CHAPTER 3 Community-Based and Home Care of the Adult Client

LEARNING OUTCOMES

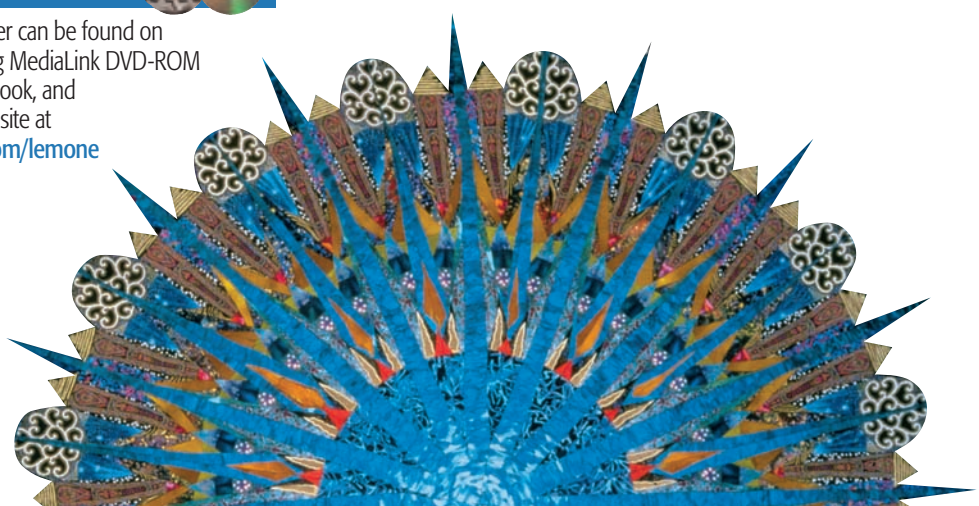
- Differentiate community-based care from community health care.
- Discuss selected factors affecting health in the community.
- Describe services and settings for healthcare consumers receiving community-based and home care.
- Describe the components of the home healthcare system, including agencies, clients, referrals, physicians, reimbursement, legal considerations, and nursing care.
- Compare and contrast the roles of the nurse providing home care with the roles of the nurse in medical-surgical nursing discussed in Chapter 1.
- Explain the purpose of rehabilitation in health care.

CLINICAL COMPETENCIES

- Provide client care in community-based settings and the home.
- Apply the nursing process to care of the client in the home.

MEDIALINK

Resources for this chapter can be found on the Prentice Hall Nursing MediaLink DVD-ROM accompanying this textbook, and on the Companion Website at http://www.prenhall.com/lemone



KEY TERMS

community-based care, *36*
contracting, *42*
disability, *47*
handicap, *47*
home care, *38*
hospice care, *38*
impairment, *47*
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Health care is provided by medical-surgical nurses in a variety of settings. There are approximately 6,000 hospitals, 17,000 residential and long-term care providers, and more than 20,000 home care providers in the United States. Currently, only clients requiring complex surgery, who are acutely ill or seriously injured, or who are having babies are hospitalized and then only for a minimum period of time. As a result, most healthcare services are provided in settings outside the hospital. Those settings include clinics, schools, prisons, day care centers for children and seniors, offices, and homes. The discussion in this chapter focuses on selected community services and settings and home care.

People requiring healthcare services may access and use the system through a variety of providers and settings, including hospital-based outpatient care, community-based offices and clinics, and home care. In the healthcare system of the 21st century, hospitals are primarily acute care providers with services focused on high-technology care for severely ill or injured people or for people having major surgery. Even those clients rarely remain in the hospital for long. They are moved as rapidly as possible to less acute care settings within the hospital and then to community-based and home care. Health care has become a managed care, community-based system. Although many nurses are still employed in hospitals, they are increasingly providing nursing care outside of the acute care, in-hospital setting.

COMMUNITY-BASED NURSING CARE

A community may be a small neighborhood in a major urban city or a large area of rural residents. Communities are formed by the characteristics of people, area, social interaction, and common ties. Each community, however, is unique. People who live in a community may share a culture, history, or heritage. Although a community is where people live, have homes, raise families, and carry on daily activities, its members often cross community boundaries to work or to seek health care. Nurses who provide care within a community must know the composition and characteristics of the clients with whom they will work.

In contrast to community health nursing, which focuses on the health of the community, **community-based care** centers on individual and family healthcare needs. The nurse practicing community-based care provides direct services to individuals to manage acute or chronic health problems and to promote self-care. The care is provided in the local community, is culturally competent, and is family centered. The philosophy of community-based nursing directs nursing care for clients wherever they are, including where they live, work, play, worship, and go to school.

Nurses provide community-based care in many different ways and locations, ranging from leading support groups in a hospital (for individuals and family members diagnosed with such illnesses as cancer or diabetes) to managing a freestanding clinic to providing care at the client's home. Box 3–1 illustrates the varied settings within the community in which a nurse may provide care.

Factors Affecting Health in the Community

Many factors can affect the health of individuals in a community. These factors include social support systems, the community healthcare structure, environmental factors, and economic resources.

BOX 3–1 Community-Based Nursing Care Settings

- Hospitals
  - Outpatient (ambulatory) surgery
  - Outpatient diagnostics and treatments
  - Cardiac rehabilitation
  - Support groups
  - Education groups
- County health departments
- Senior centers
- Long-term care
- Parish nursing
- Adult day care centers
- Homeless shelters
- Mobile vans
- Mental health centers
- Schools
- Crisis intervention centers
- Ambulatory surgery centers
- Alcohol/drug rehabilitation
- Healthcare provider offices
- Healthcare clinics
- Free clinics
- Urgent care centers
- Rural health centers
- Home care
- Hospice care
- Industry
- Jails and prisons

Social Support Systems

A person's social support system consists of the people who lend assistance to meet financial, personal, physical, or emotional needs. In most instances, family, friends, and neighbors provide the best social support within the community. To understand the community social structure, the nurse needs to know what support is available for health care for the client and family, including neighbors, friends, their church, organizations, self-help groups, and professional providers. The nurse also must know and respect the cultural and ethnic background of the community.

Community Healthcare Structure

The healthcare structure of a community has a direct effect on the health of the people living and working within it. The size of the community often determines the type of services provided as well as the access to the services. For example, urban residents have various means of transportation to a variety of community healthcare providers, whereas rural residents must often travel long distances for any type of care. The financial base of the community is also important, often determining state and county funding of services.

Nurses who provide community-based care must know about public health services, the number and kind of health screenings offered, the location and specialty of healthcare professionals within the community, and the availability and accessibility of services and supplies. Other factors to consider include facilities (e.g., day care and long-term care), housing, and the number and kind of support agencies providing assistance (e.g., housing, shelter, and food).

Environmental Factors

The environment within which a person lives and works may have both helpful and harmful effects on health. Air and water quality differs across communities. Air pollution may occur across a large area or may be limited to the home. Within the home, pollution may occur from such sources as molds, pesticides, and fumes from new carpet. The water source also varies, with water supplies coming from rivers, lakes, reservoirs, or wells. Regardless of the source, chemical runoff or bacteria may contaminate water. It is critical to determine whether clients have a safe supply of running water.

Household and community safety and health resource accessibility are also important. Nurses must consider lighting; street, sidewalk, and road upkeep and conditions; effects of ice and snow; condition of stairs and floors; and usefulness and availability of bathroom facilities. Physical barriers to accessing community resources include lack of transportation, distance to services, and location of services.

Economic Resources

Economic resources encompass the financial and insurance coverages that provide the means to have health care within the community. As private medical insurance becomes more and more expensive, fewer citizens have it; and many U.S. citizens have no insurance at all. Most unskilled jobs do not provide healthcare benefits, resulting in a substantial percentage of what might be labeled "the working poor," those who have no financial assistance for illness care or healthcare screenings from an employer. Older adults with fixed or limited incomes often find their monthly income consumed by medicines and medical supplies.

Medicare and Medicaid are health assistance programs created by 1965 Social Security amendments. Medicare is a federal health insurance plan designed to help with the acute care needs of people with disabilities and those over 65 years of age. This plan covers some services provided in hospitals, long-term facilities, and the home; however, many necessary healthcare components are not covered fully or at all, including adaptive equipment for safety, such as shower seats or raised toilet seats. Since January, 2006, those who receive Medicare, regardless of income, health status, or prescription drug usage have had access to prescription drug coverage. Coverage for care at home continues only as long as skilled providers are needed, and the person is not considered homebound even if he or she needs a wheelchair and assistance from others to leave the home. Medicaid is a state-run health insurance program for people with limited incomes. Each state has different benefits and criteria for coverage.

