoms, so it can be hard to tell them apart. They can also occur together.

Nurses must closely monitor the cognitive function of all clients and promptly report any changes in mental status to the health care provider. The provider will take a medical history, perform a physical and neurological examination, perform mental status testing, and may order diagnostic tests based on the client's medical history. After the cause of delirium is determined, treatment is targeted to the cause to reverse the effects. See Figure 6.4[26] for an illustration of an older adult experiencing delirium.

▶ Download an algorithm to assess delirium in older adults with dementia from The Hartford Institute for Geriatric Nursing.[27]

25. U.S. National Library of Medicine. (2023). *Delirium*. MedlinePlus. https://medlineplus.gov/delirium.html

26. "old-peoples-home-524234_960_720.jpg" by mikegi is licensed under CC0

27. The Hartford Institute for Geriatric Nursing, New York University, Rory

General interventions to prevent and treat delirium in older adults are as follows:

- Control the environment. Make sure that the room is quiet and well-lit, have clocks or calendars in view to provide time orientation, and encourage family members to visit.
- Ensure a safe environment with the call light within reach and side rails up as indicated.
- Administer prescribed medications, including those that control aggression or agitation, and pain relievers if there is pain.
- Ensure the client has their glasses, hearing aids, or other assistive devices for communication in place. Lack of assistive sensory devices can worsen delirium.
- Avoid sedatives. Sedatives can worsen delirium.
- Assign the same staff for client care when possible.[28]

Figure 6.4 Delirium

Meyers School of Nursing. (n.d.). *Assessment tools for best practices of care for older adults*. https://hign.org/consultgeri-resources/try-this-series

28. U.S. National Library of Medicine. (2023). *Delirium*. MedlinePlus. https://medlineplus.gov/delirium.html

Depression

Depression is a brain disorder with a variety of causes, including genetic, biological, environmental, and psychological factors. It is a commonly untreated condition in older adults and can result in impaired cognition and difficulty in making decisions. It is likely to occur in response to major life events involving health and loved ones. Having other chronic health problems, such as diabetes, dementia, Parkinson's disease, cancer, heart disease, and kidney disease, increases the likelihood for depression in older adults and can cause the loss of their ability to maintain independence.[29] See Figure 6.5[30] for an illustration of an older adult experiencing symptoms of depression.

Figure 6.5 Depression

Symptoms of depression include the following:

- Feeling sad or "empty"
- Loss of interest in favorite activities

29. Ouldred, E., & Bryant, C. (2008). Dementia care. Part 1: Guidance and the assessment process. *British Journal of Nursing, 17*(3), 138-145. https://doi.org/10.12968/bjon.2008.17.3.28401

30. "man-416470_960_720.jpg" by geralt is licensed under CC0

- Overeating or not wanting to eat at all
- Not being able to sleep or sleeping too much
- Feeling very tired
- Feeling hopeless, irritable, anxious, or guilty
- Aches, pains, headaches, cramps, or digestive problems
- Thoughts of death or suicide[31]

Depression is treatable with medication and psychotherapy. However, older adults have an increased risk for suicide, with the suicide rates for individuals over age 85 years the second highest rate overall. Nurses should provide appropriate screening to detect potential signs of depression as an important part of promoting health for older adults.

Comparison of Three Conditions

When an older adult presents with confusion, determining if it is caused by delirium, dementia, depression, or a combination of these conditions can pose many challenges to the health care team. It is helpful to know the client's baseline mental status from a family member, caregiver, or previous health care records. If a client's baseline mental status is not known, it is an important safety consideration to assume that confusion is caused by delirium with a thorough assessment for underlying causes.[32] See Table 6.2 for a comparison of symptoms of dementia, delirium, and depression.[33]

31. U.S. National Library of Medicine. (2016). *Depression*. MedlinePlus. https://medlineplus.gov/depression.html

32. Marcantonio, E. R. (2017). Delirium in hospitalized older adults. *The New England Journal of Medicine, 377*(15), 1456–1466. https://doi.org/10.1056/NEJMcp1605501

33. Ouldred, E., & Bryant, C. (2008). Dementia care. Part 1: Guidance and the assessment process. *British Journal of Nursing, 17(*3), 138-145. https://doi.org/10.12968/bjon.2008.17.3.28401

Table 6.2 Comparison of Dementia, Delirium, and Depression[34]

34. Ouldred, E., & Bryant, C. (2008). Dementia care. Part 1: Guidance and the assessment process. *British Journal of Nursing, 17(*3), 138-145. https://doi.org/10.12968/bjon.2008.17.3.28401

	Dementia	Delirium	Depression
Onset	Vague, insidious onset; symptoms progress slowly	Sudden onset over hours and days with fluctuations	Onset often rapid with identifiable trigger or life event such as bereavement
Symptoms	Symptoms may go unnoticed for years. May attempt to hide cognitive problems or may be unaware of them. Often disoriented to time, place, and person. Impaired short-term memory and information processing. Confusion is often worse in the evening (referred to as “sundowning”)	Often disoriented to time, place, and person. Impaired short-term memory loss and information processing. Confusion is often worse in the evening	Obvious at early stages and often worse in the morning. Can include subjective complaints of memory loss
Consciousness	Normal	Impaired attention/ alertness	Normal
Mental State	Possibly labile mood. Consistently decreased cognitive performance	Emotional lability with anxiety, fear, depression, aggression. Variable cognitive performance	Distressed/ unhappy. Variable cognitive performance
Delusions/Hallucinations	Common	Common	Rare
Psychomotor Disturbance	Psychomotor disturbance in later stages	Psychomotor disturbance present – hyperactive, purposeless, or apathetic	Slowed psychomotor status in severe depression

6.3 Alzheimer's Disease

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Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks. It is the most common cause of dementia. In most people with Alzheimer's disease, symptoms first appear in their mid-60s. Five percent of people age 65 to 74, 13.2% of people age 75 to 84, and 33.4% of people age 85 or older have Alzheimer's disease.[1]

Scientists continue to unravel the complex brain changes involved in the onset and progression of Alzheimer's disease. Researchers have found many genes that increase or decrease the risk of Alzheimer's dementia. In 2022 researchers identified 31 new genes that appear to affect biological processes associated with Alzheimer's disease. Changes in the brain may begin a decade or more before memory and other cognitive problems appear. Abnormal deposits of proteins form amyloid plaques and tau tangles throughout the brain. Previously healthy neurons stop functioning, lose connections with other neurons, and die. The damage initially appears to take place in the hippocampus and cortex, the parts of the brain essential in forming memories. As more neurons die, additional parts of the brain are affected and begin to shrink. By the final stage of Alzheimer's, damage is

1. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

widespread, and brain tissue has shrunk significantly.[2,3] See Figure 6.6[4] for an image of the changes occurring in the brain during Alzheimer's disease.

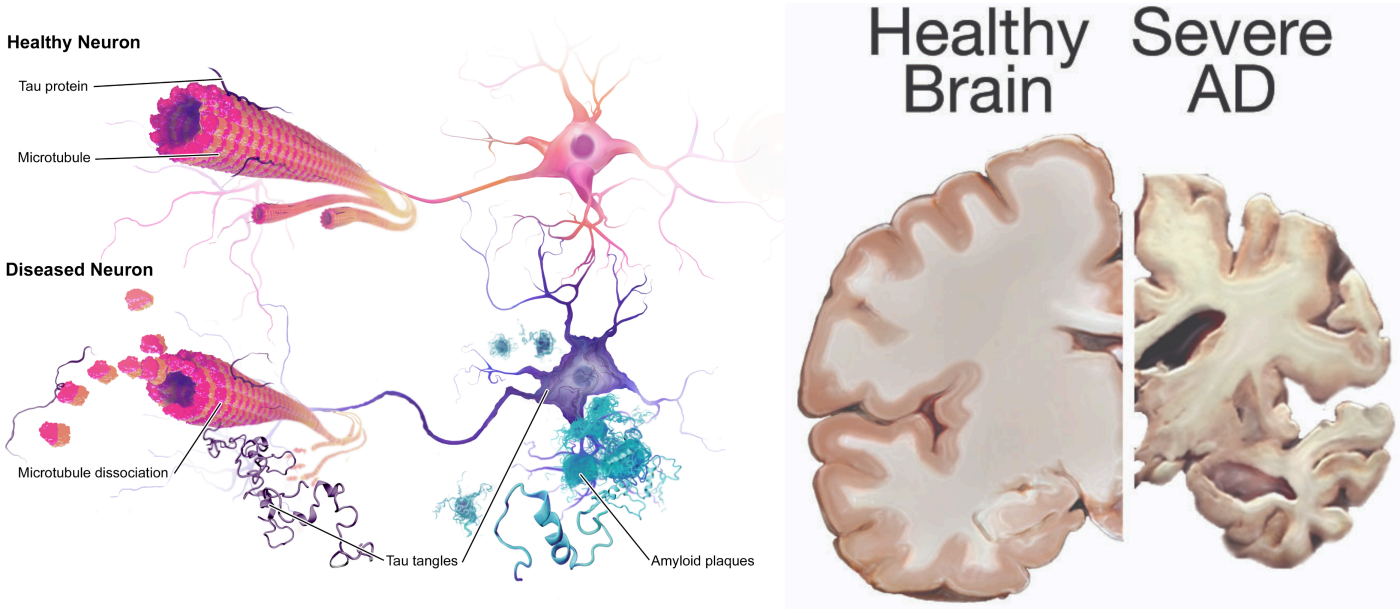

Figure 6.6 Brain and Neurons Affected by Alzheimer's Disease

View a supplementary YouTube video of the changes that

2. National Institute on Aging. (2019). *Alzheimer's disease fact sheet*. U.S. Department of Health & Human Services. https://www.nia.nih.gov/health/alzheimers-disease-fact-sheet

3. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

4. "Alzheimers_Disease.jpg" by BruceBlaus is licensed under CC BY-SA 4.0 and "24239522109_6b061a9d69_o.jpg" by NIH Image Gallery is licensed under CC0

occur in the brain during Alzheimer's disease: https://www.youtube.com/watch?v=hEw1Yq_4PaA[5]

Symptoms of Early Alzheimer's Disease

There are ten symptoms of early Alzheimer's disease[6]:

- **Memory loss that disrupts daily life.** This includes forgetting important dates or events, asking the same questions over and over, and increasingly needing to rely on memory aids (e.g., reminder notes or electronic devices) or family members for things they used to handle on their own. This is different than a typical age-related change of sometimes forgetting names or appointments, but remembering them later.
- **Challenges in planning or solving problems.** This includes changes in an individual's ability to develop and follow a plan or work with numbers. For example, they may have trouble following a familiar recipe or keeping track of monthly bills. They may have difficulty concentrating and take much longer to do things than they did before. This is different from a typical age-related change of making occasional errors when managing finances or household bills.
- **Difficulty completing familiar tasks.** This includes trouble driving to a familiar location, organizing a grocery list, or remembering the rules of a

5. National Institute on Aging. (2017, August 23). *How Alzheimer's changes the brain* [Video]. YouTube. All rights reserved. https://www.youtube.com/watch?v=hEw1Yq_4PaA

6. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

favorite game. This symptom is different from a typical age-related change of occasionally needing help to use microwave settings or to record a TV show.