COMMUNITY-BASED HEALTHCARE SERVICES

Community-based healthcare services can take many forms. Selected examples are discussed in the following sections.

Community Centers and Clinics

Community centers and clinics may be directed by physicians, advanced practice nurses in collaboration with physicians, or advanced practice nurses working independently (depending on state regulations). These healthcare settings may be located within a hospital, be part of a hospital but located in another area, or be independent of a hospital base. Healthcare centers and clinics provide a wide range of services and often meet the health needs of clients who are unable to access care elsewhere. This group includes the homeless, the poor, those with substance abuse problems, those with sexually transmitted infections, and the victims of violent or abusive behavior.

Day Care Programs

Day care programs, such as senior centers, are usually located where people gather for social, nutritional, and recreational purposes. They may provide care for older adults with physical disabilities or mild Alzheimer's disease while family caregivers are at work. These programs vary among communities. Meals may be provided at low cost.

Parish Nursing

Parish nursing is a nontraditional, community-based way of providing health promotion and health restoration nursing interventions to specific groups of people. It meets the needs of people who are often underserved by the traditional healthcare system.

A nurse who practices parish nursing works with the pastor and staff of a faith community to promote health and healing through counseling, referrals, teaching, and assessment of

healthcare needs. A parish nurse may be employed by a hospital and contracted by a church, be employed directly by a church, or work as a volunteer with the congregation of a church. The parish nurse helps bridge gaps between members of the church and the healthcare system.

Meals-on-Wheels

Many communities have a food service, usually called Meals-on-Wheels, for older people who do not have assistance in the home for food preparation. A hot, nutritionally balanced meal is delivered once a day, usually at noon. Volunteers often deliver the meals, providing not only nutrition but also a friendly, caring visit each day.

HOME CARE

Home care is not easily defined. It is not simply illness care at home, nor is it the act of setting up a hospital room in someone's house. The National Association for Home Care (NAHC) (2000) defines **home care** as services for people who are recovering, disabled, or chronically ill and who are in need of treatment or support to function effectively in the home environment. The U.S. Department of Health and Human Services places home care along a continuum of health care. Home care is provided in the client's place of residence for the purpose of promoting, maintaining, or restoring health or of maximizing the level of independence while minimizing the effects of disability and illness, including terminal illness.

Home care encompasses both health and social services provided to the person who is chronically ill, disabled, or recovering in his or her own home. Home care is usually provided when a person needs help that cannot be provided by a family member or friend. Among clients who benefit from home care services are those who:

- Cannot live independently at home because of age, illness, or disability.
- Have chronic, debilitating illnesses such as congestive heart failure, heart disease, kidney disease, respiratory diseases, diabetes mellitus, or muscle-nerve disorders.
- Are terminally ill and want to die with comfort and dignity at home.
- Do not need inpatient hospital or nursing home care but require additional assistance.
- Need short-term help at home for postoperative care.

The services provided in the home may include professional nursing care, care provided by home care aides, physical therapy, speech therapy, occupational therapy, medical social worker services, and nutritional services. Clients receiving home care services are usually under the care of a physician, with the focus of care being treatment or rehabilitation. Registered nurses or licensed practical nurses provide nursing care based on physician orders. These nurses give direct care, supervise other care providers, coordinate client care with the physician, advocate for the client and family, and teach family members and friends how to care for the client to assist the nurse as well as when professional services are no longer necessary.

MEDIALINK Respite Resources

Home care is both professional and technical. Professional home care is provided by people who are practice driven, licensed, certified, and/or have special qualifications. Nurses, therapists, social workers, and home aides are considered professional providers. Durable medical equipment companies (businesses that deliver medical equipment to homes) are technical providers. Technical home care providers are business and product driven. Customer satisfaction, field service, reimbursement, and profits are their primary concerns.

Brief History of Home Care

Many milestones marked the growth and development of home care in the United States. The passage of Medicare in 1965, Medicaid in 1970, the addition of hospice benefits in 1973, and the introduction of diagnosis-related groups (DRGs) in 1983 dramatically affected home care. Medicare legislation entitled the nation's elderly to home care services, primarily skilled nursing and other curative or restorative therapies. This same benefit was extended to certain younger Americans with disabilities in 1973.

The introduction of DRGs to help control healthcare costs greatly increased home care. DRGs are categories for reimbursement of inpatient services. The DRG system pays the same predetermined amount of money for the care of different persons with the same medical diagnosis. Many changes in the healthcare system have been attributed to the introduction of DRGs, including earlier discharge from hospitals and the increased need for home care services.

Hospice and Respite Care

Hospice care is a special component of home care, designed to provide medical, nursing, social, psychologic, and spiritual care for clients who are terminally ill and their families. Hospice care relies on a philosophy of relieving pain and suffering and allowing the client to die with dignity in a comfortable environment. Licensed nurses, medical social workers, physicians, occupational and physical therapists, and volunteers provide care. Hospice care is discussed in Chapter 5 ∞.

Respite care provides short-term or intermittent home care, often using volunteers. These services exist primarily to give the family member or friend who is the primary caregiver some time away from care. Respite care does much to relieve the burden of full-time caregiving.

The Home Care System

Nurses who practice home care do so within a system that includes home healthcare agencies, clients, referral sources, physicians, reimbursement sources, and legal considerations. The system is interactive and, like any other, functions best when its members communicate, cooperate, and collaborate with one another.

Types of Home Health Agencies

Home care agencies are either public or private organizations engaged in providing skilled nursing and other therapeutic services in the client's home. The several different types of home care agencies differ only in the way their programs are organized and

MEETING INDIVIDUALIZED NEEDS **The Client Being Discharged from Acute Care to Home Care**

QUESTIONS FOR CONSIDERATION

- Does the client need follow-up therapy, treatments, or additional education?
- What equipment, supplies, or information about community resources is necessary?
- What teaching materials can be sent home? Are they written at an acceptable reading level? Do they come in other languages?
- What cognitive abilities do the client and the caregiver seem to have? Are there any sensory deprivations that impede learning?
- Who will be the principal caregiver in the home? Is there one? Are all caregivers comfortable in doing what needs to be done? If not, what support do they need to become comfortable?
- Was the caregiver present during and included in instruction? How have the client and caregiver responded to health teaching thus far? Have they comprehended what has been taught? Was their stress level such that they could not listen?
- Has a devastating diagnosis and/or prognosis just been determined?
- Is high-technology intervention necessary?

administered. All home care agencies are similar in that they must meet uniform standards for licensing, certification, and accreditation. Home care agencies include the following:

- *Official or public agencies.* State or local governments operate these agencies, which are financed primarily by tax funds. Most official agencies offer home care, health education, and disease prevention programs in the community.
- *Voluntary or private not-for-profit agencies.* Donations, endowments, charities such as the United Way, and third-party (insurance company) reimbursement support these agencies. They are governed by a volunteer board of directors, which usually represents the community they serve.
- *Private, proprietary agencies.* Most of these agencies are for-profit organizations governed by either individual owners or national corporations. Although some participate in third-party reimbursement, others rely on clients paying their own bills (often called out-of-pocket expenses).
- *Institution-based agencies.* These agencies operate under a parent organization, such as a hospital. The home care agency is governed by the sponsoring organization and the mission of both is similar. Often, the majority of home care referrals come from the parent organization.

Home care agency personnel typically include administrators, managers, care providers (these may be experienced in social work, medical-surgical care, mental health care, or infusion services), and business office staff. Depending on the agency and geographic location, professional providers may include registered nurses, practical nurses, nurse practitioners, enterostomal therapists, physical therapists, occupational therapists, speech therapists, respiratory therapists, social workers, a chaplain or pastoral minister, dietitians, and home care aides. It is not unusual for clients to require the services of several professionals simultaneously. No matter how many providers are in the home, the responsibility for case coordination (also called case management) remains with the registered nurse.

Clients

The client in home care is the person receiving care and the person's family. The recognition that the family is also a client acknowledges the powerful influence that families exert on health. A client's family is not limited to persons related by birth, adoption, or marriage. In the home, family members may include lovers, friends, colleagues, other significant people, and even animals that hold the potential of greatly affecting the healthcare environment.

Age and functional disability are the primary predictors of need for home care services. Information from a national survey conducted by the Agency for Health Care Policy and Research found that about half of all home care clients are over the age of 65 and that the number of home care services that clients need seems to increase with age.

The old adage that discharge plans begin at admission makes more sense today than ever before. With shortened lengths of hospital stay, it is imperative for nurses to evaluate all clients for their ability to manage at home. Nurses preparing to send clients home must consider many of the questions outlined in the Meeting Individualized Needs box on this page.

Referrals

A **referral source** is a person recommending home care services and supplying the agency with details about the client's needs. The source may be a physician, nurse, social worker, therapist, or discharge planner. Families sometimes generate their own referrals, either by approaching one of the sources already mentioned or by calling a home care agency directly to make an inquiry. When the family seeks a referral and the agency believes that the client qualifies for services, usually the agency contacts the client's physician and requests a referral on the client's behalf.

The nurse may make a referral to either a home care agency, a hospice, or a community resource if the client seems to need formal follow-up beyond the present clinical setting. Hospital discharge planners, social workers, organizations for older adults, and local nonprofit agencies usually have a good command of the services and support groups available in their communities.

The nurse must talk to clients and their caregivers about concerns related to home management. It is not unusual for one family member to think that no additional help is necessary and for another to feel differently.

The nurse can facilitate an informal family meeting in which everyone shares concerns and can make inquiries about the family's insurance coverage for home care. Suggesting services that families cannot afford only adds to the problem. For

clients with limited means, the nurse can consult with staff in the institution who are most knowledgeable about funding. In every instance, it is important that the nurse avoid making assumptions: Well-educated and financially secure clients can be just as overwhelmed by illness as clients who are poor and less learned. Everyone is a referral candidate.

If the family believes that no help is necessary and the nurse believes otherwise, then the nurse may ask the family to consider an evaluation visit, explaining how the situation may look different once the client is home. If family members continue to refuse, the nurse can let them know that the door is never closed and give them contacts in the community that they can access independently should their needs change.

Physicians

Home care cannot begin without a physician's order, nor can it proceed without a physician-approved treatment plan. This is a legal and reimbursement requirement. Only after a referral is made and an initial set of physician orders is obtained can a nursing assessment visit be scheduled to identify the client's needs. If the input of another provider, such as a physical therapist, is necessary to complete the initial assessment, then the nurse arranges for this visit.

At the nursing assessment visit, the nurse begins to formulate the plan of care. Box 3–2 lists Medicare's required data for the nursing plan of care. Once formulated, the nurse sends the plan of care back to the physician for review and approval. The physician's signature on the plan of care authorizes the home care agency's providers to continue with services and also serves as a contract indicating agreement to participate in the care of the client on an ongoing basis. The plan is reviewed as necessary, but at least once every 60 days.

Reimbursement for Services

A reimbursement source pays for home care services. Medicare is home care's largest single reimbursement source, although other sources exist (Medicaid, other public funding, private insurance, and public donation). The reimbursement source evaluates each treatment plan to determine if the goals and plans set forth by the professional providers match the needs assessed. Only interventions identified on the treatment plan are covered. Periodically the reimbursement source may ask for the home care provider's notes to substantiate what is being done in the home. This is one reason why accurate documentation is critical.

Medicare does not reimburse visits made to support general health maintenance, health promotion, or clients' emotional or socioeconomic needs. Both client and nurse must meet specific criteria to secure Medicare reimbursement. The client must meet all of the following criteria:

- The physician must decide that the client needs care at home and make a plan for home care.
- The client must need at least one of the following: intermittent (not full-time) skilled nursing care, physical therapy, speech language pathology services, or occupational therapy.
- The client must be homebound. This means leaving the home is a major effort. When leaving the home, it must be infrequent, for a short time, to get medical care, or to attend religious services.
- The home care agency must be Medicare approved.

Medicare will reimburse only when the skilled provider performs at least one of the following tasks:

- Teaching about a new or acute situation
- Assessing an acute process or a change in the client's condition
- Performing a skilled procedure or a hands-on service requiring the professional skill, knowledge, ability, and judgment of a licensed nurse (Figure 3–1 ■).

The reimbursement guidelines present problems because they are not sensitive to the full scope of nursing practice. Many of the client and family needs that nurses encounter during home visits are complex and time consuming, reflecting both intense psychosocial and economic concerns. This situation presents a profound dilemma. How are nurses to reconcile spending time on issues for which their agency will receive no payment? How are they to meet agency home visit productiv-

BOX 3–2 Medicare's Required Data for the Plan of Care

1. All pertinent diagnoses
2. A notation of the beneficiary's mental status
3. Types of services, supplies, and equipment ordered
4. Frequency of visits to be made
5. Client's prognosis
6. Client's rehabilitation potential
7. Client's functional limitations
8. Activities permitted
9. Client's nutritional requirements
10. Client's medications and treatments
11. Safety measures to protect against injuries
12. Discharge plans
13. Any other items the home health agency or physician wishes to include

Source: Data from Medicare Health Insurance Manual-11, Section 204.2.

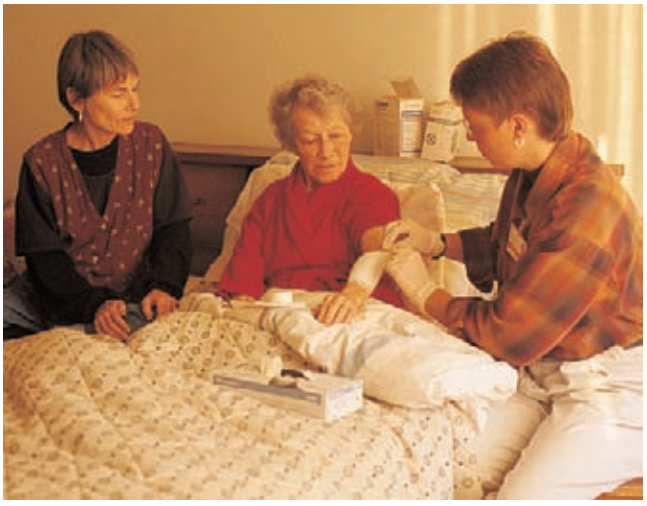


Figure 3–1 ■ The home health nurse provides client and caregiver education. This nurse is teaching the client and family how to apply dressings.

ity standards when each home they enter requires more and more from them? How are they to document activities and interventions that are not considered "skilled"? There are no easy answers to these questions.

Legal Considerations

The legal considerations in home care center around issues of privacy and confidentiality, the client's access to health information, the client's freedom from unreasonable restraint, witnessing of documents, informed consent, and matters of negligence and/or malpractice. Numerous sources suggest that nurses can best avoid lawsuits by familiarizing themselves with the standards of practice, providing care that is consistent with both the standards and their agency's policies, and documenting all care fully and accurately according to agency guidelines.

Home care nurses are responsible for adhering to the same codes and standards that guide all other nurses. These codes and standards guide nursing practice and protect the public. In addition to these guidelines, other codes and statements give specific guidance on issues that affect care in the home.

The American Nurses Association (ANA) Standards for Home Health Nursing Practice are used in conjunction with the ANA Standards of Community Health Nursing as a basis for the practice of nursing in the home. The standards address the nursing process, interdisciplinary collaboration, quality assurance, professional development, and research. The standards speak to two levels of practitioners (the generalist, who is prepared on the baccalaureate level, and the specialist, who is prepared on the graduate level) and outline what achievements are expected of the professional nurse in the home.

Another source of guidance regarding home care is the NAHC Bill of Rights. Its use is a federal requirement for all home care agencies. Although they are permitted to make additions to the NAHC's original Bill of Rights, home care agencies are required by law to address the concepts in the NAHC Bill of Rights with all home care clients on the initial visit. The Bill of Rights is shown in Box 3–3.

BOX 3–3 **Example of a Home Health Agency's Bill of Rights**

The agency acknowledges the client's rights and encourages the client and family to participate in their plan of care through informed decision making. In accordance with this belief, each client/family member will receive, prior to admission, the following bill of rights and responsibilities.