- **Confusion with time or place.** This includes losing track of dates, seasons, and the passage of time. Individuals may have trouble understanding something if it is not happening immediately. Sometimes they may forget where they are or how they got there. This symptom is different from a typical age-related change of forgetting the date or day of the week but figuring it out later.
- **Trouble understanding visual images and spatial relationships.** Vision problems that include difficulty judging distance, determining color or contrast, or causing issues with balance or driving can be symptoms of Alzheimer's. This is different from a typical age-related change of blurred vision related to presbyopia or cataracts. (See the "Sensory Impairments" chapter for more information on common vision problems.)
- **New problems with words in speaking or writing.** Individuals with Alzheimer's may have trouble following or joining a conversation. They may stop in the middle of a conversation and have no idea how to continue or they may repeat themselves. They may struggle with vocabulary, have trouble naming a familiar object, or use the wrong name (e.g., calling a "watch" a "hand-clock"). This is different from a typical age-related change of having trouble finding the right word.
- **Misplacing things and losing the ability to retrace steps.** A person with Alzheimer's disease may put things in unusual places. They may lose things and be unable to go back over their steps to find them again. They may accuse others of stealing, especially as the disease progresses. This is different from a typical age-related change of misplacing things from time to time and retracing steps to find them.
- **Decreased or poor judgment.** Individuals with Alzheimer's may experience changes in judgment or decision-making. For example, they may use poor judgment when dealing with money or pay less attention to grooming or keeping themselves clean. This is different from a typical age-related change of making a bad decision or mistake once in a while, like neglecting to change the oil in the car.

- **Withdrawal from work or social activities**. A person living with Alzheimer's disease may experience changes in the ability to hold or follow a conversation. As a result, they may withdraw from hobbies, social activities, or other engagements. They may have trouble keeping up with a favorite team or activity. This is different from a typical age-related change of sometimes feeling uninterested in family or social obligations.
- **Changes in mood, personality, and behavior.** Individuals living with Alzheimer's may experience mood and personality changes. They can become confused, suspicious, depressed, fearful, or anxious. They may be easily upset at home, with friends, or when out of their comfort zone. This is different from a typical age-related change of developing very specific ways of doing things and becoming irritable when a routine is disrupted.

Stages of Alzheimer's Disease

There are several stages of Alzheimer's disease (AD), referred to as preclinical AD, mild cognitive impairment due to AD, dementia due to mild AD, dementia due to moderate AD, and dementia due to severe AD[7]:

- **Preclinical AD:** Individuals experience brain changes associated with Alzheimer's disease, but symptoms such as memory loss or difficulty thinking are not yet present.
- **Mild cognitive impairment due to AD:** Individuals have very mild symptoms that do not interfere with everyday activities.
- **Dementia due to mild AD:** Individuals experience the ten symptoms previously discussed that interfere with some daily activities. They may still be able to drive, work and participate in their favorite activities but often need more time to complete common daily tasks and may require assistance to maximize independence and remain safe. Paying bills and making financial decisions may be especially challenging, which

7. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

increases their vulnerability to financial scams and financial abuse.

- **Dementia due to moderate AD:** Individuals experience symptoms that interfere with many daily activities. They often have difficulty completing multistep tasks such as bathing and dressing. They may have episodes of incontinence, begin to have problems recognizing loved ones, and start showing personality and behavioral changes, including suspiciousness and agitation. Behavioral symptoms such as wandering, getting lost, hallucinations, delusions, and repetitive behavior may occur. Clients living at home may engage in risky behavior, such as leaving the house in clothing inappropriate for weather conditions or leaving on the stove burners.[8]
- **Dementia due to severe AD:** The ability to verbally communicate and walk is greatly diminished, and individuals likely require around-the-clock care with full assistance in washing, dressing, eating, and toileting. They typically spend most of their time in a wheelchair or in bed. This loss of mobility increases their vulnerability to physical complications including blood clots, skin infections and sepsis. Swallowing becomes impaired, increasing their risk for aspiration pneumonia, a common cause of death. See Figure 6.7[9] of a client with dementia requiring assistance with dressing.

8. Ouldred, E., & Bryant, C. (2008). Dementia care. Part 1: Guidance and the assessment process. *British Journal of Nursing, 17*(3), 138-145. https://doi.org/10.12968/bjon.2008.17.3.28401

9. "civilian-service-63616_960_720.jpg" by geralt is licensed under CC0

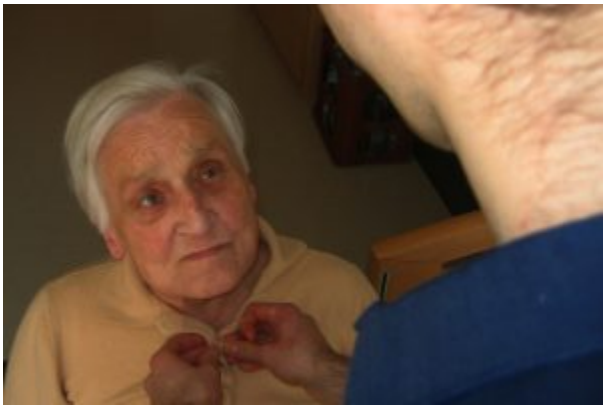

Figure 6.7 Client with Dementia Requiring Assistance

There is no single diagnostic test that can determine if a person has Alzheimer's disease. Health care providers use a client's medical history, mental status tests, physical and neurological exams, and diagnostic tests to diagnose Alzheimer's disease and other types of dementia. During the neurological exam, reflexes, coordination, muscle tone and strength, eye movement, speech, and sensation are tested.

Mental status testing evaluates memory, thinking, and simple problem-solving abilities. Some tests are brief, whereas others can be more time-intensive and complex. These tests give an overall sense of whether a person is aware of their symptoms; knows the date, time, and place where they are; can remember a short list of words; and if they can follow instructions and do simple calculations. The Mini Mental Status Examination (MMSE) and Mini-Cog test are two commonly used assessments.