1. The client and the client's property will be treated with respect by the program's staff.
2. The client will receive care without regard to race, color, creed, age, sex, religion, national origin, or mental or physical handicap.
3. The client has the right to be free from mental and physical abuse.
4. The client's medical record and related information is maintained in a confidential manner by the program.
5. The client will receive a written statement of the program's objectives, scope of services, and grievance process prior to admission.
6. The client, family, or guardian has the right to file a complaint regarding the services provided by the program without fear of disruption of service, coercion, or discrimination.
7. The client will be advised of the following in advance of service:
   a. Description of services and proposed visit frequency
   b. Overview of the anticipated plan of care and its likely outcome
   c. Options that may be available.
8. The client/family is encouraged to participate in the plan of care. The client will receive the necessary information concerning the client's condition and will be encouraged to participate in changes that may arise in care.
9. The program shall provide for the right of the client to refuse any portion of planned treatment to the extent permitted by law without relinquishing other portions of the treatment plan, except where medical contraindications exist. The client will be informed of the expected consequences of such action.
10. The client has a right to continuity of care:
    a. Services provided within a reasonable time frame
    b. A program that is capable of providing the level of care required by the client
    c. Timely referral to alternative services, as needed
    d. Information regarding impending discharge, continuing care requirements, and other services, as needed.
11. The client will be informed of the extent to which payment will be expected for items or services to be furnished to clients by Medicare, Medicaid, and any other program that is funded partially or fully with federal funds. Upon admission, the client will be informed orally and in writing of any charges for items and services that the program expects will not be covered upon admission. The client will be informed of any change in this amount as soon as possible, but no later than within 25 days after the program is made aware of the change.
12. Upon request, the client may obtain:
    a. An itemized bill
    b. The program's policy for uncompensated care
    c. The program's policy for disclosure of the medical record
    d. Identity of healthcare providers with which the program has contractual agreements, insofar as the client's care is concerned
    e. The name of the responsible person supervising the client's care and how to contact this person during regular business hours.
13. The client has the right to obtain medical equipment and other health-related items from the company of the client's choice and assumes financial responsibility for such. The program's staff will assist in obtaining supplies and physician approvals as needed.
14. The client/family is responsible for:
    a. Giving the program accurate, necessary information
    b. Being available and cooperative during scheduled visits
    c. Assisting, as much as possible, in the plan of care
    d. Alerting the staff to any problems as soon as possible.

MEDIALINK Care Plan Activity: Home Health Assessment

The Nursing Process in Home Care

The nursing process used in home care is no different from that practiced in any other setting. The unique challenges of home care present themselves chiefly in the implementation step. Generally, the differences lie in assessing how the home's unique environment affects the need or problem and using outcome criteria and mutual participation to plan goals and interventions.

Assessment

In home care, nursing assessment and data collection center chiefly around the first home visit. This is not to say that nurses do not collect information on an ongoing basis, but because most agencies require the submission of a plan of care within 48 hours of the initial evaluation, the first visit carries tremendous weight. Under ideal circumstances, a preliminary review of background information initiates the assessment process; the reality in home care, however, is that few clients are referred with copies of either their medical records or their discharge summaries. If the client has received home care services in the past, records may be available, but often all the nurse has prior to initiating care is the referral form describing the present problem, some notations about past medical history, and a projection of the skilled interventions needed. Therefore, it falls to the nurse to try to obtain as complete a clinical picture as possible when meeting the client.

Assessment begins when the nurse calls the client to arrange a visit. This initial telephone call can yield much information to the nurse who pays close attention. For example:

- How alert, oriented, and stressed does the client (and/or family) seem to be?
- Does the client know the reason for the home care referral?
- How open to intervention do the client and family seem to be?
- Have they encountered any difficulties since discharge from the prior setting?
- Do they need any supplies on the first visit?

During the visit, much of the assessment process centers around collecting the information requested on the tools and forms contained in the agency's admission packet. These packets usually include a physical and psychosocial database; a medication sheet; forms for pain assessment, spiritual assessment, and financial assessment; and a family roster. It is extremely important that the data collected be as complete and accurate as possible and reflect subjective, objective, current, and historical information. Through interviewing, direct observation, and physical assessment, the nurse can achieve the goal of the initial visit, namely, to gain as clear and accurate a clinical picture of the client as possible.

Diagnosis

After completing the initial assessment, the nurse identifies the real and/or potential client problems that emerge from the data. Nursing diagnoses describing the client's health problems and needs, based on data collection, must be part of the home care record both to organize care and to justify reimbursement.

In almost all home care situations, *Deficient Knowledge* is an appropriate nursing diagnosis. Nursing interventions for this diagnosis specific to a client with Alzheimer's disease and the client's family can be found in the Meeting Individualized Needs box on the following page.

Planning

Planning in home care includes setting priorities, establishing goals, and deciding on intervention strategies designed to meet the needs of the client. The greatest level of success is achieved when clients feel an ownership of the suggested plan. For this reason, planned interventions and outcome criteria should be client centered, realistic, achievable, and mutually accepted. The nurse works with the client to:

- Identify significant issues and needs.
- Set mutually agreed-on goals (outcome criteria).
- Make and initiate acceptable plans to meet the goals.

Outcome criteria should be verbally stated to clients and documented clearly and concisely, in timed, measurable, and observable terms. These measures help clients and care providers to better focus their work together and evaluate the effectiveness of care. In addition, outcome criteria provide the reimbursement source a measurable standard from which to judge the appropriateness of the plan of care.

Implementation

The home care nurse implements most of the planned interventions, although some may be carried out by another agency provider, a paraprofessional introduced into the setting by the nurse case manager, or the client.

Nurses and clients reach an agreement about the implementation of care through a process called **contracting**, the negotiation of a cooperative working agreement between the nurse and client that is continuously renegotiated. Contracting is a concept used often in, but not exclusively by, many home and community health settings. Contracting can occur both formally and informally. It involves exploring a need, establishing goals, evaluating resources, developing a plan, assigning responsibilities, agreeing on a time frame, evaluating, and deciding to continue or terminate the plan. Contracting requires the nurse to relinquish control as the expert and consider the client as an equal partner in the process.

Contracting is not appropriate with all clients. It is certainly inadvisable if the nurse–client relationship is to be no more than two visits or if the client has limited cognitive abilities. However, contracting is useful for clients who demonstrate a willingness to be active participants in their health care. It is empowering, can save time, and keeps the nursing care goals directed and focused.

Evaluation

Evaluation in home care is both formative and summative. Formative evaluation is the systematic ongoing comparison of the plan of care with the goals actually being achieved from visit to visit. In summative evaluation, the nurse reviews the total plan of care and the client's progress toward goals to determine the client's eligibility for discontinuation of services.

Reimbursement guidelines may be helpful in driving the evaluation process. Because reimbursement sources require that all skilled services be justified, many home care agencies have designed their clinical notes to include areas for evalua-

MEETING INDIVIDUALIZED NEEDS **Family Home Care for the Older Adult with a Dementing Disorder**

NURSING DIAGNOSIS

Deficient Knowledge related to lack of information about Alzheimer's disease process and care

OUTCOME CRITERIA

Short term: Adequate knowledge, as evidenced by family's stating of disease progression and treatment (expected within 1 week)

Long term: Adequate knowledge, as evidenced by family's following of the recommended interventions throughout illness course (within 1 month) or by discharge from home health

INTERVENTIONS

- Alert the family to both environmental hazards and client habits that could threaten safety. (first visit)
- Provide the family with specific recommendations for keeping the client safe, for example, serving foods warm, not hot; allowing the client to eat with fingers; cutting food in small pieces; wearing an ID bracelet; discouraging daytime sleep. (first visit)
- Discuss the disease course (degenerative), the prognosis (incurable), typical issues of concern (promoting adequate nutrition, activity, rest, safety, and independence); supporting cognitive function; communication, socialization, and family caregiving; the supportive care available; and the ultimate need for long-term placement with disease progression. (first visit)
- Discuss local resources, including adult day care, support groups, and Alzheimer's Disease Association. Give family a list of these resources. (first visit)
- Include all family members or significant persons in teaching and planning care. (each visit)
- Prepare the family for typical types of Alzheimer's disease behaviors: forgetfulness, disorientation, agitation, screaming, crying, physical or verbal abuse, accusations of infidelity. (subsequent visits)
- Teach the family specific interventions for dealing with these behaviors: calm, unhurried manner, music, stroking, rocking, structuring the environment, distracting the client. (subsequent visits)
- Stress the importance of both exercise and recreation in terms of quality of life and decreasing nighttime restlessness. (subsequent visits)
- Reinforce the client's continued needs for socialization and intimacy. (subsequent visits)
- Suggest specific interventions for meeting socialization needs: limiting visitors to one or two at a time, pet therapy, use of the phone. (subsequent visits)
- Suggest useful interventions that are described in the literature and/or that are utilized in more formal Alzheimer's disease settings and may also be helpful in the home. (subsequent visits)
- Keep the environment safe for the client.
- Use reality orientation with client several times a day, and post clocks, calendars, and telephone numbers within easy sight of the client.
- Give client simple directions, using simple sentences and a quiet, monotone voice so as not to excite the client.
- Allow the use of the telephone, because calls will help orient the client.

tion of the client's response to the visit's interventions and documentation of a plan of care for the next scheduled visit.