During the MMSE, a health professional asks a client a series of questions designed to test a range of everyday mental skills. The maximum MMSE score is 30 points. A score of 20 to 24 suggests mild dementia, 13 to 20 suggests moderate dementia, and less than 12 indicates severe dementia. On average, the MMSE score of a person with Alzheimer's declines about two to four points each year.

- Visit the Oxford Medical Education website to view a Mini Mental Status Exam.

During the Mini-Cog, a person is asked to complete two tasks: remember and then later repeat the names of three common objects and draw a face of a clock showing all 12 numbers in the right places with the time indicated as specified by the examiner. The results of this brief test determine if further evaluation is needed. In addition to assessing mental status, the health care provider evaluates a person's sense of well-being to detect depression or other mood disorders that can cause memory problems, loss of interest in life, and other symptoms that can overlap with dementia.

> Visit the Mini-Cog website to read more information about this instrument.

Diagnostic testing for Alzheimer's disease may include cerebrospinal fluid (CSF) testing for abnormal levels of beta-amyloid and tau, or positron emission tomography (PET) scans that can identify beta-amyloid and tau accumulations in the brain. Many research groups are currently working on developing blood tests for Alzheimer's disease that could speed up the diagnosis and facilitate early treatment.[10]

Treatments

While there is no cure for Alzheimer's disease, medications may be prescribed to slow disease progression and manage common symptomatic behaviors.

Medications

The medications aducanumab and lecanemab may be prescribed to delay disease progression by helping remove plaques and prevent the development of beta-amyloid plaques. However, in 2024 the manufacturer of aducanumab announced the drug was being discontinued. Clinical trials

10. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

using lecanemab show moderate slowing of cognitive and functional decline in individuals with mild cognitive impairment or mild dementia due to Alzheimer's disease. However, it may cause serious side effects such as brain swelling with or without bleeding and an increased risk for falls.[11]

Other medications including donepezil, rivastigmine, galantamine, and memantine may be prescribed to treat cognitive symptoms. However, they do not affect the underlying brain changes that cause Alzheimer's disease and do not slow or stop the course of the disease. These medications work by affecting the levels of neurotransmitters in the brain.[12]

Brexpiprazole has been approved by the Food and Drug Administration (FDA) to treat agitation, a common symptom of Alzheimer's disease. Brexpiprazole is an atypical antipsychotic drug that is associated with an increased risk of stroke and death in older patients with dementia-related psychosis, so nonpharmacological interventions should be attempted first.[13]

Interventions for Symptomatic Behavior

Many people find the behavioral changes caused by Alzheimer's disease to be the most challenging and distressing effect of the disease. The chief cause of behavioral symptoms is the progressive deterioration of brain cells. However, medication, environmental influences, and some medical conditions can also cause symptoms or make them worse.

In the early stages of Alzheimer's disease, people may experience behavior

11. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

12. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

13. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

and personality changes, such as irritability, anxiety, and depression. In later stages, other symptoms may occur, including the following:

- Aggression and anger
- Anxiety and agitation
- General emotional distress
- Physical or verbal outbursts
- Restlessness, pacing, or shredding paper or tissues
- Hallucinations (seeing, hearing, or feeling things that are not really there)
- Delusions (firmly held beliefs in things that are not true)
- Sleep issues and **sundowning**

Sundowning is restlessness, agitation, irritability, or confusion that typically begins or worsens as daylight begins to fade and can continue into the night, making it hard for clients with Alzheimer's to sleep. Being too tired can increase late-afternoon and early-evening restlessness. Tips to manage sundowning are as follows[14]:

- Take the person outside or expose them to bright light in the morning to reset their circadian rhythm.
- Do not plan too many activities during the day. A full schedule can be overtiring.
- Make early evening a quiet time of day. Play soothing music or ask a family member or friend to call during this time.
- Close the curtains or blinds at dusk to minimize shadows and the confusion they may cause.
- Reduce noise, clutter, or the number of people in the room.
- Do not serve coffee, cola, or other drinks with caffeine late in the day.

14. National Institute on Aging. (n.d.). *Tips for coping with sundowning*. https://www.nia.nih.gov/health/tips-coping-sundowning

AGGRESSIVE BEHAVIORS

Aggressive behaviors may be verbal or physical. They can occur suddenly, with no apparent reason, or result from a frustrating situation. While aggression can be hard to cope with, understanding this is a symptom of Alzheimer's disease and the person with Alzheimer's or dementia is not acting this way on purpose can help. See Figure 6.8[15] for an image of a resident with dementia demonstrating aggressive verbal behavior.

Figure 6.8 Aggressive Verbal Behavior

Aggression can be caused by many factors including physical discomfort, environmental factors, and poor communication. If the person with Alzheimer's is aggressive, consider what might be contributing to the change in behavior.

Physical Discomfort

- Is the person able to let you know they are experiencing physical pain? It is not uncommon for persons with Alzheimer's or other types of dementia to have chronic pain, urinary tract infections, or other conditions causing

15. "5012292106_507e008c7a_o.jpg" by borosjuli is licensed under CC BY 2.0

acute pain. Due to their loss of cognitive function, they are unable to articulate or identify the cause of physical discomfort and, therefore, may express it through physical aggression.
- Is the person tired because of inadequate rest or sleep?
- Is the person hungry or thirsty?
- Are medications causing side effects? Side effects are especially likely to occur when individuals are taking multiple medications for several health conditions.

Environmental Factors

- Is the person overstimulated by loud noises, an overactive environment, or physical clutter? Large crowds or being surrounded by unfamiliar people — even within one's own home — can be overstimulating for a person with dementia.
- Does the person feel lost?
- What time of day is the person most alert? Most people function better during a certain time of day; typically, mornings are best. Consider the time of day when making appointments or scheduling activities. Choose a time when you know the person is most alert and best able to process new information or surroundings.

Poor Communication

- Are your instructions simple and easy to understand?
- Are you asking too many questions or making too many statements at once?
- Is the person picking up on your own stress or irritability?

Techniques for Response

There are many therapeutic methods for a nurse or caregiver to respond to aggressive behaviors displayed by a person with dementia. The following are some methods that can be used with aggressive behavior:

- **Begin by trying to identify the immediate cause of the behavior.** Think about what happened right before the reaction that may have triggered the behavior. Rule out pain as the cause of the behavior. Pain can trigger aggressive behavior for a person with dementia.
- **Focus on the person's feelings, not the facts.** Look for the feelings behind the specific words or actions.
- **Don't get upset.** Be positive and reassuring and speak slowly in a soft tone.
- **Limit distractions.** Examine the person's surroundings, and adapt them to avoid future triggers.
- **Implement a relaxing activity.** Try music, massage, or exercise to help soothe the person.
- **Shift the focus to another activity.** The immediate situation or activity may have unintentionally caused the aggressive response, so try a different approach.
- **Take a break if needed.** If the person is in a safe environment and you are able, walk away and take a moment for emotions to cool.
- **Ensure safety!** Make sure you and the person are safe. Be aware of the location of the person's hands and feet in the event they become combative and try to strike out, kick, or bite you. If these interventions do not successfully calm down the person, seek assistance from others. If it is an emergency situation, call 911 and be sure to tell the responders the person has dementia that causes them to act aggressively.

When educating caregivers about responding to aggressive behaviors, encourage them to share their experience with others, such as face-to-face support groups, where they can share response strategies they have tried and also get more ideas from other caregivers.

ANXIETY AND AGITATION

A person with Alzheimer's may feel anxious or agitated. They may become restless, causing a need to move around or pace or become upset in certain

places or when focused on specific details. See Figure 6.9[16] for an illustration of an older adult feeling the need to move around. Anxiety and agitation can be caused by several medical conditions, medication interactions, or by any circumstances that worsen the person's ability to think. Ultimately, the person with dementia is biologically experiencing a profound loss of their ability to negotiate new information and stimuli. It is a direct result of the disease. Situations that may lead to agitation can include moving to a new residence or nursing home; changes in environment, such as travel, hospitalization, or the presence of houseguests; changes in caregiver arrangements; misperceived threats; or fear and fatigue resulting from trying to make sense out of a confusing world.

Figure 6.9 Anxiety and Wandering

Interventions to prevent and treat agitation include the following:

- **Create a calm environment and remove stressors.** This may involve moving the person to a safer or quieter place or offering a security object, rest, or privacy. Providing soothing rituals and limiting caffeine use are also helpful.

16. "old-63622_960_720.jpg" by geralt is licensed under CC0

- **Avoid environmental triggers.** Noise, glare, and background distraction (such as having the television on) can act as triggers.
- **Monitor personal comfort.** Check for pain, hunger, thirst, constipation, full bladder, fatigue, infections, and skin irritation. Make sure the room is at a comfortable temperature. Be sensitive to the person's fears, misperceived threats, and frustration with expressing what is wanted.
- **Simplify tasks and routines.**
- **Find outlets for the person's energy.** The person may be looking for something to do. Provide an opportunity for exercise such as going for a walk or putting on music and dancing.

Techniques for Response

If a client with dementia becomes anxious or agitated, consider these potential interventions:

- **Back off and ask permission before performing care tasks.** Use calm, positive statements, slow down, add lighting, and provide reassurance. Offer guided choices between two options when possible. Focus on pleasant events and try to limit stimulation.
- **Use effective language.** When speaking, try phrases such as, "May I help you? Do you have time to help me? You're safe here. Everything is under control. I apologize. I'm sorry that you are upset. I know it's hard. I will stay with you until you feel better."
- **Listen to the person's frustration.** Find out what may be causing the agitation and try to understand.
- **Check yourself.** Do not raise your voice; show alarm or offense; or corner, crowd, restrain, criticize, ignore, or argue with the person. Take care not to make sudden movements out of the person's view. Be aware of the client's hands and feet in the event they strike out or kick at you.

If the person's anxiety or agitation does not improve using these techniques, notify the provider to rule out physiological causes or medication-related side effects.

HALLUCINATIONS

When a person with dementia experiences hallucinations, they may see, hear, smell, taste, or feel something that isn't there. Some hallucinations may be frightening, while others may involve ordinary visions of people, situations, or objects from the past. Alzheimer's and other dementias are not the only cause of hallucinations. Other causes of hallucinations include schizophrenia; physical problems, such as kidney or bladder infections, dehydration, or intense pain; alcohol or drug abuse; eyesight or hearing problems; and medications. See Figure 6.10[17] for an illustration of hallucinations experienced by a person with dementia.

Figure 6.10 Hallucinations

If a person with dementia begins hallucinating, notify the health care provider to rule out other possible causes and to determine if medication is needed. It may also help to have the person's eyesight or hearing checked. If these strategies fail and symptoms are severe, medication may be prescribed. While

17. lewy-body-dementia-2965713_960_720.jpg" by Jetiveri is licensed under CC0

antipsychotic medications can be effective in some situations, they are associated with an increased risk of stroke and death in older adults with dementia and must be used carefully.

Techniques for Response

When responding to a client with dementia experiencing hallucinations, be cautious. First, assess the situation and determine whether the hallucination is a problem for the person or for you. Is the hallucination upsetting? Is it leading the person to do something dangerous? Is the sight of an unfamiliar face causing the person to become frightened? If so, react calmly and quickly with reassuring words and a comforting touch. Do not argue with the person about what they see or hear. If the behavior is not dangerous, there may not be a need to intervene.