Roles of the Home Care Nurse

The role expectations of the home care nurse are similar to those of the professional nurse in any setting. On behalf of clients in the home, the nurse serves as an advocate, a provider of direct care, an educator, and a coordinator of services (see Chapter 1 ∞).

Advocate

As client advocate, the nurse explores, informs, supports, and affirms the choices of clients. Advocacy begins on the first visit, when the nurse discusses advance directives, living wills, and durable power of attorney for health care. The home care agency's Bill of Rights also needs to be discussed. During the course of care, clients may need help negotiating the complex medical system (especially in regard to medical insurance), accessing community resources, recognizing and coping with required changes in lifestyle, and making informed decisions. When the family's desires differ from the client's, advocacy can be a challenge. If a conflict arises, the nurse must remain the client's primary advocate.

In the home, there are no colleagues present to consult, to assist, or to rely on for support. The home is a practice setting where nurses learn to trust their theoretical and intuitive knowledge and to be totally accountable.

Provider of Direct Care

Home care nurses usually are not involved in providing personal care for clients (bathing, changing linens, and so on). Family members often provide routine personal care, or the nurse may arrange for a home care aide. If a personal care need arises during the course of the skilled visit (e.g., if a client has an incontinent episode), the nurse typically either bathes and changes the client or assists the caregiver to do so before moving on to the skilled activities planned for the visit.

As a provider of direct care, the nurse uses the nursing process to assess, diagnose, plan care, intervene, and evaluate client needs. During the course of this process, home care nurses frequently are involved in performing specific procedures and treatments such as physical assessments, care of intravenous lines, ostomy care, wound care, and pain management.

Personal health habits, living conditions, resources, and support systems may leave much to be desired. It is not unusual for home care nurses to face unchanged dressings, undertreated infections, off-and-on self-medication, poor nutrition, filthy conditions, and unreliable caregivers. No matter how vigilant nurses may be, practice settings like these work against their best efforts. If the conditions cannot be changed,

Figure 3–2 ■ Home visits offer opportunities to work on health promotion. This nurse takes a client's blood pressure while visiting for an unrelated condition.

Source: Don Mason/Corbis Bettman.

the nurse may withdraw from the situation or continue to practice within the environment and report substandard care by caregivers.

Educator

Most of the home care nurse's time is spent teaching. Many nurses believe that their role as teacher is the crux of their nursing practice and that nurses in the home are always teaching (Figure 3–2 ■). For this reason, it is important that home care nurses develop expertise in the theory and principles of client education.

The greatest educational challenge may be motivating the client. Discovering what it takes to make the client want to learn and focusing the client on what is most important can tax the ingenuity of even the most dedicated nurse. Despite the work involved, nurses are rewarded by the knowledge that through their efforts, clients have learned to manage independently. Because the nurse's role as educator is becoming increasingly important, guidelines for community-based care are included in the discussion of each major disorder addressed in this textbook.

When preparing clients for discharge to home, the nurse focuses on safety and survival first. Even if health education is to continue with home care, a day or two may elapse before the nurse arrives, and clients must be able to manage by themselves until then. The nurse must not discharge clients without giving them the correct information and supplies to get them through the first few days at home. Additionally, clients should not be discharged without phone numbers and complete written information about their medications and the manifestations of complications they should report to their doctor or the nurse who discharged them. Finally, all clients should be able to at least minimally manage any necessary treatments. Management includes not only performing procedures safely but also knowing how to obtain necessary supplies in the community.

Clients need help understanding their situations, making healthcare decisions, and changing health behaviors. It is unrealistic, however, to believe that clients can be taught everything they need to know during today's shortened hospital stays. The nurse should therefore recommend a home care referral for anyone in need of follow-up teaching. Prioritized teaching is essential: Even under the best of circumstances, clients generally forget about one-third of what is said to them, and their recall of specific instructions and advice is less than 50%. Comprehensive information related to client and family teaching is included in most of the following chapters in this textbook. This can be used as a guide in planning teaching.

Coordinator of Services

As coordinator of services, the home care nurse is the main contact with the client's physician and all other providers involved in the treatment plan. It is the responsibility of the registered nurse case coordinator (or clinical case manager) to report client changes, discuss responses, and develop and secure treatment plan revisions on an ongoing basis. This is accomplished both formally, through scheduled case and team conferences, and informally (often over the phone) with concerned providers. Documentation of all coordination activities is legally required.

Special Considerations in Home Care Nursing

Nursing practice in the home is a unique experience that differs in many ways from nursing practice in a hospital setting. The word *home* generates strong feelings of ownership, control, security, family history, independence, comfort, protection, and conflict. The family perceives a sharing of self when they consistently allow entry to a stranger. Because clients and nurses most often meet during periods of vulnerability and crisis, and because socializing is such an integral part of the home visit process, nurse providers are often perceived as friends or extended family members, blurring the boundaries of practice.

Nurses are invited into homes. Nurses are guests and cannot assume entry, as they do in formal clinical settings. The environment belongs to the client, who retains control. Every nursing action must communicate respect for these boundaries. To negotiate both repeated entry and a share of power in the client's domain, the nurse must establish trust and rapport quickly. This is often difficult, because most home care nurses are with each client for only 1 hour a few times a week.

During the course of establishing rapport and getting to know each other as people, the nurse–client relationship often becomes something more. Nurses and clients end up giving to each other and learning from each other. By connecting as human beings, they touch each other's spirits in profound ways (Carson, 1989). In home health, it is not unusual for nurses to realize suddenly not only that they do things to create a healing environment but also that their very presence has become the healing environment.

Over time, as the nurse becomes a familiar presence and the family's behavior relaxes, the nurse can gain a clearer and more complete picture of family relationships, dynamics, lifestyle choices, and coping patterns. Multigenerational behavior patterns are more obvious, and working around them can become quite a feat.

Today, more older adults are living alone. Some may have current or potential caregivers nearby, whereas others, for any of various reasons, have no one. These people often require considerable nursing support to remain strong, independent, and resourceful. Caring for "families of one" can take a toll on even the strongest home care nurse. Some nurses have reported calling between visits, keeping in touch after discharge, and driving by on days off because they have such difficulty "letting go" of their concerns about these clients.

Caregiver burden is not easily hidden in the home. In more than 22 million American households, people are taking care of relatives and friends with disabilities (Administration on Aging, 2003b). Many of these caregivers are themselves older adults. Healthcare planners visualize the home as a place where all kinds of medical services can occur but may give little thought to how people manage. Few ever ask whether families can cope with the level of care they are expected to assume. Caregiving has only recently been acknowledged as a complex activity, requiring adjustment in family living patterns, relationships, and finances. For some families, the crisis of caregiving is short lived, but for others it lasts for years. As a result, caregivers are at great risk for both physical and emotional illness. Because the success of home care depends heavily on the supports in place, addressing the needs of the support network is imperative.

Nursing Interventions to Ensure Competent Home Care

Despite differences in the setting, nursing care for clients in their homes is a highly rewarding clinical practice. The following discussion provides practical information for competent care with successful outcomes.

Establish Trust and Rapport

To establish trust and rapport in the client's home, nurses must try to find common ground and to let go of ethnocentric ("My culture's way is the best way") views. Nurses must be sure everything they say and do communicates an understanding that they are guests—offering suggestions in a way that acknowledges the client's right to say no, sensing and honoring "where people are in their situation," maintaining a respectful distance, and noticing and honoring family customs ("I see that no one wears shoes in your house; I'll take mine off, too."). Nurses should try to negotiate their schedules around the family's needs; nursing should enhance family coping, not complicate it. Above all, nurses should validate clients' illness experiences, remembering that everyone needs someone who is willing to listen and say, "I hear what you are saying, and I think I have a sense of how you feel."

Proceed Slowly

The nurse must enter the home with an awareness that the first contact is important. On the first nursing visit, the nurse can suggest to clients that they have someone else present "to help them listen." To avoid overwhelming clients with too much information, the nurse stresses the essential information and repeats it on subsequent visits. When making suggestions, the nurse offers clients the pluses and minuses of each alternative. Informed decisions are difficult to make if people are too overwhelmed to think of their options. The nurse speaks slowly, directly, and within the client's range of vision (the client may have to lip-read) and refrains from shouting at clients who have hearing impairments. The nurse must allow time for families to process new information.

Set Goals and Boundaries

The nurse explores clients' expectations of home care. In particular, the nurse explains the primary goal (to achieve self-care), defines nurse and client roles within this framework, and discusses limitations. The nurse may make statements such as "No, a home care nurse is not the same as a private duty nurse" and "Home care nurses do not routinely do that, but today I will make an exception." It is important for the nurse to stress mutual accountability, choice, and negotiation as part of the process.

Assess the Home Environment

The nurse surveys the overall home environment, using common sense, intuition, and imagination. Among the variables to note are sights, sounds, smells, dress, tone of voice, body language, and the use of touch; visiting patterns among family members; significant relationships; what is sacred and what is not; the appearance of the house, yard, sidewalk, and neighborhood; and the effect of illness on the family. The nurse asks questions and listens carefully to stories and offhand remarks.

Set Priorities

It is important that nurses be flexible and realize they cannot tackle everything. Although it is necessary to enter the home with a plan in mind, nurses must be prepared to modify the plan according to conditions they encounter once inside. Safety, issues that are of concern to clients, and those problems that can most easily be solved should be addressed first. Alternatively, the nurse can focus on safety first, then short-term and long-term goals. If the priorities that are set are primarily the nurse's and not the client's, then they may not be met.

Promote Learning

Instead of just teaching the client, the nurse tries actively to promote the client's ability to learn by, for example, identifying what is most important to the client and teaching that. Survival takes first priority; the nurse teaches the information people need to ensure their safety until the next visit. The nurse prioritizes material on a needs-to-know, wants-to-know, ought-to-know basis, assessing and responding to learner readiness.

Timing is important; people who are not ready to listen cannot be taught. In addition, the nurse must allow a sufficient amount of time to teach, ask clients how and when they learn best, use appropriate methods and materials when possible, and capitalize on clients' frustrations and desires to regain control of self-care. When possible, the nurse teaches while providing care.

The nurse can empower clients to learn by talking them through learning tasks, encouraging them to listen to their own bodies and to ask questions, and urging them to write thoughts and questions about their care and have them ready for the next visit or doctor's appointment.

Limit Distractions

Homes are full of events or circumstances that may divert attention from the job at hand. Such distractions as children, animals, noise, clutter, and mannerisms that are controlling, manipulative, or aggressive can try even the most experienced nurse. However, environmental and behavioral distractions can yield useful information about people, their relationships, and their values. For example, a dirty house could indicate a lack of interest in housekeeping, outright neglect and abuse, depression, or increased disability.

Distractions should be limited as much as possible. For example, the nurse might ask a client, "May I please turn off your television while we visit?" or "I would like to schedule my next visit for a time when the children are in school. Is that all right with you?" The nurse must be truthful about allergies, fear of a client's pet, or difficulty hearing in a particular room, but should not debate the priority of the visit over the distraction (such as a favorite television show). The nurse may not change the client's views and may also risk losing the client's trust and rapport. If all efforts at limiting distractions fail, the nurse should leave the home and return on another day: "I can see this is not going to work for us today. I will need to leave."

If any distraction originates with the nurse, such as fear of harm, reaction to the client's lifestyle, preoccupation with role, or a feeling of being overwhelmed by the situation in the home, the nurse should seek out a colleague to discuss the problem. Often, another perspective helps when dealing with the issue.

Put Safety First

Safety assessment in the home is a nursing responsibility and a legal requirement. Nurses cannot close their eyes to an unsafe environment. Upon entering the home and on a continuing basis, it is imperative that the nurse alert the family to unsafe and hazardous conditions, suggest remedies, and document in the clinical record the family's response to the nurse's suggestions. See Box 3–4 for a sample home safety assessment list. In particular, nurses must remain alert to:

- How clients handle stairs
- How clients manage their own care if they are alone
- The presence of a smoke detector in the home
- The presence of bathroom safety equipment
- Electrical hazards
- Slippery throw rugs, clutter, or a furniture arrangement that may cause a fall
- A supply of expired medications
- Inappropriate clothing or shoes
- Cooking habits that may precipitate a fire
- An inadequate food supply
- Poorly functioning utilities
- Chipping paint
- Signs of abusive behavior

Nurses cannot go into homes and change the family's living space and lifestyle, but they can register their concern and react appropriately if the situation suggests that an injury is about to occur or if they suspect abuse or neglect. In the home and community setting, ignoring an unsafe environment is considered nursing negligence.

The disposal of toxic medications and sharp objects (such as needles used for injections) is also a safety issue in the home, especially if young children are present. Once again, it is imperative that the nurse address this with the client, demonstrate safe disposal, and provide the necessary equipment to accomplish that end. Documentation should address what information the nurse has covered, the family's response to the teaching, and assessment of the family's ongoing practice of safety precautions.

Nurses must focus on safety and survival first, for themselves as well as their clients, in all that they do. When traveling in the community, the nurse takes such precautions as keeping car doors locked, having a cellular phone, keeping supplies out of sight, and staying inside the car in potentially dangerous situations. Colleagues, families, and community members can offer useful guidelines for maintaining safety and self-protection.

Make Do

Nurses must learn to be resourceful and cost conscious with equipment, supplies, and services in the home. When needing to make do or improvise, they should do so in a low-key manner to avoid causing the family additional anxiety. The nurse must make

MEDIALINK Case Study: Safety in the Home

BOX 3–4 Home Safety Assessment Checklist

General Household Safety

1. Do stairwells and halls have good lighting?
2. Do staircases have handrails on both sides?
3. Are rugs securely tacked down?
4. Is the telephone readily accessible? Is the dial easy to read?
5. Are electrical cords in good condition and out of the way?
6. Is furniture sturdy?
7. Is the temperature of the home comfortable?
8. Are protective screens in front of fireplaces or heating devices?
9. Are smoke detectors and carbon monoxide detectors present and working?

Bathroom

1. Are grab bars present in the tub and/or shower? Around the toilet?
2. Are toilet seats high enough?
3. Are nonskid materials (rugs, mats) on the floor, tub/shower?
4. Are medications stored safely? Out of the reach of children?
5. Is the water temperature safe?
6. Are electrical outlets and appliances a safe distance from the tub?

Kitchen

1. Are floors slippery? Are nonskid rugs used?
2. Is the stove in good working order?
3. Is the refrigerator in good working order? Clean?
4. Are electrical outlets overloaded with appliance cords?
5. Are sharp objects kept in a special container or safe area?
6. Is food storage adequate? Clean?
7. Are cleaning materials stored safely?

every effort to convey the message that the situation is under control; after leaving the home, the nurse can react as necessary.

Control Infection

Infection control in the home centers around protecting clients, caregivers, and the community from the spread of disease. Within the home, nurses may encounter clients with infectious or communicable diseases, clients who are immunocompromised, and/or clients having multiple access devices, drainage tubes, or draining wounds. The home presents a challenging environment in which to practice infection control for several reasons: Families typically are set in their own ways of doing things; caregivers often lack any formal education on the subject; the setting itself may not be conducive; and the facilities for even the most basic of aseptic practices (hand washing) may be lacking. Without a doubt, the single most important nursing intervention in controlling infection is health teaching. Clients and caregivers need to know the importance of effective hand washing, the effective use of gloves, proper disposal of wastes and soiled dressings, proper handling of linens, and the practice of standard precautions. Unfortunately, the imparting of important information does not always bring about a change in behavior. Trying to change a family's values frequently demands a great deal of ingenuity from the nurse.