- **Offer reassurance.** Respond in a calm, supportive manner. You may want to respond with, “Don’t worry. I’m here. I’ll protect you. I’ll take care of you.” Gentle patting may turn the person’s attention toward you and reduce the hallucination.

- **Acknowledge the feelings behind the hallucination and try to find out what the hallucination means to the individual.** You might want to say, “It sounds as if you’re worried” or “This must be frightening for you.”

- **Use distractions.** Suggest a walk or move to another room. Frightening hallucinations often subside in well-lit areas where other people are present. Try to turn the person’s attention to music, conversation, or activities they enjoy.

- **Respond honestly.** If the person asks you about a hallucination or delusion, be honest. For example, if they ask, “Do you see the spider on the wall?,” you can respond, “I know you see something, but I don’t see it.” This way you’re not denying what the person sees or hears and avoiding escalating their agitation.

- **Modify the environment.** Check for sounds that might be misinterpreted, such as noise from a television or an air conditioner. Look for lighting that casts shadows, reflections, or distortions on the surfaces of floors, walls, and furniture. Turn on lights to reduce shadows. Cover mirrors with a cloth or remove them if the person thinks that he or she is looking at a stranger.

SUNDOWNING

Sundowning is increased confusion, anxiety, agitation, pacing, and disorientation in clients with dementia that typically begins at dusk and continues throughout the night. Although the exact cause of sundowning and sleep disorders in people with Alzheimer's disease is unknown, these changes result from the disease's impact on the brain. There are several factors that may contribute to sleep disturbances and sundowning:

- Mental and physical exhaustion from a full day trying to keep up with an unfamiliar or confusing environment.
- An upset in the "internal body clock," causing a biological mix-up between day and night.
- Reduced lighting causing shadows and misinterpretation is seen, causing agitation.
- Nonverbal behaviors of others, especially if stress or frustration is present.
- Disorientation due to the inability to separate dreams from reality when sleeping.
- Decreased need for sleep, a common condition among older adults.

There are several interventions that nurses and caregivers can implement to help manage sleep issues and sundowning:

- Promote plenty of rest.
- Encourage a regular routine of waking up, eating meals, and going to bed.
- When possible and appropriate, include walks or time outside in the sunlight.

- Make notes about what happens before sundowning events and try to identify triggers.
- Reduce stimulation during the evening hours (e.g., TV, doing chores, loud music, etc.). These distractions may add to the person's confusion.
- Offer a larger meal at lunch and keep the evening meal lighter.
- Keep the home environment well-lit in the evening. Adequate lighting may reduce the person's confusion.
- Do not physically restrain the person; it can make agitation worse.
- Try to identify activities that are soothing to the person, such as listening to calming music, looking at photographs, or watching a favorite movie.
- Take a walk with the person to help reduce their restlessness.
- Consider the best times of day for administering medication; consult with the prescribing provider or pharmacist as needed.
- Limit daytime naps if the person has trouble sleeping at night.
- Reduce or avoid alcohol, caffeine, and nicotine that can affect the ability to sleep.
- Discuss the situation with the provider when behavioral interventions and environmental changes do not work. Additional medications may be prescribed.

Caregiver Role Strain

Eighty-three percent of the help provided to people living with dementia in their homes in the United States comes from family members, friends, or other unpaid caregivers. Approximately one quarter of dementia caregivers are also "sandwich generation" caregivers — meaning that they care not only for an aging parent, but also for children under age 18. Dementia can take a devastating toll on caregivers. Compared with caregivers of people without dementia, twice as many caregivers of people with dementia indicate

substantial emotional, financial, and physical difficulties.[18] See Figure 6.11[19] of an image of a caregiver daughter caring for her mother with dementia.

Figure 6.11 Caregiver Daughter

The caregivers of clients with dementia frequently report experiencing high levels of stress that often eventually impact their health and well-being. Nurses should monitor caregivers for these symptoms of stress:

- Denial about the disease and its effect on the person who has been diagnosed. For example, the caregiver might say, "I know Mom is going to get better."
- Anger at the person with Alzheimer's or frustration that they can't do the things they used to be able to do. For example, the caregiver might say, "He knows how to get dressed — he's just being stubborn."
- Social withdrawal from friends and activities. For example, the caregiver

18. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

19. "My_mum_ill_with_dementia_with_me.png" by MariaMagdalens is licensed under CC BY-SA 4.0

may say, “I don’t care about visiting with my friends anymore.”
- Anxiety about the future and facing another day. For example, the caregiver might say, “What happens when he needs more care than I can provide?”
- Depression or decreased ability to cope. For example, the caregiver might say, “I just don’t care anymore.”
- Exhaustion that makes it difficult to complete necessary daily tasks. For example, the caregiver might say, “I’m too tired to prepare meals.”
- Sleeplessness caused by concerns. For example, the caregiver might say, “What if she wanders out of the house or falls and hurts herself?”
- Irritability, moodiness, or negative responses.
- Lack of concentration that makes it difficult to perform familiar tasks. For example, the caregiver might say, “I was so busy; I forgot my appointment.”
- Health problems that begin to take a mental and physical toll. For example, the caregiver might say, “I can’t remember the last time I felt good.”

Nurses should monitor for these signs of caregiver stress and provide information about community resources. (See additional information about community resources below.) Caregivers should be encouraged to take good care of themselves by visiting their health care provider, eating well, exercising, and getting plenty of rest. It is helpful to remind caregivers that “taking care of yourself and being healthy can help you be a better caregiver.” Teach them relaxation techniques, such as relaxation breathing, progressive muscle relaxation, visualization, and meditation.