REHABILITATION

Rehabilitation is the process of learning to live to one's maximum potential with a chronic impairment and its resultant functional disability. Rehabilitation nursing is based on a philosophy that each person has a unique set of strengths and abilities that can enable that person to live with dignity, self-worth, and independence. Nursing care to promote rehabilitation primarily focuses on clients with chronic illnesses or impairments. Rehabilitation most often begins in the acute phase of an illness or injury.

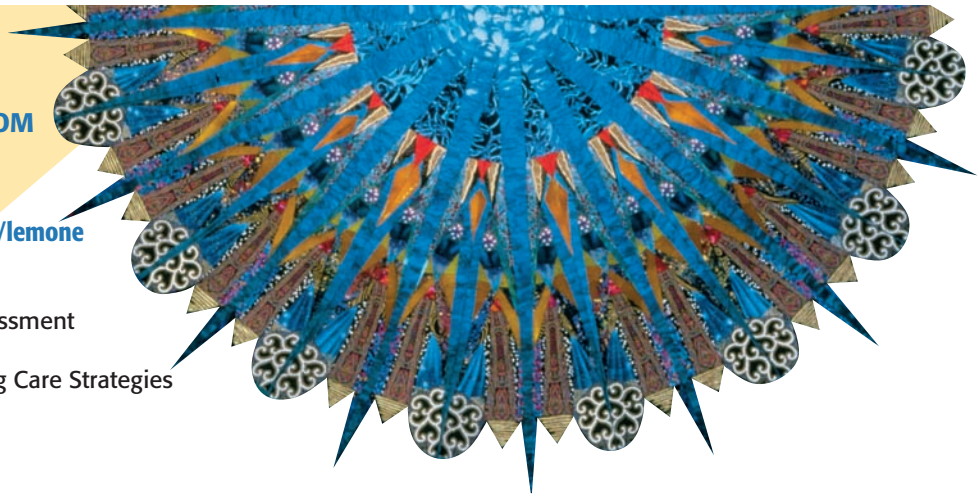
The terms *impairment, disability,* and *handicap* are often used as synonyms, but they have different meanings. An **impairment** is a disturbance in structure or function resulting from physiologic or psychologic abnormalities. A **disability** is the degree of observable and measurable impairment. A **handicap** is the total adjustment to disability that limits functioning at a normal level (Stanhope & Lancaster, 2006). For example, following a motorcycle accident, a client had damage to her left leg that resulted in an impairment in the ability to flex her knee. This resulted in a 50% disability of that leg and caused a handicap, because the client was a school bus driver and could no longer operate the bus safely.

Rehabilitation promotes reintegration into the client's family and community through a team approach. Many different aspects of the client's life are included in the plan of care, including physical function, mental health, interpersonal relationships, social interactions, family support, and vocational status. This comprehensive consideration of the client requires the expertise of a team of healthcare providers, who usually meet weekly to discuss the achievement of client goals.

Assessment of the client and family includes functional health level and self-care abilities, educational needs, psychosocial needs, and the home environment. It is critical to determine the priorities of needs from the client and family perspective before establishing any plan of care. The nurse assesses the client's level of physical function, goals, concerns, stage of loss, home environment, and available resources.

Interventions to facilitate rehabilitation are revised to meet client and family needs as the client progresses toward reintegration. In general, interventions are planned and implemented to prevent complications, assist in achieving a realistic level of independence, educate the client and family about home care, and make referrals to community agencies (for nursing care, special equipment or supplies, support groups, counseling, physical therapy, occupational therapy, respiratory therapy, vocational guidance, house cleaning, meals).

EXPLORE MEDIALINK



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Audio Glossary
NCLEX-RN® Review
Care Plan Activity: Home Health Assessment
Case Study: Safety in the Home
MediaLink Application: Home Nursing Care Strategies
Links to Resources

CHAPTER HIGHLIGHTS

- In contrast to community health, which focuses on the health of a population, community-based care focuses on individual and family healthcare needs. Services are provided in many different settings and by various programs, including community centers and clinics, day care programs, parish nursing, and Meals-on-Wheels.

- Factors affecting health in the community include social support systems, community healthcare structures, the environment, and economic resources.
- Home care is defined as services for people who are recovering, disabled, or chronically ill and who are in need of treatment or support to function effectively in the home environment.
- Two special components of home care are hospice care and respite care.
- The home care system includes agencies, clients, referral sources, physicians, reimbursement sources, and legal considerations.
- The roles of the home care nurse include advocate, provider of direct care, educator, and coordinator of services.
- Nursing interventions to ensure competent care include those used to establish trust and rapport, proceed slowly, set goals and boundaries, assess the home environment, set priorities, promote learning, limit distractions, put safety first, and control infection.
- Rehabilitation is the process of learning to live to one's maximum potential with a chronic health impairment and its resultant disability.

TEST YOURSELF NCLEX-RN® REVIEW

1 What is the focus of community-based nursing care?
   1. the function of the community
   2. the health of the community
   3. individual and family health
   4. older adult needs and services

2 One way in which urban and rural residents may differ is:
   1. access to healthcare services.
   2. age and gender of residents.
   3. family tasks and values.
   4. ability to follow directions.

3 What is the name given to nursing care provided by a faith community to promote health and healing?
   1. respite care
   2. parish nursing
   3. block nursing
   4. day care

4 Which of the following services helps relieve the stress of full-time caregiving?
   1. parish nursing
   2. block nursing
   3. day care
   4. respite care

5 Home health care provides care to clients with a wide variety of healthcare needs. Which of the following clients would benefit from home care? (Select all that apply.)
   1. Mrs. Jones, age 78, has broken her hip and cannot live independently at home.
   2. Miss Ace, age 18, has had surgery for an infected appendix.
   3. Mr. Strip, age 52, has a terminal illness and wants to die at home.
   4. Miss Taylor, age 35, living alone, has had major abdominal surgery.
   5. Mr. Wines, age 80, has some weakness from arthritis.

6 While making the first home health visit, the nurse discusses advance directives, living wills, and durable power of attorney for health care. These topics are part of which nursing role?
   1. provider of direct care
   2. coordinator of services
   3. educator
   4. advocate

7 Which of the following home health agency personnel is responsible for care coordination?
   1. physician
   2. social worker
   3. home health aide
   4. registered nurse

8 What agency is the largest single reimbursement source for home care?
   1. Medicare
   2. Medicaid
   3. private insurance
   4. self-pay

9 Nurses practicing in the home provide teaching for a variety of topics. Which of the following teaching areas is essential to maintaining infection control?
   1. fire and smoke detectors
   2. hand washing
   3. uncluttered floors and stairs
   4. medications

10 What element of home care is a requirement of reimbursement?
   1. family member approval
   2. completion of agency forms
   3. physician's order
   4. treatment plan

See Test Yourself answers in Appendix C.

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UNIT 1 BUILDING CLINICAL COMPETENCE
Dimensions of Medical-Surgical Nursing

FUNCTIONAL HEALTH PATTERN: Health Perception-Health Management

Think about clients with altered health perception or health management for whom you have cared in your clinical experiences.

- What were the clients' major medical diagnoses (e.g., hypertension, diabetes mellitus, cancer, chronic obstructive pulmonary disease, stroke, or alcoholism)?
- What manifestations did each of these clients have? Were these manifestations similar or different?
- How did the clients' healthcare behaviors interfere with their health status? Did they have yearly physical examinations and routine eye examinations? Did they obtain recommended immunizations? Did they use preventive measures, such as conducting breast or testicular self-examinations, applying sunscreen, following dietary recommendations, decreasing alcohol intake, stopping smoking, beginning to exercise regularly, practicing safer sex, using stress reduction activities? Did they achieve developmental tasks appropriate for their age? Did they interact well with family and friends?