Caregivers should also be educated about additional care options, such as adult day care, respite care, residential facilities, or hospice care. **Adult day care centers** offer people with dementia and other chronic illnesses the opportunity to be social and to participate in activities in a safe environment, while also giving their caregivers the opportunity to work, run errands, or take a break. **Respite care** can be provided at home (by a volunteer or paid service) or in a care setting, such as adult day care or residential facility, to provide the caregiver a much-needed break. If the person with Alzheimer’s or other

dementia prefers a communal living environment or requires more care than can be safely provided at home, a residential facility may be the best option for providing care. Different types of facilities provide different levels of care, depending on the person's needs. **Hospice care** is a type of care selected by clients who are terminally ill and whose health care provider has determined they are expected to live six months or less. It focuses on providing comfort and dignity at the end of life with supportive services that can be of great benefit to people in the final stages of dementia and their families.

- Read about alternative care options and caregiver support at the Alzheimer Association web page.

Community Resources

Local Alzheimer's Association chapters can connect families and caregivers with the resources they need to cope with the challenges of caring for individuals with Alzheimer's. View examples of resources provided by the Alzheimer's Association in the following box.

- Find an Alzheimer's Association chapter in your community by visiting the Find Your Local Chapter web page.
- The Alzheimer's Association 24/7 Helpline (800.272.3900) is available around the clock, 365 days a year. Through this free service, specialists and master's-level clinicians offer confidential support and information to people living with dementia, caregivers, families, and the public.
- The Alzheimer's Association has a free virtual library web

- page devoted to resources that increase knowledge about Alzheimer's and other dementias.[20]

20. Alzheimer's Association. (2025). What is Alzheimer's? Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

6.4 Applying the Nursing Process

OPEN RESOURCES FOR NURSING (OPEN RN)

This section outlines the steps of the nursing process when providing care for adults with cognitive impairments.

Assessment

Nurses provide care for older adults in a wide variety of settings including acute care facilities, clinics, adult day care facilities, retirement communities, long-term care facilities, private homes, and community-based residential facilities (CBRF). It is vital for nurses to notice any signs of changing mental status based on the client's baseline. Any new or sudden changes that indicate possible delirium should be urgently reported to the health care provider for further assessment of potential underlying health conditions. See the following box to view a delirium evaluation tool used by hospitals.

> View the Delirium Evaluation Bundle shared by the Agency for Healthcare Research and Quality (AHRQ).

When assessing an adult client with a previously diagnosed cognitive impairment, there are several assessments to include on admission. Their medical history should be reviewed and a medication reconciliation completed. A general survey provides a quick, overall assessment of the way an individual interacts with their environment and their overall mobility status. A comprehensive neurological assessment should be performed to establish a client's baseline neurological status. After a baseline status is

determined, routine focused neurological assessments are performed to monitor for changes, such as asking the client to state their name, place, and the date, as appropriate.

> Read more information about performing a neurological exam in the "Neurological Assessment" chapter of the Open RN *Nursing Skills, 2e* textbook.

Additional assessments include functional status and the client's ability to perform activities of daily living (ADLs). A decline in the ability to perform self-care and maintain ADLs can affect the individual's well-being. Functional declines can bring about feelings of inadequacy and lead to depression. The ability to live independently relies on maintenance of self-care skills, including bathing, dressing, and toileting. Other factors that must be considered include the ability to adequately handle finances; maintain a clean, safe environment; and to shop and prepare meals. When deficits in these areas occur, resources should be recommended to assist the individual to meet these needs.

Cognitive changes, including disorientation, poor judgment, loss of language skills, and memory impairment, should be assessed objectively using standardized tools. Common standardized tools used to assess a client's mental status include the Mini Mental State Exam (MMSE) and the Mini-Cog.[1] See Figure 12[2] for an image of one of the questions included on the MMSE.

1. Alzheimer's Association. (2025). *What is Alzheimer's?* Alzheimer's Association. https://www.alz.org/alzheimers-dementia/what-is-alzheimers

2. "InterlockingPentagons.svg" by Jfdwolff[2] is licensed under CC BY-SA 3.0

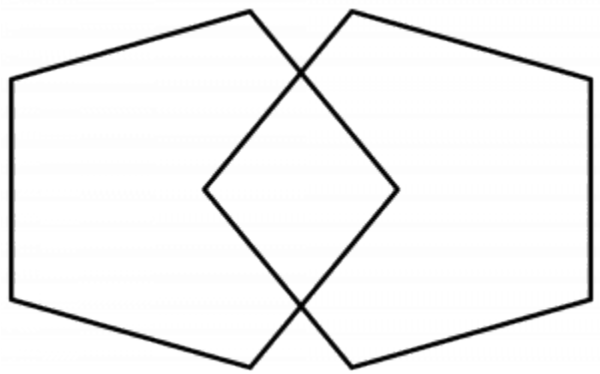

Figure 6.12 Mini Mental State Examination (MMSE)

Cultural Considerations

Nurses provide culturally competent care for all individuals. Being aware of personal biases related to ageism and cognitive impairments is necessary when providing care for older adults experiencing confusion, memory deficits, and impaired judgment. Ageism is the stereotyping and discrimination against individuals or groups on the basis of their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs. **Ageism** is widely prevalent and stems from the assumption that all members of a group (i.e., older adults) are the same and involves stereotyping and discrimination against individuals or groups based on their age. Ageism has harmful effects on the health of older adults; research has shown that older adults with negative attitudes about aging may live 7.5 years less than those with positive attitudes. Some of this prejudice arises from observable biological declines and may be distorted by awareness of disorders such as dementia, which may be mistakenly thought to reflect normal aging. Socially ingrained ageism can become self-fulfilling by promoting stereotypes of

social isolation, physical and cognitive decline, lack of physical activity, and economic burden in older adults.[3]

These biases in health care personnel, clients, and family members can prevent early recognition and treatment of health problems like dementia, delirium, and depression.

Diagnoses

Commonly used NANDA-I nursing diagnoses for older adults experiencing cognitive impairment include the following[4]:

- *Bathing Self-Care Deficit*
- *Dressing Self-Care Deficit*
- *Feeding Self-Care Deficit*
- *Toileting Self-Care Deficit*
- *Risk for Injury*
- *Impaired Memory*
- *Ineffective Coping*
- *Social Isolation*

An example of a related PES statement is, "*Toileting Self-Care Deficit related to altered cognitive functioning as evidenced by impaired ability to reach the toilet and manipulate clothing for urinating*."

Outcome Identification

An example of a broad, overall goal for an older adult experiencing cognitive

3. World Health Organization. (2024). *Health Topics: Ageism*. https://www.who.int/health-topics/ageism

4. Herdman, T. H., Kamitsuru, S., & Lopes, C. T. (Eds.). (2021). *Nursing diagnoses: Definitions and classification 2021-2023, Twelfth Edition*. Thieme Publishers New York.

impairment due to dementia is, "*The client will perform self-care activities within the level of their own ability daily.*"

An example of a SMART expected outcome criteria for a client with cognitive impairment resulting in *Self Care Deficit* is, "*The client will remain free of body odor during their hospital stay.*"

Planning Interventions

There are many nursing interventions that can be implemented for older adults with impaired cognitive function based on their individual needs. Interventions focus on maintaining safety, meeting physical and psychological needs, and promoting quality of life. As always, refer to an evidence-based nursing care planning resource when customizing interventions for specific clients. For interventions targeted for common symptoms of dementia, see the "Alzheimer's Disease" section in this chapter. See Table 6.4 for general nursing interventions to implement for clients with cognitive impairments.

Table 6.4 General Nursing Interventions for Cognitive Impairments

Therapeutic Communication: Provide nursing care in a timely manner with an attitude of caring and compassion while maintaining the dignity of the individual. Establish a therapeutic relationship based on trust by sitting at the level of the client and engaging in eye contact.
Reminiscence Therapy: Allow individuals opportunities to share their past experiences and stories. This allows expression of personal identity and supports the individual's coping and self-esteem.
Touch: When appropriate, touch provides comfort for individuals. It provides sensory stimulation to avoid sensory deprivation and demonstrates caring and warmth. It is important to assess the individual's reaction to touch before implementing therapeutic gentle touch.
Reality Orientation: This technique provides awareness of person, place, and time for those who are cognitively able. It restores a sense of reality, decreases confusion and disorientation, and promotes a healing environment. Older adults experiencing a change in environment or stressful situation benefit from the use of environmental cues for orientation, such as clocks, calendars, and whiteboards noting who is providing care and when they will return.
Validation Therapy: This technique is used for older adults who are confused. The focus is on the emotional aspect of their communication. This therapy avoids reorientation to time and place, even when incorrect, because this can trigger agitation in confused individuals. It does not reinforce incorrect perception but focuses on validating their feelings.

Implementing Interventions

When implementing interventions for clients with cognitive impairments, safety receives priority. Implement fall precautions, wandering precautions, and environmental safety precautions as appropriate.

Evaluation

It is important to routinely evaluate the effectiveness of customized interventions for clients with cognitive impairments. Review the SMART outcomes established for each specific client to determine if interventions are effectively promoting safety while also maintaining physiological and psychological needs and promoting quality of life. Modify the care plan when needed to meet these outcome criteria.

6.5 Putting It All Together

Client Scenario

Mrs. Vang is an 83-year-old resident who was recently admitted to a long-term memory care facility. She was diagnosed with Alzheimer's disease last year. She is alert to self but often has periods where she is uncooperative and is unable to follow commands. She has experienced a decline in the ability to provide self-care and wanders and paces at night. She recently fell when wandering outside of her room at night.

Applying the Nursing Process

Assessment: *Mrs. Vang is alert to self only and does not follow commands during the assessment. She is unable to provide self-care despite cueing.*

Based on the assessment information that has been gathered, the following nursing care plan is created for Mrs. Vang:

Nursing Diagnosis: *Risk for physical injury as manifested by oriented to self, wandering and pacing at night, recent fall, Alzheimer's disease, and inability to follow commands*

Overall Goal: *Client will be free from injury.*

SMART Expected Outcome: *Mrs. Vang will be free from physical injury throughout their stay at the long-term memory care facility.*

Planning and Implementing Nursing Interventions:

The nurse will provide orientation cues, such as family pictures in the client room, as appropriate. The nurse will encourage a daily routine by all caregivers to prevent discomfort issues related to thirst, hunger, or lack of sleep. The nurse will encourage client autonomy and provide choices in decisions as appropriate. The nurse will provide opportunities for reminiscence and cultivate therapeutic communication using touch and validation of emotional communication. The nurse will place a bed alarm to alert staff at night when the client is getting out of bed. The nurse will

implement a wander guard ankle bracelet to notify staff if the client wanders near an exit door.

Sample Documentation:

Mrs. Vang has impaired thought processes as a result of her Alzheimer's disease. A care routine has been established that includes visual cues and reorientation to the environment. Reminiscence therapy provided today regarding how she met her husband. Wander guard ankle bracelet was applied during the day and bed alarm in place this evening.

Evaluation:

Mrs. Vang has remained safe within the care environment and demonstrated no additional decline in thought processes. Her wandering at night has decreased, and the bed alarm alerts staff when she gets out of bed. SMART outcome "met."

View a sample nursing care plan that was created for this scenario using the template found in Appendix B.

6.6 Learning Activities

OPEN RESOURCES FOR NURSING (OPEN RN)

Learning Activities

(Answers to "Learning Activities" can be found in the "Answer Key" at the end of the book. Answers to interactive activity elements will be provided within the element as immediate feedback.)

Practice applying concepts related to cognitive impairments to the following client scenarios:

Scenario A

Figure 6.13 Simulated Client Image