The Health Perception-Health Management Pattern includes healthcare behaviors, such as health promotion and illness prevention activities, medical treatments, and follow-up care. Individuals are at different locations on the illness–wellness continuum at specific points in time. Health perception and health maintenance are affected by factors that influence the individual's health status or level of wellness in two primary ways:

- Factors affecting health that may be altered to prevent disease processes are diet (e.g., osteoporosis), substance abuse (e.g., alcoholism), smoking (e.g., chronic obstructive pulmonary disease, lung cancer), socioeconomic status (e.g., communicable disease, violence or abuse), or occupational exposure (e.g., pulmonary disease due to asbestos, tuberculosis).
- Factors affecting health that cannot be altered and may result in disease processes are genetics (e.g., sickle cell disease, hemophilia), age (e.g., type 2 diabetes mellitus, myocardial infarction), or race (e.g., hypertension).

A client's perceived pattern of health and well-being affects how health is managed. Improper health management affects the body's ability to maintain homeostasis, leading to manifestations such as:

- Vomiting (caused by a variety of factors, including ingestion of chemicals, toxic materials, or infectious materials; chronic liver or kidney disease, and allergic responses to medications)
- Bleeding (as from trauma or decreased platelets or deficient clotting factors ▶ resulting in the delay of activation or inability to activate the clotting pathway ▶ causing loss or leakage of blood)
- Pain (resulting from many physical factors, including trauma, edema, and changes in pH or inflammatory changes ▶ which may cause tissue damage that stimulates pain receptors ▶ which transmit pain impulses to the brain).

Priority nursing diagnoses within the Health Perception-Health Management functional health pattern that may be appropriate for clients include:

- *Health-Seeking Behaviors* as evidenced by making dietary changes as prescribed, decreasing alcohol intake, stopping smoking, and joining a health club to participate in an exercise program
- *Deficient Knowledge: Healthy Behaviors* as evidenced by lack of interest in learning about health care, inability to understand healthcare teaching (developmental level), and misinterpretation of healthcare teaching completed
- *Ineffective Health Maintenance* as evidenced by smoking, drinking alcohol or other substance abuse, sedentary lifestyle, and not seeking routine health care
- *Risk for Injury* related to poor hygiene habits, self-treatment of illnesses, not taking prescribed medications, and participating in risk-taking behaviors.

Two nursing diagnoses from other functional health patterns often are of high priority for the client with deficits in Health Perception-Health Management:

- *Self-Care Deficit* (Activity/Exercise)
- *Situational Low Self-Esteem* (Self-Perception/Self-Concept)

Directions: Read the clinical scenario below and answer the questions that follow. To complete this exercise successfully, you will use not only knowledge of the content in this unit, but also principles related to setting priorities and maintaining client safety.

CLINICAL SCENARIO

You have been assigned to work with the following home healthcare clients on the day shift. Significant data obtained during report are as follows:

- Mrs. Cora Clark is a 76-year-old woman with a prolapsed uterus. She uses a pessary to keep her uterus in place but the pessary fell out last night. You will need to replace it today because her uterus is prolapsing without it in place.
- Tom Smith is a 19-year-old man who is at home due to osteomyelitis in the left leg from a previous leg fracture obtained in a motorcycle–motor vehicle crash. You need to change his left leg dressing and administer IV vancomycin (Vancocin), which is to be given every 12 hours.
- Marguerite Garcia is an 86-year-old Hispanic woman who has hypertension, type 2 diabetes mellitus, and congestive heart failure. She is to have her blood pressure taken and a glucometer check done for her blood sugar level. You will need to make sure she is taking her prescribed medications and set up her medications for the week.
- Sebastian Huian is a 56-year-old Asian man who had a stroke that left him with left-sided weakness and some speech difficulties. He speaks little English. He is being discharged from the rehabilitation unit this morning. You will be doing an intake at the first home health visit to determine what his needs will be and how much assistance he will need from home health.

Questions

1 In what order would you visit these clients after report?

1. _____
2. _____
3. _____
4. _____

2 What top two priority nursing diagnoses would you choose for each of the clients presented above? Can you explain, if asked, the rationale for your choices?

	Priority Nursing Diagnosis #1	Priority Nursing Diagnosis #2
Cora Clark		
Tom Smith		
Marguerite Garcia		
Sebastian Huian		

3 The priority nursing diagnosis for Mrs. Clark is:

1. *Risk for Infection*
2. *Self-Care Deficit*
3. *Anxiety*
4. *Disturbed Body Image*

4 Mrs. Garcia understands the preventive teaching done by the nurse when she states:

1. "I will take my antihypertensive medication on a daily basis."
2. "I will walk on the days the weather is warm and dry."
3. "I will keep my doctor's appointments as scheduled."
4. "I will check my blood sugar every other day."

5 The nurse explains a diet of low-sodium foods to Mrs. Garcia. She understands this diet when she picks which meal plan?

1. Spanish rice with canned tomatoes, peppers, and onions
2. tacos with ground beef, lettuce, tomatoes, and salsa
3. burritos with beans, meat, and cheese
4. fajitas with lean beef, peppers, tomatoes, onions

6 What role is the nurse demonstrating when performing the home health intake evaluation on Mr. Huian?

1. educator
2. caregiver
3. advocate
4. manager

7 The tertiary level of prevention focuses on stopping the disease process and returning the affected client to a useful place in society. Which is an example of a tertiary level of prevention for Mr. Huian?

1. eating a nutritious diet to promote healing and gain more strength
2. having screenings for other disease processes, such as hypertension
3. enrolling in a work training program for individuals with extremity weakness
4. eliminating the use of tobacco and alcohol

8 Nursing interventions to ensure competent home care for Mr. Huian include: (Select all that apply.)

1. establish trust and rapport
2. have his 14-year-old son translate for him
3. assess the home environment for safety
4. discuss having family members feed him due to his left arm weakness
5. set goals for home health care and rehabilitation

9 Changing Tom Smith's dressing and administering the IV antibiotics demonstrates which part of the nursing process?

1. assessment
2. planning
3. implementation
4. evaluation

10 Tom Smith's family will be involved in planning and implementing his nursing care. What is the most important information to consider when assessing the family and developing a plan of care for him?

1. family interactions that are cohesive, communicative, and support self-care
2. family member roles and developmental stages and tasks
3. number of friends or relatives who will be available to assist
4. family's ability to adapt to change and ability to perform tasks

11 A client with a terminal illness has advanced directives stating no procedures or feedings for end-of-life care. On rounds, you find a nurse giving the client a tube feeding. What interventions should you carry out first?

1. Notify the supervisor and the physician about the nurse feeding the client.
2. Notify the family to change the advance directive.
3. Talk to the nurse about the client's advance directives and discuss why the nurse is feeding the client.
4. Ignore that you saw the nurse feeding the client and continue with your client care.

12 The nursing process is a reference system for improving clinical practice and evaluating quality of nursing care. Benefits for the client receiving nursing care are that the client: (Select all that apply.)

1. receives planned, individualized interventions.
2. is ensured continuity of care.
3. does not need to participate in the process.
4. has increased satisfaction in care.
5. is ensured quality of care.

CASE STUDY

Betty Jo Moore is a 20-year-old woman who is admitted to the women's health unit for treatment of lower abdominal pain, chills, and foul-smelling vaginal discharge. During the admission assessment she states that she is unmarried and has been sexually active for the past three years with multiple sexual partners. Vital signs are T 100.4°F, P 92, R 22, BP 118/76. Lab studies drawn in the emergency department indicate a WBC count of 25,000 mm^3, an erythrocyte sedimentation rate of 22 mm/h, and a positive C-reactive protein. She is to begin antibiotic therapy and needs education about safer sex practices.

Ms. Moore is diagnosed with pelvic inflammatory disease. The pathophysiology of pelvic inflammatory disease is as follows: pathogenic microorganisms enter the vagina during intercourse or other sexual activity and alter the cervical mucosa, allowing the microorganisms to travel to the uterus, the fallopian tubes, and the ovaries. Multiplication of the microorganisms results in infection and possibly abscess formation. Manifestations of pelvic inflammatory disease include fever, chills, purulent vaginal discharge, vaginal bleeding, severe lower abdominal pain, pain on movement of the cervix, and dysuria. Complications that can occur from pelvic inflammatory disease are pelvic abscess, infertility, ectopic pregnancy, chronic pelvic pain, pelvic adhesions, and dyspareunia. Based on Ms. Moore's medical diagnosis and treatment plan, *Deficient Knowledge: Safer Sex* is identified as the priority nursing diagnosis at this time.